Ending the HIV Epidemic

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

- Alameda
- Orange
- Riverside
- Sacramento
- San Bernardino
- San Diego

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

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Executive Summary

Background

The California Consortium consists of six of the eight Phase I counties designated in California as part of the Ending the HIV Epidemic in America (EtHE) initiative: Alameda, Orange, Riverside, Sacramento, San Bernardino, and San Diego. The Centers for Disease Control and Prevention (CDC) awarded PS19-1906 funds to coordinate and monitor the California Consortium. The funding was insufficient to provide the addition of support staff to each county, therefore, OA hired Facente Consulting to assist each of the counties in the development of the EtHE Plan. The six counties are in various geographic regions and have differing prevention needs for their distinct populations. Therefore, the California Consortium EtHE Plan is designed with a specific plan for each county, and a chapter on the role of OA.

The CDPH OA is guided by its 2016 Integrated HIV Surveillance, Prevention and Care plan that concludes at the end of 2021. The EtHE California Consortium Plan will provide the six Phase I counties with new plans that will guide them through 2025. OA is developing a new "Ending the Epidemics Strategic Plan," that will respond to the syndemic of HIV, STDs and HCV and influence prevention, care and surveillance for all counties in California through 2025. OA will also assist in implementing Phase II of the federal EtHE initiative.

Between the Integrated Plan and the development of the EtHE Plans, a set of common goals will be operationalized.

1. Identify individuals living with HIV that have not been diagnosed and link them to HIV care.
2. Ensure all people living with HIV have access to HIV Care, ART, and the ability to maintain viral suppression at undetectable levels.
3. Increase the proportion of PrEP eligible individuals prescribed PrEP and assist in ensuring adherence for most effective protection.
4. Identify the most impactful social determinants of health that create barriers to successfully reaching these goals and work with community partners to eliminate those barriers.

The outbreak of the Covid-19 viral pandemic pulled resources at the county and state level. The pandemic was most disruptive to community engagement activities as in-person community engagement forums became restricted. Despite the challenges, the counties and state were agile and quickly adapted to the use of telecommunications to proceed in creating the plan. A set of alternative community engagement approaches have been developed to ensure those with limited or no access to the internet or cell phone service could also provide input. Community members participated by completing surveys and through teleconferences with HIV medical and service providers, who continue to provide needed services despite the pandemic. Once this pandemic is behind us, the new normal will sustain some of the adaptations that have been effectively and favorably adopted.

Community Engagement

In collaboration with OA and Facente Consulting, each county was able to host at least one community forum prior to the COVID-19 pandemic. Since the outbreak, the community contributed to the plan through teleconferences, key informant interviews, and surveys. Feedback from community engagement activities that were originally conducted for similar projects were also utilized. Several engagement activities were conducted using Spanish translation, along with some mono-lingual Spanish events. Although the populations vary between counties, members from all of the priority communities were successfully engaged in the formation of the plans. A combined list of priority populations is listed below.

- Black/African American Women
- Hispanic/Latinx
- Transgender women
- Young Gay/MSM of color
- Black/African American Gay/MSM
- Hispanic/Latinx Gay/MSM
- People who inject drugs
- People experiencing homelessness
- PrEP Eligible individuals

California Consortium Plan to End the Epidemic

Pillar 1 Activities: Diagnose

Planned testing activities include targeted testing of priority populations, distributing home self-collection tests, increasing testing through Partner Services, expanding Routine Opt-Out Testing, and bundling HIV testing with STI screening and Hepatitis C testing. Linkage to HIV Care and Rapid ART for those who receive an HIV diagnosis is a critical element to transition from Diagnosis to Treat. Likewise, linkage to PrEP services for those who test negative for HIV but are PrEP eligible is an important link between Diagnosis and Prevention.

Pillar 2 Activities: Treat

Rapid Linkage to Care and ART is a critical activity. Staffing will be expanded to follow up on individuals identified as out of care through the Data to Care program. Non-Ryan White providers will be offered assistance with retention and reengagement of clients, as well as services for non-virally suppressed individuals. Community education about Rapid ART, viral suppression, and Undetectable equals Untransmittable will assist in realizing the value of ongoing HIV medical care. Addressing social determinants of health is critical to ensuring that treatment is effective and respectful of individuals.

Pillar 3 Activities: Prevent

Expansion of PrEP among priority populations will be aided by additional provider sites and promotion of the OA PrEP Assistance Program (PrEP AP) that will remove a fiscal barrier for many. Agencies will collaborate with pharmacies dispensing PrEP and PEP to ensure individuals are linked to a provider for ongoing PrEP services. Coordinating with the Ready Set PrEP initiative will reduce redundancy while expanding PrEP access. Effective interventions are planned for those not choosing PrEP.

Pillar 4 Activities: Respond

Counties will enhance their partner services and CDPH OA will lead Molecular Cluster identification. OA will collaborate with the county(ies) in outbreak response. If counties identify or suspect a cluster, they will work with OA to verify and develop the response plan. If cluster investigation exceeds the capacity of the county, the OA Disease Outbreak Intervention and Field Investigation Unit will assist. For significant outbreaks, the CDPH Office of Emergency Preparedness will activate its emergency response protocol.

Workforce Development

In response to input from community engagement events, peers will be employed in various conventional and innovative settings to support people with new HIV diagnoses, assist individuals in navigating the medical system, and providing support to those using PrEP. Several counties plan to increase their expertise and cultural competency by hiring community members with lived experience. The EtHE plans also propose additional education and training of PLWH and PrEP eligible individuals with the goal of increasing consumer participation in the planning and monitoring of the interventions and increasing advocacy within priority populations. Human resource policies and standards are being reviewed to remove barriers for individuals whose skills are based on experience rather than formal education. All counties will continue to be informed of webinars, workshops and trainings to expand the knowledge and skills of the workforce.

Strategies

The EtHE plan expands and enhances existing HIV programming. Coordination with EtHE HRSA initiatives for Care and Federally Qualified Health Centers will avoid duplication of services and create synergy between the various funding sources and activities. Explicit descriptions of planned strategies are described in Section IV: Ending the Epidemic Plan in each of the county chapters. The participation of all counties in monthly meetings will provide opportunities for peer skill-sharing as well as discussions of challenges and best practices. The OA EtHE Team will be in regular communication with the counties and will respond to requests for technical and capacity building assistance. Data will be reviewed and presented to the California Consortium at least semi-annually. Lastly, providing ongoing opportunities for community input will allow The Consortium to provide, monitor, and modify interventions as needed, and to ensure the success of the EtHE plan.

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California Department of Public Health, Office of AIDS

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Introduction

This chapter describes the oversight role and activities the California Department of Public Health (CDPH), Office of AIDS (OA) will administer for the implementation of the Ending the HIV Epidemic in America (EtHE) federal initiative, CDC Prevention Grant PS20-2010. Six counties, including, Alameda, Orange, Riverside, Sacramento, San Bernardino and San Diego were assigned to CDPH as phase 1 communities. Known collectively as the 'California Consortium', These counties were tasked with designing an innovative plan to achieve the goal of decreasing new infections by 75 percent. This plan was created by the five Part A Planning Councils (Riverside and San Bernardino are considered one joint Transitional Grant Area), selected staff from each county, and through extensive community input and engagement. These same essential contributors, and more, will need to regularly monitor and direct modifications of the EtHE activities throughout the grant period to ensure effectiveness and community acceptance of the activities.

Over the next five years, the California Consortium will work in unison to decrease the number of people living with HIV (PLWH) who are unaware of their diagnosis, establish rapid anti-retroviral therapy (ART) initiation as the norm, and increase patient navigation from the site of HIV diagnosis to where they are securely settled into HIV medical care. This will take support services that are culturally competent, responsive, and client-focused. It will require addressing social determinants of health, providing trauma-informed care, and utilizing a strength-based approach. Expansion of Routine Opt-Out Testing (ROOT) will continue throughout the duration of the initiative in collaboration with the California Pacific AIDS Education and Training Center (CA PAETC), partnerships with larger healthcare systems, and with professional groups such as the California Primary Care Association, California Board of Nursing, EMS Medical Directors Association of California, and other healthcare professional organizations. Coordination between the California Consortium and the recipients of HRSA 20-078 and HRSA 20-091 will enhance ROOT, improve linkage to care and to Pre-exposure Prophylaxis (PrEP), and increase same-day medical appointments and rapid ART initiation for those who are newly diagnosed with HIV. Activities to increase retention in care will be expanded by reducing barriers to care such as lack of transportation, childcare, and evening/weekend hours. The use of surveillance data and collaboration between medical clinics and community-based organization staff will also increase retention in care by allowing staff to follow and reach people who have missed appointments before they fall out of care. Increasing understanding of treatment as prevention (TaSP) and Undetectable Equals Untransmittable (U=U) will help PLWH, people at risk of HIV infection, and the general community to recognize the benefits of helping every PLWH to achieve and sustain viral suppression. The anticipated outcome is that PLWH will engage in and maintain HIV medical care and utilize ART on an ongoing basis, resulting in sustained viral suppression and optimal health. Lower HIV incidence will result from increased viral suppression.

In order to reduce new HIV infections, it is also vital to increase PrEP use among PrEP-eligible individuals. The plan includes an expansion of the capacity of health care providers, HIV and STD testing sites, and community-based organizations. It is also crucial to assess PrEP eligibility, link PrEP-eligible candidates to PrEP providers, and enroll eligible individuals in the California PrEP Assistance Program, Ready, Set, PrEP, and other patient assistance programs.

The California legislature has passed SB 159, allowing pharmacists to dispense between 30 and 60 days of PrEP or post-exposure prophylaxis (PEP) beginning July 1, 2020. The California Consortium will work with pharmacies to link their PrEP and PEP users to a PrEP provider for ongoing care and monitoring, as well as to offer prevention education to those who do not refill their prescription. Increasing social marketing about PrEP and PEP, especially addressing the communities that have yet been effectively reached with this biomedical prevention tool, such as Black and Hispanic/Latinx gay/men who have sex with men (Gay/MSM), the transgender community, and women. All these activities are crucial to increase the number of PrEP-eligible individuals using this highly effective prevention method. Barriers to adherence and ongoing use of PrEP will also be addressed to maximize the benefits for the individual and the community.

Current State of HIV in California

Epidemiologic Summary[i]

The information presented is based on HIV surveillance data reported to the OA through January 6, 2020, allowing for a minimum 12-month reporting delay. Persons are presumed to reside in California if the most recent available address is located in the state.

- From 2014 through 2018, both the annual number and rate of new HIV diagnoses declined in California. The number of new diagnoses declined by 9.6 percent — from 5,249 in 2014 to 4,747 in 2018, while the rate of new diagnoses per 100,000 population declined by 11.9 percent, from 13.5 to 11.9 during the same time period.
- From 2014 through 2018, the number of persons in California living with diagnosed HIV infection increased from approximately 126,372 to over 136,000. In 2018, the prevalence of diagnosed HIV infection was 342.9 per 100,000 population, compared to 326.1 in 2014—an increase of 5.2 percent.
- Of the 136,566 people living with diagnosed HIV infection in 2018, 73.8 percent were in HIV care and 64.2 percent achieved viral suppression. California's Integrated Plan objectives are to increase the percentage of Californians with diagnosed HIV infection who are in HIV medical care to at least 90 percent and increase viral suppression to 80 percent by 2021.
- From 2014 through 2018, the annual number of deaths of persons with diagnosed HIV infection in California increased from 1,774 to 1,872. In 2018, the crude death rate of persons with diagnosed HIV infection was 4.7 per 100,000 population—a 2.2 percent increase since 2014. Data on deaths of persons with diagnosed HIV infection represent all causes of death and may or may not be related to HIV infection.

Health Disparities

Statewide, an estimated 13 percent of people living with HIV in 2018 were unaware of their infection. Youth (aged 13-24) were the most likely to be living with undiagnosed HIV of any age group, with an estimated 45.3 percent unaware of their infection.

Blacks/African Americans are the most disproportionately affected by HIV with rates 4.1 times higher than Whites among men and 8.6 times higher among women. Hispanic/Latinx persons

are also disproportionately affected by HIV, with rates of new HIV diagnoses 1.8 times higher than Whites among men and 1.6 times higher among women. Compared to women, men are disproportionately affected by HIV.

Although rates for the transgender community are not calculated statewide due to lack of availability of population denominators, national estimates indicate 14.1 percent of transgender women are living with HIV. Black/African American and Hispanic/Latinx transgender women are at increased risk of contracting HIV.

Among cisgender women, the rate of new HIV diagnoses declined or remained stable since 2010 across all race/ethnicity groups. New HIV diagnosis rates among Black/African American women decreased 17 percent, from 17.8 per 100,000 in 2010 to 14.7 per 100,000 in 2018. Yet, HIV disparities between Blacks/African Americans and Whites remain substantial, and the inequities are more stark for women than for men.

From 2010 to 2018, the rates of new HIV diagnoses among all age groups have declined, except for 25-34 year olds. The 25-34 age group had the highest rates of new HIV diagnoses, which increased by twelve percent since 2010. The rate in the 44-55 age group decreased the most since 2010, at 32 percent.

Among 13-24 year olds, Blacks/African Americans have significantly higher rates of new HIV diagnoses than any other racial/ethnic group. Although the rate among newly diagnosed Black/African American 13-24 year olds has declined by almost 13 percent since 2010, the rate in 2018 was 6.0 times higher than White 13-24 year olds. The rate among 13-24 year old Asians had the highest increase since 2010, at 21 percent.

California's Getting to Zero objectives include linking 85 percent of newly diagnosed persons to care within one month and increasing the percentage who achieve viral suppression within six months of HIV diagnosis to 75 percent by 2021. In 2018, linkage to care within one month of diagnosis was similar across transmission categories, but viral suppression within six months varied widely. Statewide, the overall viral suppression rate for newly diagnosed in 2018 was 63.5 percent. The lowest viral suppression was among people with transmission via injection drug use, especially women who inject drugs (49.3 percent), and the highest was among injectors with male-to-male sexual contact (66.5 percent).

Linkage to care within one month of diagnosis was similar among Black/African American, Hispanic/Latinx, and White women, ranging from 72 to 75 percent, while Asians had the highest linkage to care within one month at 80.8 percent. In contrast, viral suppression varied, with Black/African American and White women having the lowest viral suppression within six months of diagnosis at 55.9 and 56.3 percent, respectively. Asian women achieved the highest viral suppression within six months of diagnosis at 76.9 percent.

Compared with cisgender men and women, transgender women had the highest linkage to care within one month of HIV diagnosis (82.2 percent) and achieved the highest viral suppression within six months of HIV diagnosis (73.8 percent).

Hispanic/Latinx and Black/African American heterosexual men have low rates of linkage to care within one month and low rates of viral suppression within six months of diagnosis, while White heterosexual men have the best health outcomes.

Cis-women whose transmission was attributed to heterosexual contact had significantly better viral suppression than those whose transmission was via injection drug use, despite similar rates of linkage to care. Overall, health outcomes for heterosexual women are better than the statewide average and better than those of their male heterosexual counterparts.

The only way to achieve California's Getting to Zero objectives is by ensuring that effective HIV prevention and treatment reaches all communities, especially those disproportionately affected by HIV. It is also important to consider all factors that contribute to health disparities, including structural factors and social determinants of health such as racism, poverty, stigma, access to care, and education. Efforts should focus on reducing and ultimately eliminating disparities among the populations most impacted by HIV, especially Blacks/African Americans. Since Hispanic/Latinx persons are quickly becoming the largest proportion of PLWH, it is important to offer education and services that are culturally and linguistically appropriate. Both individual-level and structural interventions are necessary to reduce HIV transmission and eliminate health inequities.

Current HIV-Related Efforts and Infrastructure

The Office of AIDS has 175 employees, working in seven branches: Division-level, HIV Care Branch, HIV Prevention Branch, Surveillance and Prevention Evaluation and Reporting Branch, AIDS Drug Assistance Program (ADAP) Branch, and the ADAP and Care Evaluation and Informatics Branch, and Office of AIDS Support Branch (See Organizational Chart, Appendix 1). The office is part of the Center for Infectious Diseases (CID), which includes the STD Control Branch, with whom the OA collaborates on an ongoing basis. CID, which has the lead responsibility within CDPH to respond to epidemics and pandemics, has been tirelessly responding to COVID-19, reassigning a significant portion of its workforce to COVID-19 activities, including staff from OA. This has strained the resources and slowed progress in day to day operations on other health conditions. OA continues to maintain its essential functions and is assisting the Phase I counties to adjust their efforts to continue responding to HIV as they also respond to COVID-19.

The EtHE PS20-2010 funding expands the CDPH OA portfolio of funding, which includes HRSA Ryan White Part B funds administered and distributed to the 61 local health jurisdictions (LHJs), HOPWA funds to house some of the currently homeless and unstably housed, and CDC 18-1802 funding distributed to the 20 LHJs with the highest HIV prevalence of HIV (excluding Los Angeles and San Francisco, which receive CDC funding directly). These 20 LHJs comprise over 90 percent of PLWH in California, including the six Phase I counties but excluding Los Angeles and San Francisco. Additional funds support the Syringe Services Clearing House and prevention initiatives such as Project Empowerment, which reaches Black/African American and Hispanic/Latinx gay/MSM.

OA has an EtHE Program Manager dedicated to managing the EtHE initiative and who joins OA leadership in coordinating the OA's funded programs to ensure the broadest reach, avoid duplication, and ensure OA is nimble and responsive to current trends in PrEP uptake, new infections, and rates of viral suppression.

Local Prevention and Care Integrated Planning Bodies

The OA EtHE Program Manager is the liaison between OA and the six Phase I counties that constitute the California Consortium. The EtHE Team also includes a Research Scientist II and a Health Program Specialist. The California Consortium has only five Part A planning bodies because Riverside and San Bernardino constitute the Inland Empire TGA. The OA Ending the Epidemic staff have worked closely with each of the planning bodies from the commencement of PS19-1906, briefing them on the goals and requirements at the beginning of the grant period, soliciting input and advice in the initial stage of plan development, providing progress reports throughout the formative phase, and sharing iterative drafts of the plans. OA staff presented a summary of the plans prior to seeking concurrence from each of the planning councils and responded to questions, inquiries, and suggestions throughout the PS19-1906 grant period. These relationships will continue throughout PS20-2010, starting with presentations at each planning council summarizing the final plans developed and describing the first steps to initiate the interventions. Planning council members will be encouraged to assist in developing and conducting ongoing community engagement activities, and OA will provide semi-annual progress updates, which will include evaluation data and the solicitation of feedback and input from the planning councils.

California Consortium PS20-2010 Community Advisory Board

Each county will use their Part A Planning Council as their Community Advisory Board specifically to monitor and advise the California Consortium on the implementation of PS20-2010. The State Ending the Epidemic team will consult with representatives from HRSA 20-078 and HRSA 20-091 funded agencies, and a set of NIH, PACE, CA PAETC and CA PTC staff members. This list is not final and it will be adjusted to add additional voices throughout the process.

Local Partners

OA is supporting each of the Phase I counties to engage a broad set of local partners, including current as well as new partners who have not been part of the response to HIV in the past. Support offered includes co-hosting community engagement activities, monitoring the variety of partners and providing assistance in seeking out additional partners. OA will also coordinate communication between CDC PS20-2010 and HRSA 20-078 and 20-091 funded entities throughout California. OA is also reaching out to other professional and medical coalitions, such as the California Primary Care Association, EMS Medical Directors Association of California, California State Board of Pharmacy, and California Consortium for Urban Indian Health. Lastly, presentations to traditional local Social Services providers will be offered, with the assistance of advocates and consumers from each of the Phase I counties, to increase competence of all providers serving PLWH.

California's Plan to End the HIV Epidemic

The federal EtHE initiative has provided California a guide to begin to transition from its 2016 Integrated HIV Surveillance, Prevention and Care plan to the next step: a statewide Ending the Epidemics Strategic Plan. The plan produced with CDC PS19-1906 funds is one action the OA

will take to advance its goal of Getting to Zero. The CDC PS20-2010 funds will increase California's surveillance, prevention, and care activities in the highest prevalent areas, where more than 80 percent of California's PLWH reside. The second activity that will help California to get to zero is a new statewide Ending the Epidemics Strategic plan to ensure all counties have specific goals similar to those in the PS19-1906 plan. In the transition from the 2016 Integrated Plan, the indicators selected for the 2016 Integrated Plan are still being monitored, and they closely align with the new indicators reflected in the America's HIV Epidemic Analysis Dashboard (AHEAD).

In addition to the PS19-1906 EtHE initiative, staff at OA, the STD Control Branch, and community stakeholders are developing a statewide Ending the Epidemics Strategic Plan (ETE plan) that will address the syndemic of HIV, STDs and HCV. There are a common set of communities impacted significantly by HIV, STDs, and HCV. There are also similar behavioral acquisition, disparities, and social determinants of health impacting transmission of these infectious diseases. At the start of the AIDS epidemic, treating HIV distinctly was critical due to the discrimination, fear, and social consequences of being known to be living with HIV. Harsher morbidities often created physical conditions that were easily presumed to be related to AIDS. But continuing with "HIV exceptionalism" misses the opportunity to identify co-infections and promote sexual health using a comprehensive approach. Advances in laboratory testing enable testing for all three infections through simple, efficient, and accurate methods. To promote comprehensive sexual health, attending to this "family of infections" is necessary, including both the biological/medical and social aspects driving the syndemic.

The diversion of staff to respond to the COVID-19 pandemic has slowed progress toward developing the ETE Plan. OA and the STD Control Branch realize the necessity of significant input from staff, providers, consumers, and other stakeholders. Community input gathered through PS19-1906 and PS20-2010 implementation will be used in the development of the ETE Strategic Plan. However, more participation is needed from non-Phase I jurisdictions, and voices speaking to STDs and HCV are essential as well. In the interim, greater attentiveness to inclusion of comprehensive sexual health, sexual screening, education, prevention, and treatment is evolving throughout OA and the STD Control Branch. Operationally, the shift to address HIV, STDs and HCV simultaneously is underway.

Social Determinants of Health

Throughout the gathering of community input for this report, participants consistently described the social determinants of health (SDoH) that contribute to the challenges of people living with and at risk for HIV. OA stakeholders also identify SDoH that are critical to address, and evidence suggests that these SDoH cut across HIV, STDs, and HCV, creating a strong rationale for responding to the syndemic rather than HIV alone. In addition, throughout CDPH, there is an increased appreciation of SDoH and the fact that they contribute to health inequities. As work to eliminate health disparities increases, SDoH will remain a primary focus.

The CDC PS20-2010 plan will address SDoH elements identified in the formative phase that have been integrated into county plans. These include, but are not limited to, poverty, a lack of affordable housing, addressing transportation needs, childcare, alternative hours for service provision, mobile services, culturally competent services including services provided to monolingual Spanish speakers. In OA's monitoring and evaluation, SDoH will be consistently assessed.

Office of AIDS CDC20-2010 Response to the EtHE Pillars

The OA has multiple roles in responding to the four EtHE pillars: diagnose, treat, prevent, respond. All activities and interventions the OA oversees are directly tied to one or more of the pillars. For CDC PS20-2010, OA EtHE staff will ensure each county is executing comprehensive programming addressing all pillars of the EtHE initiative. In addition, OA has a lead role in the Response Pillar, as described below.

Diagnose

The OA has vital roles in ensuring people are diagnosed as early as possible. Through its oversight of CDC PS18-1802 funding, monitoring of testing is ongoing to ensure that the venues conducting testing are serving those at high risk of HIV infection and/or yield acceptable rates of new diagnoses. In collaboration with the CA PAETC, expansion of ROOT is an ongoing activity. Within Project Empowerment, which targets Black and Hispanic/Latinx Gay/MSM, a primary objective is to ensure individuals know their HIV status. Individuals will also be guided and supported through testing via Partner Services. Partner Services is both an element of the diagnose and respond pillars. In addition, Ryan White funding also supports services for PLWH to refer partners or friends who may need an HIV test. COVID caused a significant increase in home- or self-testing, providing self-administered HIV tests for individuals. OA has initiated a pilot program of distributing self-collection tests through gay men's dating applications developed and maintained by Building Healthy Online Communities (BHOC). Men in any of the six Phase I counties who are on these selected sites can receive a test free of charge. BHOC collects initial data, and if men choose to participate in a post-test survey, additional information is gained. BHOC is disseminating data from the pilot program to each county as well as to the State. The pilot requires no action from the counties, an advantage as they are strained by COVID and the addition of the two additional EtHE Grants. Given the positive reception of self-collection, it is presumed most counties will continue to offer home- or self-collection as a testing option post-COVID. If STD screening can be added, the program will expand to include those tests. A shift in this method will occur if a self-collected dried blood spot test for HIV, Syphilis, and Hepatitis C becomes available, assuming it is affordable.

Treat

Increasing the number of newly diagnosed individuals who are rapidly linked to care is a strong focus of CDC PS18-1802 grantees. OA assists in the expansion of Routine Opt-Out Testing through technical assistance and referral to the CA PAETC. Technical assistance is being provided to expand same-day ART initiation. The prime objective of Ryan White care services is to ensure individuals are in HIV medical care and on ART. The Office of AIDS ADAP program is used to decrease barriers for those who are low income without insurance or have high insurance costs. All service providers contracted with OA are encouraged to ask clients about when their last clinical visit was and when their next appointment is scheduled. The OA Surveillance branch sends "Data to Care" lists to the LHJs monthly for follow up by LHJ surveillance and designated county staff. CA PAETC is trying to expand the number of general practice, family medicine, and other health care providers who treat HIV, now that specialty care is not needed as frequently and the UCSF HIV warm-line is available to assist physicians with questions or complex clinical needs.

Prevent

CDC PS18-1802 funding is distributed to the 20 funded LHJs that comprise over 90 percent of people living with HIV in California, excluding Los Angeles and San Francisco. Additional funds support the Syringe Services Clearing House, and prevention initiatives such as Project Empowerment, which is reaching Black/African American and Hispanic/Latinx gay/MSM. Treatment as Prevention (TaSP) and Undetectable equals Untransmittable (U=U) messaging is provided to PLWH, services providers, and the general community in order to increase understanding of the role viral suppression plays in prevention. Increasing the infrastructure to supply PrEP easily and readily to PrEP eligible persons is needed. The OA is cross-training ADAP enrollment workers to enroll in PrEP as well, and expanding the number of enrollment sites throughout the state. State legislation now allows pharmacists who complete a training to dispense up to 60 days of PrEP or PEP, and our ADAP system has been modified to temporarily enroll individuals who access PrEP or PEP through a pharmacy. CBO and ADAP staff follow up to complete the enrollment after the initial medications were dispensed. ADAP has also created systems for young adults (13 – 24) may not want to use their family insurance due to privacy concerns, as well as systems for adults who may not want other family members to see their use of PrEP documented on their insurance Explanation of Benefits. All these systems changes increase easy access to PrEP and PEP.

OA coordinates condom distribution and manages a syringe services clearinghouse, both providing essential prevention tools needed for comprehensive prevention programing.

Respond

The OA has a significant role in the Respond Pillar. Within the Prevention Branch, a new unit led by the OA's staff Disease Intervention Specialist (DIS) expert—the Disease Outbreak Intervention and Field Investigation (DOIFI) Unit—is designed to notify others who may have undiagnosed infections. The Unit will also be deployed to work on specific outbreaks when the number of individuals to be reached outweighs the capacity of local DIS. Partner services, which is a key prevention response, may be able to disrupt clusters before they grow to the need for cluster investigation.

OA will provide oversight in identifying potential molecular clusters, working closely with the LHJ Surveillance Coordinators throughout the state. OA has the capacity to identify clusters and will provide consultation when local health departments have reason to believe there may be a cluster within their county. Anecdotal reports from HIV test counselors, county DIS and local surveillance coordinators may identify atypical spikes in new infections, common individuals being named by multiple people during partner elicitation, or a set of individuals diagnosed with STDs reporting the same location/event where they suspect they contracted the infection.

When a cluster is confirmed, the State will work with the local Surveillance Coordinator(s) in the counties that have individuals identified in the cluster. The first line of response is provided by county staff, who will reach out to those identified in the cluster, conduct partner elicitation interviews, and follow up with named partners. If the capacity of the county(ies) is insufficient, the OA DOIFI unit will provide staff to join in the partner solicitation activities. Throughout each

investigation, OA will work with local Surveillance Coordinator(s) to enter data promptly so data analysis can be conducted in real time.

When a cluster is larger than the capacity of the OA, or when the circumstances are extraordinary, the OA medical director will inform the CDPH Emergency Preparedness Office that will consult with OA and the LHJ(s) and decide if they need to initiate an Emergency Response. Explicit protocols are defined in the Emergency Operations Response Plan https://cdph.sharepoint.com/SitePages/Emergency-Operations-Response-Plan.aspx. Training in Emergency Response is provided to all staff members, and more in-depth training is provided to those who will take on leadership roles during an emergency response. The CDPH/OA/LHJ team will consult with the CDC per protocol and when technical assistance is needed.

The LHJs will respond to outbreaks when identified, using their DIS staff to contact individuals in the cluster and notify their partners, and will always work in tandem with the Medical Director and Surveillance staff at OA.

Local Gaps: Need for Technical Assistance & Capacity Building

Technical Assistance and Capacity Building for LHJs

When gaps are identified in resources or programming at the local level, OA will strategize with the LHJ to identify potential new resources or to assess how staffing may be transformed to be able to respond to the gap. This may include seeking TA or CBA, which OA has a role of requesting on behalf of the LHJs. The consultants working with OA on CDC PS20-2010 (Facente Consulting) are “first responders” for many TA and CBA needs. They will coordinate with any TA and CBA providers funded by the CDC, HRSA, and the other EtHE Federal Agencies to provide TA or CBA with the counties.

The OA Ending the Epidemics staff and contractors will be working side by side with the LHJs as they initiate and provide the interventions outlined in the plan. OA monitoring will allow for rapid response when barriers, challenges, or gaps occur. Our team has staff experienced in program development and implementation, harm reduction, SDoH, and working with Black/African American women, gay men of color, and people who inject drugs (PWID). Other OA staff will be consulted and bring additional expertise in HIV testing, partner services, evidence-based interventions, harm reduction and public policy, evaluation, molecular cluster identification and investigation, and data analysis and interpretation. The team has bilingual staff through its consultants, as well as access to OA bilingual staff.

Building Relationships with other Resources

OA continually expands its collaborative network to include more agencies and services that respond to populations we have yet to successfully reach, as shown by disparities in health outcomes. To expand ROOT, OA is working with the California Primary Care Association and using the Medical Board mailing list to send "Dear Colleague" letters to large number of health care providers in the areas of Emergency Medicine, Internal Medicine, Family Practice, General Practice, Infectious Diseases, Obstetrics and Gynecology, and Pediatrics/Adolescent Health.

The OA medical director presents at conferences for health care providers throughout the state, including conferences and webinars not only for physicians, but also for medical case managers, HIV counselors, outreach workers, nurse practitioners and physician assistants. Similar relationships and education related to molecular cluster identification and investigation are provided.

Reaching Underserved Populations

OA is participating in a formative phase of bringing together tribal health leaders from throughout California to review current data and data collection practices and to assess current HIV prevention and care needs of tribal healthcare settings. Using culturally competent and expert HIV consultants, OA is listening to what tribes want OA to provide in serving indigenous people with cultural humility and respect.

OA has collaborated with The Black AIDS Institute for training and capacity-building assistance and has increased its rapport with that significant resource. Staff created a monthly call for providers serving women, which has proved valuable in providers exchanging information and supporting each other, as often only one or two providers in an area focus on serving women. Within the California Planning Group: HIV, STDs and HCV, committees are addressing the needs of adolescent/young adults, women, and HIV and aging. The Harm Reduction Unit within the Prevention Branch has expertise in working with PWID. OA's Health and Racial Health Equity workgroup is reviewing all aspects of OA's structure and services to more explicitly and intentionally address the needs of both staff within OA and the communities of color and those with disparities relative to other populations whom OA serve.

Areas Yet to Be Reached Effectively

Relationships with larger, non-Ryan White health care providers are still needed. In the last few years, OA administration and physicians from Kaiser have worked together to create better PrEP enrollment opportunities, and a bypass for the Kaiser pharmacy policy in which clients pay for medication upfront and get reimbursed later through patient assistance programs. Discussions regarding data sharing are ongoing. Building relationships with providers such as Scribbs, AltaMed, and the VA system will benefit PLWH using those systems as well as both OA and the local health jurisdictions.

Stronger collaboration with new partners to HIV prevention and care like mental health and Substance Use Disorder (SUD) Treatment providers and professional organizations such as the California Board of Behavioral Scientists and California Association for Alcohol and Drug Educators is needed. This includes increasing knowledge of PLWH for mental health and SUD providers, as well as increasing the capacity of HIV providers to effectively make warm hand-offs when mental health or substance use treatment needs are identified. Working with MediCal and state insurance programs to ensure PLWH who enroll in those insurance programs can access mental health and substance use services is also needed.

Increased collaboration with local Social Security Administration offices can yield better services for PLWH, including guidance on transition from disability back to the work force, applying for SSDI, and transition from SSDI to SSI.

The capacity-building assistance providers funded through CDC PS20-2010 will be asked to assist in developing these relationships.

EPMP

Our EtHE team includes a Research Scientist II, who will work collaboratively with the CDC and the LHJs, and have access to additional staff in the Surveillance Prevention and Evaluation Reporting Branch. That staff includes someone with extensive experience with CDC data submission, which will be helpful as CDC PS20-2010 starts to upload data to the CDC. The Research Scientist will collaborate with the consultants and CBA providers as needed.

The final EPMP and necessary data collection tools for the Phase I counties will be presented once the CDC has finalized the EPMP (not expected to March, 2021), and work with each to ensure data collection is done properly for every intervention. TA will be provided as needed, and CBA will be requested as needs are identified. The Research Scientist II will lead data monitoring and evaluation sessions with the EtHE Team on a regular basis, prepare the data for submission and assist the Program Manger in writing required reports and summary reports that will be shared with each LHJ. LHJs have the option to collect additional information, and with OA will determine if it is something beneficial for all counties to monitor, if the data can be incorporated into the data collection tools, or if it is distinct to a specific county, in which case the county will be responsible for collection and interpretation of the supplemental data.

Contract Monitoring

The Ending the Epidemics Program Manager will take the lead on ensuring all contractual requirements are fulfilled and deliverables are submitted on time. He is supported by the Research Scientist II and a Health Program Specialist, which constitutes the EtHE team. Key tasks will be ensuring all counties issue Request for Proposals, hire the necessary staff, and implement activities in a timely manner. In addition, the Program Manager will work with Research Scientist II and the Surveillance Branch regarding data submission. The EtHE Team will also work with the OA Support Branch to ensure that invoicing and payment is timely and that invoices are submitted promptly to the CDC for reimbursement. Counties will provide summaries of progress that will be compiled into CDC required reports, and these reports will also be distributed to all Part A Planning Councils, LHJ administration, and OA senior management. Lastly, the Program Manager will attend all required meetings hosted by CDC or their designees, whether virtually or in person.

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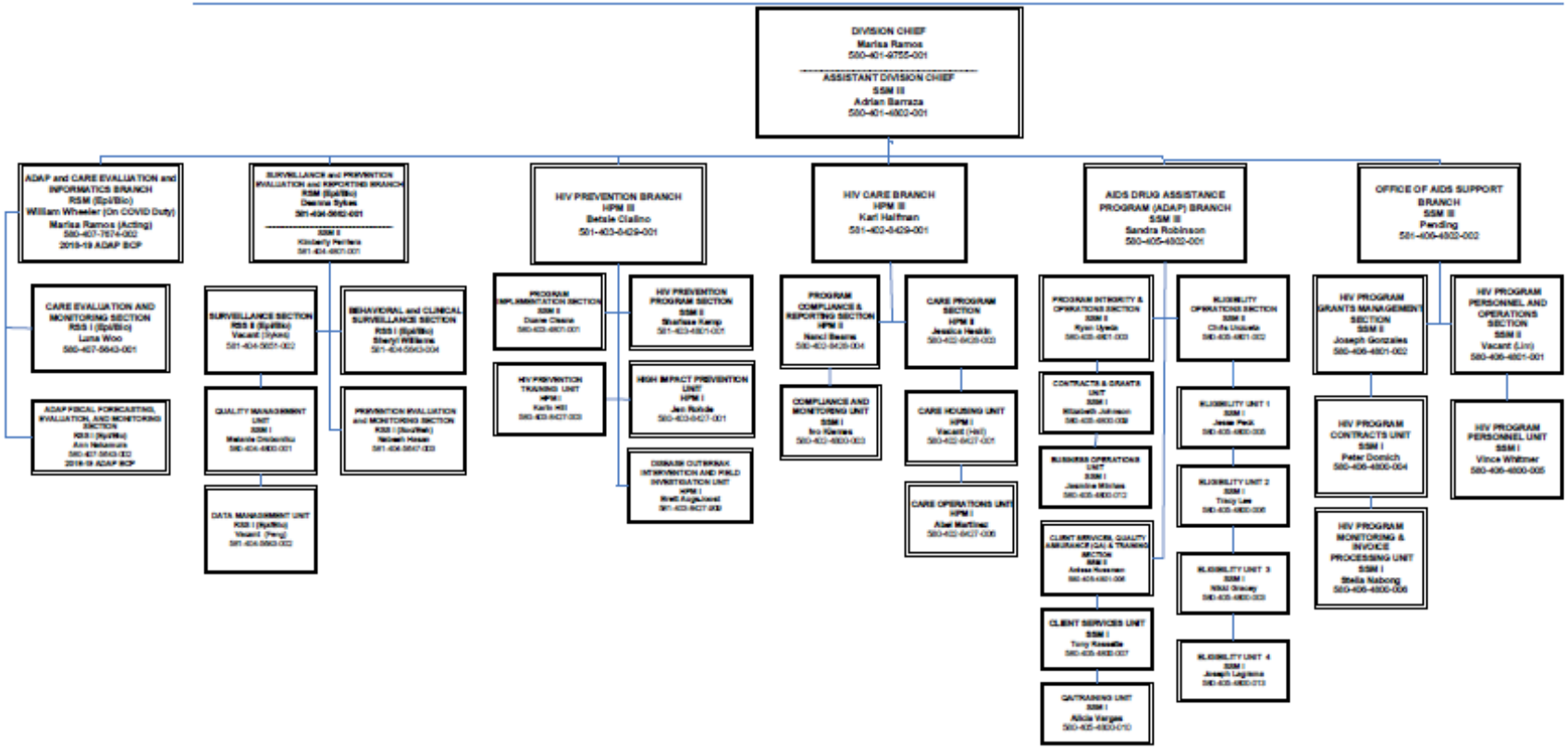
[i]California Department of Public Health, Office of AIDS, California HIV Surveillance Report — 2018.

August 2020
Updated 09/23/2020

California Department of Public Health
Center for Infectious Diseases
Office of AIDS



ALAMEDA

Alameda County

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

CALFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

ALAMEDA COUNTY
OFFICES OF HIV CARE AND PREVENTION

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Introduction

About This Plan

This plan describes Alameda County's bold and innovative plan for ending the HIV epidemic in the county. HIV efforts in the county are led by the Alameda County Public Health Department (ACPHD) in collaboration with the Oakland Transitional Grant Area (OTGA) Planning Council. ACPHD and its community and clinical partners are part of an extensive network of HIV prevention, care, and treatment services in the county. These foundational HIV services were built based on the *2017-2021 Alameda and Contra Costa County Integrated Prevention and Care Plan*,[1] which covers both Alameda County and its OTGA partner jurisdiction for Ryan White Part A, Contra Costa County, as well as the regional community-driven Getting to Zero effort including both Alameda and Contra Costa Counties—East Bay Getting to Zero (EBGTZ)—established in 2017.[2]

These current baseline activities, and the infrastructure that supports them, are critical for reducing and ultimately eliminating new HIV infections and optimizing the health of people living with HIV, but they are not sufficient – hence the need for this Ending the HIV Epidemic (EtHE) plan. This EtHE plan does not replace the other plans; instead, based on the current state of HIV in the county, it expands on them by describing the additional innovative efforts needed.

This Plan is organized as follows:

- The **Introduction** provides a high-level overview of 1) the HIV epidemic in Alameda County, 2) the baseline services, activities, and infrastructure that currently exist, and 3) Alameda County's plan to end the epidemic.
- **Section I: Community Engagement** describes Alameda County's completed and planned community, provider, and planning council engagement activities and findings to date.
- **Section II: Epidemiologic Profile** presents the latest available data on HIV in Alameda County, including demographics, trends, and disparities across age, race/ethnicity, geography, and more.
- **Section III: Situational Analysis** synthesizes information from the prior two sections and a needs assessment to paint a comprehensive picture of the current state of HIV in the county, including needs, resources, and gaps.
- **Section IV: EtHE Plan** outlines the disruptively innovative activities Alameda County will implement between now and 2025, across all funding sources, along with key partnerships, workforce development needs, and plans for outcome monitoring.
- **Section V: Concurrence** describes the process for securing Planning Council concurrence.

Current State of HIV in Alameda County

Overall, new HIV diagnoses in Alameda County have been declining slightly, with a 6 percent drop in the number of new diagnoses between 2014 and 2018.[3] However, new diagnoses have recently been rising slightly among Hispanic/Latinx residents and have continued to hold steady or decline slightly for other ethnic groups.[3,4] The city of Oakland is disproportionately affected, accounting for 58 percent of new HIV diagnoses from 2015-2017.[5] Supporting access to HIV services for Black/African American (B/AA) and Hispanic/Latinx men who have sex with men (MSM), especially those under age 30, the transgender community, currently and formerly incarcerated people, and women of color is key to ending the epidemic.

Findings from community engagement efforts offer some insight into the barriers and challenges that are impacting the county's ability to further reduce new HIV infections. The barriers can be divided into four major categories: (1) social determinants of health (SDoH)—such as structural inequities, discrimination, racism, and oppression; (2) being unhoused; (3) mental health disorders; and (4) substance use (see *Section II: Community Engagement*). These barriers limit the ability of many Alameda residents to seek and access resources and services that support HIV diagnosis, treatment, prevention, and response efforts.

Current HIV Efforts and Infrastructure

Planning

Alameda County has a long-standing history of planning local HIV prevention, care, and treatment efforts in conjunction with community partners and the local OTGA Planning Council. The county HIV work sharpened with the development of the *2017-2021 Alameda and Contra Costa County Integrated Prevention and Care Plan*,[1] which includes both care and prevention goals in alignment with federal guidance. In addition, the regional community-driven Getting to Zero effort including both Alameda and Contra Costa Counties—East Bay Getting to Zero (EBGTZ), established in 2011,[2] has grown to more than 300 active members and supports movement toward goals adapted from the Integrated Prevention and Care Plan.

Services

A number of public funding sources support HIV services in Alameda County, including prevention funding from CDPH (CDC PS18-1802, State General Fund, and Project Empowerment), Ryan White Parts A, B, C, and D (including Early Intervention Services [EIS] and Minority AIDS Initiative [MAI] funding), Housing Opportunities for Persons with AIDS (HOPWA), County General Funds, Veterans Administration, as well as revenue from third party billing, including Medi-Cal and Medicare. Collectively, these funding sources support the robust HIV services network that exists today which includes services such as HIV testing, prevention with positives, primary care, mental health services, dental services, medical case management, and a multitude of wrap-around services for PLWH (**Exhibit 1**, page 3). A more extensive resource inventory listing baseline services and programs by funding source and by pillar is included as **Appendix 1,** page 62.

Infrastructure

Health Department. The ACPHD HIV/STD Division oversees all health department HIV- and STI-related functions and services. Within this Division, the Offices of HIV Care and Prevention, with 10 FTE, is responsible for administering much of the funding for the direct services previously noted. With the exception of partner services and linkage to care, the Offices of HIV Care and Prevention do not provide direct services. Instead, they manage contracting of services to clinical and community partners. The HIV Epidemiology and Surveillance Unit, also located within the HIV/STD Division, collaborates closely with the Offices of HIV Care and Prevention. In addition, ACPHD offers a range of assessment, planning, technical assistance, and training countywide.

Additional Assets. Alameda County collaborates with the National Institutes of Health (NIH)-supported Center for AIDS Research (CFAR) at the University of California, San Francisco (UCSF) Gladstone Institute of Virology and Immunology. The UCSF-Gladstone CFAR coordinates interdisciplinary research in HIV disease at the intersection of basic, clinical, and behavioral/epidemiological scientific disciplines.[6] Alameda County has conducted CFAR projects alone and in conjunction with the City and County of San Francisco to strengthen capacity for collecting, organizing, and responding to local HIV surveillance data.

Alameda County's Plan to End the HIV Epidemic

Exhibit 2 (see p. 7) depicts a high-level overview of how Alameda County plans to enhance its current HIV efforts with new, disruptively innovative activities funded with federal EtHE funds. The planned activities will expand and leverage, but not duplicate,

Exhibit 1: *Alameda County Clinical and Community-Based Partners*

Clinical Providers

- Alameda County Medical Center HIV Services – Fairmont Campus
- Alameda County Medical Center Adult Immunology Clinic –Highland Campus
- Asian Health Services
- East Bay AIDS Center (EBAC) Alta Bates Summit Medical Center
- La Clinica de la Raza
- Lifelong Medical Care
- Roots Community Health Center
- Bay Area Community Health (formerly Tri-City Health Center) HIV/Hepatitis Services/Dimensions Project
- UCSF Benioff Children's Hospital – Oakland Pediatric HIV/AIDS Program

Community-Based Organizations

- AIDS Healthcare Foundation
- AIDS Project of the East Bay
- Alameda Health Consortium HIV Dental Care Program
- Allen Temple Health & Social Services Ministry
- Ark of Refuge, Inc. / Yvette A. Flunder Foundation, Inc.
- California Prostitutes Education Project (Cal-PEP)
- Catholic Charities of the East Bay HIV AIDS Services
- East Bay Community Law Center
- East Bay Community Recovery Project
- East Oakland Community Project
- Family Support Services of the Bay Area
- HIV Education & Prevention Project of Alameda County (HEPPAC)
- Lion Bridge
- Pacific Center for Human Growth
- Project Open Hand
- Providence House
- Resources for Community Development
- Women Organized to Respond to Life-threatening Disease (WORLD)

Capacity Building/Technical Assistance

- Cardea Services
- UCSF Bay Area North and Central Coast (BANCC) AIDS Education & Training Center (AETC) EBGTZ
- Cardea Services

the foundational efforts already in place. Some of the proposed activities utilize multiple funding sources that will be noted for each such activity. In particular, the planned activities will build a foundation of community trust that is essential for facilitating improvement across all EtHE pillars, and will emphasize populations disproportionately impacted by HIV, including MSM of color with an emphasis on African American and Hispanic/Latinx MSM including young MSM of color, women of color, and the transgender community.

The **Exhibit 2** logic model shows the needs strengths and gaps identified through this planning process (local epidemiologic data, community engagement, and situational analysis) and the new, disruptively innovative activities designed to leverage these strengths and address the gaps. While there is a strong community testing effort in Alameda County, there are still an estimated 670 undiagnosed PLWH, as well as gaps in routine opt out testing (ROOT) among private providers and jails. And while there is also a strong network of existing HIV service providers, there are still linkage and viral suppression disparities among B/AA and Hispanic/Latinx groups. Further, older adults, Hispanic/Latinx and Asian and Pacific Islanders(A/PI) are more likely to be late HIV testers. Also, people experiencing homelessness need additional supportive services connected to housing programs to link to and maintain HIV care. While the county has above average PrEP uptake and a trend of decreasing HIV diagnoses, there were still 200 new HIV diagnoses in 2018 and STIs are still increasing. Finally, ACPHD has a strong capacity to use data to inform long-term HIV prevention and care planning but needs to grow infrastructure and processes for data to care and prevention efforts. All of these issues provide impetus for the proposed EtHE activities.

New EtHE activities will work across all four EtHE pillars and will support the short-term, intermediate, and long-term outcomes identified by the CDC in PS19-1906. The primary activities for Alameda County are listed below. Multiple funding sources (noted in **Exhibit 2**), including CDC PS-20-2010 and HRSA 20-078, will be leveraged to support these activities and community partnerships will be strengthened to ensure success.

- **Enhanced Testing.** ACPHD will offer enhanced testing services to increase routine opt opt-out testing (ROOT) in health care, correctional facilities, and increased focused testing in non-clinical settings of priority populations. Self-testing through home-delivered kits will be expanded. All these efforts will increase access to services in a test-everywhere priority populations gather strategy. *(Diagnose, Treat, Prevent)*
- **Expanded Data-to-care/Data-to-PrEP** will use HIV and STD surveillance data to identify and link newly diagnosed persons and PLWH not engaged in care with HIV care, and link individuals diagnosed with an STD for HIV testing, HIV care, PrEP, or PEP, as indicated. *(Treat, Prevent, Respond)*
- **Same-day PrEP for Alameda County priority populations**, including B/AA and Hispanic/Latinx MSM, young MSM of color (24 and younger), the transgender community, sexual and substance using partners of PLWH, and women, will improve PrEP uptake among these populations who are experiencing disproportionate rates of new HIV diagnoses. *(Prevent)*
- **Augmentation over Baseline Initiative** will strategically increase the stability of HIV services and will be focused on supporting PLWH, especially those who are most affected by systemic racism and its outcomes including unemployment, police violence, trauma, et cetera. Services augmented include direct financial assistance, employment support and whole person wellness. This program is funded by HRSA 20-078. *(Treat)*

- **Capacity Building and Innovations Fund (CBIF)** will create an iterated pathway and menu of resources to empower new small, emerging and/or current provider organizations to 1) join the county's network of HIV providers; 2) build their capacity to provide new and innovative services; and/or 3) initiate cross organization collaborative service models to more effectively focus on EtHE populations. Up to 10 CBOs will enter this capacity building program focused on supporting growth in at least one of these key areas: 1) organizational capacity; 2) cross agency collaborative service provision; 3) community partnerships; 4) HIV sector specific knowledge, including data to care discussions; 5) diversity, equity and inclusion; 6) adoption of new and promising practices; 7) housing, behavioral health and/or asset building activities; 8) trauma informed care practices; 9) culturally specific programming; and 10) special populations. A more robust and innovative HIV services network is needed and this initiative will help build it. This program is funded by HRSA 20-078. *(Treat, Respond)*
- **Project Empowerment - Oakland LGBTQ Community Center.** This program will focus on HIV testing, linkage to and retention in care and PEP/PrEP. The primary populations to be served include members of the LGBTQ community, specifically Black gay and bisexual men and Black transgender persons living with or at risk for contracting HIV. The Oakland LGBTQ Community Center will serve as a wellness hub in Oakland and will transform the existing sexual health landscape for people in the East Bay. Importantly, this hub will serve individuals of all ages, providing resources for adults, teens, and children, with strategic design features to meet the needs of diverse groups within a shared space. All Project Empowerment programs are funded by state prevention funds. (Diagnose, Treat, Prevent)

- **Project Empowerment - UCSF Benioff Children's Hospital (Oakland).** This program will provide linkage and retention in care, PEP/PrEP, and high-quality culturally responsive HIV prevention services for Black/African American (AA) transgender women and cisgender women living with HIV/AIDS who are not virally suppressed. The program will also provide direct outreach to transgender and cisgender women living on the streets or in homeless encampments who engage in sex work and are a substantial risk for HIV. The overall intent of the proposed program is to reach key underserved populations in Alameda County with innovative, culturally appropriate, peer-based outreach and education services, and linkage to appropriate treatment options in their own language and from their own perspective while honestly addressing personal and social barriers to health equity and self-sufficiency. (Diagnose, Treat, Prevent)

- **Project Empowerment** - **Bay Area Community Health (BACH).** This program will fund staffing and capacity building to implement a program of expanded PrEP and PEP outreach, linkage, and retention services specifically targeted to transgender B/AA and Hispanic/Latinx women in Alameda County. The program will support critically needed funding to hire a new full-time Transgender PrEP Outreach Specialist/Peer Coordinator as well as an outreach staff of transgender peers who will be trained and given stipends through the program. The proposed intervention will build on BACH's nationally recognized transgender services program, TransVision, with the goal of significantly increasing the number of transgender women of color in Alameda County who are

enrolled and retained in PrEP and PEP services which will in turn decrease new HIV infections among the transgender community in this region.

The county's EtHE plan was developed with extensive community, partner engagement and endorsed by the OTGA Planning Council, Alameda County's local HIV community planning body. The plan is also informed by the innovative strategies developed by EBGTZ, mentioned in more detail in the body of this document. All participating partners represent a large diversity of community input. With the new federal EtHE funding, Alameda County expects to make significant progress over the next 5 years toward ending the HIV epidemic in the county.

Exhibit 2. *Logic Model for Ending the HIV Epidemic in Alameda County, organized by pillar. Current county strengths and gaps inform planned EtHE activities, which will impact the short-, intermediate-, and long-term outcomes identified by CDC and the California Department of Public Health.*

1. CDC PS20-2010; 2. HRSA 20-078.

Section I: Community Engagement

Community engagement is an essential component of Alameda County's EtHE efforts. Effective community engagement enhances the understanding of the day-to-day realities of priority populations and sparks discussions about creative ways to harness community strengths, address barriers to accessing HIV prevention, care, and treatment, and digs deeper into the underlying social determinants of health (SDoH). CDPH, the PS19-1906 grantee, has worked very closely with Alameda County, and the other five Phase I counties covered under the grant (Riverside, Orange, Sacramento, San Bernardino, and San Diego) to put community engagement front and center. Despite challenges posed by the Bay Area's COVID-19 Shelter-in-Place order, community engagement efforts have proceeded. The following is a description of Alameda County's community engagement efforts during the accelerated planning year (**Exhibit 3**) and a community engagement plan for years 2-5.

Exhibit 3. Community Engagement Successes

- Engagement of the OTGA Planning Council
- PrEP Listening Sessions
- EBGTZ-ACDPH Collaborative
- Pivot to virtual CE due to COVID-19

Community Engagement Activities

The COVID-19 epidemic and response has affected Alameda County's ability to implement in-person outreach and face-to-face community engagement during most of the months allocated to the PS19-1906 accelerated planning year. However, virtual engagement methods were undertaken, including several Zoom-based EtHE-related events. The county met the following community engagement targets for the accelerated planning year **Exhibit 4**:

Exhibit 4. Alameda County Community Engagement Outcomes (met in Year 1)

- Convened multiple Zoom listening sessions to hear more about what is working, what is not, and how to scale up PrEP in Alameda County for priority populations in partnership with EBGTZ
- Presentations to the OTGA Planning Council to solicit input to the EtHE plan
- EBGTZ Collaborative strategy meetings with over 200 participants focusing on drilling down further into critical EtHE implementation
- Review of secondary sources of data developed from community engagement efforts pre-COVID-19 response

Alameda County's EtHE community engagement efforts brought together new voices—clients, providers, governmental groups and academic institutions—to inform the next best steps to getting to zero. **Exhibits 5 and 6** summarize the completed and planned community engagement efforts for the PS19-1906 accelerated planning year. **Appendix 2** provides more detailed descriptions of these efforts.

Exhibit 5. Overview of county EtHE community engagement activities, completed and planned

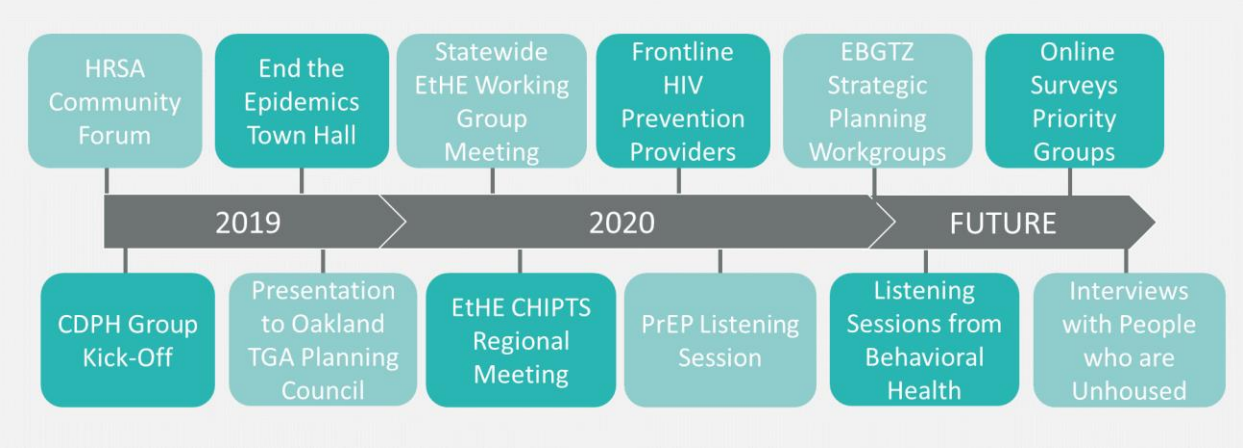


Exhibit 6. Detailed summary of Alameda County EtHE community engagement activities.

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
HRSA Community Forum[7] 10/7/2019	A community forum to share and gather input on the HRSA EtHE funding opportunity (HRSA 20-078) was held at the ROOTS Community Health Center in Oakland.	***Participants:*** HIV Service providers. OTGA Planning Council members.
CDPH Planning Group Kick-Off Meeting[8] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants:*** Dr. Nicholas Moss, ACPHD HIV STD Section Director, Dr. Neena Murgai, ACPHD HIV Epidemiology and Surveillance Director, Steven Gibson, ACPHD HIV Prevention Director, two members of the OTGA Planning Council.

EVENT	DESCRIPTION	VOICES & PARTNERS
End the Epidemics Town Hall[9] 11/15/2019	More than 100 community members gathered for an *End the Epidemics* Town Hall to discuss the best ways to advocate for new, coordinated strategies to address not just HIV but also the hepatitis C and sexually transmitted disease syndemics. Dr. Erica Pan, ACPHD Interim Health Officer, delivered the keynote speech.	***Participants:*** More than 100 community stakeholders and representatives of community organizations, academic institutions, and healthcare providers in Alameda County.
Statewide EtHE Working Group Meeting[9] 11/30/2019	This Oakland meeting was held with a cross-disciplinary group of community stakeholders to advance the *End the Epidemics* initiative locally and statewide.	***Participants:*** More than a dozen stakeholders including many who had not previously been involved in HIV prevention efforts at the regional or state level.
EtHE CHIPTS Regional Meeting[10] 01/24/2020	Alameda County presented an overview of county's draft EtHE plan and gave input about approaches to the regional EtHE response.	***Participants****:* County Health Department and Planning Council representatives from Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Diego Counties. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.
Frontline HIV Prevention Providers[11] 5/15/2020	ACPHD and EBGTZ facilitated a discussion of what is and isn't currently working regarding current PrEP strategies and how to scale up PrEP in Alameda County for priority populations, HIV test options, including in-home HIV testing and the use of telemedicine. Staff from two agencies presented how their organizations have adapted their service delivery models due to COVID-19.	***Participants:*** ACDPH, EBGTZ, Frontline PrEP Providers, PrEP navigators, PrEP advocates. Via Zoom.
PrEP Listening Session[12] 6/5/2020	ACPHD and Facente Consulting facilitated a Zoom meeting called "Love in the Time of COVID" to discuss what is next for strategies to overcome challenges to PrEP initiation and provision during emergency response to COVID-19.	***Participants****:* PrEP Program Managers, PrEP Evaluators, Federal, State and County policy-makers. Via Zoom

EVENT	DESCRIPTION	VOICES & PARTNERS
EtHE Presentation and Discussion[13] 7/22/2020	CDPH and Facente Consulting presented an overview of the Alameda County draft EtHE plan and solicited input.	***Participants:*** Via Zoom. Planning Council Members, members of the public, HIV providers, ACPHD staff.
EtHE Presentation and Discussion II[12] 8/26/2020	CDPH and Facente Consulting presented a second overview of the Alameda County draft EtHE plan and solicited input. Concurrence was granted at this meeting.	***Participants:*** Via Zoom. Planning Council Members, members of the public, HIV providers, ACPHD staff.
EBGTZ-Alameda County Collaborative HIV Strategic Plan Writing Workshops[14] 9/11/2020 10/23/2020 11/13/2020 12/4/2020	East Bay Getting to Zero, in collaboration with ACPHD are held a series of writing workshops meant to drill down into key steps to getting to zero across the whole Oakland TGA including both Alameda and Contra Costa Counties. More information can be found at: East Bay HIV Strategic Plan – East Bay Getting to Zero (ebgtz.org)	***Participants:*** Via Zoom. Over 300 regular participating members of the PrEP and Linkage to Care collaborations (HIV providers, managers and frontline staff). Participants included: AIDS Project East Bay, AHIP/Eden I&R, Alameda County Public Health Dept., Alameda Health Consortium, Asian Health Services, Bay Area Community Health – TransVision, CAL-PEP, Contra Costa County Public Health, EBAC, Facente Consulting/CDPH, Gilead Sciences, Highland – AIC, Kaiser – HIV Services, La Clinica de la Raza, Lifelong Medical Care, Oakland LGBTQ Community Center, Office of the Assistant Secretary for Health, Oakland TGA Planning Council, Pacific AETC, Primary Care at Home, Roots Health Center, RTI International, UCSF School of Nursing, UCSF Benioff Children's Hospital, WORLD.

EVENT	DESCRIPTION	VOICES & PARTNERS
PLANNED ACTIVITIES (dates TBD)		
Online Surveys of Priority Groups	Throughout the first year of EtHE implementation, ACPHD will solicit input about how to scale up interventions to reach priority populations.	***Participants:*** EtHE priority populations.
Integration of Listening Sessions from Alameda County Behavioral Health	ACPHD will work in collaboration with members of Alameda County Behavioral Health to incorporate findings from their listening sessions about utilization of mental health services among Black/African Americans in Alameda County to better tailor their EtHE services for primary users of mental health programs.	***Participants:*** Mental health providers and B/AA primary consumers of mental health services in Alameda County.
Interviews with People who are Unhoused	ACPHD will work with Healthcare for the Homeless, Roots Community Health, HEPPAC, and BACH to conduct phone interviews with unhoused clients/consumers of HIV prevention and care services and other people experiencing homelessness who are at substantial risk for HIV transmission in order to better tailor EtHE interventions.	***Participants:*** People experiencing homelessness and the providers that serve them.

The ACPHD oversaw the development and implementation of the community engagement plan in collaboration with EBGTZ, CDPH and Facente Consulting, a California-based public health consulting firm specializing in HIV planning and community engagement. Together, they worked to support and build Alameda County's capacity to broaden and deepen connections with local priority populations. EBGTZ, a longstanding ACPHD partner, held an EtHE strategic planning process to solicit broad community input for EtHE goals for the TGA. Facente Consulting coordinated and collaborated with EBGTZ and provided support for community engagement events and interviews, including developing an online EtHE survey, designing key informant interview tools, working with ACPHD to develop meeting agendas and materials, co-facilitating a PrEP listening session, taking meeting notes, producing summary reports and supporting the review of the EtHE plan by the OTGA Planning Council and other community constituents.

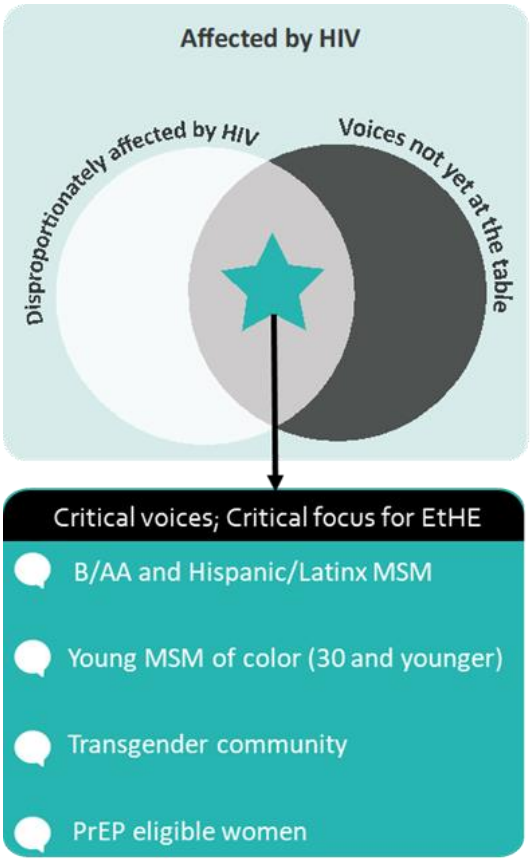
New Voices

In addition to deepening the partnerships within our current provider and community networks, Alameda County continues to place a special emphasis on including new voices in the development and implementation of the EtHE Plan.

Alameda County used an intentional data-driven process to identify affected populations not currently being reached effectively in order to focus on engaging these new voices. Based on HIV surveillance data and the experience of key stakeholders within ACPHD and the OTGA Planning Council, Alameda County identified the following priority populations who will be the critical focus of EtHE work in the CDC PS20-2010 funding. **(Exhibit 7** and described below**)**:

- **Black/African American (B/AA) and Hispanic/Latinx gay men and other MSM, especially those not identifying as gay or bisexual.** African American and Hispanic/Latinx G/MSM, particularly those who do not identify as gay or bisexual, have very high rates of HIV incidence yet are not well served by our existing strategies.
- **Young people (age 30 and under), particularly young G/MSM of color.** Young people, particularly young G/MSM of color, make up a disproportionate proportion of new HIV diagnoses in Alameda County and are currently under-represented in HIV prevention and care programs.
- **Transgender community.** Transgender women and transgender MSM made up 2 percent of the new HIV diagnoses in 2018. Community engagement efforts have also suggested that these populations are underrepresented in the data and that there are fewer Transgender prevention and care support services compared to the actual need.
- **PrEP eligible women.** HIV negative Cisgender and Transgender women have substantial risk of contracting HIV from sex or needle-sharing partners who are living with HIV or who are unaware of their HIV status. Black/AA cisgender and transgender women are especially critical to reach with PrEP services.

Exhibit 7. Critical EtHE Focus



Additionally, the following groups identified in community engagement efforts will be an ongoing focus of EtHE work:

- **People who use drugs.** Drug user health should include not only harm reduction services but also linkages to comprehensive health care that includes linkage to PrEP and HIV care services. People who use drugs do not experience the same successes across the HIV continuum of care that other groups do.
- **People who are incarcerated.** ROOT is not universal in institutions like jails and prisons. People who are incarcerated need pre-release planning and supportive services upon re-entry in order to initiate linkage to PrEP or HIV care services.
- **People experiencing homelessness.** Housing is health care and those experiencing homelessness have critical barriers to HIV prevention and care services.
- **Older adults (ages 50+).** Older adults are more likely to be late HIV testers.
- **Asian and Pacific Islander people.** The API population are also more likely to be late HIV testers.

- **Hispanic/Latinx people.** Hispanic/Latinx people are a higher proportions of late diagnoses.

The following sections describe our efforts to engage new voices prioritized in PS19-1906, with an emphasis on inclusion of the identified priority populations.

Local Prevention and Care Integrated Planning Bodies

As previously noted, Alameda County and neighboring Contra Costa County together comprise the Oakland Transitional Grant Area (OTGA). The OTGA has a joint integrated community planning body called the OTGA HIV Planning Council. ACPHD continuously seeks the Council's input and guidance when developing HIV care and treatment strategies, and has actively engaged the Council throughout the EtHE planning process, especially regarding the priority populations and proposed interventions.

The Planning Council brings a wealth of knowledge and experience to the EtHE planning process. Planning Council membership is composed of stakeholders with diverse personal and professional experiences, including service providers (both HIV and non-HIV related). By statute, PLWH need to make up 33 percent of the Planning Council and additional members include people with substantial risk for HIV, HIV service providers, and public health staff. Accessibility is important to the Planning Council so all meetings are held in venues that are wheelchair accessible and sign language interpretation services are available upon request.

Local Community Partners

With the exception of a cure or vaccine for HIV, all the tools to end the HIV epidemic exist—PrEP, condoms, safer injection equipment, and effective HIV treatment. However, policy barriers, SDoH, disparities in health care access, stigma, and many other factors create a situation where not all communities benefit equally from these tools. Only through engaging affected community members in the planning process can the county ensure the proposed programmatic activities meet community needs and are conducted in ways that resonate with those communities. Therefore, engaging local community members and partners is a significant element in EtHE planning.

Local Service Provider Partners

Service providers, both HIV- and non-HIV-related, are key partners for ending the HIV epidemic in Alameda County. Clinical and community-based providers have a wealth of experience regarding what works and what does not work to reach priority populations and a strong knowledge of the barriers that need to be overcome in order to more effectively serve PLWH and persons at risk. Other partners who may not provide direct services but who have expertise in or connections with priority populations are also key to building a robust, feasible, and sustainable HIV prevention, care, and treatment strategy. This includes EBGTZ. EBGTZ is a community-driven, multisector collective impact organization (described in greater detail on pages 27 and 57) which has convened community stakeholders to develop strategic activities for 2021-2025, which include the following areas:

1. Community messaging
2. Improving collaborations
3. Innovative models
4. Youth engagement
5. Housing initiatives

ACPHD has pre-existing strong partnerships with the Planning Council, the Contra Costa Department of Public Health, and the clinical and CBO providers listed in **Exhibit 1** (Introduction p. 3). During the EtHE planning process, ACPHD engaged the following new service providers and non-traditional partners:

- **Other public health departments,** including Contra Costa County and San Francisco Public Health Departments to coordinate EtHE planning efforts and strategic implementation of interventions like PrEP expansion.
- **Clinical providers,** including Kaiser.
- **Medical insurance,** including Medi-Cal and Covered California.
- **Housing providers,** including Loaves and Fishes.
- **Pharmaceuticals,** including Gilead.
- **Substance use providers**, including Alameda County Behavioral Health.
- **PrEP Network.** The PrEP Network is a collaborative facilitated by EBGTZ and ACPHD. This collaboration was expanded during the 19-1906 planning year and its deliberations informed the Alameda County EtHE Plan.
- **Oakland LGBTQ Center.** A recipient of the Project Empowerment and Gilead funds to create a wellness center to include comprehensive sexual health services including PrEP and HIV care linkages.
- **Youth services providers.**
- **Homeless services providers.**

ACPHD is strongly invested in maintaining these new relationships and continuing to forge new partnerships for ending the HIV epidemic.

Selected Community Engagement Findings

The following sections summarize and highlight selected findings from the community engagement efforts related to four domains affecting the HIV epidemic in all California Phase I counties: social determinants of health (SDoH), being unhoused, mental health, and substance use (summarized in **Exhibit 8** and described in more detail below). These findings represent a synthesis of information gathered from all the activities in **Exhibit 6** completed as of December 4, 2020 (see **Appendix 2** for additional documentation). The information presented sheds light on some of the prevailing issues and conditions the priority populations are experiencing, serving as an initial indication of how these conditions might influence the county's ability to achieve EtHE goals. These early insights point to key focus populations as well as potentially impactful strategies and interventions.

Exhibit 8. Key considerations for EtHE in the county, from community engagement processes

Social Determinants of Health, including HIV provider cultural competency, PrEP-related stigma, medical mistrust and structural racism impact access to services.

Secure housing is key to supporting health and well-being for PLWH; continued efforts to support people who are unhoused are needed.

Mental health services are critically needed, especially given COVID-19. The Planning Council has prioritized a mental health needs assessment in FY 2020.

Substance use, particularly stimulant and opioid use, is on the rise, with substance use treatment as a major unmet need.

Social Determinants of Health

Community engagement efforts documented the pervasive effect that social determinants of health (SDoH) have on PLHW and at risk residents of Alameda County. The recent PrEP Network meeting: *Love in the Time of COVID-19* brought together PrEP program managers and services providers to discuss how to expand PrEP services to meet EtHE goals despite barriers due to COVID-19 response. Key themes from the forum suggested ways that SoDH can be barriers to EtHE work. One overarching theme suggested that the dangers posed from systemic racism on the bodies of B/AA people are of critical and immediate importance, eclipsing GTZ and COVID-19 response in the minds of the Black Lives Matter movement and their allies. The key remarks at the forum emphasized that justice is also necessary to achieve EtHE goals. The forum also suggested that HIV work and the COVID-19 response would be best approached as justice work and must be aligned with the core values of the Black Lives Matter movement. Until B/AA and other POC have the same or better health outcomes compared to all population averages, Alameda County is losing the battle to end the HIV epidemic. Community engagement efforts to develop this plan found other ways to describe SDoH and their effects on health outcomes for key groups listed below.[12]

Individuals disproportionally affected by systemic racism in medicine*.* As one participant shared, it is hard to refer people to care if they do not trust the people providing care. Large health clinics and hospitals are not always the best options for some people. Community members might have had a traumatic experience there; they often do not see people that look like them; and given COVID-19 testing on site, there is fear of getting infected with COVID-19.

To reach the Black community, one participant shared that is still important to do in-person outreach while also following COVID-19 safety guidelines (e.g., wear masks, maintain 6-feet distance). At-home HIV testing is another approach because it is literally meeting people where they are at, in their homes. Lastly, non-traditional settings are vital in expanding testing and prevention efforts to community members. Here are some of the examples participants suggested: health coaching at barber shops; education and drumming circles; working with churches (framing PrEP as a “health pill” or “vitamin”); anywhere where people get condoms.[11,12]

Individuals excluded from services because of language and culture. Hispanic/Latinx individuals are disproportionately excluded from access to medical services and other resources.[12] The PrEP Network forum findings found most written materials, professional meetings, and conferences regarding PrEP and HIVs services are presented in English. Mono-lingual Spanish-speakers feel disconnected during these English-only discussions and hope that someone will be available to translate the discussion. All PrEP and HIV information and materials must be initially dually presented in Spanish and other languages and not as an after-thought once something has been shared in English. More insidious and excluding are the xenophobic immigration policies enforced by Immigration and Customs Enforcement (ICE) that keep Hispanic/Latinx residents from using services for fear of be targeted for deportation or blocked from obtaining state-recognized residence.[12] While the use of medical care for HIV treatment and prevention is excluded from the list of services that can affect immigration status, PrEP providers report that clients do not know or trust that this is the case.[12]

Individuals involved in the criminal justice system. The Santa Rita Jail, located in Dublin on the eastern side of Alameda County, is the third largest jail in California and the fifth largest in the United States. The Alameda County Probation Department and the California Department of Corrections and Rehabilitation estimates that there are more than 30,000 former state and local inmates on active supervision in Alameda County at any given time. Although firm data on HIV among the individuals with a history of criminal justice involvement in the region is not available, conservative estimates suggest there are between 320 to as many as 2,500 PLWH previously incarcerated who re-entered the community within the last decade.[14,15]

Older adults (ages 50+). Nearly five out of nine (54.9 percent) PLWH in the TGA are over 50 years old and this number has grown over time as survival among PLWH has improved due to increased access to antiretroviral therapy. Among women living with HIV, 56.3 percent are over 50 years old. The region, like much of the nation, is facing a severe shortage of geriatricians and other providers with training in caring for older adults.[15] At the same time, as the population of PLWH ages, they face new medical concerns and co-morbidities that may be complicated by their HIV diagnosis and treatment regimen. Also, they may encounter renewed stigma—and the reluctance to seek care that stigma often sparks—as they enter new care settings and housing situations where staff may wrongly assume that older adults are not sexually active or that they are all cisgender and heterosexual.[14]

Special Populations: All the identified priority populations listed above are underserved and hardly reached within the existing service network. To end the epidemic locally, we recognize that service providers will need to deploy novel and innovative strategies to reach them. For example, the recent Community Forum highlighted the re-entry population, transgender women, immigrants, older adults, and individuals experiencing homelessness as groups who are not

adequately served through traditional medical settings and case management techniques. Participants at the Forum also noted that there are no current providers with specific expertise in reaching older African-American cisgender men and very few providers working with older women, especially women of color.[14]

Being Unhoused

Alameda County faces severe challenges related to poverty and a shortage of affordable housing, issues that have particularly damaging impacts on PLWH. According to the National Low-Income Housing Coalition, Alameda County ranks among the six least affordable counties in the United States in terms of the hourly wage needed to rent a two-bedroom apartment at HUD fair market rents.[16] This means in Alameda County an individual must make between $41 and $50 an hour to afford a 2-bedroom apartment. Consequently, a majority of individuals in the county- regardless of income - spend more than 30 percent of their monthly income on rent, according to the U.S. Census. Because of the high costs of housing, low vacancy rental unit rates in the county, and ongoing discrimination against many populations highly impacted by HIV, high rates of homelessness exist in the region. The most recent Alameda County Homeless Count conducted in January 2019 found 8,022 individuals living on the streets or in shelters on the night of the count. Surveys of homeless individuals done in conjunction with the Count, found that 5 percent of people experiencing homelessness in Alameda County reported HIV-related illness. Utilization databases indicated that 26 percent of Ryan White clients in the region had a period of homelessness or unstable housing during the most recent 12-month reporting period, while 14 percent of respondents in the most recent Oakland region Needs Assessment reported that they had been homeless in the last five years, and 14 percent stated that they had lived in a homeless shelter at some point during that time.

Stable Housing: As noted above, at least one quarter of current Ryan White clients report temporary or unstable housing. Among PLWH who are undiagnosed or not in care, the proportion is likely even higher. Stabilizing housing and putting appropriate support services in place requires much more than HOPWA vouchers; low-income clients also need more flexible emergency financial assistance to help them avoid evictions or foreclosures, make needed repairs to their dwellings, pay moving expenses or rental deposits, among other items.[5]

Mental Health

The exact burden of mental health diagnoses and substance use disorders among PLWH in the county is difficult to estimate but reasonable estimates, based on reports and surveys of current Ryan White clients, suggest that at least 50 percent have a mental health diagnosis and at least 25 percent have a substance use disorder. These co-occurring conditions may themselves pose barriers to continuity of care.[15] ACPHD will continue to explore how mental health interacts with health outcomes of PLWH and other priority populations. In the community engagement planning, ACPHD noted a recent set of listening sessions implemented by Alameda County Behavioral Health which will result in a report describing experiences of B/AA consumers of mental health care in the county. Coordination and collaboration with mental health providers was suggested in community engagement efforts as one step in achieving EtHE goals.

Substance Use

Community engagement efforts have linked methamphetamine use to increased risk for HIV infection and falling out of medical care. County-specific data on methamphetamine use is not easily accessible. As a proxy, this report utilizes county-specific data on 1) amphetamine-related Emergency Department (ED) visits and 2) amphetamine-related deaths 2011-2018; all data obtained from the *California Opioid Overdose Surveillance Dashboard,* https://skylab.cdph.ca.gov/ODdash/.

Findings: From 2011-2013, there was an overall increase of ED visits attributable to amphetamine use in Alameda County, from 5.01 visits/100,000 population in 2011, to 5.81/100,000 in 2013. Since 2013, ED visits steadily declined to a low of 1.7/100,000 in 2018. Deaths, on the other hand, fluctuated more widely, from a low of 1.18/100,000 in 2011 to a high of 4/100,000 in 2013. However, in 2018, deaths attributable to amphetamine use spiked dramatically to a high of 8.26/100,000. This spike, coming as ED visits continued to decline, may reflect persons not seeking medical care for amphetamine overdose rather than decreased use. Not seeking medical care for amphetamine overdose could be secondary to a lack of access to medical care, fear of legal ramifications, or to unwitnessed overdose—the reasons are unclear from this data.

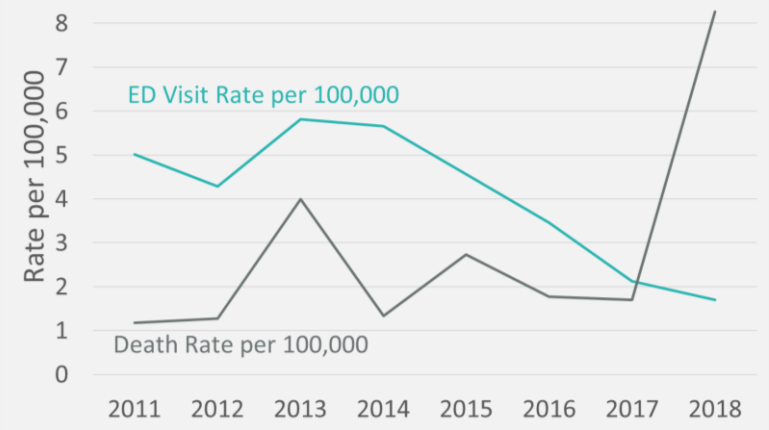
Community Engagement, Years 2-5

ACPHD will use Years 2-5 of EtHE implementation to continuously engage community members in the planning and implementation of services and interventions, as was done to develop *Section IV: Ending the HIV Epidemic Plan.* Moving forward it will be critical to keep the Planning Council, community members, and service providers engaged in the most effective approaches to implementing services and strategies. ACPHD is prepared to develop on going alternative and innovative engagement methods if necessary due to COVID-19 or other unanticipated factors.

Planning for Integration, Implmentation and Ongoing Community Engagement

Year 2-5 engagement activities will expand on lessons learned during year 1 and how that information can translate into service delivery models, while continuing to improve on the trust/satisfaction scores of people attending meetings (or in other venues). To counteract the significant HIV prevention and care barriers for the priority populations named in this plan, ACPHD will continue to develop and refine prevention and care models. While these will be informed by community engagement activities, they may include innovative models such as telemedicine and pharmacy delivered PrEP. Reciprocally the interventions will inform community engagement needs for the priority populations so as we approach EtHE goals Alameda County communities will have increased capacity to:

Exhibit 9. ED visit and death rates related to amphetamine use



- Better support African American and Hispanic/Latinx gay men and other men who have sex with men, especially those under 30, to access HIV prevention services and PrEP. The greatest observed disparities in new HIV rates are in these populations.
- Better engage transgender women and men in all HIV prevention services.
- Improve delivery of HIV testing, PrEP and PEP services to men with diagnosed bacterial STDs and unknown HIV status, particularly G/MSM.
- Improve engagement in care for all persons living with HIV but out of care, and those attending care visits but with unsuppressed viral loads.
- Continue to ensure access to prevention services for women of color, particularly African American women. Although the overall numbers are small, African American women are even more disproportionately impacted compared to other racial/ethnic groups than African American men in Alameda County.

Workforce Development

The success of Alameda County's EtHE plan depends on a highly skilled workforce that reflects the populations served across the entire county including at ACPHD, in clinical settings, and at CBOs. ACPHD has adopted key values to guide its ongoing community engagement work. These key values were also adopted by the EBGTZ strategic planning process and include being antiracist and centered in equity; trauma-informed; sex positive; healing; putting people first/community driven, as well as being data and science driven.[14] These values will also underlie workforce development.

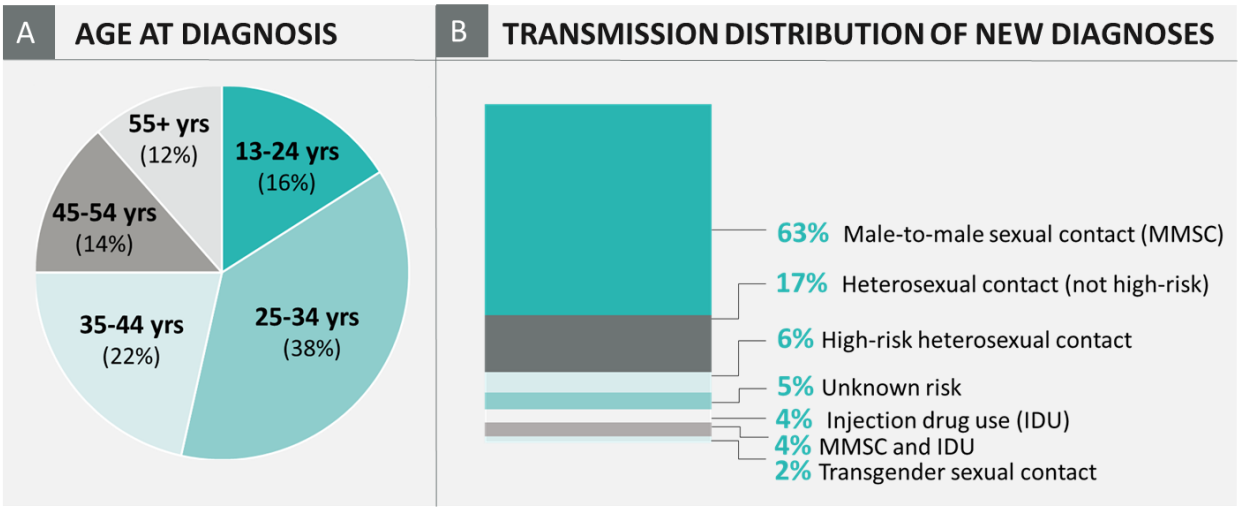
Community engagement efforts addressed workforce development needs. Key recommendations and questions included: The HIV workforce needs to be prepared for another (or the next) epidemic. How can we make sure the next time something like COVID happens we are ready for it? How can we ensure that clients maintain safety and health during another epidemic or another shelter-in-place where we are again not able to physically contact them? These and other questions will be addressed through implementation.[12]

Section II: Epidemiologic Profile

HIV Diagnoses

In 2018, there were approximately 6,799 people living with HIV in Alameda County. Of those, 6,129 (90.1 percent) people had been diagnosed with HIV – up from only 86.4 percent diagnosed in 2016. In 2018, there were 200 new diagnoses. Of the people diagnosed in 2018, 118 (60 percent) were ages 25 to 44, 126 (63 percent) were infected through male-to-male sexual contact, and 33 (17 percent) were infected through heterosexual contact not typically considered high risk (i.e., not with a partner who was MSM or injected drugs).[3]

Exhibit 10 highlights the age and transmission distribution of new HIV diagnoses in Alameda County in 2018.



Overall, age and gender at diagnosis have remained relatively constant between 2014 and 2018 in Alameda County. However, the rates of new diagnoses per 100,000 population have fluctuated notably since 2014 when stratified by race/ethnicity, as can be seen in **Exhibit 11.** Specifically, the rate of diagnosis among B/AAs has been steadily dropping since 2015, though rates remain substantially higher than for other ethnic groups. The diagnosis rate for Hispanic/Latinx people in Alameda County was higher in 2018 than in the previous year, but the overall trend has been variable over time.[3]

American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups are not included in the data tables below due to small to zero numbers reported each year from 2014-2018. This report does not intend to diminish the impact of HIV on American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups. Small numbers are not reported to preserve the confidentiality of PLWH.

Exhibit 11. Rate of New HIV Diagnosis by Race/ethnicity, Alameda County

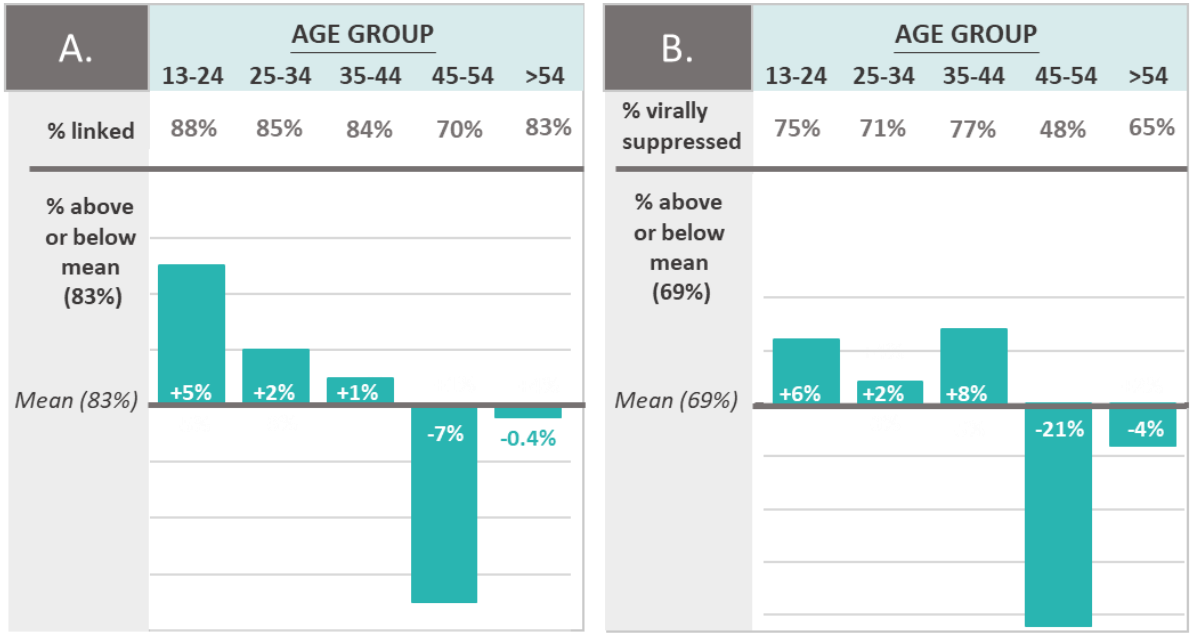
Race/ethnicity	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2014-2018 Sparklines
Black/African American	41.0	51.8	49.1	43.9	36.1	
Hispanic/Latinx	13.9	16.6	23.0	14.1	19.1	
Asian	6.4	4.9	4.9	5.3	3.6	
White	8.8	11.9	10.0	6.7	6.5	

Note: Rates are per 100,000 population.
Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

Linkage to Care and Viral Suppression

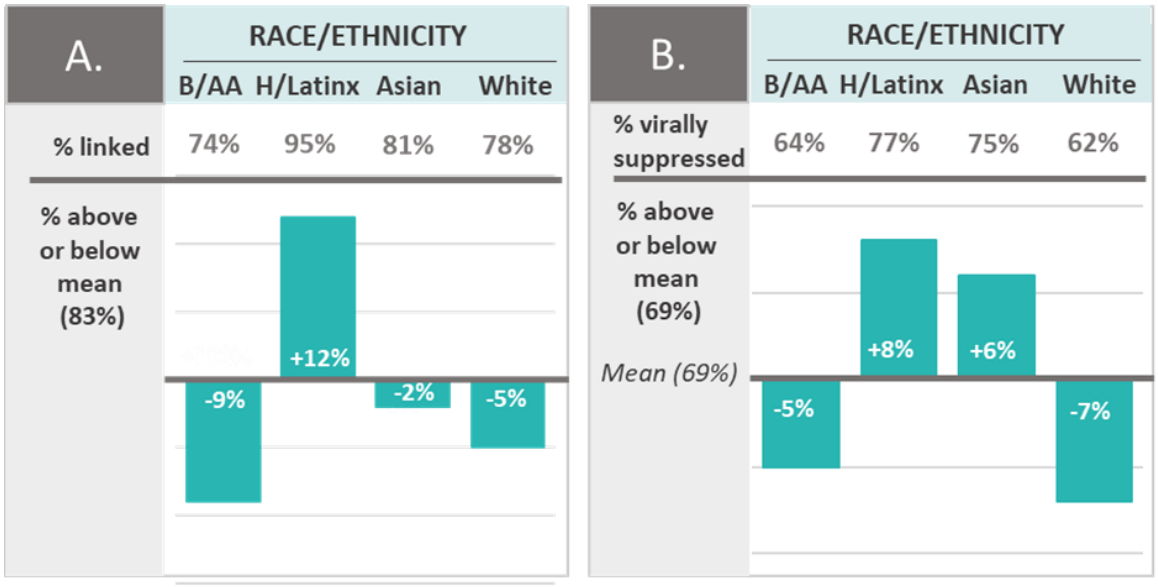
New diagnoses are not the only important piece of HIV epidemiology. Also key are the percentages of people linked to care within 30 days and who are virally suppressed within six months of diagnosis. Overall, 83 percent of people diagnosed with HIV in Alameda County in 2018 were linked to care within 30 days of diagnosis and 69 percent were virally suppressed within 6 months. However, there were notable disparities, with people ages 45-54 having considerably worse rates of linkage to care within 30 days, and people age 45 and older having worse viral suppression rates (**Exhibit 12**).[3]

Exhibit 12. Linkage to Care (A) and Viral Suppression (B) by Age, Alameda County 2018



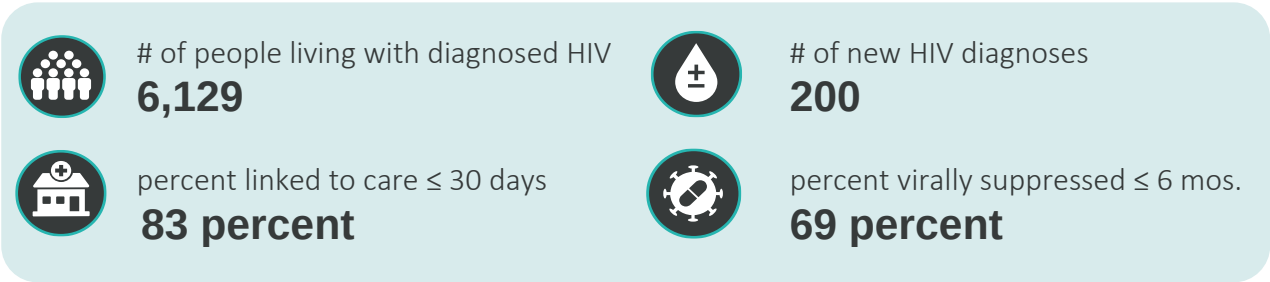
Similarly, disparities in linkage to care and viral suppression were also seen by race/ethnicity, with B/AAs and Whites having substantially worse outcomes regarding both linkage to care within 30 days and viral suppression within 6 months compared to Hispanic/Latinx and Asians. An impressive 94.6 percent of Hispanic/Latinx(H/Latinx) people in Alameda County were linked to care within 30 days of diagnosis in 2018, far better than people in other racial/ethnic groups (**Exhibit 13**).[3]

Exhibit 13. Linkage to Care (A) and Viral Suppression (B) by Race/ethnicity, Alameda County 2018



In summary, **Exhibit 14** provides a few key features of Alameda County's HIV epidemic in 2018

Exhibit 14. Key features of Alameda County's HIV epidemic (2018)



Section III: Situational Analysis

This Situational Analysis provides a high-level overview of the strengths, needs, gaps, and barriers related to ending the HIV epidemic in Alameda County. It synthesizes information from the epidemiological profile, community engagement efforts, planning conversations, and consultations with key partners and stakeholders.

The Situational Analysis is organized into the following three sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps.

Methods

To ascertain the needs of the priority populations, as well as resources to meet those needs and gaps in services, a needs assessment was conducted. The needs assessment consisted of data gathered through community engagement efforts, assembly of a list of current HIV-related services and the agencies that provide them, and identification of gaps based on the current epidemiologic profile and current needs. (**Exhibit 15**).

Exhibit 15: *Methods and sources used for the county's situational analysis*

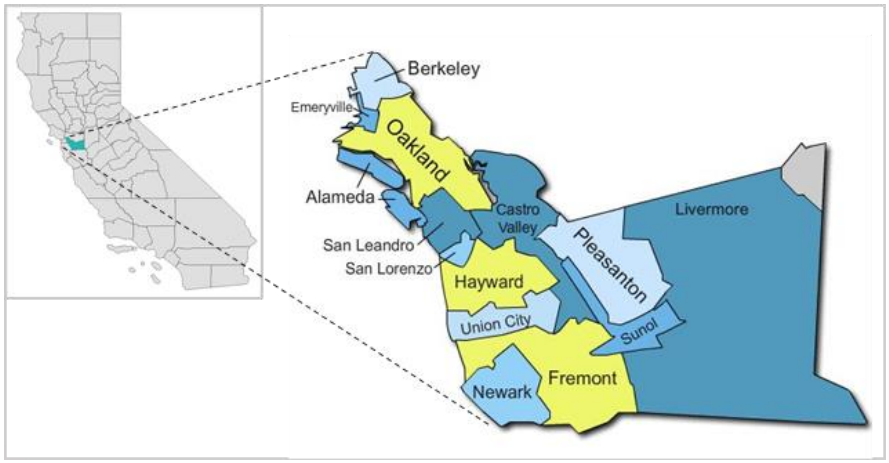
Method	Description
Needs assessment to ascertain needs, resources, and service gaps	• EtHE community engagement efforts[7-13,17] • County information on existing services • California Directory of Syringe Services Programs[18] • Family Care Network 2019 Needs Assessment[19]
Review of secondary data and reports	• AIDSVu local PrEP estimates[20] • Alameda County Epi Profile 2018[3] • Alameda County Homeless Count & Survey[21] • CA Opioid Surveillance Dashboard[22] • HRSA 20-078 application[15] • OTGA Ryan White HIV/AIDS Program Part A application[23] • CA HIV Surveillance Report 2017[24] • U.S. Census Population Estimates for Alameda County[25] • East Bay HIV Epidemic Presentation[4] • East Bay Getting to Zero Presentation[26] • HIV in Alameda County, 2015-2017[5] • HIV in Alameda County, 2016-2018[27] • Opioids in Alameda County[28] • Net Migration, Alameda[29] • EBGTZ Strategic Plan 2021-2025[14,17]
Community engagement and consultation	• OTGA HIV Planning Council • Service providers • Community members representing the priority populations disproportionately impacted by HIV

Review of relevant County and State plans	• 2017-2021 Alameda and Contra Costa Integrated HIV Prevention and Care Plan[1] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan[30] • East Bay Getting to Zero: 0 HIV Stigma, 0 Health Disparities, 0 HIV Transmissions[2] • PS 20-2010 EPMP and Work Plan[31]
Consultation with key stakeholders	• Local: ACPHD staff and others • Regional and State: SFDPH, CDPH; CARG; Federal Ryan White Program Staff

Situational Analysis Snapshot

Situational Analysis Summary

***Exhibit 16**:* Map of Alameda County and its cities



Alameda County (**Exhibit 16**), home to the cities of Oakland and Berkeley, is a 738-square-mile area bordered by Contra Costa County to the north, the San Francisco Bay to the west, Santa Clara County to the south, and San Joaquin County to the east. The population was estimated to be 1,671,329 in July 2019 according to the Population Estimates Program of the U.S. Census Bureau, making Alameda County the seventh most populated county in the State of California. It is one also of the most diverse places in the United States: more than 50 percent of residents are people of color, with 22.4 percent being Hispanic/Latinx, 31.8 percent Asian, 11.2 percent African American, and 5.3 percent more than one race/ethnicity.[25]

Alameda County is a mix of urban, suburban, rural communities and is generally divided into two zones for planning purposes: West County and East County (formerly known as the Livermore-Amador Valley), with running hills dividing the county in two.[32]

HIV in Alameda County

During 2015-2017, the city of Oakland in the West County accounted for over half (58 percent) of new HIV diagnoses in Alameda County, with an average annual diagnosis rate of 27.4 per 100,000 people.[5] Overall, the rate of new HIV diagnoses in Alameda County has been dropping among all genders; however, new diagnoses have recently been rising slightly among Hispanic/Latinx (H/Latinx) residents and have continued to hold steady for other ethnic groups. African Americans still have the highest rate of new HIV diagnoses (see **Exhibits 17 and 18**).[4]

Exhibit 17. New HIV Diagnoses in Alameda County, 2006-2018

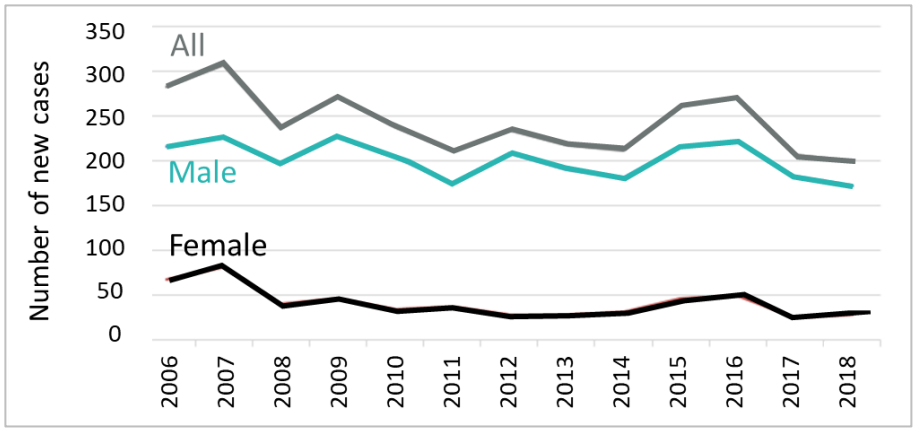
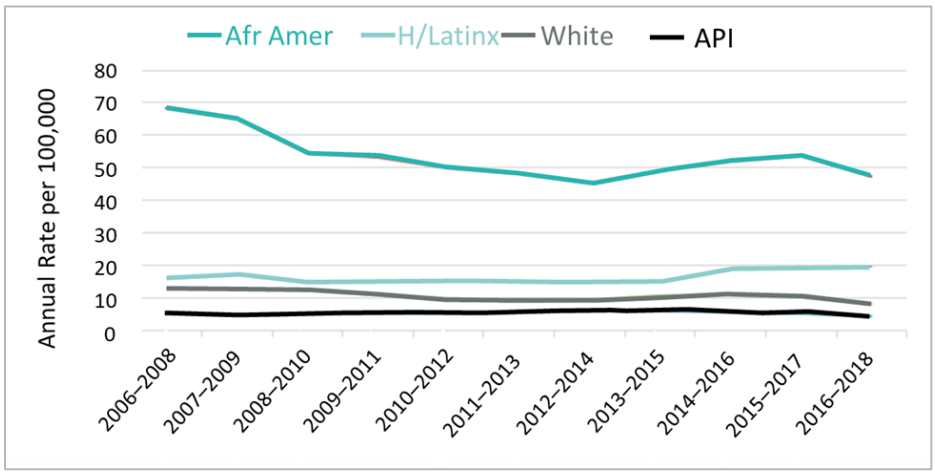


Exhibit 18. HIV Diagnosis Rates by Race/Ethnicity, 2006-2018



While the majority of new HIV diagnoses in Alameda County continue to be among gay men and other men who have sex with men (G/MSM), 63 percent of new diagnoses in 2018 among G/MSM and another 4 percent among G/MSM who also inject drugs, 23 percent of new infections in the county were transmitted through heterosexual contact in 2018. The rate of diagnoses among people who inject drugs remains fairly low overall, at only 8 percent of new HIV diagnoses.[3]

However, as illustrated in the epidemiological profile. other disparities, beside mode of transmission, are critical to the story of HIV in Alameda County, People aged 45-54 who were diagnosed with HIV in 2018 have substantially worse rates of linkage to care within 30 days and worse rates of viral suppression within 6 months, compared to people in other age groups.[3] Both B/AA and white residents diagnosed with HIV in 2018 had lower rates of linkage to care and viral suppression that year as well, compared to Hispanic/Latinx and Asian people.[3]

Getting to Zero Initiative

Since 2016, the Alameda County Public Health Department (ACPHD) has been working toward the goals laid out in the Oakland Transitional Grant Area (OTGA) Integrated HIV Prevention and Care Plan[1] with regional stakeholders and in coordination with other local HIV efforts. The plan was released by the OTGA Planning Council and covers both Alameda County and its OTGA partner jurisdiction for Ryan White Part A, Contra Costa County. The plan was the culmination of a year-long process that included nine Community Input Groups. Although the OTGA Planning Council is traditionally focused on Ryan White Part A, per federal guidance the Integrated HIV Plan incorporates both care and prevention goals.

In 2017 a regional community driven Getting to Zero effort that included both Alameda and Contra Costa Counties known as East Bay Getting to Zero (EBGTZ)[2] was established. EBGTZ drew inspiration from the Integrated HIV Plan and other End HIV/Getting to Zero efforts and is affiliated with the international Fast-Track Cities Initiative, to which Oakland Mayor Libby Schaaf signed on in 2015, which is committed to attaining the UNAIDS 90-90-90 targets by 2020. Since the first EBGTZ Steering Committee meeting in August 2017 the steering committee membership has grown to over 30 active members, and the overall network has grown to over 300 members including the linkage and retention and PrEP working groups, transforming in 2019 from an all-volunteer organization to a fiscally-sponsored project of Community Initiatives, with seed funding from Levi Strauss Foundation, Kaiser Community Benefits, and ViiV. A community-wide public launch of EBGTZ was held at Oakland Pride in September 2019. The heart of EBGTZ implementation activities are the Linkage and Retention and PrEP Network working groups. Frontline staff participate in these workgroups and make sure the planning gets implemented on the ground and in programs that serve clients directly.

EBGTZ has identified 4 goals for 2023, each adapted from the Integrated HIV Plan:

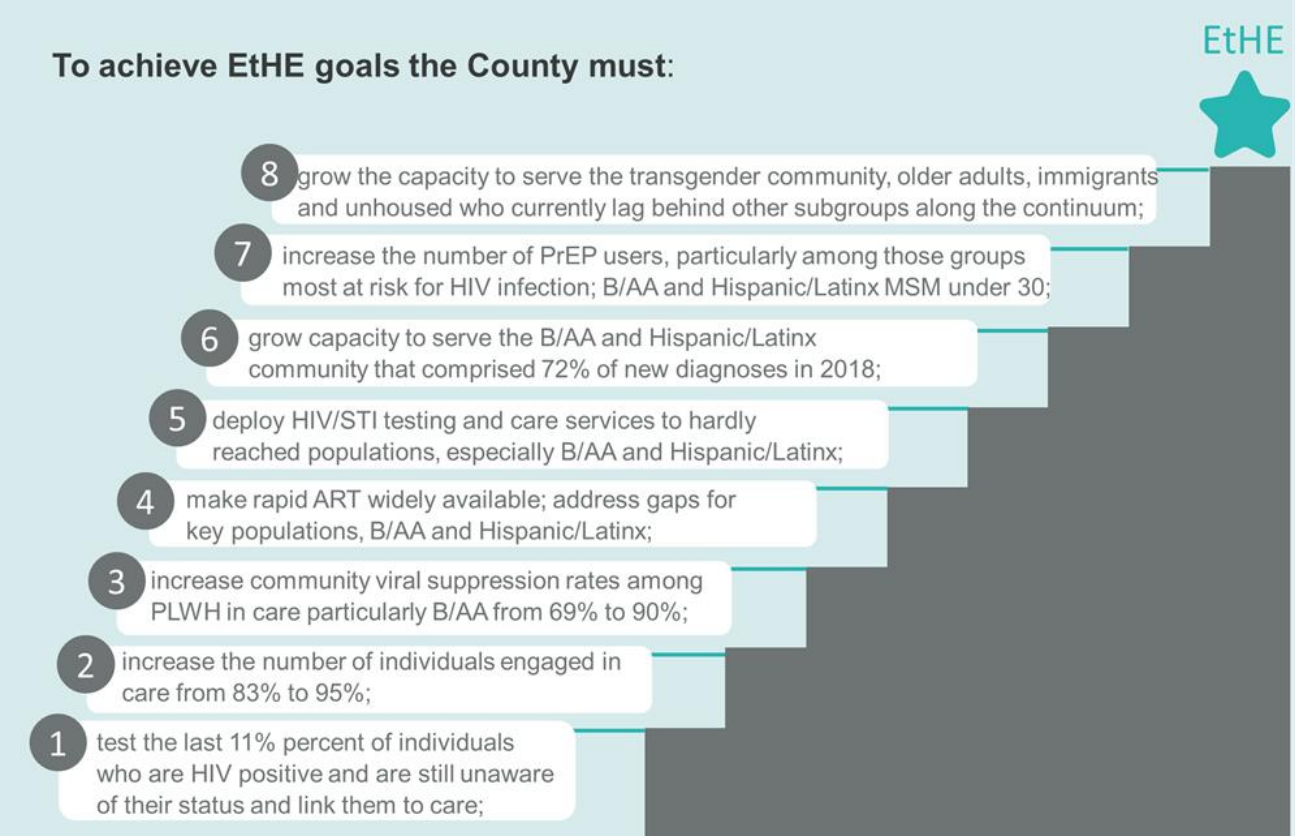
- Reduce the annual number of HIV diagnoses by 25 percent
- Increase the number of people using PrEP by 100 percent
- Link 90 percent of newly diagnosed people to care by 30 days
- Achieve 80 percent viral suppression among people with HIV

In recent years, HIV prevention and care activities have been increasing as an integrated, collaborative force in Alameda County. This transformation has been augmented by both the federal EHE initiative and by the selection of Oakland and San Francisco as the location for AIDS 2020, the 23rd International AIDS Conference (IAC). While this conference became "virtual" due to the COVID-19 pandemic, the initial selection as the first two-city IAC nonetheless spurred new efforts to improve regional coordination to address the HIV epidemic. Over the year and a half of planning in preparation for this conference, Alameda County ramped up its local and regional efforts to engage community, develop and launch innovative new strategies, and

make cross-jurisdictional progress toward Ending the HIV Epidemic, working closely with San Francisco, Contra Costa and other neighboring counties.

These key issues and others will be critical to reaching EtHE goals. **Exhibit 19** summarizes steps to ending the HIV epidemic in Alameda County.

***Exhibit 19*.** High-level summary of what is needed to end the HIV epidemic in Alameda County



Situational Analysis Snapshot by Pillar

Diagnose

As noted in *Section II: Epidemiologic Profile,* the percent of PLWH in Alameda County who know their HIV status increased from 86.4 percent in 2016 to 90.1 percent in 2018,[3] making substantial progress toward the state goal of 95 percent.[30] It is noteworthy that of all the new diagnoses in 2018, the mode of transmission for nearly a quarter (23 percent) was either unknown risk or non-high risk heterosexual contact.[3] Since HIV became reportable by name in California in 2006, between 200 and 300 new cases of HIV disease have been reported each year among Alameda County residents. In 2018, there were 200 new HIV diagnoses in Alameda County and those newly diagnosed were overwhelmingly male. The proportion of new diagnoses among males increased from 76.2 percent in 2006 to 86.4 percent in 2018. Among the 575 men diagnosed with HIV from 2016 to 2018, the overwhelming majority (76 percent) were MSM. Nearly eight in ten (78 percent) newly diagnosed women were reported to or presumed to have acquired HIV through heterosexual contact with a partner with known or unknown HIV status; most of the remaining women with a known transmission category were infected through injection drug use (IDU).[27]

Treat

HIV surveillance data from 2018 indicates that 83 percent of people diagnosed with HIV in Alameda County were linked to care within 30 days and 69 percent were virally suppressed within 6 months of diagnosis[3] falling shy of statewide goals of 85 percent and 75 percent, respectively.[30] Unlike many other places, older people (age 45+) have worse linkage and viral suppression rates, despite making up a relatively small proportion of new diagnoses. B/AA and Hispanic/Latinx people in Alameda County make up the majority of new infections in 2018 (35 percent and 37 percent, respectively, compared to only 19 percent among whites); however, both B/AA and whites have worse linkage and viral suppression outcomes than other groups, with Hispanic/Latinx people having substantially better outcomes than others in the county in the first year after initial diagnosis.[3]

These aggregate data may mask some of the realities faced by particular groups. For example, a recent needs assessment among women, infants, children, and youth with HIV found that young people who were born with HIV and who are now in their teens and early 20's face numerous psychological and practical barriers to staying in care and on medication.[19]

Prevent

***Exhibit 20*: 2021 Target and 2018 Estimated PrEP Utilization in Alameda and California**

	Total Users	Rate (per 100,000)
California 2021 target	60,000	152
California 2018	27,283	82
Alameda 2018	1,355	98

In Alameda County, prevention efforts are having an impact for some groups. For example, new diagnoses are declining for B/AAs although they still remain higher than for other groups. Perhaps Alameda County's biggest prevention challenge is that while PrEP uptake rates are higher than California as a whole, there is lower uptake of PrEP among people of color. Data show that there were 1,355 people estimated to be on PrEP in 2018 in a county of nearly 1.7 million people (**Exhibit 20)**.[33] Focused outreach and

messaging that is tailored especially to Hispanic/Latinx and B/AA is critical to correcting PrEP uptake disparities and reaching Alameda County's EtHE goals.

Respond

Alameda County's capacity to coordinate between HIV prevention and HIV surveillance has been recently enhanced with a Center for AIDS Research (CFAR) supplement using NIH funding for Ending the HIV Epidemic. Joint funding to Drs. Neena Murgai at the ACPHD and Willi McFarland in the San Francisco Department of Public Health has led to the alignment and strengthening of two sources of data: 1) HIV case-based surveillance (HCBS) that tracks new diagnoses through health outcomes, and 2) National HIV Behavioral Surveillance (NHBS) that identifies barriers to diagnosis, care, and prevention in communities at risk. HCBS and NHBS data are complementary and both are needed to complete the continuum of engagement in HIV care and prevention programs. HCBS data are available in all health jurisdictions in the US; NHBS is implemented in 23 metropolitan areas (including San Francisco but not Alameda County). These CFAR funds, however, have enabled meetings of investigators/county officials, collection of community stakeholder input, joint analyses, cross-county training, and pilot testing of NHBS methods in Alameda County. Extending NHBS from San Francisco into Alameda County could also lead to a model protocol to bring NHBS coverage to other priority counties and cities, improving epidemiological understanding and enhancing counties' ability to respond to HIV outbreaks.

The Alameda County Office of HIV Care (OHC) coordinates with CDPH for HIV transmission cluster detection. CDPH provides technical resources and coordinates HIV molecular cluster detection efforts across California, using the secure HIV Trace program. CDPH uses routine molecular sequences from drug-resistance screenings of PLWH to detect groups of individuals who represent geographically and temporally connected HIV transmission events. ACPHD utilizes these resources to support outreach to populations with notably active or increasing HIV transmission, in order to enhance prevention, testing, and linkage to care. Along with conventional HIV surveillance and epidemiology, this also helps define the leading edge of the local epidemic.

As described above, ACPHD uses HIV Data-to-Care processes and the LEO database to track outreach and linkage efforts and outcomes. The HIV Linkage Coordinator and the EBGTZ Linkage and Retention Network provide outreach and linkage or re-engagement support, as needed, in coordination with the last known provider, and documents these services. The HIV Linkage Coordinator also serves as point-person working with providers in re-engaging PLWH who have been out of care for six months or more and who local HIV provider agencies have been unsuccessful in tracking and/or re-linking to care. This process is used to track referrals from the State as well as individuals newly testing positive during cluster investigations. Contractors who case manage or serve PLWH identified through cluster detection efforts use CDPH's ARIES database to track retention and health outcomes. In addition to these activities, in 2019 the HIV ACCESS Ryan White Part C-funded clinical teams started a formal data-to-care process with the ACPHD epi/surveillance team.

Summary of Resources and Assets

Resources and Assets

Exhibit 21 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance EtHE planning and implementation.

One of the greatest assets in Alameda County is its large and robust network of clinics and community-based organizations (CBOs). These services are often, although not exclusively, funded through ACPHD's Offices of HIV Care and Prevention, and informed by both the Integrated HIV Plan and EBGTZ's work. To further its HIV prevention goals, in 2019 the ACPHD Office of HIV Prevention held a competitive bidding process for biomedical HIV prevention services, with new services beginning July 1, 2019. Based on this process, ACPHD is funding organizations to improve PrEP utilization, increase and improve HIV testing, expand partner services, and improve linkage to care, particularly among African American and Hispanic/Latinx G/MSM, G/MSM of color aged 24 and under, the transgender community, sexual and needle-sharing partners of people living with HIV (PLWH), and women at high risk, including women with HIV-positive or substantial-risk partners, women who inject or use substances, and women who engage in sex work. The ACPHD Office of HIV Care currently funds 24 different clinics and CBOs to provide Ryan White services, including ambulatory care, case management and multiple wrap-around support services for PLWH.

Exhibit 21: Alameda County Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Targeted community-based testing. Six CBOs are funded to provide targeted testing to an underserved segment of the community with which they have strong, trusting relationships (e.g., people who inject drugs, sex workers, and B/AAs).	●			
HIV screening in clinical settings. Highland Hospital, Alameda County's public hospital, has been a national leader in emergency department-based screening for HIV and other bloodborne diseases; Highland Hospital is one of 5 clinical providers funded by Alameda County specifically for HIV screening including ROOTS Community Health Testing.	●			
Longstanding federally-funded HIV care programs with an experienced health department team. The Alameda County Office of HIV Care (OHC) has contracts with 22 separate agencies providing Ryan White-funded services.		●		
ART coverage and viral suppression. More than 80 percent of all PLWH in the county are engaged in care, with more than 70 percent virally suppressed at the end of 2018.		●		
PrEP. Alameda County has numerous PrEP navigation programs, as well as a planned cross-jurisdictional PrEP initiative, to increase the numbers of B/AA residents taking PrEP.			●	

Syringe access. Alameda County has a long history of harm reduction outreach and syringe exchange services, especially through the HIV Education and Prevention Project of Alameda County (HEPPAC) as well as BACH in southern part of County. Syringe services are also provided by volunteer-led Community Outreach Harm Reduction Team (aka: Punks with Lunch).			●	
HIV surveillance. Alameda County's partnerships with researchers and health department staff in San Francisco has strengthened its epidemiological capacity and use of data to improve HIV linkage to care.				●

Cross-Pillar
Large network of experienced, indigenous HIV-focused community-based organizations. Many of our HIV CBOs have been in existence for more than 20 years, with deep roots and long histories in the community and connections to specific priority populations.
Strong HIV clinical provider network. In addition to community-based organizations focused on HIV prevention, testing, and linkage to care, Alameda County also has a number of outstanding HIV clinical providers.
Institutional support for HIV work among county leadership and elected officials. The City of Oakland Mayor, the Alameda County Board of Supervisors and Congresswoman Barbara Lee actively support, rather than hinder, innovative and effective HIV work throughout the county, as do the leaders of ACPHD and its parent agency.
Research collaborations help Alameda County stay on the cutting edge. There are 4 NIH-funded CFAR EHE supplement projects currently under way in Alameda County.
A strong health care safety net. Alameda County has a large network of federally qualified health centers, along with a strong health care reimbursement safety net.
Longstanding institutional commitment to health equity. ACPHD has led the way in investigating causes of health inequity and strategizing effective methods for achieving equity.
Inclusive and affirming community with strong history of advocacy for marginalized populations. From the 1946 Oakland General Strike to the founding of the Black Panther Party to the opening of the Ella Baker Center for Human Rights, Alameda County has long been a national center of advocacy and activism for those mistreated in society.

Targeted community-based testing, as well as robust screening programs to identify additional infections earlier. Six CBOs are funded to provide targeted testing to an underserved segment of the community with which they have strong, trusting relationships, as described above. However, HIV screening regardless of risk in clinical settings – particularly in the emergency department of Highland Hospital – has also helped to reduce the rates of "late testers" throughout the county. Also, the Alameda County Community Health Center Network of FQHCs has also been implementing universal opt-out HIV testing since 2014, and they have tested over 100,000 individuals in 5 FQHCs in that initiative from 2014-2016 alone.

Longstanding federally-funded HIV care programs with an experienced health department team. The Alameda County Offices of HIV Care and Prevention have contracts with 22 local agencies providing an extensive network of Ryan White-funded core and support services for PLWH in the county. This is one of the factors that has led to strong ART coverage and viral suppression rates in the county: More than 80 percent of all PLWH in the county are engaged in care, with more than 70 percent virally suppressed at the end of 2018.

Holistic prevention strategies. Alameda County has numerous community-based prevention programs, including innovative strategies that will be deepened as part of the Plan described here. Alameda County has numerous county and CDPH-funded PrEP navigation programs, as well as a planned cross-jurisdictional PrEP initiative to increase the numbers of B/AA residents taking PrEP. It also has a long history of harm reduction outreach and syringe exchange services through HEPPAC.

A large network of experienced, indigenous HIV-focused community-based organizations. Many of the organizations providing HIV prevention and care services in Alameda County have been in existence for more than 20 years; these organizations have deep roots and long histories in the community and connections to specific priority populations, especially African Americans (e.g. AIDS Project East Bay), Hispanic/Latinx (e.g. La Clinica de la Raza), women (e.g. WORLD), people who use drugs (e.g. HIV Education and Prevention Project of Alameda County – HEPPAC), and people who do sex work (e.g. CAL-PEP). By supporting the existing network of HIV-focused organizations to adapt and participate in the game-changing strategies proposed in this plan, the county can build on years of trust and relationship-building to rapidly reach those most in need.

Strong HIV clinical provider network. In addition to CBOs focused on HIV prevention, testing, and linkage to care, Alameda County has a number of experienced HIV clinical providers representing both independent small practices, medium sized health centers and very large health care organizations.

Institutional support for HIV work among county leadership and elected officials. The Alameda County Board of Supervisors and Congresswoman Barbara Lee actively support, rather than hinder, innovative and effective HIV work throughout the county. Congresswoman Lee has authored or co-authored every major piece of HIV/AIDS legislation the Congress has considered, both domestic and global, since coming to Congress. She is also the co-chair and co-founder of the bipartisan and bicameral Congressional HIV/AIDS Caucus, and one of the main forces behind persuading the International AIDS Society to select Oakland and San Francisco as the planned in-person location for the AIDS 2020 conference before the decision was made to make it "virtual" due to COVID-19. The Alameda County Board of Supervisors has consistently supported HIV-related efforts (including *Get Screened Oakland!* which was housed in the Office of the Mayor) with both policy and funding when needed.

Research collaborations help Alameda County stay on the cutting edge, including in the areas of HIV surveillance and outbreak response. There are 4 NIH-funded Center for AIDS Research EHE projects currently under way in Alameda County:

- Public health surveillance staff from both Alameda County (Murgai) and San Francisco Department of Public Heath (McFarland) are funded to work jointly to generate accurate cross-county comparisons of surveillance data and improve the understanding of the HIV epidemic in Alameda County.
- Collaborative team from San Francisco (Liu) and Alameda County (Moss) are funded to explore metrics, barriers to and facilitators of expanding rapid ART initiation in East Bay clinics.
- Truong and colleagues are funded to integrate partner elicitation with HIV and syphilis rapid testing to improve partner notification outcomes.

- Sevelius and colleagues are funded to expand a successful community driven PrEP project for transgender women to include HIV treatment.

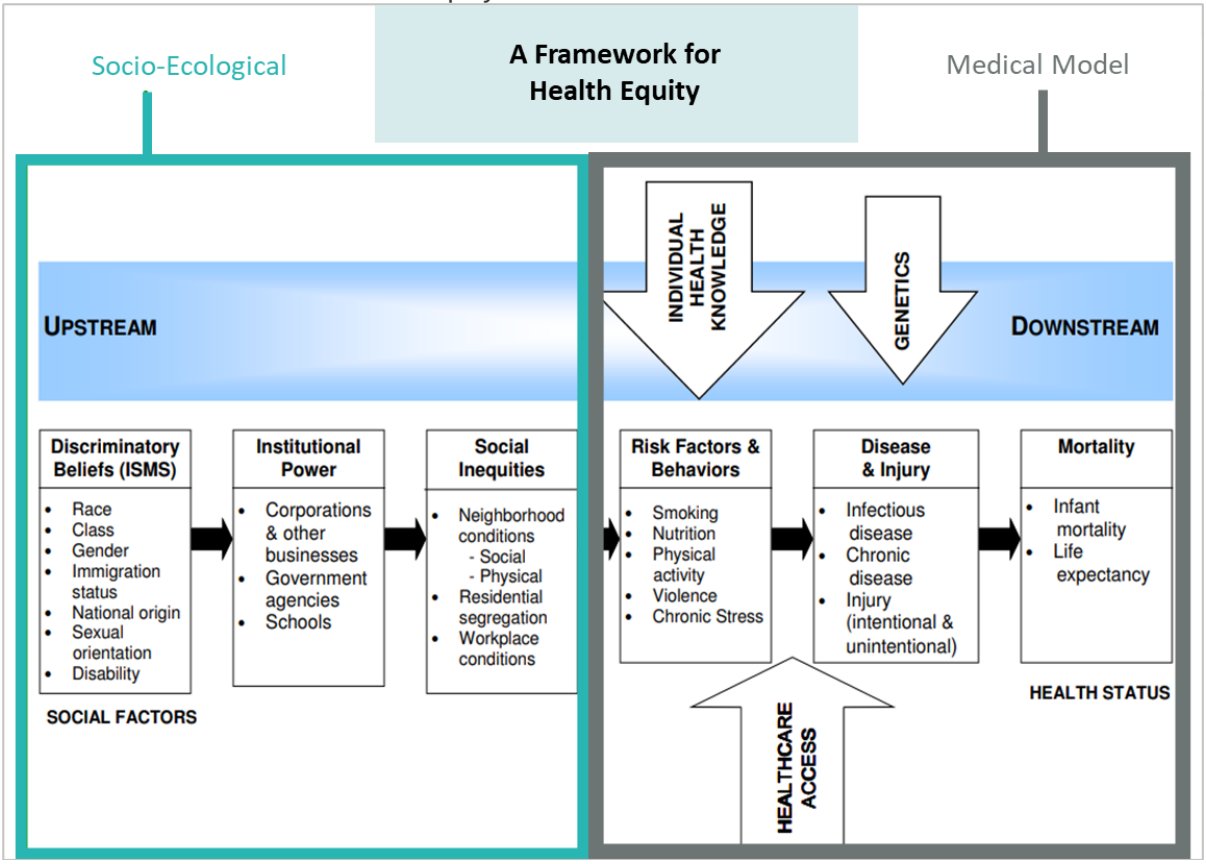
A hearty health care safety net. Alameda County has a large network of federally qualified health centers, extensive Medi-Cal (Medicaid) and AIDS Drug Assistance Program (ADAP), including PrEP-Assistance Program (PrEP-AP) resources, along with a strong health care reimbursement safety net. We have a strong track record of ensuring that no one living with HIV goes without medical care simply because of lack of ability to pay. The state Pre-Exposure Prophylaxis Assistance Program now provides access to PrEP medication and clinical services for those who do not have insurance or cannot afford the co-pays. In 2020, the PrEP-AP program was extended to young people age 12 and older.

Longstanding institutional commitment to health equity. Since publication of a seminal work about health and social inequity in Alameda County in 2008,[34] ACPHD has led the way in investigating causes of health inequity and strategizing effective methods for achieving equity. To achieve health equity, we must tackle broader social inequalities – access to power, resources, and opportunities – all of which determine the distribution of health and disease within the population. ACPHD is working to achieve health equity through several strategies:

1. transforming our own organization through institutional change;
2. working with residents on neighborhood initiatives and building partnerships to address the root causes of health inequities;
3. addressing local, state, and federal policies that impact social and health inequities;
4. supporting this innovative work with data and research; and
5. connecting our programs and services to all of these areas.

Our work is also guided by our Framework for Achieving Health Equity, adapted from the Bay Area Regional Health Inequities Initiative (**Exhibit 22**).

Exhibit 22. Framework for health equity



Inclusive and affirming community with strong history of advocacy for marginalized populations. In 1946 following World War II, the Oakland General Strike began when more than 400 women working at two department stores downtown went on strike for wage equality. When the police brought in professional strike-breakers and began beating the protesters, more than 1/4 of the entire population of Oakland went on a general strike for 54 hours to protest in solidarity. Twenty years later, the Black Panther Party was founded in Oakland. The Black Panther Party would go on to challenge police brutality, address food injustice, and even provide basic healthcare for African American Oakland residents not being served by the system. Today, the Ella Baker Center for Human Rights works in Oakland to organize with Black, Brown, and low-income people to shift resources away from prisons and punishment and towards opportunities that make our communities safe, healthy, and strong. The Black Lives Matter movement, co-founded by Oakland residents, seeks to affirm the lives of Black queer and transgender folks, disabled folks, undocumented folks, folks with records, women, and all Black lives along the gender spectrum. The network centers on those who have been marginalized within Black liberation movements. The City of Berkeley has also long been known as a leader of activism and social justice, with UC Berkeley often lauded as the birthplace of the Free Speech Movement. In short, Alameda County is a diverse, progressive place with a long history of citizens working toward positive change and the betterment of the lives of those around them. This legacy will serve as an important backdrop for the work we need to do to finally close the gap on multiple health disparities and end the HIV epidemic in Alameda County.

Gaps and Challenges

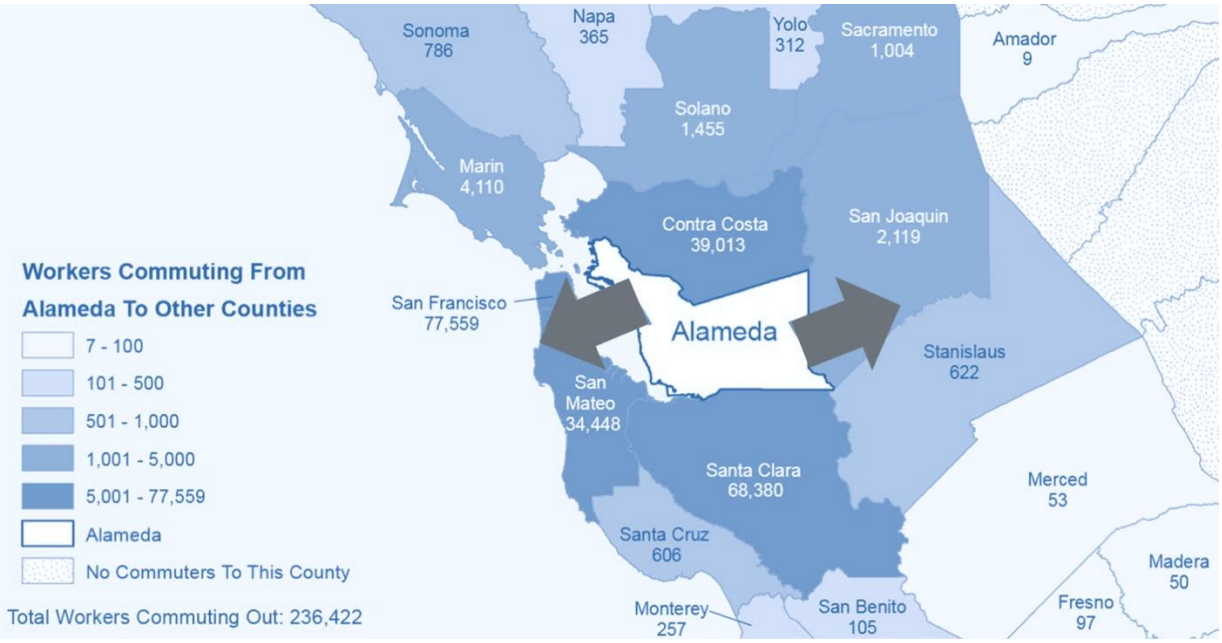
Alameda County has a number of pillar-specific and cross-pillar challenges and gaps that will need to be addressed in order to reach EtHE goals. See below.

Exhibit 23: Alameda County Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Insufficient extended service hours and nontraditional models to better meet the needs of priority populations. Many of our priority populations are simply not well served by traditional 4-wall clinics or service organizations with hours from 9 – 5 on Monday through Friday, a structure that inhibits HIV testing and screening rates and is a barrier to care linkage for people testing positive.	●			
Insufficient education and community knowledge regarding HIV and its treatments. While there have been incredible advancements in HIV treatment, many people in Alameda County continue to hold outdated perceptions about the options available to them if they do become infected with HIV.		●		
Lack of programs to support HIV retention in care for formerly incarcerated persons. A great area of need is for recently released PLWH who were able to access treatment while incarcerated, but for whom there is insufficient re-entry support.		●		
Ongoing opioid and methamphetamine epidemics. The “war on drugs” has failed people in Alameda County and increasing epidemics of opioid and methamphetamine use make it difficult to prevent both primary and secondary HIV infections.			●	
No free, publicly funded sexual and reproductive health clinic. There is no public clinic in Alameda County that focuses on sexual and reproductive health, including stigma-free STD testing.			●	
Data to Care. Limited capacity for epidemiological analyses and HIV surveillance activities including Data to Care prevent Alameda County from ideal targeting of resources and programs to best address HIV.				●
Cross-Pillar				
Racism. Like all counties, Alameda County residents continue to suffer from racism, including structural racism and its many pervasive effects on social determinants of health and access to healthcare.				
Medical mistrust. Failure by health and research institutions to rebuild trust among African Americans has impacted their access to and use of health- and HIV-related services.				
Stigma. Like most Americans, our residents continue to be impacted by persistent stigma regarding sexual and gender identity, as well as HIV status.				

Insufficient institutional support to nurture community and public health leadership among communities most impacted. The ACPHD partially holds the responsibility to cultivate and support development of new leaders in HIV public health locally, particularly among African American and Hispanic/Latinx men and the transgender community.
A substantial and worsening housing crisis. Without a safe place to sleep, it is nearly impossible to expect people to avoid risk for HIV or achieve viral suppression if they are already living with HIV.
Lack of accessible, culturally competent mental health and substance use services. For those struggling with problematic substance use and/or mental health concerns, there are insufficient options for behavioral health services that will meet their needs in a culturally appropriate way.
Increasing economic pressure and substantially increased migration. Increased flow into Alameda County from San Francisco, and out of Alameda County to less expensive outlying areas, causes challenges for retention in HIV care and other challenges to HIV treatment.
In the hierarchy of need, systematically mistreated and underserved people are less likely to prioritize non-emergency healthcare. Food insecurity, housing loss, threat of violence, and fear of stigmatization all dwarf non-urgent health concerns.

Insufficient extended service hours and nontraditional models to better meet the needs of priority populations. Many of our priority populations are simply not well served by traditional 4-wall clinics or service organizations with hours from 9 – 5 on Monday through Friday. Some clients experience additional difficulty in paying for or accessing public transportation, as many are forced to move further out from the city centers due to gentrification. Transportation vouchers are available, but not in sufficient numbers to meet need. In Alameda County, about a third (236,422) of the approximately 693,000 residents who worked commuted to another county to work between 2009 and 2013 (**Exhibit 24**).[35] The median commute time is almost 33 minutes, and a large proportion of residents commute more than an hour to work.[35] Low-income clients with daytime jobs or family obligations may find it particularly difficult to access clinics or other services that are only open during traditional workday hours. Community Forum participants and EBGTZ stakeholders have repeatedly stressed the need for more after-hours services, drop-in clinics, and street outreach, “tent visits” at homeless encampments, or other community interventions that meet potential clients where they are.

Exhibit 24. *Commuter Flows out of Alameda County, 2009-2013.*

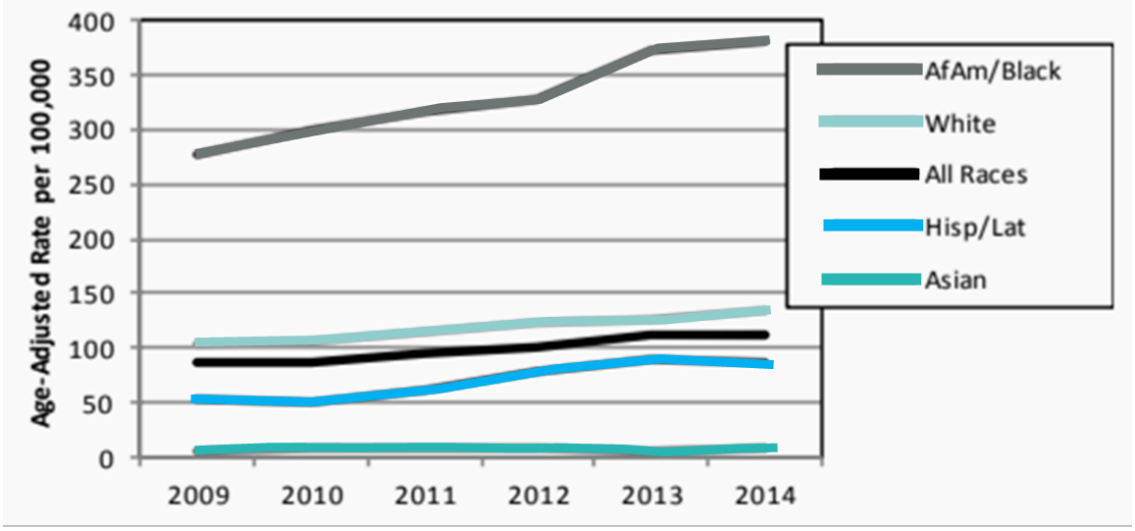


Insufficient education and community knowledge regarding HIV and its treatments. While there have been incredible advancements in HIV treatment, many people in Alameda County continue to hold outdated perceptions about the options available to them if they do become infected with HIV. This exacerbates existing health disparities and prevents us from making the strides we need to drive down HIV incidence and improving rates of viral suppression. This challenge exists in the context of underfunded public education and consequent inadequate resources to meet community needs, especially in Oakland. Additional context includes low high school graduation rates and a heavy burden of incarceration among young men of color.

Lack of programs to support HIV retention in care for formerly incarcerated persons. People incarcerated in Alameda County jails are able to access HIV treatment; however, once released, there is insufficient re-entry support to ensure continuity of care. ACPHD needs to work with partners that serve re-entry persons to better understand the gaps and where additional coordination and services are needed. ACPHD is not able to fund testing in jails but CBO partners can be funded to offer more testing and prevention and care linkages to individuals once released.

Ongoing opioid and methamphetamine epidemics. Increasing epidemics of opioid and methamphetamine use make it difficult to prevent and treat HIV. The complexity of addressing these issues is increased by the use of Fentanyl and methamphetamine in combination in the Bay Area, instead of more traditional heroin,[22] which increases the risk of overdose and other complications of drug use. Emergency Department (ED) visits as a result of heroin, Fentanyl, or other opioids illustrate the ongoing racial health disparities in Alameda County, with African Americans making up a highly disproportionate number of the opioid-related ED visits in the county (**Exhibit 25**).[28]

Exhibit 25. Opioid-Related Emergency Department Visits, Alameda County



No free, publicly funded sexual and reproductive health clinic. There is no publicly-funded clinic in Alameda County that focuses on sexual and reproductive health, including stigma-free STD testing. While HIV and STD testing are available at a number of community health clinics, Planned Parenthood, private providers and other community-based organizations, the lack of a municipal sexual health clinic is notable in the Bay Area.

Data to Care. There are only 2.5 staff at the ACPHD with epidemiological training and a job description that allows them to focus on HIV surveillance, data analysis, and Data to Care activities. Given the size of Alameda County's HIV epidemic along with its geographic spread and demographic diversity, more capacity for detailed epidemiological analysis is needed to improve the county's capacity to identify people newly diagnosed with HIV and link them to care as quickly as possible.

Racism. A growing body of literature clearly documents the effects of both individual and structural racism,[36-38] including its many pervasive effects on social determinants of health and access to healthcare. A profound history of racism and white supremacy in the U.S. means that many African American and Hispanic/Latinx residents lack sufficient socioeconomic resources to maximize their health and wellness,[39] and suffer increased mental and physical health challenges as a result of longstanding stress responses to experienced and perceived discrimination.[40] In addition to the legacies of slavery and discriminatory legal and criminal justice systems and exploitative use of labor and migratory work-forces, Alameda County continues to manifest the costs of redlining and environmental racism through allowing communities of color to experience higher levels of pollution and a lack of support for public and private investment in certain communities, for example, with persistent food deserts. Furthermore, African American and Hispanic/Latinx people frequently experience racist discriminatory treatment directly from healthcare providers or their staff. Even ACPHD itself uses work, hiring and procurement strategies through which racism and bias have a pervasive and damaging impact, although the department has begun the slow and difficult work to uncover and address these. We invite other institutions working in HIV and beyond to follow suit. Without

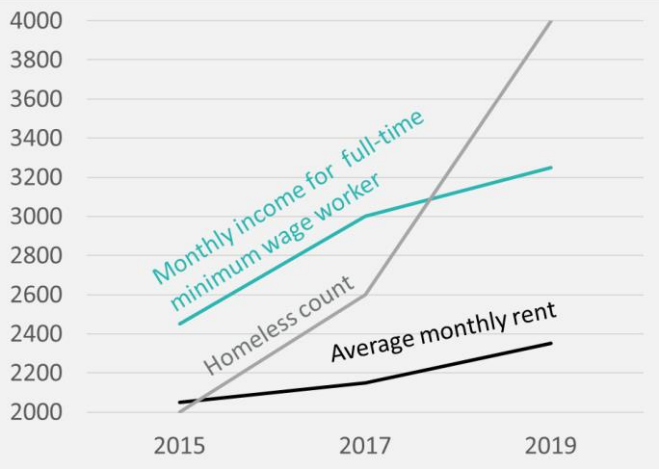
addressing these major, lifelong individual and systemic offenses, we will continue to see disparities in HIV-related outcomes in Alameda County.

Medical mistrust. After a long history of poor treatment by a racist medical system, health and research institutions have mostly failed to rebuild trust among African Americans regarding medical treatments. Though often framed more as personal failings, this continued breakdown between our White-dominated health systems and African American consumers is one of the major contributing factors to disproportionately low uptake of PrEP in this demographic. Similarly, we have not succeeded in maximizing the individual and community benefits of HIV treatment (particularly in the era of U=U) among African Americans some of whom may be unwilling to engage in a system that has served them badly over many decades.

Stigma. Residents of Alameda County continue to be impacted by persistent stigma regarding sexual and gender identity as well as HIV status. Stigma related to sexual behavior and sexual or gender identity has been proven to hinder HIV prevention and treatment efforts for many of those most in need,[41] especially when stigma about multiple identities (e.g. race, sexual orientation, and gender) converge.[42] HIV-related stigma has been strongly associated with higher rates of depression, lower levels of healthcare access, and lower levels of adherence to ART.[43,44] Stigma experienced in health facilities undermines health outcomes, particularly in diagnosis and treatment.[45] Interventions that actively address real and perceived stigma are required to disrupt current patterns in the HIV epidemic.

A substantial and worsening housing crisis. Without a safe place to sleep, it is nearly impossible to expect people to avoid risk for HIV or achieve viral suppression if they are already living with HIV. The housing crisis in Alameda County is worsening rapidly (**Exhibit 26**),[46] creating a state of emergency for many at risk for or living with HIV.

Exhibit 26. Oakland Rent, Wages, and Homelessness

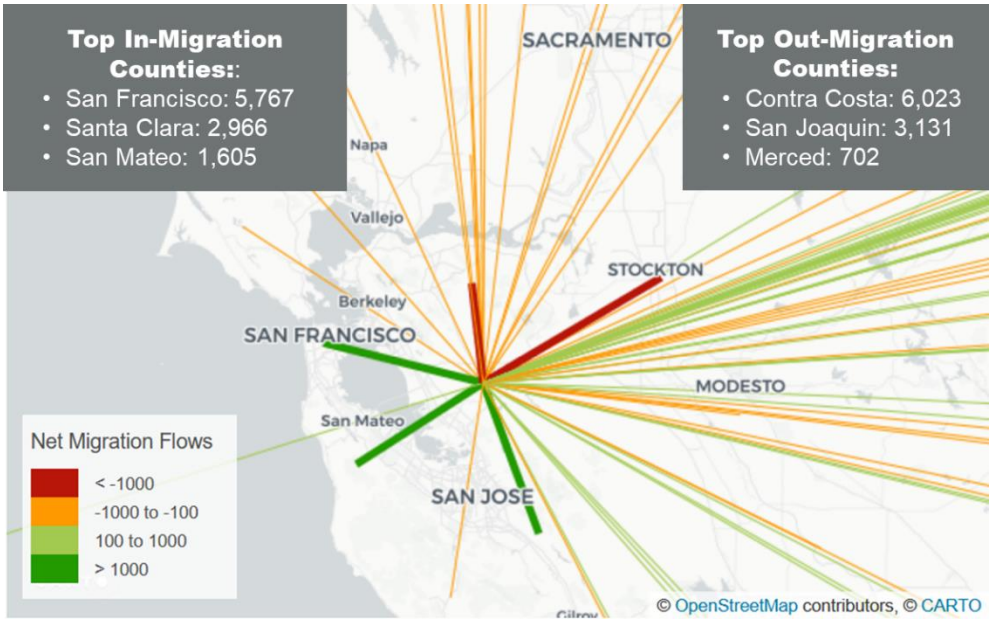


Lack of accessible, culturally competent mental health and substance use services. For those struggling with problematic substance use and/or mental health concerns, there are insufficient options for behavioral health services that meet their needs in a culturally appropriate way. Providers and PLWH both report that there is a dearth of accessible, culturally competent behavioral health providers in Alameda County. The mental health providers who do serve Ryan White clients and other PLWH are often subject to high staff turnover, leaving a rotating group of less experienced staff working with populations where behavioral health needs and substance use are common and who have experienced high levels of trauma. In FY 2020, the Oakland TGA Planning Council has prioritized conducting a mental health needs assessment for PLWH to better understand these needs and to inform future resource allocations.

Increasing economic pressure and substantially increased migration. As costs of living in the Bay Area continue to skyrocket, gentrification and other economic pressures have led to

increased flow into Alameda County from San Francisco and out of Alameda County to less expensive outlying areas, as shown in **Exhibit 27**, from 2014.[29] This causes challenges for retention in HIV care and other challenges to HIV treatment.

Exhibit 27. Migration Patterns to and from Alameda County



In the hierarchy of need, systematically mistreated and underserved people are less likely to prioritize non-emergency healthcare. Simply put, food insecurity, housing loss, threat of violence, and fear of stigmatization all dwarf non-urgent health concerns for anyone. Disruptive innovations to end HIV in Alameda County will require collaborative and creative approaches to all of these issues, not simply healthcare-focused prevention and care responses to disease.

Section IV: Ending the Epidemic Plan

This section provides a detailed overview of the disruptively innovative activities that Alameda County will implement to End the HIV Epidemic by 2025. The EtHE activities are above and beyond the foundational efforts and are designed to be directly responsive to the needs and gaps identified in *Section III: Situational Analysis.* The proposed EtHE activities are designed to enhance but not duplicate current programs and services and are inclusive of all disruptively innovative activities, regardless of funding source. As ACPHD discovers more through implementation these activities are subject to revision.

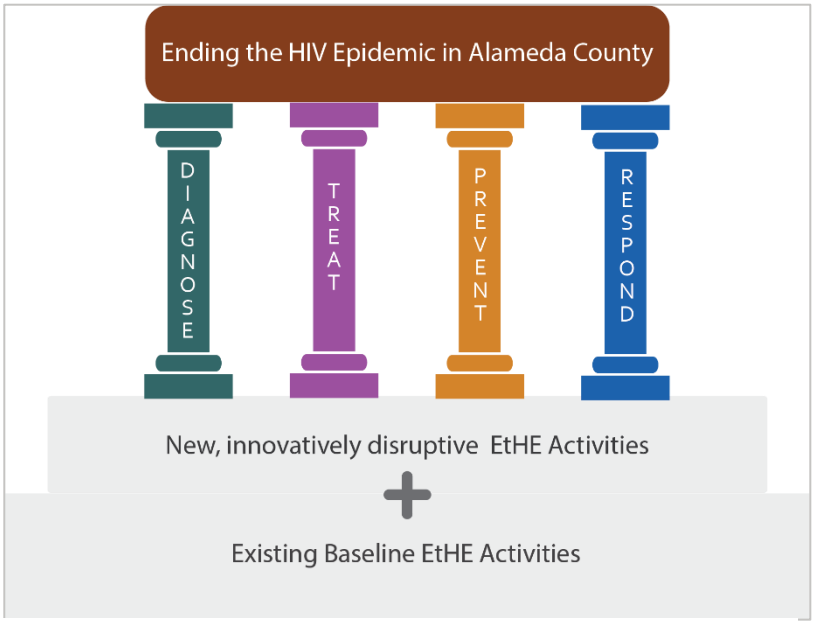


Exhibit 28. Schematic of how new, disruptively innovative EtHE activities in Alameda County will build upon existing efforts to respond to local needs and gaps that have not been sufficiently addressed to date.

EtHE Programs and Key Partners

Alameda County has identified six innovative efforts that will help propel us toward ending the HIV epidemic. These efforts will require close partnership with several existing as well as new partners in order to be successful. The programs and partners are described below.

Summary of Proposed Programs

- **Enhanced Testing.** ACPHD will offer enhanced testing services to increase routine opt-out testing (ROOT) in health care and correctional facilities, to increase focused testing of priority populations, and to offer self-testing through home-delivered kits. *(Diagnose, Treat, Prevent)*

- **Data to Care/Data to PrEP.** The Data to Care activity will use HIV surveillance data to identify newly diagnosed persons for linkage and partner services and PLWH who are not in care to reengage them in care. *(Treat, Prevent, Respond)*

- **Same Day PrEP.** This program will provide same-day PrEP to B/AA and Hispanic/Latinx MSM, young MSM of color, the transgender community, sexual and substance using partners of PLWH, and women at high risk for HIV. It will increase screening for PrEP indications among HIV-negative clients, and increase referral and rapid linkage of persons with indications for PrEP. *(Prevent)*

- **Augmentation over Baseline Initiative** will strategically increase the stability of HIV services and will be focused on supporting PLWH, especially those who are most affected by systemic racism and its outcomes: unemployment, police violence, trauma, et cetera. Services augmented include direct financial assistance, employment support and whole person wellness. Funded through HRSA 20-078 funding. *(Treat)*
- **Capacity Building and Innovations Fund (CBIF)** will create an iterated pathway and menu of resources to empower new small, emerging and/or exiting provider organizations to 1) join the county's network of HIV providers; 2) build their capacity to provide new and innovative services; and/or 3) initiate cross organization collaborative service models to more effectively meet the EtHE focus populations. Up to 10 CBOs will enter this capacity building program focused on supporting growth in at least one of key areas 1) organizational capacity; 2) cross agency collaborative service provision; 3) community partnerships; 4) HIV sector specific knowledge; 5) diversity, equity and inclusion; 6) adoption of new and promising practices; 7) housing, behavioral health and/or asset building activities; 8) trauma informed care practices; 9) culturally specific programming; and 10) special populations. Funded through HRSA 20-078 funding. *(Treat)*
- **Project Empowerment- Oakland LGBTQ Community Center.** This program will focus on HIV testing, linkage to and retention in care and PEP/PrEP. The primary populations to be served include members of the LGBTQ community, specifically Black, gay and bisexual men and Black transgender women and men living with or at risk for HIV. The Oakland LGBTQ Community Center will serve as a wellness hub in Oakland and will transform the existing sexual health landscape for people in the East Bay. Importantly, this hub will serve individuals of all ages, providing resources for adults, teens, and children, with strategic design features to meet the needs of diverse groups within a shared space. (Diagnose, Treat, Prevent)

- **Project Empowerment- UCSF Benioff.** This program will provide linkage to and retention in care and PEP/PrEP and high-quality culturally responsive HIV prevention services for Black/African American (B/AA) transgender women and cisgender women living with HIV/AIDS (not virally suppressed). The program will also provide direct outreach to substantial-risk transgender and cisgender women living on the streets or in homeless encampments who engage in sex work. The overall intent of the proposed program is to reach key underserved (sub)populations in Alameda County with innovative, culturally appropriate, and peer-based outreach and education services and linkage to appropriate treatment options in their own language and from their own perspective, while honestly addressing personal and social barriers to health equity and self-sufficiency. (Diagnose, Treat, Prevent)

- **Project Empowerment-Bay Area Community Health (BACH).** This program will fund staffing and capacity building to implement a program of expanded PrEP and PEP outreach, linkage, and retention services specifically targeted to B/AA and Hispanic/Latinx transgender women in Alameda County. The program will support critically needed funding to hire a new full-time Transgender PrEP Outreach Specialist/Peer Coordinator as well as transgender peer outreach staff who will be trained and given stipends through the program. The proposed intervention will build on

BACH's nationally recognized transgender services program, TransVision, with the goal of significantly increasing the number of transgender women of color in Alameda County who are enrolled and retained in PrEP and PEP services which will in turn decrease the number and incidence of new HIV infections among the transgender community in this region.

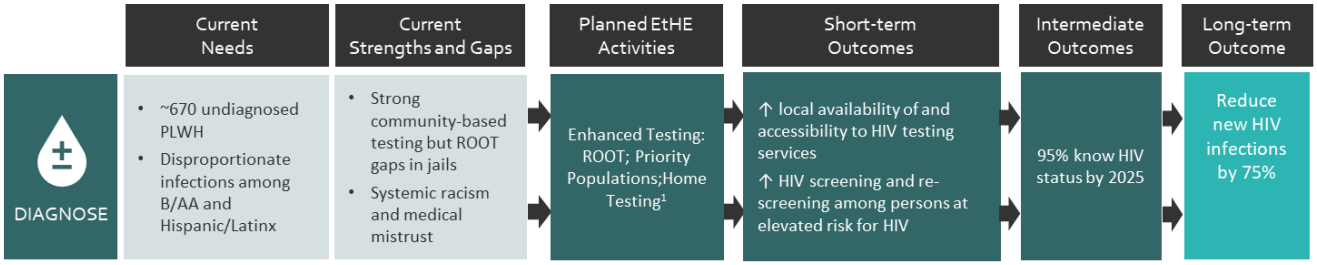
Key Partners

Alameda County will work with key partners to develop and implement the proposed programs and services including organizations serving MSM of color, especially those under age 30; the transgender community; current and formerly incarcerated people; women of color; those working with PWID; and those with particular technical expertise. These include:

- **Alameda County Departments/Surveillance.** Alameda County personnel responsible for HIV/STD testing and surveillance will be crucial in our efforts to expand our data-to-care and data-to-PrEP efforts by identifying newly diagnosed persons and PLWH not engaged in HIV care, and individuals diagnosed with an STD for HIV testing, PrEP, or PEP.
- **Community Based Organizations.** Organizations that service B/AA and Hispanic/Latinx G/MSM, the transgender community, and other priority populations have built trusting relationships within the communities they serve. They will be important partners in engaging these populations.
- **Correctional Facilities.** The participation of partners in correctional facilities will be instrumental in successful implementation and expansion of ROOT, helping to identify PLWH who would not be diagnosed otherwise. ACDPH will work with CBO partners with established relationships with correctional facilities and that serve substantial risk and PLWH pre-release and reentry clients.
- **East Bay Getting to Zero** (EBGTZ). EBGTZ is a collaboration between ACPHD UCSF PAETC-GTZ and over 300 participants included Contra Costa County, community-based organizations and clinical providers. EBGTZ has been a leader in bringing community voices to the table and creating a plan reflective of that input.
- **Harm Reduction Services Organizations.** Harm Reduction Services Organizations have longstanding relationships with PWID and will help build trust with this hard-to-reach community.
- **Healthcare Facilities.** Healthcare facility partners will be key to increasing the number of PLWH who are diagnosed through ROOT.
- **HIV/STD Testing Services Providers.** HIV/STD testing services providers can be crucial partners, enabling us to engage more communities.
- **Oakland TGA Planning Council.** The OTGA Planning Council will be an invaluable partner in engaging new voices in the planning process.
- **Other County Health Departments.** ACPHD has active collaborations with Contra Costa and San Francisco Counties and each were consulted while developing this EtHE plan.

Alameda County's Plan to End the HIV Epidemic

Diagnose



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Enhanced Testing**

Diagnose: Alameda County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities **Strategy 1B.** Develop locally-tailored HIV testing programs to reach persons in non- healthcare settings **Strategy 1C.** Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings	
Enhanced Testing Initiative	
• **Assess the gaps in testing services for EtHE priority populations in order** to link the last 670 undiagnosed individuals in the county to testing using strategic expansion of ROOT; focused testing; and home testing. • **Create a TA plan** to assist with Enhanced Testing implementation including, for example, medical detailing, capacity building for healthcare providers, navigators to link and re-engage PLWH in HIV care with providers, and building capacity to reach EtHE priority populations. • Issue an RFP to solicit proposals for **Enhanced Testing** using one or more of the models: ROOT expansion, focused testing or self-testing. • **Implement or expand Enhanced Testing** in healthcare settings and/or correctional settings to identify people with HIV who would not be diagnosed otherwise.	• Evaluate results of RFP and replicate best practices in new settings.

HIV Workforce Development Needs

Positions

- **Outreach Workers.** Outreach workers will be frontline staff with key knowledge and connections to the priority populations.
- **Communicable Disease Investigation (CDI) Staff.** CDI Staff will be responsible for collecting and analyzing surveillance data to identify partners of newly-diagnosed HIV and STI patients for follow-up. CDI Staff will also use surveillance data to identify potential disease hot spots.
- **HIV Care, Prevention, and Surveillance Training.** Anticipated turnover in these ACPHD divisions will require training staff to maintain departmental qualifications.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, Alameda County will make special efforts to recruit a workforce that mirrors the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations and build trust.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Alameda County Departments**
- **Community Based Organizations**
- **Correctional Facilities**
- **East Bay Getting to Zero**
- **Healthcare Facilities**
- **Oakland TGA Planning Council**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Enhanced Testing	$ 902,198	CDC PS20-2010
TOTAL FUNDING FOR DIAGNOSE PILLAR*	$902,198	

*$0.00 exclusively for Diagnose Pillar, and $902,198 for programs that cut across Diagnose and other pillars.

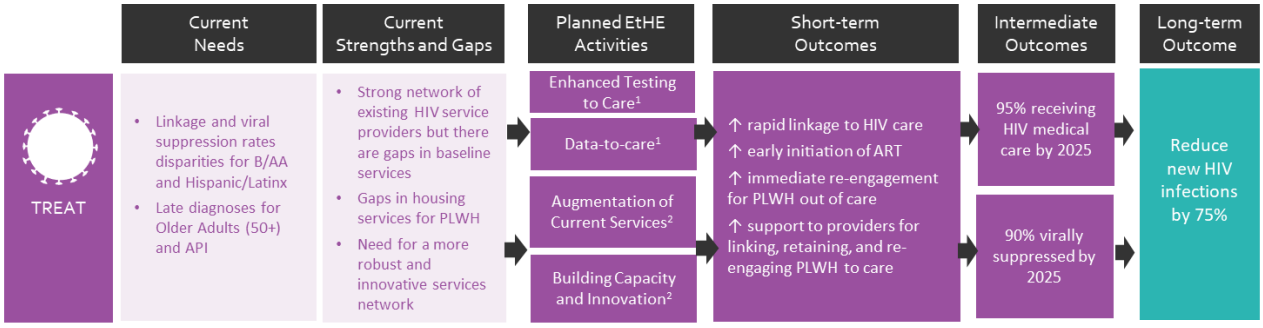
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[31] Targets will be determined in coordination with CDC as the EPMP is finalized.

Diagnose: Alameda County	
Outcome Measure	**Data Source**
Percentage of health care facilities identified as priority settings for routine opt-out HIV screening*	
Percentage of HIV tests conducted in healthcare facilities identified as a priority for EHE testing services*	Patient charts
Percentage of persons incarcerated in large county jails who were tested for HIV*	
Establish systems whereby patients with elevated risk are routinely identified and HIV tests are ordered at least yearly*	Documentation of systems and HIV testing orders
Number of “champions” who lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population*	

*ROOT in Healthcare Settings/Correctional Facilities

Treat



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Enhanced Testing to Care**
- **Data to Care/Data to PrEP**
- **Augmentation over Baseline Initiative**
- **Capacity Building and Innovations Fund (CBIF)**

Treat: Alameda County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)	
Data to Care/Data to PrEP	
• Use HIV surveillance data to **identify newly *diagnosed persons*** for linkage and partner services. • Use HIV surveillance data to **identify people living with HIV who are not in care** and re-engage them in care. • Use HIV and STD surveillance data to **identify people diagnosed with an STD** for HIV testing, PrEP, or PEP as indicated.	• Continue to refine and improve protocols
Enhanced Testing to Care	
• Release RFP for enhanced HIV testing services in Alameda County focused on priority populations listed in this EtHE plan. • Activities TBD – enhanced linkage to care referrals.	• Continue to refine and improve linkage to care protocols.
Augmentation over Baseline	
• Develop RFP to distribute EtHE funds among Ryan White providers in order to strategically increase the stability of HIV services and focus on supporting PLWH, especially those who are most affected by systemic racism and its outcomes: unemployment, police violence, trauma, et cetera. Services augmented include direct financial assistance, employment support and whole person wellness.	• Refine and focus funding to align with gaps identified through ongoing needs assessment.
Capacity Building and Innovations Fund	
• Capacity building trainings content and format TBD through formative evaluation by a capacity-building consultant. • Develop RFP for mini-grants for up to 10 CBOs organizations with connections to EtHE priority populations but with limited HIV program experience.	• Provide ongoing technical assistance and training to CBOs to build capacity to expand effective programs.

HIV Workforce Development Needs

Positions

- **Linkage Specialists.** Linkage specialists will use surveillance and other data to identify patients not in care and work with them to re-engage in care.
- **Alameda County Surveillance.** Epidemiologists and data analysts to support Data to Care, HIV transmission cluster and other analyses of surveillance data.

- **HIV / PrEP Navigation Training**. We will provide training to ensure that staff are well equipped to provide disease intervention and navigation services.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, Alameda County will make special efforts to recruit a workforce that mirrors the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Alameda County Departments**
- **Capacity building consultants**
- **Community Based Organizations**
- **Community leaders**
- **Correctional Facilities**
- **East Bay Getting to Zero**
- **Healthcare Facilities**
- **Oakland TGA Planning Council**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Data to Care/Data to PrEP **Enhanced Testing to Care**	$902,198	CDC PS20-2010
Augmentation over Baseline Initiative **Capacity Building and Innovations Fund**	$850,000	HRSA 20-078
TOTAL FUNDING FOR TREAT PILLAR*	$1,752,198	

- $0 exclusively for Treat Pillar, and $1,752,198 for programs that cut across Treat and other pillars.

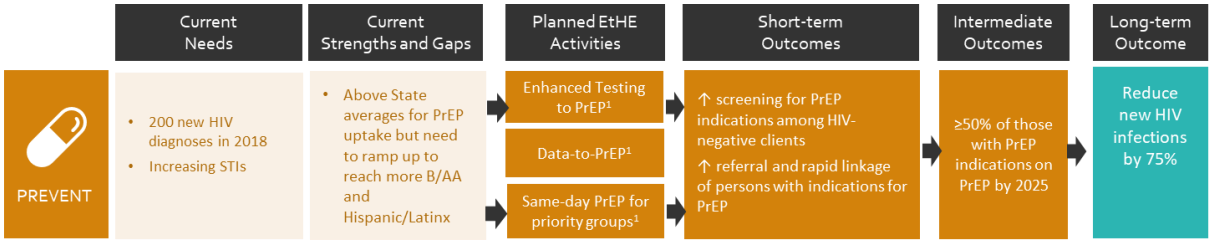
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[31] Targets will be determined in coordination with CDC as the EPMP is finalized.

Treat: Alameda County	
Outcome Measure	**Data Source**
Develop, expand and scale up Data to Care programs using surveillance data and other data sources to identify patients not in care (e.g., within 30 days of missed ART pick-up) and develop re-engagement strategies (e.g., utilizing linkage specialists, disease intervention specialists).*	Program documentation

*Data to Care/Data to PrEP

Prevent



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Data to Care/Data to PrEP**
- **Same Day PrEP**
- **Enhanced Testing to PrEP**

Prevent: Alameda County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	
Data to Care/Data to PrEP	
• Use HIV surveillance data to identify newly diagnosed persons for linkage and partner services. • Use HIV surveillance data to identify people living with HIV who are not in care and re-engage them in care. • Use HIV and STD surveillance data to **identify people diagnosed with an STD** for HIV testing, PrEP, or PEP as indicated.	• Continue to refine and improve protocols
Same-Day PrEP	
• **Provide same-day PrEP** to B/AA and Latino MSM, MSM of color (age 24 and younger), the transgender community, sexual and substance using partners of PLWH, and women at substantial-risk. • **Issue an RFP to expand same-day PrEP** in Alameda County. Subcontracting agencies may provide capacity building for healthcare providers to implement same-day PrEP; navigators to link people with a recent HIV negative test and those diagnosed with an STD to a PrEP prescriber.	• Evaluate and monitor subcontracts • Continue to provide and expand services
Enhanced Testing to PrEP	
• **Release RFP** for enhanced HIV testing services in Alameda County focused on priority populations listed in this EtHE plan. • Activities TBD – PrEP referrals.	• Evaluate services and track outcomes

HIV Workforce Development Needs

Positions

- **PrEP Linkage Specialists.** PrEP linkage specialists will use surveillance and other data to identify patients at risk for HIV, those with a recent HIV test, and those diagnosed with an STD, and provide linkage to a PrEP prescriber.
- **Alameda County Surveillance.**
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.
- **PrEP Navigation Training**. Provide training to ensure staff are well equipped to ensure persons testing negative for HIV can be rapidly evaluated for and initiate PrEP at the time care is provided.

Capacity-Building

When building capacity, Alameda County will make special efforts to recruit a workforce that mirrors the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations. Provider education programs will build provider skills and capacity for linking clients living with HIV to care, and follow-up technical assistance will help ensure implementation.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Alameda County Surveillance**
- **Community Organizations**
- **East Bay Getting to Zero**
- **Harm Reduction Services Organizations**
- **HIV/STD Testing Services Providers**
- **Oakland TGA Planning Council**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Data to Care/Data to PrEP	$902,198	CDC PS20-2010
Same Day PrEP		
Enhanced Testing		
TOTAL FUNDING FOR PREVENT PILLAR*	$902,198	

- *$0 exclusively for Prevent Pillar, and $902,198 for programs that cut across Diagnose and other pillars.

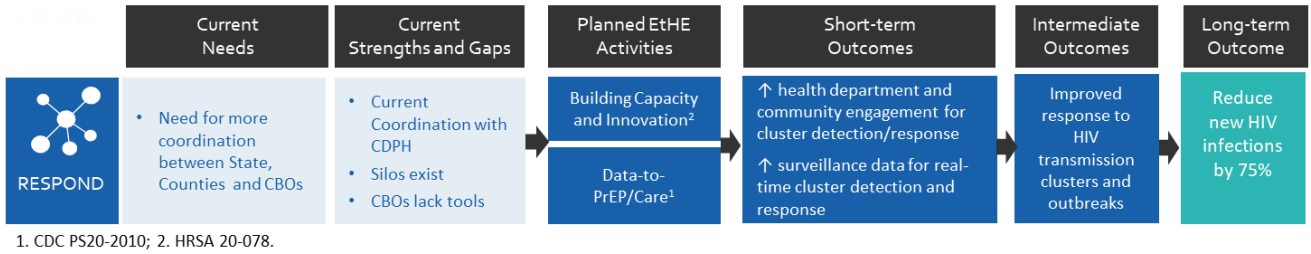
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[31] Targets will be determined in coordination with CDC as the EPMP is finalized.

Prevent: Alameda County	
Outcome Measure	**Data Source**
Number and percentage of clinicians prescribing PrEP within 3 months following detailing visit(s)†	Detailing and prescribing records
Number of HIV-negative clients who are screened for PrEP†	Patient charts
Number and percentage of HIV-negative clients with indications for PrEP who are linked to PrEP†	Patient charts
Number of persons prescribed PrEP among those with indications for PrEP†	Patient charts
Provide trainings and technical assistance to non-clinical CBOs that provide HIV testing services to screen clients for PrEP indications, support clients in learning about PrEP, and facilitate linkage to PrEP care (e.g., CBOs, SSPs)#	Documentation of trainings and technical assistance
Number of non-clinical CBO staff provided trainings or TA on PrEP screening and linkage#	Training/TA records
Documentation of supporting client access to existing traditional PrEP care delivery systems and non-traditional PrEP care delivery systems†	Patient charts
Develop, expand, and scale-up Data to PrEP programs using surveillance data and other data sources to identify patients eligible for PrEP and develop outreach strategies*	Documentation of programs and outreach strategies

*Data to Care/Data to PrEP
†Same Day PrEP
#Training for PrEP and Harm Reduction Services

Respond



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **Capacity Building and Innovations Fund (CBIF)**
- **Data to Care/Data to PrEP**

Respond: Alameda County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response **Strategy 4B.** Investigate and intervene in networks with active transmission **Strategy 4C.** Identify and address gaps in programs and services revealed by cluster detection and response	
Capacity Building and Innovations Fund	
Data to Care/Data to PrEP	
• **Coordination with CDPH**-The county Surveillance Staff will work with the CDPH OA Surveillance Staff to ensure ability to respond when clusters are identified and investigation is needed. • **Coordination with CDPH-** County surveillance staff will provide CID as much locating information as possible so that CID can reach out and contact those identified as part of the cluster, as well as the partners identified in the initial interviews. If the number of people to be interviewed is higher than the capacity of the county CID staff, CDPH OA will deploy their partner services staff to the county. If the cluster response is elevated, CDPH Emergency Response protocols will be followed. • **Coordination with CDPH-** A debrief meeting with county staff and CDPH OA staff will happen after each outbreak response in order to refine and ensure the most effective response actions are initiated.	• **Coordination with CDPH**-Sustain communication between surveillance staff and CDPH OA. • **Coordination with CDPH-** Continued initiation of Cluster Response activities. • **Coordination with CDPH-** Post-response debrief meetings will continue to be conducted.

HIV Workforce Development Needs

Positions

- **Communicable Disease Investigation (CDI) Staff.** CDI Staff will be responsible for collecting and analyzing surveillance data to identify partners of newly-diagnosed HIV and STI patients for follow-up. CDI Staff will also use surveillance data to identify potential disease hot spots.

Capacity-Building

ACPHD will work closely with state and federal partners to respond quickly to a newly identified HIV cluster, utilizing trained county epidemiological staff and Communicable Disease Investigators. ACPHD will leverage resources and expertise of the California State Office of AIDS to tailor local response efforts.

For the Capacity Building and Innovative Fund, ACPHD will work closely with Jeweled Consulting to train a cadre of new HIV support services mini-grant recipients on a range of issues including use of data to improve programs and partnering with surveillance staff to better link clients to prevention and care services.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 42. A list of those related to this pillar is below.

- **CDPH-OA**
- **Community Based Organizations**
- **Jeweled Consulting**

Funding

ACPHD does have funding identified for the RESPOND Pillar in the CDC 20-2010 and HRSA 20-078 grants including support staff, including additional Communicable Disease Investigators, who would play a vital role in cluster response efforts.

Program/Effort	Total Funding	Proposed Funding Source
Capacity Building and Innovations Fund	$850,000	HRSA 20-078
Data to Care/Data to PrEP	$902,198	CDC 20-2010
TOTAL FUNDING FOR RESPOND PILLAR*	$1,752,198	

- *$0 exclusively for Respond Pillar, and $1,752,198 for programs that cut across Respond and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[31] Targets will be determined in coordination with CDC as the EPMP is finalized.

Respond: Alameda County	
Outcome Measure	**Data Source**
Cluster data is reviewed and prioritized, response is guided and reviewed, procedures are modified to improve responses.	Reports of committee and community meetings, after action review meetings
Percent of all persons with diagnosed HIV infection who are entered into the local surveillance system within ≤30 days of date of diagnosis.	Surveillance system
Percent of laboratory results that are entered into the surveillance system ≤ 14 days after specimen collection**.**	Surveillance system
A data system is developed to rapidly analyze, integrate, visualize, and share data in real time.	Data system documentation
A flexible funding mechanism is developed to allow reallocation of resources for a response within one month.	Funding mechanism documentation
Implementation of methods to understand the entire network, including people with diagnosed HIV, undiagnosed HIV, or at high risk for HIV infection.	Methodology documentation
Processes and mechanisms are developed to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, for people identified through investigation of cluster networks.	Documentation of processes and mechanisms
Data analysis and response results for clusters of concern are reported to CDC until investigation and intervention activities are closed.	Documentation of submission

Regional Coordination and Planning

Alameda County and San Francisco County collaboration. Alameda County and neighboring San Francisco recognize the need for a coordinated regional effort to ensure seamless access to PrEP and referrals to care. This is a collaboration effort while not funded through PS20-2010, will enhance EtHE work. Alameda and San Francisco Counties are the anchors of the Bay Area on their respective sides of the Bay. Their close proximity and easy inter-county movement requires a coordinated effort to End the HIV Epidemic. Therefore, these two counties have designed a cross-jurisdictional plan to ensure widespread and equitable PrEP access and referrals to care. This plan unites the key activities proposed by each jurisdiction to create a unified bridge to ensure that residents of both counties will have the support they need to access PrEP and referrals to other needed services. Alameda County's health equity innovations grants and Same Day PrEP activities are keystone interventions of the partnership. In addition, the counties will cooperate on a mass transit social marketing campaign to raise awareness and connect people to PrEP and other critical services.

Alameda County and Contra Costa County collaboration. Alameda County and Contra Costa County together comprise the Oakland Transitional Grant Area. Both counties participate

in the annual planning, prioritizations and resource allocation for baseline HIV care services. Both counties are sponsors and active participants of EBGTZ's Linkage and PrEP networks discussed in more detail on page 30. These networks and other community partners were mobilized into a special strategic planning effort that overlapped and enhanced the development of the Alameda EtHE plan. The strategic areas of focus identified by the EBGTZ strategic plan[14] are referenced in this plan and will enhance Alameda counties ability to reach its EtHE goals. These strategic areas were first listed on page 17 of this plan. **Exhibit 29** is an infographic that reviews and details these strategic areas. Through the implementation of this parallel strategic plan, Alameda and Contra Costa County will continue to grow and leverage their EtHE efforts to serve PLWH and those at risk of HIV infection regionally. Alameda and Contra Costa County will continue to work with the EBGTZ collaborative and to coordinate this work with the Alameda County EtHE plan to maximize all resources and accelerate EtHE goals.

***Exhibit 29. EBGTZ Strategic Priorities Summary*, 2021-2025**

Strategic priorities:
The following are strategic areas determined by community members to address disparities and gaps and aim to increase routine opt-out HIV testing, same-day PrEP, data-to-PrEP/care, rapid ART for people living with HIV (PLWH), linkage and retention in care. An equity and key communities task force will review these activities.

Community messaging	• **Determine messages** for the East Bay that reflect our diversity, are multilingual, inspire hope, break stigma, reach all communities on U=U/i=i and PrEP-for-All. • **Engage local civil & government leaders, sports figures, creatives, PLWH, youth and other influencers** in this process and leverage political will to push our messages.
Improving collaborations	• **Ensure EBGTZ.org is an easy place online to find** services and contacts, local events, resources and resource guides. Include materials created in Spanish. • **Quarterly collaborative meetings** to discuss shared goals, service directory, resources, strengthen warm handoffs & referrals, collaborative funding and events.
Innovative service models	• **Regional "test-everywhere" strategy**: home testing & linkage protocol, cross-county referral system, address gaps in phlebotomy and access due to immigration status. • **Integrate HIV and PrEP linkages into other services** such as housing, food, re-entry and COVID testing with clear referral/linkage person for every organization.
Youth engagement	• **Regional youth & youth-serving provider network**: share best practices to increase PrEP uptake, integrate youth leadership & build a youth service sustainability plan. • **Youth-led community messaging**: utilize the network to develop and distribute education via youth-focused social media. Engage parents/guardians separately.
Housing initiatives	• **Enhanced cross-training, case coordination and information exchange** between housing and HIV organizations while integrating trauma-informed care practices. • **Exploration of housing policy and funding changes** to increase access to housing, address complex needs, reduce eligibility barriers & create more housing resources.

Section V: Concurrence

ACPHD received concurrence from the OTGA Planning Council for the Alameda County EtHE plan on August 26, 2020. The OTGA Planning Council is an HIV-focused planning group made up of community members, county officials, agencies who serve the HIV community, and people living with HIV/AIDS who are appointed by ACPHD. The Planning Council decides how federal Ryan White funds should be spent in the Oakland TGA (encompassing both Alameda and Contra Costa Counties), and provides comprehensive planning, prioritization, and resource allocation regarding HIV services in the Oakland TGA that are inclusive, equitable, compassionate, and respectful of human rights.

The Council has been kept apprised of progress in the development of the EHE plan, including receiving a draft of this document, which was presented at the July 22, 2020 meeting. **The Council used the following criteria to grant concurrence of the EtHE plan**:

- Best efforts of getting community input in the most challenging of circumstances given the COVID-19 response; and
- Review of the most recent epidemiological data, and subsequent focus on key populations for whom the existing HIV prevention and care services are not sufficient; and
- Community engagement will continue to be a vital part of implementation of this plan for the next 5 years.

The HIV Planning Council will be kept apprised of progress in implementing and any needed revisions of the EtHE plan. Members of the HPC will be encouraged to participate in community engagement activities throughout the implementation years. ACPHD will also work with EBGTZ to align long-standing prevention and planning efforts with the CDC EtHE funded activities described in this plan.

References

1. Oakland Transitional Grant Area Collaborative Community Planning Council, Alameda County Office of AIDS Administration, Contra Costa County HIV/AIDS & STD Program. *2017 - 2021 Alameda & Contra Costa County Integrated HIV Prevention & Care Plan.* Oakland, CA2016.
2. East Bay Getting to Zero. East Bay Getting to Zero: 0 HIV Stigma, 0 Health Disparities, 0 HIV Transmissions. 2020; https://www.ebgtz.org. Accessed December 4, 2020.
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Appendix 1: Resource Inventory

Exhibit 30 lists the services and programs currently available in Alameda County along with their funding sources.

Exhibit 30. Alameda County Baseline HIV Activities and their Funding Sources

Pillar	Baseline Program/Activity	Funding Sources
DIAGNOSE	• Use of HIV surveillance data to inform partner services planning[i] • Use of HIV surveillance data to identify areas with high rates of HIV diagnoses and large numbers of PLWH to inform HIV testing efforts [i] • Training and technical assistance for contracted agencies to engage priority populations in HIV testing[i] • Facilitation of implementation of routine opt-out testing programs[i] • HIV testing for individuals diagnosed with HIV[i] • Use of data to inform quality improvement and promote buy-in for routine testing programs[i]	i. CDC PS-18-1802 ii. HRSA Ryan White Part A iii. HRSA Ryan White Part B (incl MAI) iv. HRSA Ryan White Part C v. HRSA Ryan White Part D vi. HOPWA vii. County GF viii. CDPH Project Empowerment ix. Alameda County General Fund (syringe services programs, prevention for positives) x. CDC PS-21-2102 (pending)
TREAT	• Core care and treatment services (primary care, early intervention services, medical case management, mental health and outpatient substance use services, early intervention services, oral health care, medical nutrition therapy, home and community-based health services)[ii,iii,iv,v] • Support services (housing, medical transportation, food bank/home-delivered meals, case management, emergency financial assistance, psychosocial support, residential substance use services, legal services, medical transportation services, linguistic services, health education/risk reduction, child care services, referrals, treatment adherence counseling)[ii,iv,v,vi] • Protocols for linkage to and retention in care by county staff[i] • East Bay Linkage and Retention Network—community of HIV providers • Use of HIV surveillance data to improve linkage to and retention in care[i] • Use of HIV surveillance data to inform partner services planning[i] • Engagement, re-engagement, and retention of HIV positive PWID in HIV care services	
PREVENT	• Quarterly PrEP/PEP Stakeholder meetings[i] • Support of agencies conducting PrEP navigation and retention[i] • Training/education of providers regarding PrEP, including PrEP PHI[i] • Promotion/information about PrEP in priority populations (“Be Here” campaign) • Use of HIV surveillance data to inform partner services planning[i] • Use of HIV surveillance data to inform PrEP prescriber candidates and priority populations for PrEP[i] • Training of service providers on overdose education, including naloxone use • Syringe disposal services with active collection and drop of sites for used needles • Harm reduction programs[vii] • Use of HIV surveillance data to improve syringe exchange services	

 RESPOND	• Use of HIV surveillance data to improve syringe exchange services • Use of HIV surveillance data to improve linkage to and retention in care[i] • Use of HIV surveillance data to inform partner services planning[i] • Use of HIV surveillance data to identify geographic areas with larger proportion of PLWH[i] • Use of HIV surveillance data to inform quality improvement and promote buy-in for routine testing programs[i] • Collection and reporting of PrEP use data to identify gaps in PrEP availability[i] • Use of HIV surveillance data to inform PrEP prescriber candidates and priority populations for PrEP[i]	

Note: Additional resources for HIV services that cannot be quantified or broken down by pillar include Medi-Cal, Medicare, Veterans Administration, and 3rd party reimbursement

Appendix 2: Community Engagement Documentation

Exhibit 31 lists community engagement event dates, descriptions and key voices and partners.

Exhibit 31. Community Engagement Documentation

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
HRSA Community Forum **10/7/2019**	A community forum to share and gather input on the HRSA EtHE funding opportunity (HRSA-20-078) was held at the ROOTS Community Health Center in Oakland.	***Participants:*** HIV Service providers. OTGA Planning Council members.
CDPH Planning Group Kick-Off Meeting **10/24/2019**	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants:*** Dr. Nicholas Moss, ACPHD HIV STD Section Director, Dr. Neena Murgai, ACPHD HIV Epidemiology and Surveillance Director, Steven Gibson, ACPHD HIV Prevention Director, two members of the OTGA Planning Council.
End the Epidemics Town Hall **11/15/2019**	More than 100 community members gathered for an *End the Epidemics* Town Hall to discuss the best ways to advocate for new, coordinated strategies to address not just HIV but also the hepatitis C and sexually transmitted disease syndemics. Dr. Erica Pan, ACPHD Interim Health Officer, delivered the keynote speech.	***Participants:*** More than 100 community stakeholders and representatives of community organizations, academic institutions, and healthcare providers in Alameda County.
Statewide EtHE Working Group Meeting **11/30/2019**	This Oakland meeting was held with a cross-disciplinary group of community stakeholders to advance the *End the Epidemics* initiative locally and statewide.	***Participants:*** More than a dozen stakeholders including many who had not previously been involved in HIV prevention efforts at the regional or state level.
EtHE CHIPTS Regional Meeting **01/24/2020**	Alameda County presented an overview of county's draft EtHE plan and gave input about approaches to the regional EtHE response.	***Participants****:* County Health Department and Planning Council representatives from Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Diego Counties. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.

EVENT	DESCRIPTION	VOICES & PARTNERS
Frontline HIV Prevention Providers **5/15/2020**	ACPHD and AETC facilitated a discussion of what is and isn't currently working regarding current PrEP strategies and how to scale up PrEP in Alameda County for priority populations, HIV test options, including in-home HIV testing and the use of telemedicine. Staff from two agencies presented how their organizations have adapted their service delivery models due to COVID-19.	***Participants:*** ACDPH, EBGTZ, Frontline PrEP Providers, PrEP navigators, PrEP advocates.
PrEP Listening Session **6/5/2020**	ACPHD and Facente Consulting facilitated a Zoom meeting called "Love in the Time of COVID" to discuss what is next for strategies to overcome challenges to PrEP initiation and provision during emergency response to COVID-19.	***Participants:*** PrEP Program Managers, PrEP Evaluators, Federal, State and County policy-makers
EtHE Presentation and Discussion **7/22/2020**	CDPH and Facente Consulting presented an overview of the Alameda County draft EtHE plan and solicited input. CDC 19-1906 accelerated planning year and present to solicit input.	***Participants:*** Via Zoom. Planning Council Members, members of the public, HIV providers, ACPHD staff.
EtHE Presentation and Discussion **8/26/2020**	CDPH and Facente Consulting presented a second overview of the Alameda County draft EtHE plan and solicited input. CDC 19-1906 accelerated planning year and present to solicit input. Concurrence was granted at this meeting.	***Participants:*** Via Zoom. Planning Council Members, members of the public, HIV providers, ACPHD staff.
EBGTZ-Alameda County Collaborative HIV Strategic Plan Writing Workshops **9/11/2020** **10/23/2020** **11/13/2020** **12/4/2020**	East Bay Getting to Zero, a program of the Pacific AIDS Education and Training Center, in collaboration with ACPHD are held a series of writing workshops meant to drill down into key steps to getting to zero across the whole Oakland TGA including both Alameda and Contra Costa Counties.	***Participants:*** Via Zoom. Over 30 regular participating members of the PrEP and Linkage to Care collaborations (HIV providers, managers and frontline staff). Participants included: AIDS Project East Bay, AHIP/Eden I&R, Alameda County Public Health Dept., Alameda Health Consortium, Asian Health Services, Bay Area Community Health – TransVision, CAL-PEP, Contra Costa County Public Health, EBAC, Facente Consulting/CDPH, Gilead Sciences, Highland – AIC, Kaiser – HIV Services, La Clinica de la Raza, Lifelong Medical Care, Oakland LGBTQ Community Center, Office of the Assistant Secretary for

EVENT	DESCRIPTION	VOICES & PARTNERS
		Health, Oakland TGA Planning Council, Pacific AETC, Primary Care at Home, Roots Health Center, RTI International, UCSF School of Nursing, UCSF Benioff Children's Hospital, WORLD.

Appendix 3: Letter of Concurrence

Alameda County Health Care Services Agency
Public Health Department

Colleen Chawla, Director
Kimi Watkins-Tartt, Director
Nicholas J. Moss, MD, MPH Interim Health Officer

Office of the Director
Tartt
1000 Broadway, Suite 500
Oakland, CA 94607

Kimi Watkins-
Public Health Director
510 267-8000

Marisa Ramos, Ph.D.
Chief, Office of AIDS
Center for Infectious Diseases, California Department of Public Health
Sacramento, CA 95899-7426

Dr. Ramos,

This letter documents that the Oakland Transitional Grant Area Planning Council (OGTA) is in concurrence with the Ending the HIV Epidemic in America, Phase I accelerated planning report submitted by Alameda County and funded through Centers for Disease Control and Prevention (CDC), grant number PS 19-1906.

Facente Consulting provided an overview of the plan at the July OGTA meeting as well as the draft copy of the Ending the HIV Epidemic plan for Alameda County. OGTA council members were provided an opportunity to review the materials, offer comments, and ask questions.

The plan being submitted is in harmony with our other HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero Plans and other county documents that guide the delivery of HIV prevention and care services, and maintains a surveillance system in collaboration with the State Office of AIDS.

The selected activities will expand our reach to populations underserved to date, with novel and innovative interventions that will increase testing, provision of rapid ART, use of PrEP, and will assist more people living with HIV in our county to achieve and sustain viral suppression.

The CDC PS 20-2010 funding to implement the plan will expand services and will work in unison with the HRSA 20-078 and in partnership with health centers provided Ending the Epidemic funding through HRSA 20-091.

The OGTA will continue to monitor the implementation of the Ending the Epidemic Federal Initiative and its family of interventions. We will also continue to engage the community to assure ongoing, real-time feedback so that the interventions are executed optimally for the populations they are serving.

Sincerely,

DocuSigned by:
Angela Moore
3B75DD8A65A24C7...
Angele Moore
Oakland TGA Co-chair

Date:
10/7/2020

DocuSigned by:
Ramon Jackson
AF07AEA48843445...
Ramon Jackson
Oakland TGA Co-chair

Date:
10/7/2020

Appendix 4: Planning Council Membership Roster

Oakland Transitional Grant Area Planning Council (Alameda & Contra Costa Counties) **Website: https://www.otgaplanningcouncil.org/** **Contact Number: Dr. Akilah Cadet (510) 969-6120 or via email changecadet.com**	
Council Members	**Title/ Position**
Agripina Alejandres	Council Member
Angel Dominguez	Council Member
Angel Mateo	Council Member
Angela Moore	Council Member
Barbara Green-Ajufo	Council Member
Betty Blackmore-Gee	Co-Chair
Felicia Greenly	Council Member
Freddie Smith	Council Member
Jessica Osorio	Council Member
Jessica Price	Council Member
Judy Eliachar	Council Member
Kristina Wong	Council Member
Lance Brittain	Council Member
Liam Galbreth	Council Member
Loren Jones	Council Member
Nancy Brownlow	Council Member
Nilda Rodriguez	Council Member
Phoenix Smith (or Recipient Designee)	Council Member
Ramon Jackson	Co-Chair
Rob Yaeger	Council Member
Sean Abucay	Council Member

ORANGE

Orange County

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

ORANGE COUNTY HEALTH CARE AGENCY

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Continued on next page

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Introduction

About This Plan

This plan describes Orange County's bold and innovative approach for ending the HIV epidemic in the county. HIV efforts in Orange County are led by the Orange County Health Care Agency (OCHCA), HIV Planning and Coordination (HIVPAC) Unit, in collaboration with the Orange County HIV Planning Council (HPC). In conjunction with community and clinical partners, the county has built a strong foundation of HIV prevention, care, and treatment services. These foundational HIV services were built based on the *2017-2021 County of Orange Integrated HIV Prevention and Care Plan*[1] which provides guidance to 1) reduce new HIV infections, 2) increase access to care and improve health outcomes for people living with HIV (PLWH), and 3) reduce HIV-related health disparities. The plan aligns with the California Department of Public Health's (CDPH) *Laying a Foundation for Getting to Zero*[1] plan and the *National HIV/AIDS Strategy*.[2]

These current baseline activities, and the infrastructure that supports them, are critical for reducing and ultimately eliminating new HIV infections and optimizing the health of PLWH. However, new and innovative approaches are also needed to accelerate the process and achieve the goal of ending the HIV epidemic in Orange County. Orange County's Ending the HIV Epidemic (EtHE) plan does not replace the other plans; instead, based on the current state of HIV in the county, it expands on them by describing the additional innovative efforts needed.

This plan is organized as follows:

- The **Introduction** provides a high-level overview of 1) the HIV epidemic in the county, 2) the baseline services, activities, and infrastructure that currently exist, and 3) Orange County's plan to end the epidemic.
- **Section I: Community Engagement** describes Orange County's completed and planned community, provider, and Planning Council engagement activities and findings to date.
- **Section II: Epidemiologic Profile** presents the latest available data on HIV in Orange County, including demographics, trends, and disparities across age, race/ethnicity, geography and more.
- **Section III: Situational Analysis** synthesizes information from the prior two sections and a needs assessment to paint a comprehensive picture of the current state of HIV in the county, including needs, resources, and gaps.
- **Section IV: EtHE Plan** outlines the disruptively innovative activities that Orange County will implement between now and 2025, across all funding sources, along with key partnerships, workforce development needs, and plans for outcome monitoring.
- **Section V: Concurrence** describes the process for securing the Council's concurrence.

Current State of HIV in Orange County

In Orange County, there has been a 15 percent decrease in HIV incident infections between 2009 and 2018.[3] Despite this success, the majority of HIV diagnoses have shifted from white MSM to Hispanic/Latinx MSM and other MSM of color. Youth ages 13-24 are also disproportionately affected, and now represent 23 percent of new diagnoses.[4] In addition, there is a need for better data on populations who are likely to be at increased risk for HIV, such as transgender women (especially transgender women of color), sex workers and people experiencing homelessness.

Findings from needs assessments and community engagement efforts offer some insight into the barriers and challenges that impact the county's ability to further reduce new HIV infections, especially among disproportionately affected populations. Structural barriers include clinical provider shortages, a difficult-to-navigate system of care, and lags in implementation of standards of care and best practices for HIV patient care in the public (managed care system of care) and private health care system. HIV-related stigma, linguistic and cultural barriers to access, mental illness, substance use, high cost of living, and homelessness are also factors affecting the HIV landscape.[5,6]

Current HIV Efforts and Infrastructure

Planning

Orange County has a long-standing history of coordinating local HIV prevention, care, and treatment efforts in conjunction with community partners and the Orange County HPC. Soon after the release of the National HIV/AIDS Strategy (NHAS)[2] in 2010, Orange County began to incorporate the NHAS principles and strategies and continues to use that framework. The county's HIV efforts accelerated with the development of the *2017-2021 County of Orange Integrated HIV Prevention and Care Plan*[5] which was developed with the active and collaborative participation of community members and organizations directly impacted by the HIV epidemic, such as the HPC, PLWH, the Ryan White Quality Management Committee, and HIV prevention and care service providers. This plan aligns with NHAS as well as the California Department of Public Health's (CDPH) *Laying a Foundation for Getting to Zero* plan.[1,2]

Services

A number of public funding sources support HIV services in Orange County, including prevention funding from CDPH (CDC PS18-1802 and State General Fund); Ryan White Parts A, B, C, D, and F (including Early Intervention Services [EIS] and Minority AIDS Initiative [MAI]

***Exhibit 1**: Publicly funded clinics and Community-Based Organizations providing HIV services in Orange County*

Clinical Providers

- 17th St. Testing, Treatment, and Care Clinic
- AltaMed Health Services
- APAIT
- Community Dental Providers
- Laguna Beach Community Clinic
- Radiant Health Centers
- Shanti Orange County
- Orange County Jails

Community-Based Organizations (CBOs)

- The LGBT Center Orange County
- Public Law Center

funding); Housing Opportunities for Persons with AIDS (HOPWA), County General Funds, Veterans Administration, as well as revenue from third party billing, including Medi-Cal and Medicare (**Exhibit 1**). A more extensive resource inventory is included in **Appendix 1**.

Collectively, these funding sources support a number of clinical and community-based HIV service providers in the county to deliver HIV testing, pre-exposure prophylaxis (PrEP), prevention with positives, primary care, mental health services, dental services, medical case management, and a multitude of wrap-around services for PLWH.

Infrastructure

Health Department. The Orange County Health Care Agency's (OCHCA) HIVPAC Unit's mission is, "to prevent the transmission of HIV, to encourage early intervention for those who are aware of their HIV status, and to ensure that persons living with HIV have access to needed health care and services." [7] HIVPAC is the grant administrator for Ryan White, CDC, HOPWA, and other HIV funding and contracts with local agencies to provide direct services. In addition, this funding supports the county's HIV Testing, Treatment, and Care (TTC) Clinic to provide HIV testing, prevention, and care services, as well as the HIV surveillance program. In addition, OCHCA's Correctional Health Services (CHS) oversees medical care for the 5 Orange County jails. HIVPAC, the TTC Clinic, and CHS collaborate to make testing, treatment, and case management services available to incarcerated individuals and to facilitate linkage to care after release.

Additional Assets. Orange County collaborates with the National Institutes of Health (NIH)-supported Center for AIDS Research (CFAR) in Southern California. This CFAR, located at the University of California, Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS),[8] shares the CFAR mission "to support multidisciplinary research aimed at reducing the burden of HIV both in the United States and around the globe." Another key partnership that the county established was with the Pacific AIDS Education Training Center (PAETC). Together, Orange County and PAETC facilitated community engagement events through organizing and presenting at regional webinars. Orange County also has an HIV Quality Management Committee that supports provider education on retention in care through a newsletter and other methods.[9]

Orange County's Plan to End the HIV Epidemic

Exhibit 2 (see p. 6) depicts a high-level overview of how Orange County plans to enhance its current HIV efforts with new, disruptively innovative activities funded with federal EtHE funds. The planned activities will expand and leverage, but not duplicate, the foundational efforts already in place. Importantly, the planned activities will focus on priority populations currently underserved by HIV efforts, including MSM of color (especially Black and Hispanic/Latinx MSM), youth, the transgender community, and people who inject drugs (PWID).

The **Exhibit 2** logic model shows the strengths and gaps identified through this planning process (local epidemiologic data, community engagement, and situational analysis) and the new, disruptively innovative activities designed to leverage these strengths and address the gaps. In particular, the growing epidemic among younger MSM of color and those who are experiencing homelessness provides impetus for the proposed EtHE activities which focus on accessible, culturally competent care for priority populations.

New EtHE activities span across all four EtHE pillars and will support the short-term, intermediate, and long-term outcomes identified by the CDC in PS-19-1906. The primary activities for Orange County are listed below. Multiple funding sources (noted in **Exhibit 2**), including CDC PS-20-2010 and HRSA 20-078, will be leveraged to support these activities and community partnerships will be strengthened to ensure success.

- **Testing Innovations.** OCHCA will make HIV and/or STI testing more available to EtHE priority populations through multiple strategies:
    - **Mail to Home Test Kit Pilot Program.** Orange County will make available mail to home (or another preferred location) HIV and/or STI test kits. This will help eliminate barriers to testing for clinic patients as well individuals in the community who have not tested in over a year or who have never tested. *(Diagnose, Treat, Prevent)*
    - **Mobile Testing, STD Care, and Referral Services for at-risk groups.** Collaborate with a community-based provider(s) to offer mobile services to people who are unable to visit a provider office for testing, treatment, or referral services due to barriers such as homelessness. *(Diagnose, Treat, Prevent Respond)*
    - **PrEP Navigation.** Orange County will expand HIV prevention activities to increase initiation of PrEP/PEP by assisting clients with public or private insurance with PrEP access. *(Test, Treat and Prevent)*
- **Health Summits for Gay Men and the Transgender Community** will increase awareness of health issues faced by these communities in Orange County and provide tools and community resources—including HIV testing and PrEP—to help them stay healthy. *(Diagnose, Prevent)*
- **Health Education Videos in multiple languages** that address the Orange County HIV epidemic and the unique needs of priority populations. *(Treat, Prevent)*
- **Trauma-Informed Prevention and Care Services for Black/African American (B/AA) and Transgender Populations** will engage members of the B/AA and Transgender communities, as well as related organizations and community groups, to identify barriers to care, inform service delivery, and build capacity within the county to provide culturally competent and trauma-informed care. *(Treat, Prevent)*
- The **Viral Suppression Patient Incentive Program (Viral suppression PIP)** will incentivize PLWH to engage in HIV care, reach and maintain viral suppression, and use case management and partner services. (*Treat)*
- **Community-Based Case Management Services.** Case Manager will be located at providers outside the Ryan White System of Care who serve a high volume of patients not virally suppressed. *(Treat)*
- **Focus Groups with PLWH who are not virally suppressed.** This activity will use local surveillance data to strategically engage individuals not virally suppressed in order to identify barriers to care and solutions to address these barriers. *(Treat, Prevent)*

- **Mental Health Services for PLWH.** Psychiatry mental health services to PLWH to improve retention in care and viral load suppression. *(Treat, Prevent)*

- **Rapid Antiretroviral Treatment (Rapid ART).** Develop and implement a protocol for Rapid ART implementation in the county clinic and jails and ensure a coordinated approach to Rapid ART delivery in the county**.** The activity will expand access to Rapid ART to individuals who are newly diagnosed or have fallen out of care. This activity will link to care newly diagnosed individuals who are identified though targeted testing in the community or through testing at the county jails. *(Treat)*

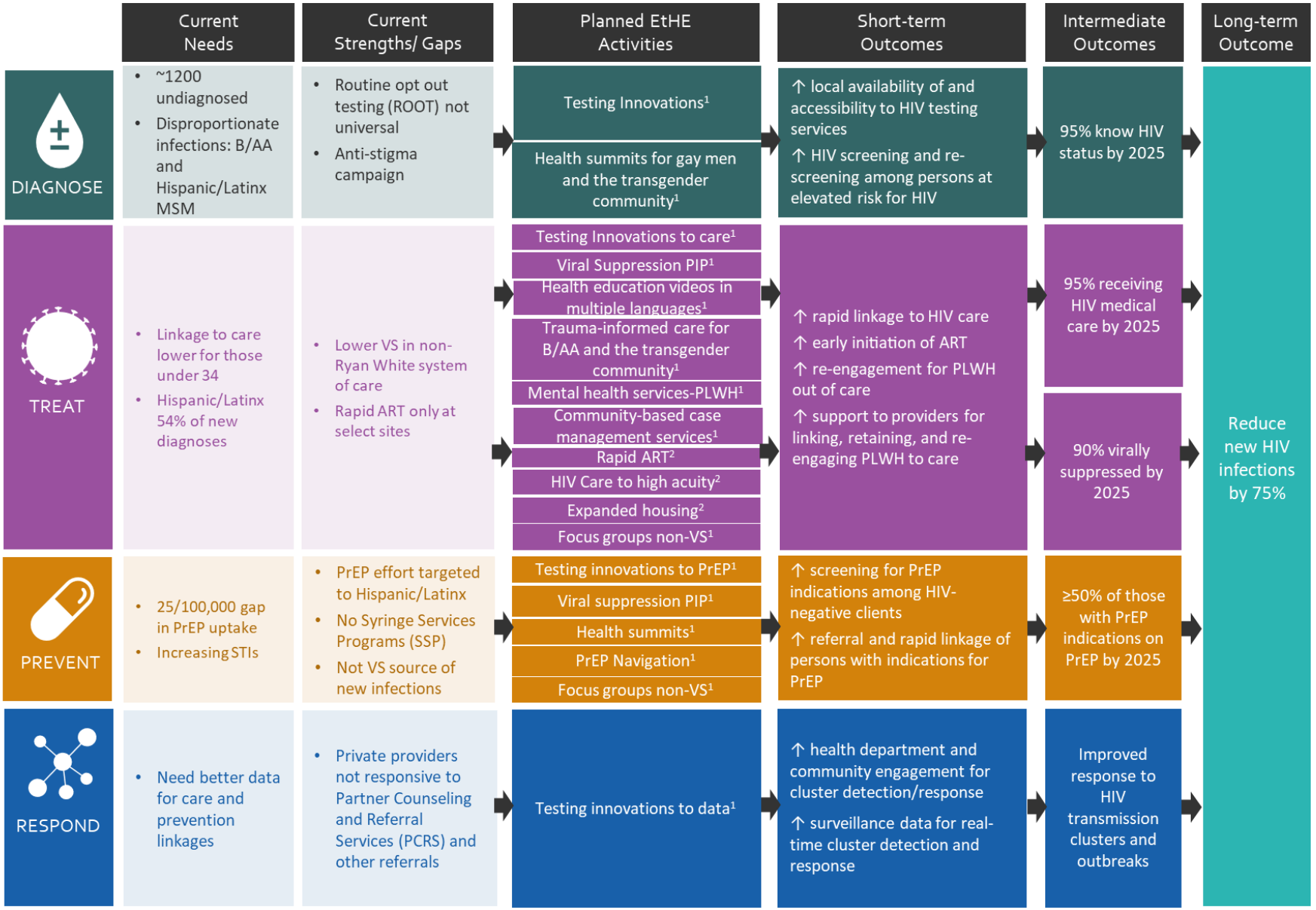
- **HIV Care to High Acuity Individuals**. This activity focuses on providing care to high acuity clients who are insured and do not qualify for Ryan White but are at highest risk of falling out of care. This program will provide case management services to clients with high acuity conditions that may affect their ability to navigate the HIV system of care, such as homelessness, substance use, mental health conditions, or history of incarceration. *(Treat)*

- **Expanded Housing Availability.** Housing instability among PLWH can result in intermittent HIV care. OCHCA will coordinate with the existing housing infrastructure to expand housing for PLWH to improve housing stability and engagement in care for PLWH. *(Treat)*

- **CHIPTS CFAR Project: Regional Response to HIV Eradication Efforts in Southern CA Counties.** Orange County is participating in a CHIPTS CFAR study led by Stephen Shoptaw titled *Regional Response to HIV Eradication Efforts in Southern CA Counties*[8], along with San Diego, Los Angeles, Riverside, and San Bernardino Counties. CHIPTS will build linkages between public health departments, clinicians, researchers, stakeholders, and communities living with or at risk for HIV to address the HIV epidemic in Southern California. It aims to support regional data coordination and sharing that would guide scale-up of large implementation science projects designed to reduce new HIV infections across the five counties. *(Respond)*

Orange County's EtHE plan was developed with extensive community and partner engagement and endorsed by the Orange County HPC. With the new federal EtHE funding, Orange County expects to make significant progress over the next 5 years towards ending the HIV epidemic in the county.

Exhibit 2. *Logic Model for Ending the HIV Epidemic in Orange County, organized by pillar. Current county strengths and gaps inform planned EtHE activities which will impact the short-, intermediate-, and long-term outcomes identified by CDC and the California Department of Public Health.*



1. CDC PS20-2010; 2. HRSA 20-078

Section I: Community Engagement

Orange County used CDC PS-19-1906 as an opportunity to further develop its capacity for ongoing community engagement (**Exhibit 3**). Community engagement (CE) is an essential component of the County's EtHE initiative. To date, Orange County has completed multiple CE activities with additional activities planned for years 2-5 of EtHE implementation.

Exhibit 3. Community Engagement Successes

- HIV Planning Council engagement
- Integrated Plan Committee activities
- Ongoing community engagement (CE)
- Pivoting to virtual CE due to COVID-19

These community engagement efforts have been integral in developing the proposed Year 1 activities and obtaining feedback and recommendations on the proposed EtHE plan. Orange County will continue to build on this momentum for community engagement activities in Years 2-5. Community engagement enhances the OCHCA's understanding of the identified priority populations and helps identify innovative ways to harness community strengths, address barriers to HIV prevention, care, and treatment, and gain insight on underlying social determinants of health (SDoH). CDPH, the PS-19-1906 grantee, has worked very closely with Orange County and the other five Phase I counties covered under this grant (Alameda, Riverside, Sacramento, San Bernardino, and San Diego) to put community engagement at the forefront of EtHE activities.

Even though Orange County has seen a general decrease in HIV diagnoses in the past decade, stark health disparities exist, and EtHE is a timely initiative for improving the county's capacity to address these disparities. Youth and men of color, particularly B/AA and Hispanic/Latinx men who have sex with men (MSM), are disproportionally represented in Orange County among new HIV diagnoses. Stigma, fears associated with immigration status, and lack of health care access are all barriers these populations face in accessing HIV care and prevention services, including PrEP. People who inject drugs (PWID) make up approximately 10 percent of new diagnoses in the county,[4] yet they can be difficult to reach because they are often homeless, incarcerated, or live in impoverished circumstances. Due to these factors, B/AA and Hispanic/Latinx MSM, PWID, youth, and the providers who serve them have been included as critical new voices in the planning process.

Section I: Community Engagement describes the county's community engagement plans, new voices to be included in the community engagement process, and selected findings from completed community engagement activities. While the COVID-19 pandemic interfered with implementing planned in-person community engagement activities, the county continued to solicit input from key stakeholders utilizing alternative methods. The completed activities have shed light on priority populations' current barriers and circumstances and have given the county a better picture of the subsequent impact on EtHE activities.

Community Engagement Activities

The COVID-19 response affected Orange County's ability to implement planned in-person community engagement activities for the 2020 PS-19-1906 accelerated planning year. Despite this, the county quickly adapted to virtual community engagement methods, including webinars with the Integrated Plan Committee, a subcommittee of the HPC and designated EtHE Steering Committee, to solicit input on the draft EtHE plan. The county's Year 1 (2020) community engagement goals are listed below **(Exhibit 4)**. OCHCA collaborated with the CDPH Office of AIDS to ensure that community engagement remained a priority through the development of this plan.

Exhibit 4. Orange County Community Engagement Goals (Year 1)

- Engage priority populations through at least one community engagement activity to identify barriers to HIV prevention and care services and strategies to address these barriers.
- Conduct analysis of secondary data to identify best practices to improve delivery of prevention and care services to priority populations.
- Implement EtHE community engagement activities to inform county-wide integrated prevention activities for HIV, HCV, and STIs.
- Distribute an online survey to inform priority populations with special focus on engaging Hispanic/Latinx Spanish speakers.
- Engage medical providers from Orange County and neighboring areas to engage in critical capacity building and information sharing about improving HIV prevention and care.
- Participate in regional planning.
- Plan for ongoing community engagement activities in years 2-5.
- Engage with community members throughout the planning process from initial planning to concurrence of this plan.

OCHCA engaged HPC members and brought together new voices—PLWH providers, CBOs, and academic institutions—to inform the EtHE planning process. **Exhibit 5** provides an overview of the completed and planned community engagement activities for the 2020 PS19-1906 accelerated planning year.

Exhibit 5. Detailed summary of Orange County's EtHE community engagement activities.

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
Ending the Epidemics Town Hall 10/18/2019	Orange County and community partners held a town hall to launch community-driven efforts to inform county-wide HIV, HCV, and STI prevention strategies. ***Sponsors:*** California HIV/AIDS Research Policy Center, Radiant Health Centers, RADAR, The LGBT Center OC, Public Law Center, STI Coalition Orange County, UCI Student Health Center, Shanti Orange County, Orange County's Women's Health Project, Project Youth-Orange County Bar Foundation, and the End the Epidemics Statewide Workgroup.	***New Voices – Priority Populations****:* Youth, Hispanic/Latinx MSM, Communities of Color, and PLWH ***New Voices – Providers****:* HIV providers and non- HIV/STD service providers
Integrated Plan Committee (EtHE Steering Committee) Feedback 10/18/2019 2/19/2020 5/20/2020 7/15/2020 8/19/2020 10/21/2020	At this series of meetings, committee input was solicited on: (1) innovative programs and services to include as part of the county's proposals to HRSA in response to NOFO 20-078and CDC/CDPH in response to NOFO PS20-2010;and (2) the draft EtHE Plan, including assessment of current HIV related efforts (resources and challenges), community engagement strategies, priority populations, and key stakeholders.	***Participants:*** Integrated Plan Committee
CDPH Planning Group Kick-Off Meeting 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants****:* Orange County Health Care Agency

EVENT	DESCRIPTION	VOICES & PARTNERS
EtHE Presentation and Discussion 11/13/2019	CDPH and Facente Consulting were invited to present an overview of CDC PS-19-1906 accelerated planning year to the HPC and solicit preliminary input on the EtHE plan. *Sponsors:* CDPH, Facente Consulting	***Participants:*** Orange County HIV Planning Council and community attendees
EtHE Community Updates 11/13/2019 2/5/2020 3/11/2020 6/10/2020 7/8/2020 8/12/020 9/9/2020	The Orange County HIV Planning Council receives regular updates on EtHE Initiative and provides ongoing input on strategies, interventions, and EtHE Plan. The HCP provided concurrence on the EtHE Initiative, Phase I accelerated planning process and plan funded through CDC PS-19-1906 on 7/8/2020.	***Participants:*** Orange County HIV Planning Council
SOA Online Survey[10] 11/13/2019-9/20/2020	Orange County distributed the State Office of AIDS (SOA) sponsored online survey to community members and other key stakeholders for input on how to better engage hard-to-reach populations in HIV prevention and care. A final report summarizing the results will inform EtHE implementation.	***New Voices – Priority Populations*:** Youth, MSM of Color, PLWH, Communities of Color ***Participants:*** Priority populations, HIV providers, other stakeholders
EtHE CHIPTS Regional Meeting 01/24/2020	Orange County attended the CHIPTS regional meeting to plan, coordinate, and align the county's draft EtHE plan with the best practices to foment California's regional EtHE response.	***Participants:*** County health departments and Planning Council representatives from Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC
STI Coalition Meeting 7/20/20 and 8/17/20 *(Ongoing)*	Orange County provided an overview of the EtHE plan and solicited input from STI Coalition members on proposed activities, priority populations, and community engagement strategies.	***New Voices – Providers**:* HIV/STD providers, advocacy groups, colleges and universities, and CBOs

EVENT	DESCRIPTION	VOICES & PARTNERS
	Orange County is a member of the STIC Coalition and participates in monthly meetings to identify opportunities for collaboration.	
Healthcare Executives of Southern California Webinar Series 9/2/2020	Orange County presented an overview of EtHE proposed strategies and interventions and discussed challenges and opportunities for EtHE implementation as a result of the COVID-19 pandemic. The webinar series was sponsored by the HHS Office of the Assistant Secretary for Health – Region 9 Prevention Through Active Community Engagement (PACE) Program, Healthcare Executives of Southern California Association, and Gilead Sciences.	***New Voices-Providers:*** Providers outside of the Ryan White system of care, other local health jurisdictions, and CBO's
HIV/AIDS on the Front Line Conference 9/16/2020	Orange County facilitated a session at the conference and provided an overview of proposed EtHE activities, priority populations, and community engagement strategies, as well as solicited provider input on the County's EtHE plan. The conference was sponsored by the PAETC in collaboration with County and community-based providers.	***New Voices – Providers****:* Medical providers
CHIPTS EHE Regional Learning Collaborative 9/30/2020	***Building Our Coalition to End the HIV Epidemic in California*** Initial meeting hosted by CHPTS including representatives from each of the counties in the California Consortium.	***Participants:*** County health departments and Planning Council representatives from Alameda, Orange, Riverside, Sacramento, San Bernardino, and San Diego. Los Angeles and San Francisco had staff in the meeting as well.
PLANNED ACTIVITIES (dates TBD)		
Online EtHE Focus Group Session	Orange County will conduct online focus groups with mental health and/or youth-serving providers, and/or youth to collect input on the EtHE plan and barriers to PrEP and HIV services utilization. This will help tailor EtHE activities to make them more accessible to youth.	***New Voices – Priority Populations****:* Youth ***New Voices – Providers****:* Mental health providers, youth service providers
Key Informant Interviews	Orange County will conduct key informant interviews with persons experiencing homelessness, at risk of homelessness, or providers serving these populations to collect	***New Voices – Priority Populations****:* People

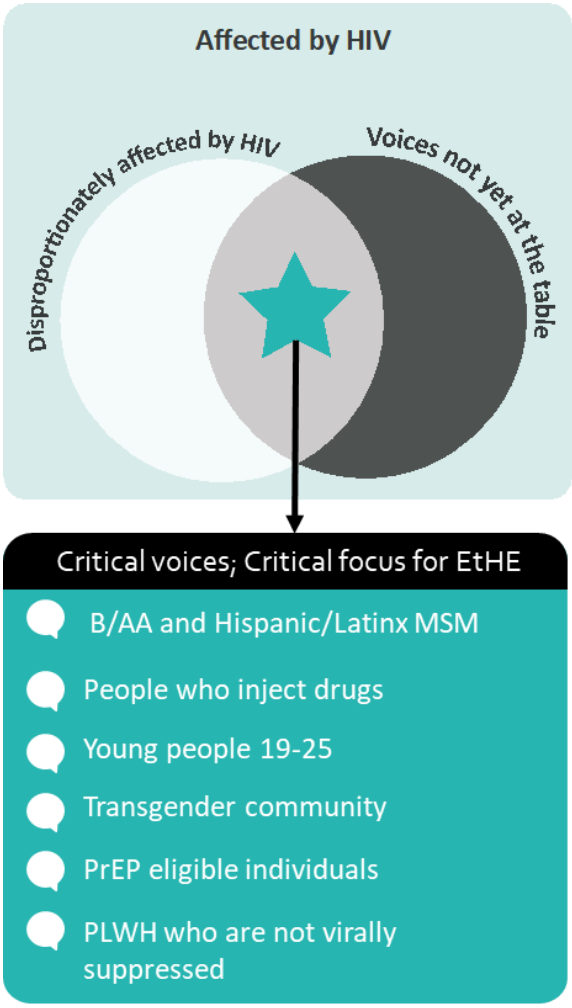
EVENT	DESCRIPTION	VOICES & PARTNERS
	input on the EtHE plan and barriers to PrEP and HIV services utilization.	experiencing homelessness or at risk of homeless ***New Voices – Providers**:* Homeless service providers
Key Informant Interviews	Orange County will conduct key informant interviews with clinical providers who will participate in the proposed patient incentive program. Orange County will collect input on the proposed intervention and barriers to PrEP and HIV services utilization. This will help refine the intervention as it is implemented.	***New Voices – Priority Populations**:* PLWH not virally suppressed ***New Voices –*** Providers outside of the Ryan White system of care

OCHCA oversaw the development and implementation of Orange County's EtHE community engagement plan. The Integrated Plan Committee, a subcommittee of Orange County's HPC and designated EtHE Steering Committee, spearheaded the development of the community engagement plan. In addition, CDPH contracted with Facente Consulting, a California-based public health consulting firm specializing in HIV planning and community engagement, to support and build Phase I county capacity to engage priority populations. For Orange County, Facente Consulting will provide support for upcoming community engagement events, including developing meeting agendas and materials, co-facilitating events, taking meeting notes, and producing summary reports.

New Voices

Although the HIV epidemic and the factors driving it are complex, the voices missing at the planning table are clear and OCHCA is committed to doing what it takes to engage and retain these new voices. Based on HIV surveillance data, client surveys, previous assessments (e.g., disparities, service utilization), and an evaluation of who is not currently participating in the HIV planning process, Orange County identified the following priority populations as ***new voices*** who need to be included **(Exhibit 6** and described below**)**:

Exhibit 6. Critical new voices to engage.



- **B/AA and Hispanic/Latinx MSM.** B/AA MSM make up a disproportionate number of new HIV diagnoses in the county and have low rates of PrEP utilization. Hispanic/Latinx MSM make up the majority of new HIV diagnoses in the county and have low rates of PrEP utilization.
- **PWID.** HIV transmission via injection drug use has increased in the county. This population has low rates of PrEP utilization.
- **Young people.** Individuals 19-25 are disproportionately affected, representing a large proportion of new HIV diagnoses in the county.
- **Transgender community.** Community engagement and programmatic information highlighted this group as a priority.
- **PrEP eligible individuals.** PrEP expansion will build on OCHCA's past efforts.
- **PLWH who are not virally suppressed**. An innovative effort will focus on PLWH who are not virally suppressed.

The following sections describe the County's efforts to engage partners prioritized in PS19-1906. OCHCA will focus on engaging partners from priority populations and partners who serve priority populations.

Local Prevention and Care Integrated Planning Bodies

The Orange County Transitional Grant Area (TGA) community planning body is called the Orange County HPC. The mission of the HPC is to "work in partnership with affected communities, service providers, philanthropists and public health professionals, to support an accessible, culturally competent continuum of HIV prevention and care services that promotes optimal health, fosters self-sufficiency, reduces stigma and discrimination and results in a community where new HIV infections are rare."[11]

Orange County continuously seeks the HPC's input and guidance when developing HIV prevention, care, and treatment strategies. The county has actively engaged the HPC throughout the EtHE planning process to help identify priority populations, proposed interventions, and community engagement strategies.

The HPC brings a wealth of knowledge and expertise to the EtHE planning process. HPC membership is composed of stakeholders with diverse personal and professional experiences, including service providers and PLWH (unaligned consumers) who make up 47 percent of the HPC membership. Other HPC members represent the following membership categories:

- Community-Based Organization (CBO) or AIDS Services Organization (ASO) serving affected populations
- Affected communities including PLWH and other historically underserved populations
- Part C Providers
- Other Federal HIV Programs (AETC, CFAR, PACE)
- Social Service Providers (Including providers of housing and homeless services)
- Non-elected Community Leaders
- Other Federal HIV Programs (Prevention Services, HOPWA)
- State Part B Agency
- Representatives of/or formerly incarcerated PLWH
- Local Public Health Agency-Orange County
- General Community Members

The HPC has designated the Integrated Plan Committee (IPC) as the EtHE Steering Committee because of its focus on addressing HIV prevention and care needs in the county. In this role, the IPC has been instrumental in guiding the development of Orange County's EtHE plan. The IPC has also provided input on innovative programs and services to include in the County's HRSA 20-078 and CDC 20-2010 grant proposals, community engagement strategies, and identified priority populations and key stakeholders to ensure meaningful impact and successful implementation.

Local Partners

Engaging local partners, including members of the community and service providers, is a significant element in EtHE planning. Orange County is directly engaging with the identified priority populations shown in **Exhibit 6**.

Both HIV and non-HIV service providers are key partners for ending the HIV epidemic in Orange County. These partnerships will help inform Orange County's strategies for reaching priority populations and identifying and addressing barriers to care in order to more effectively serve people living with, or at risk for, HIV. Other partners who may not provide direct services but who have expertise in or connections with priority populations are also key to building a robust, feasible, and sustainable HIV prevention, care, and treatment strategy.

Orange County has strong partnerships with the HPC and the community-based providers listed in **Exhibit 1**. Throughout the implementation process, Orange County will engage new service providers and non-traditional partners, including, but not limited to:

- **Other county departments,** including Maternal Child Health, Public Health Nursing, Social Services Agency, and Behavioral Health Services, including community-based medication-assisted treatment (MAT) programs.
- **Local coalitions,** including the Orange County Health Improvement Partnership (HIP) and the Sexually Transmitted Infection Coalition-Orange County (STIC).
- **Faith-based organizations,** including B/AA churches.

The County is strongly invested in both maintaining existing relationships and continuing to forge new partnerships to end the HIV epidemic. Engagement of local partners will continue in Years 2-5.

Selected Findings

The following are select findings from community engagement efforts. These findings represent a synthesis of information gathered from community engagement activities detailed in **Exhibit 6** completed as of September 30, 2020. The findings are organized into four domains representing barriers to end the HIV epidemic: social determinants of health, being unhoused, mental health, and substance use (**Exhibit 7**).

Community engagement efforts help the county understand the dynamic factors and conditions impacting the priority populations. A fuller picture will continue to emerge as more community engagement activities are implemented, but these early insights point to potentially impactful strategies and interventions.

Exhibit 7. Key considerations for EtHE in Orange County, from community engagement processes

Social Determinants of Health such as stigma, undocumented status, and lack of access to high quality HIV services pose barriers to ending the epidemic.

Secure housing is needed to help people experiencing homelessness and housing insecurity meet basic needs and prioritize their health.

Mental health services are needed to support viral suppression, especially among people who are unhoused and people with substance use issues.

Substance use services are urgently needed to support HIV prevention and care efforts, especially given local rates of amphetamine use.

Social Determinants of Health

A common theme that emerged from the community engagement activities implemented was the pervasive effect social determinants of health (SDoH) have on the well-being of communities. Community engagement participants highlighted three of many SDoH: stigma, undocumented immigration status, and health care access.

Stigma. Orange County community members described experiencing stigma because of their gender identity, sexuality, or HIV status. Stigma often produces feelings of shame and isolation which impacts mental and emotional health.[12] Persistent stigma poses a significant barrier to testing, HIV care and support services, and general well-being. Community engagement efforts confirm that fear of being judged not only keeps people from testing for HIV and other STIs, it also keeps people from talking about sexual health with providers, and makes it difficult to access services even when they feel they need them.[10] Peer support and education was cited as one strategy that can help decrease the stigma associated with seeking or accessing sexual health information.[10] Other strategies included normalizing sexual health topics in the context of whole-person health care services and conducting outreach and social marketing to the community as a whole about the need for HIV testing.[10]

Undocumented status. As of 2017, Orange County had the 4th largest foreign-born population of all U.S. counties, with nearly one third (31.5 percent) of its residents born outside of the U.S. Approximately 45 percent are from Asian countries, 45 percent from Latin American countries, and 10 percent are from other locations. Approximately one-half (50.9 percent) of the foreign-born population in Orange County are U.S. citizens.[13] As many as 1,000,000 unauthorized immigrants live in Los Angeles and Orange Counties.[14] Current federal immigration policies have created a heightened sense of fear and uncertainty for the undocumented and Hispanic/Latinx community. Community engagement participants raised two specific issues that affect willingness to access HIV-related services:[6] (1) fear of consequences, such as deportation, for participating in government health services, and (2) fear of disenrollment from public benefits (e.g., Medi-Cal). Anecdotally, staff have reported that people have fallen out of care and purposely discontinued public benefits in response to the revised federal “public charge” rule.[6] Ending the epidemic in Orange County is not possible without providing direct support and advocacy for undocumented communities. Community engagement efforts suggest that there is a need to increase access to services and educational materials in other languages, especially Spanish.[10]

Health care access. Orange County residents face significant challenges in accessing health care. The county has identified three barriers to access to high-quality HIV services: (1) medical provider shortage for PLWH insured by Medi-Cal, (2) worse health outcomes for PLWH receiving services outside of the Ryan White system of care, suggesting the need for quality improvement, and (3) difficult-to-navigate medical care and insurance systems.[5,6] These challenges are discussed in more detail in *Section III: Situational Analysis.* Community engagement efforts suggest that PrEP is not easily accessible even when people have insurance. Outreach and education to PrEP eligible individuals is needed on resources and services available. In addition, outreach deployed in a targeted manner is still needed to increase PrEP uptake, including to online communities.[10]

Being Unhoused

The number of people who are experiencing homelessness in Orange County has increased year over year. The 2019 Point In Time (PIT) Homelessness Count estimated that there were 6,860 people experiencing homelessness in Orange County, a 43 percent increase since 2017. Of these individuals, nearly 2 percent indicated they were living with HIV,[15] which is likely an undercount. In a 2019 needs survey of HIV/AIDS clients, 28.9 percent reported being unstably housed in the previous 12 months.[16] People experiencing homelessness are more likely to experience harmful mental health outcomes. For youth, homelessness places them at an increased risk for sexual abuse and exploitation and chemical and alcohol dependency;[17,18] increases in homelessness among LGBTQ people and youth of color[17,18] are of particular concern due to their disproportionate risk for HIV. An Orange County community needs survey of PLWH identified housing as one of the top five most important services.[6] Respondents particularly mentioned a need for transitional housing and emergency financial assistance (EFA) for housing.[6] In addition, the high cost of living in Orange County severely limits low-income communities from being able to afford safe and affordable housing, placing them at an increased risk for displacement.[6] PLWH experiencing homelessness are likely to prioritize daily shelter and food over medical care. Therefore, positive health outcomes are conditional on the county's ability to meet housing and other basic needs.

Mental Health

OCHCA has observed that PLWH with mental illness and those with substance use disorders have greater barriers to achieving viral load suppression than others, especially if they do not get their medical care through the Ryan White program where mental health and substance use services are more easily accessible.[6] Mental health conditions often co-occur with other factors that compound the risk for poor HIV-related and other health outcomes. For example, the 2019 PIT homeless count found that approximately 59 percent of homeless individuals reported mental health and/or substance use issues.[15]

Substance Use

Orange County has identified substance use disorders as a prevalent problem in HIV-affected and at-risk communities. Similar to mental health conditions, substance use, often as a result of trauma and structural inequalities, highly impacts priority populations.

In Orange County, PLWH have higher rates of substance use compared to others,[5] creating a barrier to achieving the EtHE goals. PWID are also less likely to be linked to HIV care and experience disparities along all stages of the HIV continuum of care.[5] Up to now, this community has not been effectively reached because they are often experiencing homelessness, incarceration, or live in impoverished circumstances. Furthermore, without a trusted connection (e.g., peers), people who use substances are less likely to access care and treatment from traditional healthcare providers.[6]

In a recent survey, community members expressed an increased need for substance use services in Orange County.[6] While treatment services are available in Orange County, survey results warrant an assessment of access to services and knowledge of risk-reduction strategies (e.g., syringe exchange, sharps disposal).

From 2011-2018, there was an increase in deaths attributable to amphetamine use in Orange County, from 1.32 to 5.16 deaths per 100,000 population. Emergency Department (ED) visits

held steady until 2015, between 4.4 and 4.46/100,000, and dropped precipitously from 2016-2018, to a low of 2.71/100,000. While Emergency Department (ED) visits have decreased, deaths attributable to amphetamine use have continued to increase, which may be representative of persons not seeking medical care for amphetamine overdose, rather than decreased use. Not seeking medical care for amphetamine overdoses could be secondary to a lack of access to medical care, fear of legal ramifications, or to unrecorded overdose—the reason is unclear from this data.

OCHCA will collaborate with providers that serve this population to ensure that HIV prevention and care services reach PWID and other people that use drugs.

Community Engagement, Years 2-5

Orange County will use Years 2-5 to continuously engage community members in the planning and implementation of services and interventions. Community input was essential in developing the proposed activities outlined in *Section IV: Ending the HIV Epidemic Plan.* Moving forward, it will be equally important to keep the HPC, IPC (EtHE Steering Committee), community members, and service providers engaged to ensure effective approaches for implementing services. Future engagement strategies will include hosting community forums, focus groups, and listening sessions co-sponsored by the OCHCA and CBOs. The county is prepared to develop innovative engagement methods if necessary due to COVID-19 or other unanticipated factors. IPC will continue to take the lead on identifying EtHE priorities and community engagement strategies and ensure ongoing representation from the community throughout the 5-year project period. Documentation of all community engagement activities will be reviewed regularly to ensure engagement of priority populations.

For Years 2-5, Orange County's community engagement priorities are including new voices by strengthening collaborative relationships with CBOs and focusing on workforce development as shown in **Exhibit 8** and described below.

Exhibit 8. Community engagement priorities, Years 2-5

1. Include additional new voices through collaborative relationships with CBOs
2. Focusing on workforce development

Collaboration with Community-Based Organizations

Many of the communities that have not been effectively reached have a deep-rooted mistrust of large institutions due to historical discrimination that has not only excluded people but has also caused extreme harm.[19,20] To begin to overcome these barriers, Orange County will prioritize building relationships with non-HIV-related CBOs grounded in the experiences and cultures of the priority communities. CBOs have the long-standing trust and rapport with those they serve, an invaluable asset that Orange County can leverage and learn from.

The county will seek technical assistance from community-based partners that are locally rooted, culturally and linguistically competent, and committed to advancing health and social equity. From the outset, Orange County will authentically engage representatives from each organization in ways that build mutual trust. With the support and guidance of CBOs, Orange County will implement best practices and innovative strategies for connecting with new voices from the priority populations. Orange County is also prepared to try new strategies to connect with hard-to reach populations. One example is to participate in non-HIV community events to

get a better idea of the landscape of what is happening in the county and how to better reach new voices.

In Years 2-5, Orange County will work with CBOs to reduce barriers to community engagement by hosting events on evenings and weekends or other times when people are not working. In line with previous engagement efforts, the county will continue to make community engagement activities available in a culturally competent manner (e.g., making interpretation services available, using language that destigmatizes HIV, awareness of and humility around different cultural beliefs and practices).

In addition to continuing to engage the communities identified in Year 1, Orange County will also seek to bring the following new voices to the table:

- People newly diagnosed with HIV
- PrEP-eligible persons
- Non-English speakers
- Transgender community members
- People experiencing homelessness
- Black/African American (B/AA) populations
- Youth (ages 19-25)
- PLWH not virally suppressed

Workforce Development

The success of Orange County's EtHE plan depends on a highly skilled workforce that reflects the populations served.

Workforce development efforts will focus on building capacity throughout Orange County to effectively reduce HIV-related health disparities and improve health outcomes among Black/African American (AA) and transgender populations utilizing a trauma-informed approach.

The OCHCA will utilize the following strategies and collaborations to build capacity among HIV service providers:

- Leverage long-standing partnerships with HIV prevention and care service providers within the County and in the community to enhance the current system of care and address barriers identified by the community to HIV prevention and care services utilizing a trauma-informed approach
- Implement provider/staff trainings to improve capacity throughout Orange County to deliver culturally competent and trauma-informed care to specially address the needs of Black/AA and transgender PLWH in Orange County
- Develop and implement a plan for delivering trauma-informed prevention and care services to improve viral load suppression, linkage to, and retention in care among Black/AA and transgender PLWH and other communities disproportionality impacted by HIV in Orange County

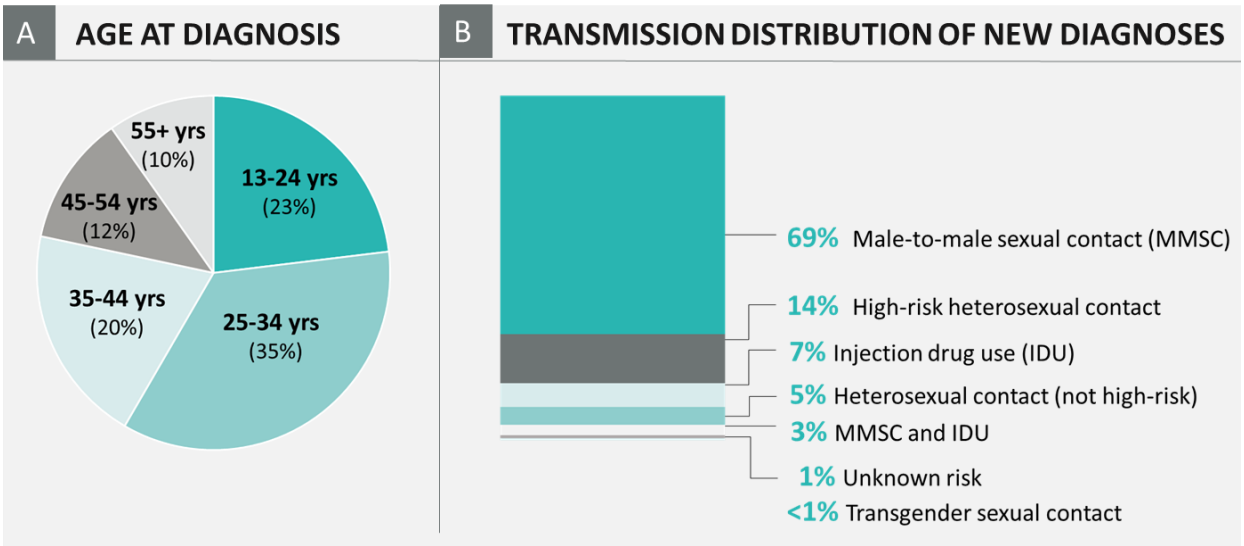
Section II: Epidemiologic Profile

HIV Diagnoses

In 2018, there were approximately 8,365 people living with HIV in Orange County. Of those, 7,165 (85.5 percent) people had their infection diagnosed, down from 86.2 percent in 2016. In 2018, there were 286 people diagnosed with HIV, of which 158 (55 percent) were ages 25 to 44, 198 (69 percent) were infected through male-to-male sexual contact, and 41 (14 percent) were infected through heterosexual contact not typically considered high risk (i.e., not with a partner who was MSM or who injected drugs).[4]

Exhibit 9 highlights the age and transmission distribution of new HIV diagnoses in Orange County in 2018.

Exhibit 9. Age at Time of Diagnosis (A) and Transmission Distribution of New Diagnoses (B), 2018



Overall, age and gender at diagnosis have remained relatively constant between 2014 and 2018 in Orange County. However, the rates of new diagnoses per 100,000 population have fluctuated notably since 2014 when stratified by race/ethnicity, as can be seen in **Exhibit 10**. Specifically, Black/African Americans and Hispanic/Latinx persons consistently have the highest the rate of transmission. The rates for these two populations peaked in 2016 and since then rates have declined for both groups. Across all years, rates of new diagnoses among Black/African Americans remained substantially higher than for other ethnic groups. It is important to note that when overall numbers of individuals in a group are small, sparklines or other trend analyses should be interpreted with caution.[4]

American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups are not included in the race/ethnicity data tables below due to small to zero numbers reported each year from 2014-2018. This report does not intend to diminish the impact of HIV on American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups. Small numbers are not reported to preserve the confidentiality of PLWH.

Exhibit 10. Rate of Transmission by Race/ethnicity, New HIV Diagnoses, Orange County 2014-2018

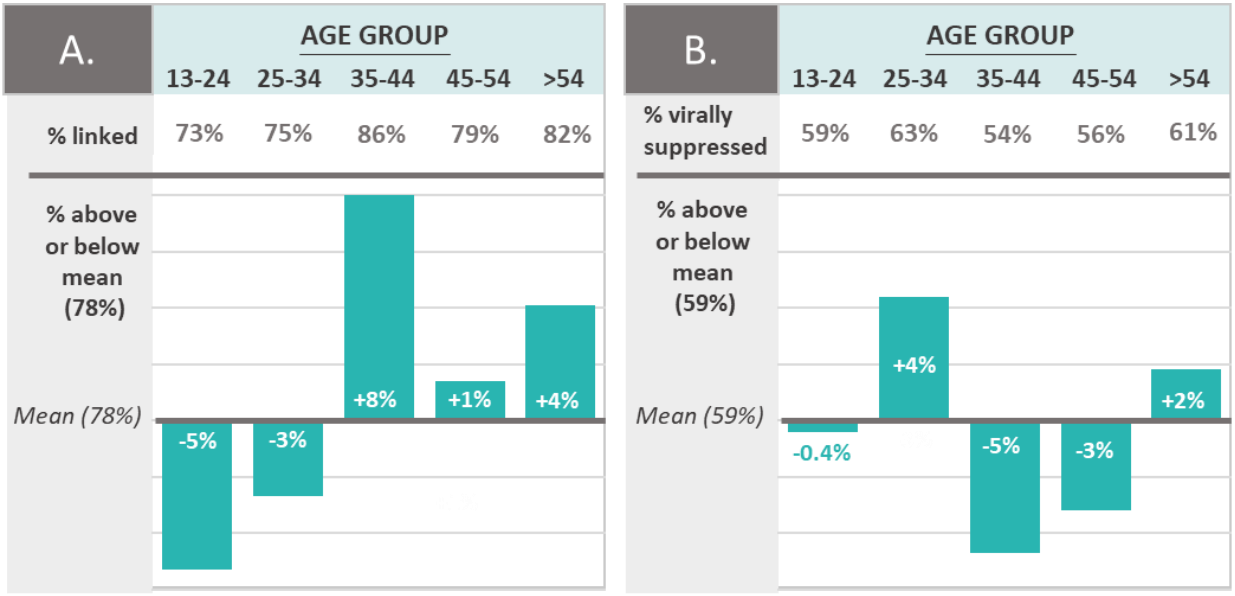
Race/ethnicity	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2014-2018 Sparklines
Black/African American	31.6	29.3	47.8	22.7	20.5	
Hispanic/Latinx	12.1	15.5	15.3	12.8	13.6	
Asian	6.6	5.8	8.0	7.4	4.9	
White	7.0	7.6	7.5	8.0	6.5	

Note: Rates are per 100,000 population.
Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

Linkage to Care and Viral Suppression

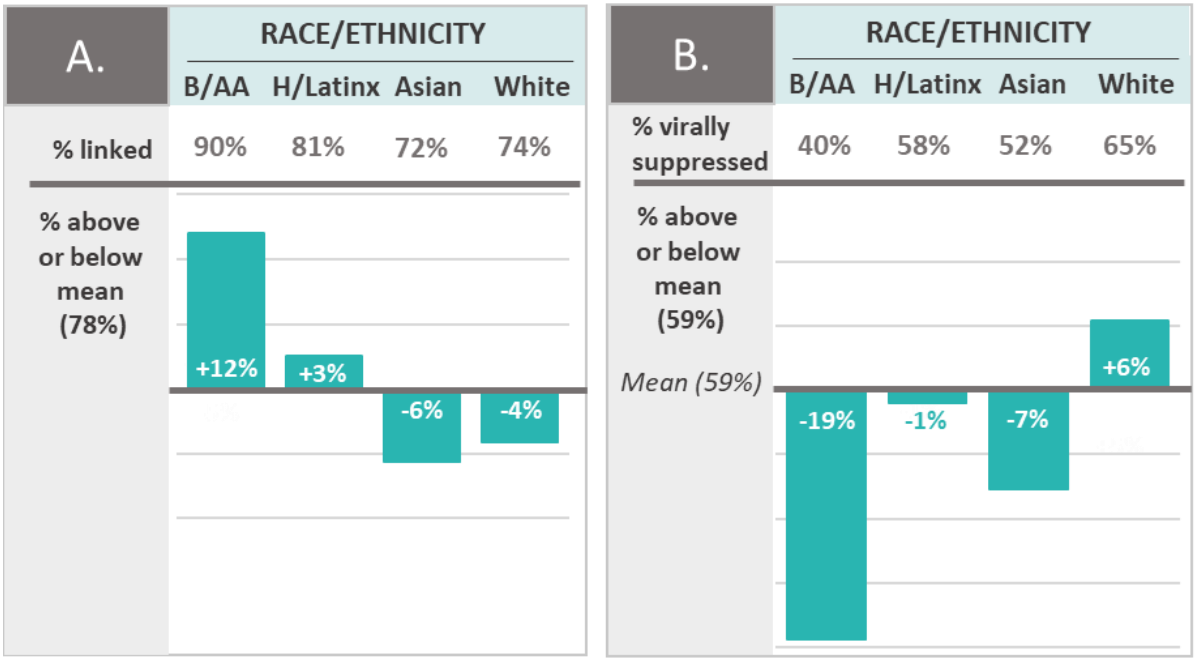
However, new diagnoses are not the only important piece of HIV epidemiology. Other key indicators are the percentages of people linked to care within 30 days and virally suppressed within six months of diagnosis. Overall, 78.0 percent of people diagnosed with HIV in Orange County in 2018 were linked to care within 30 days of diagnosis and 59.4 percent were virally suppressed within 6 months. However, there were notable disparities; youth – those 13-34 years of age – experience lower rates of linkage to care within 30 days and people ages 35-54 have lower viral suppression rates (**Exhibit 11)**.

Exhibit 11. Linkage to Care (A) and Viral Suppression (B) by Age, Orange County 2018



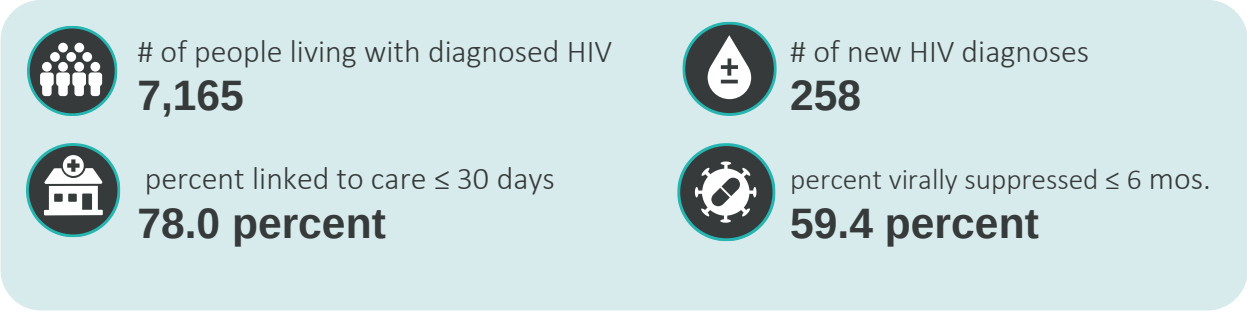
Similarly, disparities in linkage to care and viral suppression were also seen by race/ethnicity, with Asian and white persons having substantially worse outcomes for linkage to care within 30 days compared to B/AA and Hispanic/Latinx (H/Latinx). When looking at viral suppression, however, B/AA were the least likely to be virally suppressed compared to all other racial/ethnic groups. (**Exhibit 12**).[4]

Exhibit 12. Linkage to Care (A) and Viral Suppression (B) by Race/ethnicity, Orange County 2018.



In summary, **Exhibit 13** highlights key characteristics of Orange County's HIV epidemic in 2018.

Exhibit 13. Key characteristics of Orange County's HIV epidemic (2018)



Section III: Situational Analysis

This Situational Analysis provides a high-level overview of the strengths, needs, gaps, and barriers related to ending the HIV epidemic in Orange County. It synthesizes information from the epidemiological profile, community engagement efforts, planning process, and consultations with key HIV and non-HIV providers and stakeholders.

The Situational Analysis is organized into the following three sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps.

Methods

Orange County's needs assessment consisted of documenting HIV-related community needs and assets, describing the existing resources to meet those needs, and identifying gaps to fully meet the needs (**Exhibit 14**).

Exhibit 14. Methods and data sources used for the County's situational analysis

Method	Description
Needs assessment to ascertain needs, resources, and service gaps	• EtHE community engagement efforts • County information on existing services • California Directory of Syringe Services Programs[21] • Orange County 2019 HIV/AIDS Client Needs Survey Highlights[16]
Review of secondary data and reports	• AIDSVu local PrEP estimates[22] • Orange County Epi Profile 2018[4] • Point in Time Homeless Count[15] • CA Opioid Surveillance Dashboard[23] • HRSA 20-078 application[6] • CA HIV Surveillance Report 2017[24] • Orange County 2018 HIV Disease Fact Sheet[3] • Orange County Immigration Profile[13] • U.S. Census Population Estimates for Orange County[25]
Community engagement and consultation	• Orange County HIV Planning Council • Service providers and community-based organizations • Community members representing the priority populations disproportionately impacted by HIV
Review of relevant County and State plans	• 2017-2021 County of Orange Integrated HIV Prevention and Care Plan[5] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan[1] • PS 20-2010 EPMP and Work Plan[26]
Consultation with key stakeholders	• Local: OCHCA staff and community-based organizations • Regional and State: CDPH; CARG; Federal Ryan White Program Staff

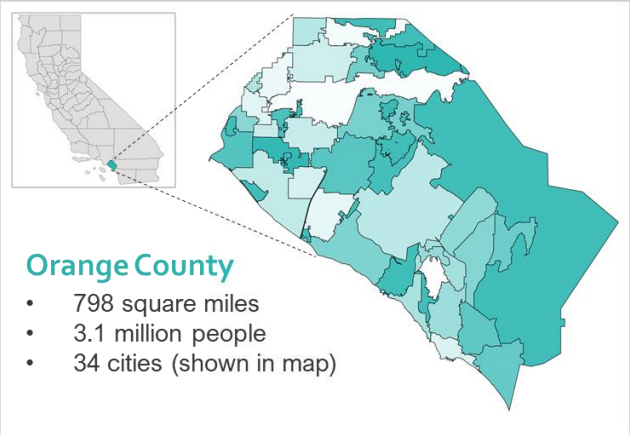
Situational Analysis Snapshot

Situational Analysis Summary

Orange County (**Exhibit 15**) covers an area of 798 square miles and is located in Southern California, bordered by Los Angeles County, San Diego County, and the Pacific Ocean. It includes 34 cities and has an estimated population of 3.1 million people. It is the third most populous and second most dense county in California, and the sixth most populous in the United States.[25] Santa Ana, which is an urban area of the county with a high concentration of Hispanic/Latinx and low-income residents, is also home to the largest number of PLWH in the county. A number of clinical services for HIV are also in Santa Ana including OCHCA's HIV/STD Testing, Treatment, and Care Clinic and the meeting facility for the HPC.

Orange County ranks 5th in total number of persons living with HIV (PLWH) among all California counties.[5] In 2018, there were 7,165 PLWH in the county who were aware of their HIV status and an estimated 1,200 individuals who were unaware of their status.[4] The estimated number of undiagnosed persons has held steady for the last three years,[4] but there has been other progress towards ending the epidemic in the county.

Exhibit 15. Orange County Map and Overview

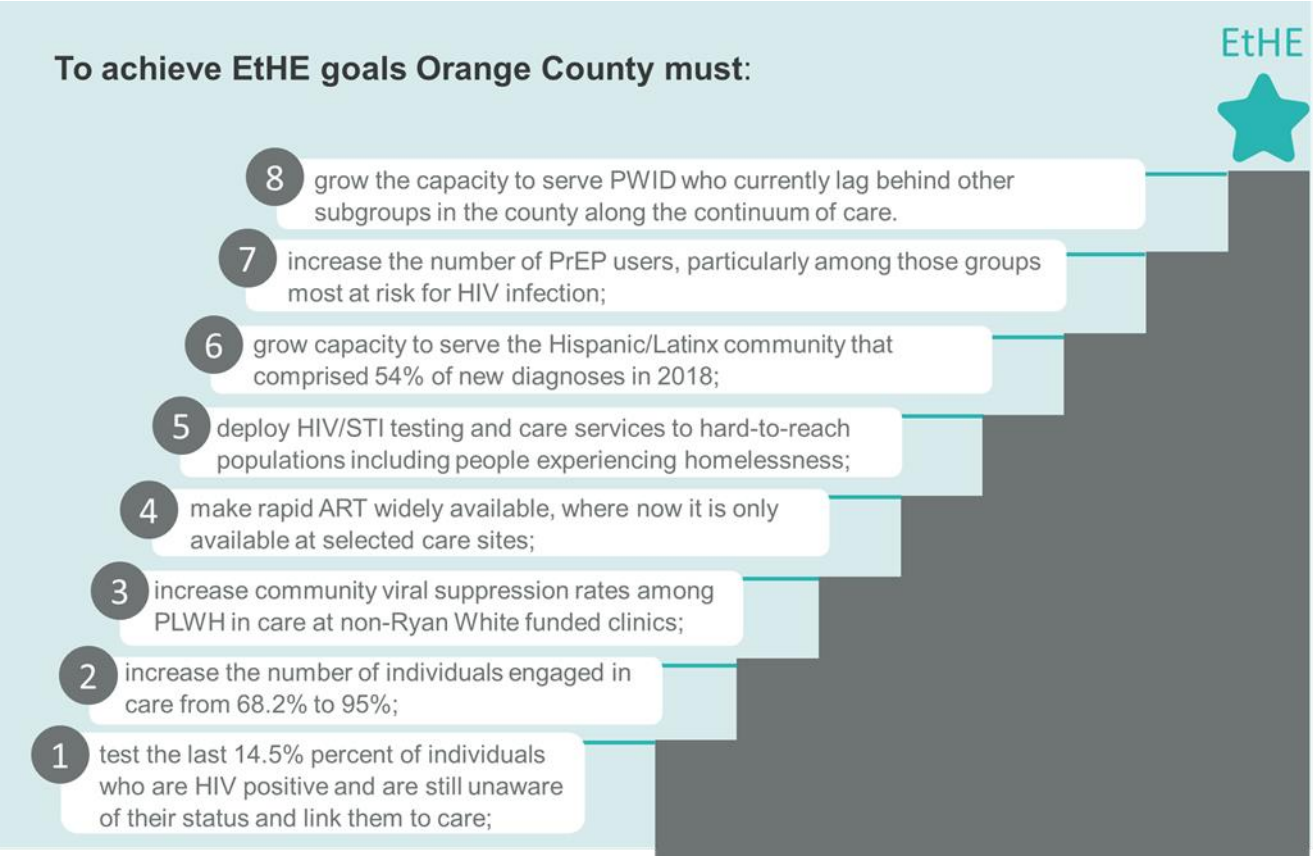


There were 286 new people diagnosed with HIV in 2018, and 78 percent of these individuals were linked to care within 1 month of their diagnosis.[4] In addition, new HIV diagnoses have shown a moderate decrease of 11 percent from 2011 to 2018.[3] Viral suppression among PLWH in Ryan White funded programs reached 89 percent in 2018.[27] Further, the OCHCA has embarked on a focused effort to provide technical assistance to selected non-Ryan White providers to help improve community viral suppression rates, which are currently at 59 percent. Orange County has also ramped up key resources and activities focused on increasing PrEP uptake through lessons learned from participation in a 3-year CDC-funded demonstration project (Project PrIDE) focused on Hispanic/Latinx MSM and transgender women. As a result of the CDC funded project, PrEP materials were developed, including fact sheets and other education materials. Finally, OCHCA is improving surveillance coordination with CDPH and other county partners, increasing capacity for data to prevention and care activities.

Though substantial work is in progress there is still much to do to achieve EtHE goals. There are populations that continue to be disproportionately affected. In 2018, MSM and MSM/IDU individuals combined comprised 72 percent of new HIV diagnoses.[4] Among MSM, most HIV diagnoses have shifted from white MSM to Hispanic/Latinx MSM and other MSM of color.[4] Young people under 34 are also disproportionately affected, representing 58 percent of new diagnoses in 2018.[4] While PWID represent only 7 percent of new diagnoses in 2018, they are a group that is considered underserved in the county by current programs.[4] Similarly, transgender women of color, sex workers, and incarcerated individuals represent population groups whom

there is less data and less capacity to reach with current testing and prevention programs. **Exhibit 16** summarizes what Orange County must do to reach EtHE goals.

Exhibit 16. High-level summary of what is needed to end the HIV epidemic in Orange County



Through a needs assessment and community engagement work, the OCHCA/CDPH has explored key resources, gaps, and challenges related to the HIV epidemic and how to address them. These issues will be discussed throughout the situational analysis.

Situational Analysis Snapshot by Pillar

Diagnose

As stated above, new diagnoses of HIV are still affecting MSM more than any other risk group, with 69 percent of infections occurring among this group in 2018. By comparison, 19 percent of diagnoses were attributed to heterosexual contact and 7 percent were linked to PWID transmission.[4] Also, in 2018, two-thirds of new diagnoses were among people of color, with Hispanic/Latinx individuals comprising 54 percent of new diagnoses overall.[4]

Needs assessment data suggests HIV stigma remains a persistent barrier to testing. Also, some MSM may not understand their risk for HIV, while others fear hearing the results of the test.[6]

The Hispanic/Latinx MSM population, who are reported to face similar fears, must also contend with other barriers such as lack of cultural and linguistic capacity among providers.[6] In addition, community engagement efforts suggest HIV messaging is not reaching Hispanic/Latinx MSM, putting them at elevated risk for testing late after HIV infection. The growing numbers of other STI infections in the county among MSM of color are also an indication of a potential increase of HIV infections without further intervention.[6]

Moreover, findings from the Gay Men's Health Summit (2019) suggest that HIV stigma can be combatted if MSM health is shifted from a problem-based framework to a wellness framework. Community engagement efforts suggest MSM need a wellness model that places their needs in the center of Orange County community life and celebrates them for who they are. Sexual health and HIV care are part of this larger wellness framework and discussions of HIV/STI risk, status disclosure and testing must be normalized and destigmatized. The OCHCA has committed to supporting additional Summits, supported through PS 20-2010.

Treat

In 2018, Orange County's 1-month linkage to care and 6-month viral suppression rates among people newly diagnosed with HIV were slightly lower than the State averages. In the county, 78 percent of individuals newly diagnosed with HIV were linked to care within 1 month (1 percent lower than the State average) and 59 percent achieved viral suppression within 6 months (4 percent lower than the State average). Among all PLWH, viral suppression was 57 percent in 2018 and has been steady since 2014.

Needs assessment data suggest why progress might be stalling for some indicators and opportunities for improvement. Trauma and medical mistrust is more prevalent among communities of color and must be addressed in order to make progress.[19] According to community engagement efforts, the burden of trauma and medical mistrust disproportionately affects the B/AA and transgender communities.[19,28] Rapid ART has decreased disparities among people of color in achieving viral suppression in other communities, but has only been implemented in limited capacity in Orange County.

The 2018 HIV Continuum of Care for Orange County estimated that 402 individuals were retained in care, but were not virally suppressed.[3] These PLWH see their doctor but are unable to maintain viral load suppression because of comorbidities or because they are not being adherent to medications. They require support from case managers and peer navigators to address clinical barriers to maintaining viral load suppression. Community engagement efforts suggest non-clinical issues, like maintaining health insurance coverage, can also be a barrier.

The complexity of health care coverage is a barrier to both clients and providers of care. In Orange County, providing treatment to PLWH requires navigating multiple layers of private and public health care coverage. PLWH may also require assistance transitioning between payer sources due to changes in employment, not completing eligibility screening, or simply deciding to discontinue coverage. Further, PLWH report challenges with accessing care outside of the Ryan White system due to doctors or networks not accepting new enrollees or their insurance coverage. These challenges appear to occur more with clients who have Medi-Cal coverage. As a result, the burden is on PLWH to find new medical care and transition through different networks and medical providers. The difficulty in navigating these systems of care can lead to a higher number of PLWH falling out of care.

Prevent

There were 286 new HIV diagnoses in 2018 in Orange County. While there was a decline in the rate of new HIV diagnoses (new diagnoses per 100,000) from 11.1 in 2014 to 8.9 in 2018, PrEP uptake falls far short of the California average as seen in **Exhibit 17** to the right.[29]

***Exhibit 17*:** 2021 Target and 2018 Estimated PrEP Utilization in Orange and California

	Total Users	Rate (per 100,000)
California 2021 target	60,000	152
California 2018	27,283	82
Orange 2018	1,518	57

OCHCA recognizes the importance of PrEP uptake as a vital step to reach community EtHE goals. Orange County was part of Project PrIDE, a 3-year demonstration project from 2015-2018 that worked to ramp up PrEP uptake. AltaMed Health Services, a local provider developed PrEP education and outreach materials for Hispanic/Latinx MSM as well as other populations. While PrEP uptake did increase in the Orange County, there is still much work to do.

Community efforts to reach Hispanic/Latinx need to be scaled-up. Community engagement efforts suggest that peers should be recruited as PrEP champions. Clients not only need to have a plan to get on PrEP, but also a plan to restart PrEP if they discontinue services. Educational materials should also feature images of peers and be designed in multiple languages. One community member in a neighboring county recalls getting information about sex coded in “dichos” or humorous sayings that have a double meaning and which allowed for discussion of difficult topics in a culturally sensitive and sex positive way.

Respond

OCHCA's capacity to coordinate between prevention and HIV surveillance has been bolstered by CDC's integrated approach facilitated by PS18-1802. OCHCA is working to further integrate linkage to care and partner services through cross-training and the use surveillance data to identify candidates for linkage to care and partner services. Some private providers have been resistant to completing mandated paperwork for new HIV diagnoses and other STIs, or fail to assist disease intervention specialists (DIS) in reaching out to clients. OCHCA plans to engage a provider liaison to offer education and training about HIV standards of care and requirements to providers outside of the Ryan White system of care.

OCHCA coordinates with CDPH's HIV Surveillance Branch on all aspects of HIV reporting, including potential HIV cluster investigations involving Orange County cases. OCHCA’s surveillance team works closely with neighboring counties to address cross-jurisdictional cases as well as with other counties throughout the state that may be involved in the case.

In 2014, OCHCA initiated a surveillance-based HIV Partner Services Program integrating surveillance activities with disease intervention. All newly diagnosed individuals are contacted to ensure that they are aware of their HIV status, linked to care and offered Partner Services. Since 2019, DIS have included Rapid ART referrals as part of this program.

Data to Care (DTC) is another effort to coordinate with HIV Surveillance. Historically, OCHCA conducted DTC with individuals identified through surveillance data as being out of care for over

18 months. In an effort to focus on individuals disproportionately affected, OCHCA changed the focus of DTC to target individuals from disproportionately impacted racial/ethnic groups and geographic locations with the highest HIV burden in the county, which included all Black/African American and Hispanic/Latinx MSM living in Santa Ana and Anaheim. OCHCA found these DTC efforts were not successful and, in 2019, shifted focus to newly diagnosed individuals who had not linked to care in 30 days and individuals who are not virally suppressed and recently diagnosed with an STD. The goal of these DTC efforts is to address the barriers to linkage/retention in care and partner services.

Summary of Resources and Gaps

Resources and Assets

Exhibit 18 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance EtHE planning and implementation. For example, Orange County has a robust HIV testing program that supported 7,927 HIV tests in 2018. Routine opt-out testing (ROOT) in the five county jails has been ongoing since 2012. Investments in PrEP have resulted in increased uptake and in lessons learned to inform program expansion. Viral suppression in Ryan White funded programs is a success that needs to be replicated in private health care settings. Additional resources and assets are also presented in **Exhibit 18** and described in more detail in the narrative that follows.

Exhibit 18: Orange County Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Targeted testing	●			
Community-level HIV testing	●			
Access to HIV care for undocumented individuals		●		
Viral suppression successes in Ryan White system of care		●		
Scaling up PrEP investment			●	
HIV surveillance data to care progress				●
Cross-Pillar				

- **Promising trends in new HIV diagnoses set the stage for future efforts**
- **Strong HIV leadership from OCHCA**
- **HIV Planning Council engagement**
- **Strong partnerships with key HIV service providers**
- **Gay Men's Health Summit**

Targeted Testing. Targeted community-based and routine jail-based HIV testing accounted for 27 percent (66 of 245) of people newly diagnosed in 2019.[6] Twelve individuals were newly diagnosed through routine jail testing and 56 individuals were identified through targeted testing. Targeted testing approaches have yielded good results in the county, and lessons learned from this strategy can be applied innovatively to better reach marginalized populations and other populations who may not access traditional health care settings.

Community-level HIV testing. Orange County has worked to educate providers about federal guidelines recommending routine HIV screening for people ages 15 to 65. In 2019, OCHCA and its partners 245 newly diagnosed patients with HIV.[5]

Viral suppression successes in Ryan White funded clinics. Viral suppression among clients in the Ryan White system of care was 89 percent in 2018.[6] County Ryan White providers have extensive capacity and experience with HIV standards of care. They provide both care and support services, such as case management and medical transportation, which may not be available or easy to access in other systems of care. Access to these services provides clients with the tools they need to achieve and maintain viral suppression.

Scaling up PrEP investment. OCHCA has made significant efforts and investments to expand PrEP using funding from CDC PS18-1802. For example, the OCHCA hired a nurse to provide PrEP education to new and existing PrEP users at the county-run clinic. This key position provides appropriate medical follow-up to all county clinic patients. OCHCA is in the process of scaling up provider capacity for PrEP. This includes training for clinicians on how to assess clients for PrEP and screen for eligibility. Also, OCHCA will offer free PrEP educational materials to CBOs, Federally Qualified Health Centers (FQHCs), and other clinics to distribute to PrEP eligible clients.

Promising Trends in New HIV Diagnoses. Orange County has been successful in decreasing new HIV diagnoses by 47.8 percent over the past ten years (2010 – 2019).[5] This achievement is a testament to targeted prevention and treatment efforts. The greatest progress has been made among white MSM. However, other communities have not benefited equally; currently, most new HIV diagnoses occur among Hispanic/Latinx MSM and other communities of color.[4] Other successes include a 17.8 percent decrease in late testing between 2010-2019 as shown by a reduction in the number of concurrent HIV and AIDS diagnoses.[5] It will be important to apply lessons learned from these successes, as well as to develop innovative strategies for more vulnerable populations, in order to further decrease new diagnoses and ultimately get to zero new diagnoses.

Strong HIV Leadership. At the center of the HIV work and progress in the county is strong community and health department leadership. OCHCA leadership and staff are diverse, skilled, and actively engaged in the planning of care and prevention strategies for the county. They have developed a strong team and structure to respond effectively to challenges and to

administer HIV programming. The health department leadership takes purposeful steps to engage with the HPC, making sure their concerns and voices are lifted in the process.

HIV Planning Council (HPC). The HPC is composed of key consumers, providers, advocates, and agencies that serve people living with and at risk for HIV. The HPC recognizes the significance of continuing to increase community engagement by bringing new voices to the planning table. As a result, the HPC includes Hispanic/Latinx members who speak Spanish as their first language to reflect the changes in the local HIV epidemic. Organizations that provide mental health and other key services to PLWH continue to have seats at the table.

Strong Partnerships with Key Service Providers. Partnerships with service providers are pivotal to reach populations that are underserved or not currently being reached. The health department has a good track record of cultivating mutually reinforcing partnerships within the community to better serve clients. Over many years, the health department has established strong connections and collaborations with providers in alignment with changes in the HIV landscape. For example, as the Hispanic/Latinx MSM population has become more impacted by HIV, the county has used Minority AIDS Initiative funding to support linguistically and culturally appropriate case management services for Hispanic/Latinx PLWH, as well as other groups. The provision of culturally and linguistically appropriate care is at the forefront of service delivery, for example, ensuring that food banks offer culturally appropriate food options for Hispanic/Latinx people. Community partnerships go beyond HIV to address the growing needs of the community, including the social determinants of health.

Gay Men's Health Summit The Orange County Gay Men's Health Summit was sponsored by the OCHCA, and implemented in collaboration with the Pacific AIDS Education & Training Center (PAETC) and local partners including: The LGBTQ Center OC, Radiant Health Centers/RADAR, AltaMed Health Services, and the California Prevention Training Center. The purpose of the summit was to accomplish the following overall learning objectives for both community members and health care providers:

1. Increase awareness of the health issues gay men face in Orange County.
2. Identify key sources of stigma for gay men, and identity the tools of resiliency they can use to work through those barriers.
3. Discuss the ways in which gay men can increase their ability to self-advocate for health needs.

Exhibit 19. Gay Men's Health Summit Outcomes

Gaps and Challenges

Orange County has several pillar-specific and cross-pillar challenges and gaps **(Exhibit 20**) that will need to be addressed in order to reach EtHE goals. For example, further expanding routine opt out testing (ROOT), improving rapid linkage to care and ART initiation, and working with non-Ryan White providers to improve the quality of HIV care.

Exhibit 20: Orange County Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Need for implementation of ROOT in new healthcare provider settings	●			
HIV clinical provider shortages		●		
Limited availability of Rapid ART		●		
Need for support services for priority populations to achieve viral suppression		●		
Need for improvements in linkage to HIV care post-incarceration		●		
Worse health outcomes for PLWH receiving care outside the Ryan White system		●		
Low community PrEP uptake			●	
Increasing STI rates			●	
Need to strengthen protocols for outbreak response				●
Cross-Pillar				
• **Social determinants of health** • **Low perception of risk of acquiring HIV among MSM** • **Stigma** • **Fear of deportation among those with undocumented immigration status** • **Increases in homelessness** • **Barriers to reaching PWID** • **Difficult-to-navigate system of care** • **Substance use**				

ROOT. Routine opt out testing has been an ongoing activity in Orange County jails since 2012. OCHCA will build upon existing successes and work to expand ROOT in other provider settings.

HIV Clinical Provider Shortages. There are too few medical providers to serve all the PLWH insured by Medi-Cal. There are 1,136 PLWH on Medi-Cal, yet there are only 29 HIV providers who accept Medi-Cal.[6] Some of these providers are not accepting new patients because they have reached capacity. Among this limited number of providers there are even fewer with linguistic and cultural competency to serve the full diversity of PLWH in the county.

Limited availability of RAPID ART. Rapid ART has been implemented in a limited capacity. Rapid ART services need to be expanded to include OCHCA's HIV clinic and five county jails that accounted for 27 percent (66 of 245) of all new positives in the TGA in 2018. There is also a need to coordinate the delivery of Rapid ART in the county. The State Office of AIDS recently

awarded Radiant Health Centers, a Ryan White provider, a contract to implement Rapid ART. Rapid ART has proven to be effective in decreasing the average amount of time it takes an individual to reach viral load suppression and thereby reducing the time they can potentially transmit the virus to partners.[30] Additionally, when Rapid ART was made available to all newly diagnosed individuals regardless of insurance type, disparities among people of color in achieving viral load suppression decreased.

Need for support services for priority populations to achieve viral suppression. As discussed above, retention in care does not equal viral suppression. Some PLWH are unable to maintain viral load suppression despite being engaged in care and therefore require additional support, such as medical case management services and peer navigation to address related barriers.

Worse health outcomes for PLWH receiving care outside of the Ryan White system. PLWH receiving care outside of the Ryan White (RW) system experience worse outcomes along the HIV continuum of care compared to PLWH receiving RW services. Ensuring that non-RW providers are knowledgeable of and trained to deliver care in accordance with HIV Standards of Care is key to closing this gap. There is much room for improvement in coordinating with the large systems of care outside of the RW system including Kaiser and CalOptima (Medi-Cal Managed Care Provider for Orange County). OCHCA's EtHE plan will address these areas.

Linkage to Care Post-Incarceration. Orange County has five county jails. Compared to the general U.S. population, people who are incarcerated have a disproportionately high risk of HIV infection. Additionally, many jails and prisons provide ART to PLWH; however, maintaining ART after release can be challenging.[31] In Orange County, only 31 percent (18 of 58) of previously incarcerated people maintained care after release from jail in 2018.[6] To make improvements and to create a seamless continuum of care from the jail system to release and re-entry, collaboration among HIV clinicians, Correction Health Services, public health departments, and re-entry organizations needs to be strengthened.

Low PrEP Uptake. An ongoing challenge has been identifying a reliable source of PrEP data that is truly reflective of PrEP uptake in the County. Based on AIDSVu data, it is estimated that 1,518 individuals in Orange County were on PrEP in 2018. Estimates from Gilead indicate that 800 individuals were on PrEP in Orange County in 2019; approximately 300 of these individuals were County STD clinic patients. Gilead data is inclusive of all insured individuals and individuals receiving PrEP via Gilead's Advancing Access Program. Regardless of the data source, PrEP uptake in the county is low. In alignment with the National HIV/AIDS Strategy, OCHCA has set a goal to increase the number of individuals on PrEP to 880 by the year 2021, which represents a 10 percent increase in the number of individuals on PrEP based on Gilead data estimates. Multiple barriers can hinder PrEP uptake, including health insurance coverage limitations, provider practices around screening and prescription, stigma, and lack of knowledge. In a 2016 local survey, only 38 percent (74 of 194) of respondents had heard of PrEP and knew what it was, providing further evidence of the lack of awareness and knowledge among community members.[5] Despite the strong evidence on the efficacy of PrEP, many populations at risk for HIV are not using PrEP. Significant efforts are needed to increase uptake, especially among B/AA MSM, Hispanic/Latinx MSM, and PWID.

Barriers to reaching PWID. People who inject drugs (PWID) made up 6.8 percent of new HIV diagnoses in 2018, up 1.5 percent from 2017.[4] This population is often hard to reach if there are no established linkages or gatekeepers to facilitate access. Furthermore, people who use substances are less likely to access healthcare or HIV testing if they are dealing with addiction, homelessness, or extreme poverty. Some PWID believe sharing needles with a small circle of friends will prevent the transmission of HIV. Without appropriate education related to risk reduction techniques, these beliefs could lead to increased transmission. As indicated in the most recent (2019) Client Needs Survey, PLWH indicated a need for increased access to substance use services.[16] While there is currently no wait list for treatment services, there may be a general lack of knowledge among PWID about services available. One point of outreach to PWID could be harm reduction services. As of March 2020, Orange County had no syringe services programs authorized by CDPH.

Increasing STI rates. The number and rates of chlamydia trachomatis (CT), gonorrhea (GC), and syphilis cases all trending up, with rates of CT increasing 24.6 percent, GC increasing 67.8 percent, and syphilis increasing 65.9 percent between 2015-2018[32] Increasing STI rates indicate the need to address behaviors that put clients at high risk for HIV.

Lack of a protocol for HIV outbreak response. Although Orange County has an interdisciplinary HIV surveillance team, there is no formal protocol for HIV outbreak response. As a result, if an HIV cluster were identified in Orange County, an appropriate response might not be as timely or coordinated as needed, which could pose challenges to effective containment and response. Orange County will follow guidance from the OA Outbreak Response Plan and utilize the OA Prevention Branch Disease Outbreak Intervention and Field Investigation Unit for technical assistance and additional staffing, as needed.

Social Determinants of Health. Addressing social determinants of health (SDOH) remains a challenge in the county. To create conditions to achieve a reduction in new HIV infections and reduce health disparities, the following SDoH in Orange County must be addressed: systemic discrimination, the high cost of living, and lack of HIV-related knowledge.

- **Systemic discrimination** manifests in homophobia, transphobia, sexism, racism, and sex negativity which creates structural barriers to HIV testing, treatment, and prevention. Systematic marginalization of groups, such as MSM of color, in turn determines whether these individuals will seek information and resources to manage HIV risk or medical care.
- **Cost of living** in Orange County is 18 percent higher than the national average. An individual working a minimum wage job ($12/hour) is likely unable to afford housing in the county. This particularly affects low-income individuals, including PLWH or those who rely on disability and Social Security income and typically make less than minimum wage, increasing their risk for displacement.
- **Lack of HIV-related knowledge.** There is a stark disparity in access to basic knowledge about HIV and prevention methods among vulnerable populations.[6]

Low Perception of Risk. Anecdotally, many MSM in Orange County have a low perceived risk of acquiring HIV. This phenomenon is not unique to the Orange County and may reflect changes in the epidemic over decades.[6] In the early days of HIV, there was a sense of urgency and a high-perceived risk among MSM as deaths soared and prevention tools were limited [6] While the new prevention approaches available are cause for celebration, the downside is that

this sense of urgency has been replaced by a sense of "invincibility" related to acquiring HIV. Similarly, since HIV is thankfully no longer a death sentence, this also impacts the sense of importance around prevention.

Stigma. Some communities face stigma based on their sexual identity, gender orientation, sexual behaviors, and HIV status. Stigma has negative effects on health outcomes and health behaviors. It often produces feelings of shame and isolation, impacting mental and emotional health.[12] Stigma can also prevent people from seeking HIV/STI screening and treatment due to fear of being identified as HIV-positive or even being at risk for HIV. This fear is especially salient for communities of color who face unique stigma-related factors such as culture. Internalized stigma may also be prevalent among gay or bisexual populations and among individuals who do not identify as gay or bisexual but engage in same-gender sexual activities. In sum, stigma leads to marginalization and secrecy and creates barriers to health and accessing health care. Orange County is actively addressing HIV stigma through an anti-stigma campaign "*HIV: It's a Human Thing*."[33] The multimedia campaign included a digital component and indoor ads at restaurants and other community-based locations as well as outdoor ads on billboards and bus stops strategically placed in cities with the highest number of HIV rates or new infections in the county. Providers and community members can visit the campaign site and download materials for distribution with messages about HIV education, PrEP, testing, and HIV status disclosure.

Fear of Deportation. Some undocumented residents of Orange County have reported being fearful of receiving services from governmental organizations because of potential consequences on their ability to stay in the United States. There have also been reports that the changes to federal immigration policy, including heightened immigration enforcement and expansion of the "public charge" rule, are causing fear and confusion leading to families dropping out of public assistance programs.[34] Anecdotally, DIS workers have reported people falling out of care because of fears about how accessing services may affect their ability to obtain legal residency. Other anecdotal reports include individuals discontinuing insurance coverage or declining treatment because of concerns over the public charge rule.[6] These anecdotes suggest the current federal immigration stance may be having harmful effects on health care access, lending support to the need to provide legal services to the Hispanic/Latinx and undocumented communities in conjunction with case management and other social services.

Cultural and language barriers must be addressed given the increase in new diagnoses among Hispanic/Latinx MSM in the county. Hispanic/Latinx MSM experience unique barriers to prevention and care services. There is a high level of stigma in the Hispanic/Latinx community associated with HIV, as well as a need for information and outreach in Spanish.[6] Culturally and linguistically appropriate outreach, information and services must be enhanced to better meet the needs of this population.

Difficult-to-Navigate System of Care. PLWH, especially those newly diagnosed, can have difficulties navigating the system of care. Medical insurance jargon is difficult for lay people to understand. When trying to access care, clients can face multiple hurdles. Individuals need to find a provider who accepts their insurance, is accepting new patients, and has appointments readily available. The burden is on PLWH to find medical care and transition through different networks and medical providers. Medi-Cal regulations pose additional barriers. Individuals can only be enrolled in Medi-Cal in one county, meaning if they move to another county, they must

reapply in that county. That process can take as long as six months in some jurisdictions, leaving people without health insurance and is a barrier to accessing and remaining in care. PLWH may also require assistance transitioning between payer sources due to changes in employment, not completing eligibility screening, or simply deciding to discontinue coverage. These barriers can make it difficult for PLWH to reach and maintain viral suppression.[6]

Section IV: Ending the Epidemic Plan

This section provides a detailed overview of the disruptively innovative activities that Orange County will implement to End the HIV Epidemic in the county by 2025. The proposed EtHE activities are above and beyond the foundational efforts already in place and are designed to be directly responsive to the needs and gaps identified in *Section III: Situational Analysis.* The proposed EtHE activities are designed to enhance but not duplicate current programs and services, and are inclusive of all disruptively innovative activities, regardless of funding source.

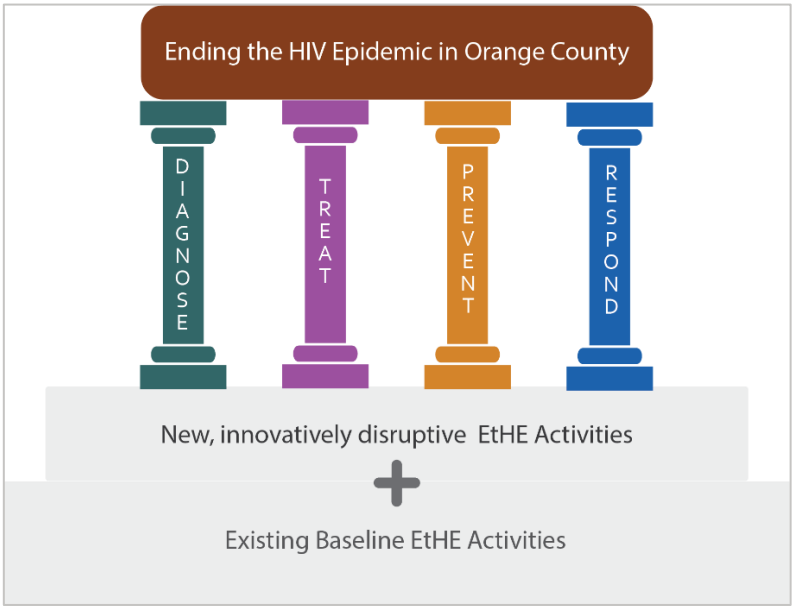


Exhibit 21. Schematic of how new, disruptively innovative EtHE activities in Orange County will build upon existing efforts to respond to local needs and gaps that have not been sufficiently addressed to date.

EtHE Programs and Key Partners

Orange County has identified fourteen innovative efforts that will help end the HIV epidemic. These efforts will require close partnership with several existing as well as new partners to be successful. The programs and partners are described below.

Summary of Proposed Programs

- **Testing Innovations.** OCHCA will make HIV and/or STI testing more available to EtHE priority populations through multiple strategies:
    - **Mail to Home Test Kit Pilot Program.** Orange County will make available mail to home (or another preferred location) HIV and/or STI test kits. This will help eliminate barriers to testing for clinic patients as well as individuals in the community who have never tested or have not tested in over a year. *(Diagnose, Treat, Prevent)*
    - **Mobile Testing, STD Care, and Referral Services for at-risk groups.** Orange County will collaborate with community-based providers to offer mobile services to people who are unable to visit a provider office for testing, treatment, and referral services due to barriers such as homelessness. *(Diagnose, Treat, Prevent Respond)*

  - **PrEP Navigation.** Orange County will expand HIV prevention activities to increase initiation of PrEP/PEP by assisting clients with PrEP access with public or private insurance.

- **Health Summits for Gay Men and the Transgender Community** will increase awareness of the health issues these communities face in Orange County and provide tools and community resources—including HIV testing, HIV care and PrEP—to help them stay healthy. *(Diagnose, Prevent)*
- **Health Education Videos in multiple languages** will be developed to address the unique needs priority populations in Orange County face in the HIV epidemic. *(Treat, Prevent)*
- **Trauma-Informed Prevention and Care Services for the Black/African American (B/AA) and Transgender Populations** will engage members of the B/AA and transgender communities, as well as related organizations and community groups, to identify barriers to care, inform service delivery, and build capacity within the county to provide culturally competent and trauma-informed care. *(Treat, Prevent)*
- **The Viral Suppression Patient Incentive Program (Viral suppression PIP)** will incentivize PLWH to engage in HIV care, reach and maintain viral suppression, and use case management and partner services. (*Treat)*
- **Community-Based Case Management Services.** Case manager will be located at provider offices outside the Ryan White System of Care who have a high volume of patients not virally suppressed. *(Treat)*
- **Focus Groups with PLWH who are not virally suppressed.** This activity will use local surveillance data to strategically identify and engage individuals who are not virally suppressed to identify barriers to care and solutions to address these barriers. *(Treat, Prevent)*
- **Mental Health Services for PLWH** will provide psychiatry mental health services to PLWH to improve retention in care and viral load suppression. Funded through HRSA 20-078. *(Treat, Prevent)*
- **Rapid Antiretroviral Treatment (Rapid ART).** Develop and implement a protocol for Rapid ART implementation in the county HIV clinic and jails and ensure a coordinated approach to delivery of Rapid ART in the county**.** This activity will expand access to Rapid ART for individuals who are newly HIV diagnosed or have fallen out of care. This activity will link newly diagnosed individuals identified though targeted testing in the community or through testing at the county jails to care. Funded through HRSA 20-078 . *(Treat)*
- **HIV Care to High Acuity Individuals**. This activity focuses on providing care to high acuity clients who are insured but do not qualify for Ryan White medical services and who are unable to engage or be retained in medical care due to barriers such as homelessness, substance use, mental health conditions, or history of incarceration. Proposed methods will improve retention in care and viral load suppression for clients at greatest risk for falling out of care by providing case management services. Funded through the HRSA 20-078. *(Treat)*

- **Expanded Housing Availability.** Housing instability among PLWH can result in intermittent HIV care. OCHCA will coordinate with the existing housing infrastructure to expand housing for PLWH to improve housing stability and engagement in care. Funded through HRSA PS 20-078. *(Treat)*

- **CHIPTS CFAR Project: Regional Response to HIV Eradication Efforts in Southern CA Counties.** Orange County is participating in a CHIPTS CFAR study led by Stephen Shoptaw titled *Regional Response to HIV Eradication Efforts in Southern CA Counties,* along with San Diego, Los Angeles, Riverside, and San Bernardino Counties.[8] OCHCA is supporting the project by participating in regional meetings, reviewing and commenting on reports and sharing best practices with other county partners. Not funded through CDC PS 20-2010. *(Respond)*

Key Partners

Orange County will work with key partners, including organizations serving MSM of color, the transgender community, youth, PWID, and those with technical expertise to develop and implement the proposed programs and services. These include:

- **Pacific AIDS Education and Training Center (PAETC).** PAETC is the regional partner of the AIDS Education Training Center (AETC). They have the technical expertise to support the planning and implementation of the health summits, including subject matter experts, continuing education, and program evaluations services. Orange County will collaborate with PAETC to plan and implement the health summits.

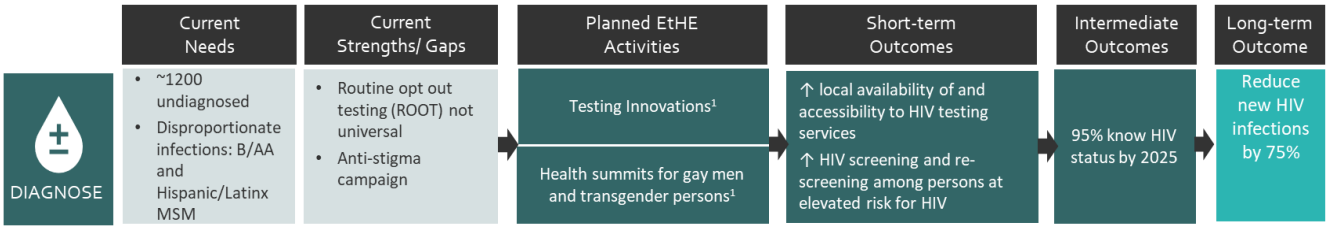
- **Community Providers.** Community providers such as mental health, substance use, emergency room, and homeless services providers with longstanding ties to the community will be instrumental in reaching marginalized and hard-to reach individuals via the mobile unit.

- **CalOptima.** CalOptima (Medicaid Managed Care Plan in Orange County) is a key stakeholder to reach priority populations, facilitate access to and coordination of care, and support promotion of proposed programs and services.

- **Faith-based, civic, and community groups.** Faith-based, civic, and community groups have relationships and knowledge that will be key in reaching the B/AA and transgender communities.

Orange County's Plan to End the HIV Epidemic

Diagnose



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Testing Innovations**
  - **Mail to Home Test Kit Pilot Program**
  - **Mobile Testing, STD Care, and Referral Services**
- **Health Summits for Gay Men and the Transgender Community**

Diagnose: Orange County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings	
Testing Innovations: Mobile Testing, STD Care, and Referral Services	
• Develop mobile unit program design and protocols • Collaborate with community provider(s) to reach marginalized and hard-to-reach individuals via mobile unit • Monitor and map new HIV cases for strategic deployment of mobile unit services • **Provide testing,** treatment, and referrals to marginalized and hard-to-reach individuals	• Continue to deploy services using the mobile unit • Develop and implement protocols for the mobile unit to engage in a coordinated response to HIV clusters throughout Orange County
Health Summits for Gay Men and the Transgender Community	
• Plan and implement Health Summit for gay men • The summit will include a community and health care provider track • **Provide HIV testing (25 participants),** STD testing (25 participants) and PrEP services (enroll at least 10 participants) to summit participants including community members • Provide CEU's to providers	• Plan and implement Health Summit for the transgender community in Year 2 • The summit will include a community and health care provider track • Provide HIV testing (15 participants), STD testing (15 participants) and PrEP services (enroll at least 5 participants) to summit participants including community members • Provide CEU's to providers
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings **Strategy 1C.** Increase to at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings	
Testing Innovations: Mail to Home Test Kit Pilot Program	

Diagnose: Orange County	
Year 1 Activities	**Year 2-5 Activities**
• Offer Orange County HIV/STD clinic patients and community members who have never tested or not tested in the last year the option to receive **HIV and/or STD test kits mailed** to their home or preferred location • Develop pilot program protocol	• Implement pilot program

HIV Workforce Development Needs

Positions

- **Contract Nurse Practitioner.** The nurse practitioner will lead the development and implementation of the Mail to Home Test Kit pilot program and provide oversight of all related clinical activities. This position will also provider oversight of testing and PrEP activities to be implemented at the health summits.
- **Contracted Testing Service Provider.** The contracted community-based provider(s) will implement mobile services to meet the needs of individuals who are unable to visit a provider office for testing, treatment, and referral services due to barriers such as homelessness.
- **Consultant Services with technical assistance organization with HIV expertise.** The technical assistance organization will be contracted to lead the coordination and promotion of the health summits and provide continuing education units to attendees as appropriate.
- **Grants Support Specialist.** The Grants Support Specialist will provide support for all EtHE reporting requirements. This position supports activities across all pillars.
- **Program Support Specialist.** The Program Support Specialist will work directly with subcontractors to implement proposed programs and services, coordinate evaluation activities, and provide support with program monitoring for the EtHE grant. This position will support activities across all pillars.

Capacity-Building

When building capacity, Orange County will continue to make a concerted effort to recruit a workforce mirroring the priority populations demographically, linguistically, and in lived experience to increase capacity to reach these populations.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of key partners related to this pillar is below.

- **Pacific AIDS Education and Training Center (PAETC)**
- **Community Providers**
- **CalOptima**

Funding

Activities proposed under the Diagnose Pillar will be implemented utilizing CDC PS20-2010 and HRSA 20-078 funding as detailed below.

Program/Effort	Total Funding (Requested)	Proposed Funding Source
• Mobile Testing, STD Care, and Referral Services	$1,263,239	CDC PS20-2010
• Health Summits for Gay Men and the Transgender Community		
• Mail to Home Test Kit Pilot Program		
TOTAL FUNDING FOR DIAGNOSE PILLAR*	$1,263,239	

*$0 exclusively for Diagnose Pillar, and $1,263,239 for programs that cut across Diagnose and other pillars.

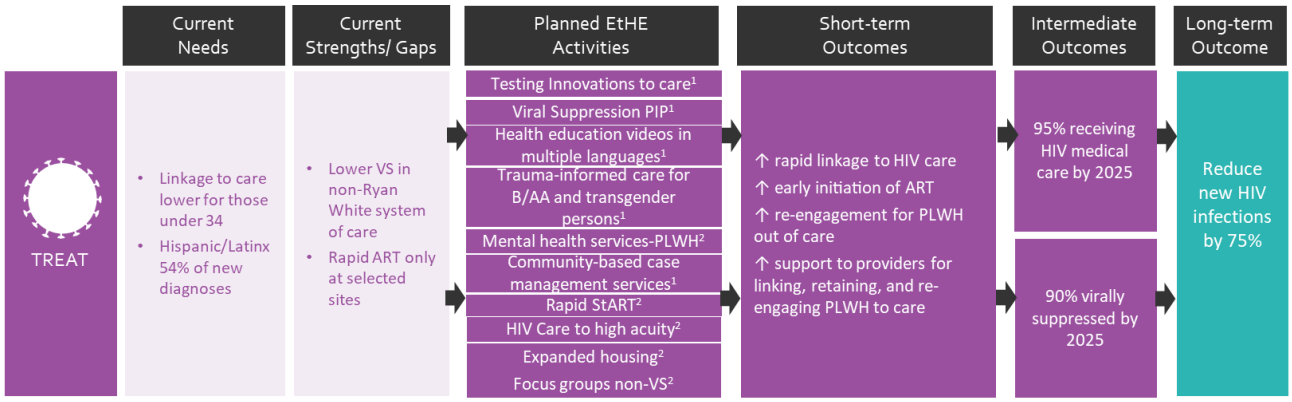
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[26] Targets will be determined in coordination with CDC as the EPMP is finalized. Only CDC PS 20-2010 funded program indicators are in the table below.

Diagnose: Orange County	
Outcome Measure	**Data Source**
Number of non-traditional venues conducting HIV testing*†	Records of HIV testing events
Percent of HIV tests that are conducted in non-traditional venues identified as a priority for the EHE testing services*†	Records of HIV testing events
Number of HIV self-test kits distribution events planned#	Records of HIV self-test kits distribution events
Number of events where HIV testing is bundled with screening for other conditions relevant to the local population*†	Records of HIV testing and medical screening events
Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings*†	Documentation of strategies utilized
Percent of all persons tested in non-traditional test settings are linked to medical care within 30 days*†	Linkage to care records
Percent of all persons tested in non-traditional test settings linked to appropriate prevention services*†	Linkage records
Promote rapid HIV self-test programs in both healthcare and non-healthcare settings that can offer HIV rapid self-tests to persons at ongoing risk#	Documentation of promotion
Identify novel approaches to make HIV tests widely available in non-healthcare settings where marginalized populations, including people experiencing homelessness and/or those injecting drugs, congregate*	Documentation of novel approaches

*Mobile Testing, STD Care, and Referral Services
†Health Summits for Gay Men and the Transgender Community
#Mail to Home Test Kit Pilot Program

Treat



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Testing Innovations**
    - **Mail to Home Test Kit Pilot Program**
    - **Mobile Testing, STD Care, and Referral Services**
- **Health Education Videos**
- **Trauma-Informed Prevention and Care Services for the Black/African American and Transgender Communities**
- **Viral Suppression Patient Incentive Program**
- **Community-Based Case Management Services**
- **Mental Health Services for PLWH**
- **Focus Groups with HIV positive individuals not virally suppressed**
- **Rapid Antiretroviral Treatment (Rapid ART), County Clinic and Jails**
- **HIV Care to High Acuity Individuals**
- **Expand Housing Availability**

Treat: Orange County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV	
Testing Innovations: Mobile Testing, Care, and Referral Services	

Treat: Orange County	
Year 1 Activities	**Year 2-5 Activities**
• Develop mobile unit program design and protocols • Collaborate with community provider(s) to reach marginalized and hard-to-reach individuals via mobile unit • Monitor and map new HIV cases for strategic deployment of mobile unit services • **Provide** testing, **treatment, and referrals** to marginalized and hard-to-reach individuals	• Continue to deploy services using the mobile unit
Testing Innovations: Mail to Home Test Kit Pilot Program	
• Offer Orange County HIV/STD clinic patients and community members who have never tested or not tested in the last year the option to receive **HIV and/or STD test kits mailed** to their home or preferred location • Develop pilot program protocol including linkage to care	• Implement pilot program
Health Education Videos	
• Develop content for **health education videos** in multiple languages for newly identified HIV positive people, youth, and/or immigrants to **help address barriers for linkage to and retention in care** • The project will be community driven, feature members of the community, and address the unique needs of the Orange County HIV epidemic • Develop a communications/dissemination plan	• Continue to develop video content • Promote and disseminate video content
Rapid ART (078)	
• Develop protocol for Rapid ART implementation. • Offer Rapid ART to all newly diagnosed individuals.	• Continue to offer Rapid ART

Strategy 2B. Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of the Ryan White HIV/AIDS Program (RWHAP)

Viral Suppression Patient Incentive Program	
• Develop program protocol **to incentivize PLWH to engage in HIV care,** reach and maintain viral suppression, and use case management support services • Develop client and provider recruitment strategy • Develop incentive program promotional/recruitment messaging and materials • Identify and outreach to community providers • Conduct outreach to PLWH who meet program criteria • Conduct staff training for program implementation	• Implement program and track program outcomes • Engage at least 100 participants per year
Community-Based Case Management Services	

• Recruit and hire a **case manager** co-located and/or floating at community-based provider sites (outside of the Ryan White system of care) that have a high volume of patients not virally suppressed • Identify at least three providers with a high volume of patients with unsuppressed viral load to partner with and develop MOUs	• Provide case management services in collaboration with partner providers identified
Mental Health Services for HIV-Positive (078)	
• Design program protocols and hire staff • Provide **psychiatry and mental health services to individuals with HIV** (100 persons)	• Continue to provide psychiatry and mental health services to individuals with HIV (100 persons per year) • Evaluate program and track outcomes
Focus Groups with people living with HIV who are not virally suppressed	
• Use surveillance data to strategically engage persons not virally suppressed • Conduct 4 **focus groups** with PLWH who are not virally suppressed **to identify barriers to care** and inform service delivery	• Continue to engage community members and modify service delivery as needed • Evaluate program and track outcomes
HIV to Care to High Acuity Individuals (078)	
• Develop protocol for identifying clients who do not quality for Ryan White with demonstrated inability to link or stay engaged in to care due to mental health, substance use, homelessness, and/or formerly incarcerated. • Provide and coordinate medical care for clients who are unable to access care through their insurance carrier.	• Provide and coordinate medical care for clients who are unable to access care through their insurance carrier.
Expand Housing Availability (078)	
• Collaborate with local housing authority to provide housing assistance to 10 households through the Rental Assistance Program (RAP). • Update and maintain RAP wait list	• Continue to provide housing services
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)	
Trauma-Informed Prevention and Care services for the Black/African American and Transgender Communities	
• Engage: 1) B/AA community, faith-based, and civic organizations and 2) the transgender community, and community groups to **identify barriers to HIV care** and prevention services and inform service delivery • Leverage long-standing **partnerships** with HIV prevention and care service providers within the county and in the community **to enhance the current system of care and address barriers** identified by the community utilizing a trauma-informed approach	• Continue to engage communities and build partnerships • Evaluate and improve efforts and track impact on HIV-related health disparities and community experiences with stigma, medical mistrust, and systemic/institutional barriers.

• Conduct at least six **community engagement activities** (focus groups, key stakeholder interviews, or community listening sessions) and at least two staff/provider trainings on the delivery of **culturally competent and trauma-informed care** for B/AA and transgender persons • **Increase** the percentage of **B/AA and transgender persons who are linked to care** in the community within seven days • **Increase retention in care** for B/AA and transgender persons	

HIV Workforce Development Needs

Positions

- **Contracted Psychiatrist/Licensed Marriage and Family Therapist.** The contracted providers will be responsible for providing psychiatry and/or mental health services to PLWH and persons at substantial risk of HIV.
- **Contracted Case Manager.** The contracted personnel will support linkage to and retention in care to help PLWH outside the Ryan White system of care achieve viral suppression.
- **Contracted Testing Service Provider.** The role of contracted community-based provider(s) is described in detail on page 40.
- **Consultant Services with a CBO with expertise working with the transgender community.** The CBO will be contracted to lead engagement of the transgender community, solicit community input to identify barriers to prevention and care, and conduct training to service providers to build capacity throughout Orange County to deliver trauma informed care to transgender PLWH and those at risk for HIV.
- **Consultant Services with a CBO with expertise working with the Black/African American (AA) community.** The CBO will be contracted to lead community engagement efforts, solicit community input to identify barriers to prevention and care, and conduct training to service providers to build capacity throughout Orange County to deliver trauma informed care to B/AA PLWH and at risk for HIV.
- **Health Communications Consultant**. The consultant will provide expertise in the production and promotion of health education videos to address barriers for linkage to and retention in care among priority populations. The consultant will also lead implementation of the focus groups with PLWH who not virally suppressed to identify barriers to care and inform the development of the Viral Suppression Patient Incentive Program.
- **Program Consultant.** The consultant will develop and implement a Viral Suppression Patient Incentive Program to support individuals outside of the Ryan White system of care achieve and maintain viral load suppression.

- **Contract Pharmacist.** The contracted provider will support individuals outside of the Ryan White system of care participating in the Viral Suppression Patient Incentive Program with medication management and treatment adherence.
- **Grants Support Specialist.** The Grants Support Specialist is described on page 40.
- **Program Support Specialist**. The Program Support Specialist is described on page 40.

Capacity-Building

When building capacity, Orange County will continue to make a concerted effort to recruit a workforce mirroring the priority populations demographically, linguistically, and in lived experience to increase capacity to reach priority populations.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of the partners related to this pillar is below

- **Faith-based, civic and community groups**
- **Community Providers**
- **CalOptima**

Funding

Activities proposed under the Treat Pillar will be implemented utilizing CDC PS20-2010 and HRSA 20-078 funding as detailed below.

Program/Effort	Total Funding (Requested)	Proposed Funding Source
• Mail to Home Test Kits	$1,263,239	CDC PS20-2010
• Health Summits for Gay Men and the Transgender Community		
• Health Education Videos		
• Viral Suppression Patient Incentive Program		
• Community- Based Case Management Services		
• Focus Groups with Individuals Not Virally Suppressed		
• Trauma Informed Care for the B/AA and Transgender Communities		
• Mobile Testing, Care, and Referral Services		
• Rapid ART	$850,000	HRSA 20-078
• Mental Health Services for PLWH		
• HIV to Care to High Acuity Individuals		
• Expand Housing Availability		
TOTAL FUNDING FOR TREAT PILLAR*	$2,113,239	

*$0 exclusively for Treat Pillar, and $2,113,239 for programs that cut across Treat and other pillars.

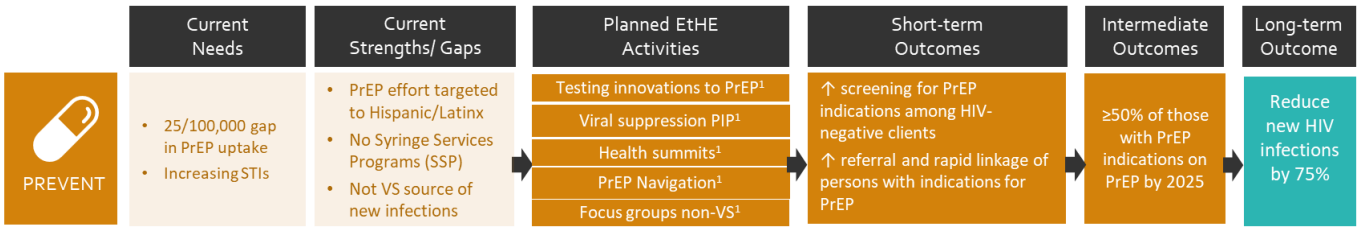
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[26] Targets will be determined in coordination with CDC as the EPMP is finalized. Only CDC PS 20-2010 funded program indicators are in the table below.

Treat: Orange County	
Outcome Measure	**Data Source**
Develop programs to support and promote rapid linkage and immediate ART initiation (or as soon as possible) by HIV medical care and treatment providers in non-Ryan White HIV/AIDS Program facilities*	Program documentation
Number of PLWH provided with locally informed, evidence-based incentives (non-monetary) for retention in care and viral suppression†	Incentive records
Number of clients provided with case management and other support services#^	Case management and support services records

*Mobile Testing, Care, and Referral Services
†Viral Suppression Patient Incentive Program
#Community-Based Case Management Services

Prevent



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Health Summits for Gay Men and the Transgender Community**
- **Mental Health Services for PLWH and PrEP-Eligible Persons**
- **Trauma-Informed Prevention and Care Services for the Black/African American (B/AA) and Transgender Communities**
- **Focus Groups with PLWH who are not virally suppressed**
- **Health Education Videos**
- **Testing Innovations:**
    - **Mail to Home Test Kit Pilot Program**
    - **Mobile Testing, Care, and Referral Services**
    - **PrEP Navigation**
    - **Viral Suppression PIP**

Prevent: Orange County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	
Health Summits for Gay Men and the Transgender Community	
• Plan and implement Health Summit for Gay Men • The summit will include a community and health care provider track • **Provide** HIV testing (25 participants), STD testing (25 participants), and **PrEP services** (enroll at least 10 participants) to summit participants	• Plan and implement the Health Summit for the transgender community in Year 2 • The summit will include a community and health care provider track • Provide HIV testing (25 participants), STD testing (25 participants) and PrEP services

Prevent: Orange County	
Year 1 Activities	**Year 2-5 Activities**
• Provide CEU's to providers	(enroll at least 10 participants) to summit participants • Provide CEU's to providers
PrEP Navigation	
• Expand current PrEP program for uninsured clients including program redesign and protocol updates • Collaborate with community provider(s) to reach marginalized and hard-to-reach individuals via PrEP detailing Develop a PrEP Navigation program with guidance from PAETC	• Continue to provide services through the existing STD Clinic • Continue to provide PrEP detailing • PrEP Navigation for insured clients to access medications through their primary care provider • Develop and implement partnerships with community clinics for PrEP prescribing
Mental Health Services for HIV-positive and PrEP Eligible Persons (078)	
• Design program protocols and hire staff • **Provide psychiatry and mental health services to** PLWH (100 persons)	• Continue to provide psychiatry and mental health services to PLWH (100 persons per year) • Evaluate program and track outcomes
Trauma-Informed Prevention and Care services for the Black/African American (B/AA) and Transgender Communities	
• Engage: 1) B/AA community, faith-based, and civic organizations and 2) the transgender community, and community groups **to identify barriers to** HIV care and **prevention services** and inform service delivery • Leverage long-standing partnerships with HIV prevention and care service providers within the county and in the community to enhance the current system of care and **address barriers identified by the community** utilizing a trauma-informed approach • Conduct at least six community engagement activities (focus groups, key stakeholder interviews, or community listening sessions) and at least two staff/ provider trainings on the delivery of culturally competent and trauma-informed care for the B/AA and transgender communities • **Increase the percentage** of the B/AAs and transgender persons **linked to care** in ten days • **Increase retention in care** for B/AAs and transgender persons	• Continue to engage communities and build partnerships • Evaluate and improve efforts and track impact on HIV-related health disparities and population experiences with stigma, medical mistrust, and systemic/ institutional barriers.
Focus Groups with HIV Positive Individuals not Virally Suppressed	
• Use surveillance data to strategically identify and engage persons not virally suppressed • Conduct 4 **focus groups** with PLWH who are not virally suppressed **to identify barriers to care** and inform service delivery	• Continue to engage community members and modify service delivery as needed • Evaluate program and track outcomes
Health Education Videos	
• Develop content for **health education videos** in multiple languages for newly diagnosed people, youth, and/or immigrants to **help address barriers for linkage to and retention in care**	• Continue to develop video content • Promote and disseminate video content

Prevent: Orange County	
Year 1 Activities	**Year 2-5 Activities**
• The project will be community driven, feature members of the community, and address the unique needs of the Orange County HIV epidemic • Develop a communications/dissemination plan	
Testing Innovations: Mobile Testing, Care, and Referral Services	
• Develop mobile unit program design and protocols • Collaborate with community provider(s) to reach marginalized and hard-to-reach individuals via mobile unit • Monitor and map new HIV cases for strategic deployment of mobile unit services • **Provide testing, treatment, and referrals** to marginalized and hard-to-reach individuals	• Implement pilot program
Testing Innovations: Mail to Home Test Kit Pilot Program	
• Offer Orange County HIV/STD clinic patients and individuals who have never tested or have not tested in the last year the option to receive **HIV and/or STD test kits mailed** to their home or preferred location • Develop pilot program protocol including linkage to PrEP	• Implement pilot program

HIV Workforce Development Needs

Positions

- **Contracted Psychiatrist/Licensed Marriage and Family Therapist.** The contracted providers will be responsible for providing psychiatry and/or mental health services to PLWH and persons at high risk of HIV.
- **Consultant Services with technical assistance organization with HIV expertise.** The technical assistance organization will be contracted to lead the coordination and promotion of the Health Summits and provide continuing education units to attendees as appropriate.
- **Contracted Nurse Practitioner.** The role of the contracted nurse practitioner is described in detail on page 40.
- **Consultant Services with CBO with expertise working with the transgender community.** The CBO is described in detail on page 45.
- **Consultant Services with CBO with expertise working with the Black/African American (B/AA) community.** The CBO is described in detail on page 45.
- **Health Communications Consultant.** The consultant is described in detail on page 45.
- **Grants Support Specialist.** The Grants Support Specialist is described on page 40.
- **Program Support Specialist**. The Program Support Specialist is described on page 40.

Capacity-Building

When building capacity, Orange County will continue to make a concerted effort to recruit a workforce mirroring the priority populations demographically, linguistically, and in lived experience to increase capacity to reach these priority populations.

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Pacific AIDS Education and Training Center (PAETC)**
- **Community Providers**

Funding

Activities proposed under the Prevent Pillar will be implemented utilizing CDC PS20-2010 and HRSA 078 funding as detailed below.

Program/Effort	Total Funding (Requested)	Proposed Funding Source
• Trauma Informed Care for the B/AA and Transgender Communities	$1,263,239	CDC PS20-2010
• Health Summits for Gay Men and the Transgender Community		
• Focus Groups with Individuals Not Virally Suppressed		
• Health Education Videos		
• PrEP Navigation		
• Mental Health Services for PLWH	$850,000	HRSA 078
TOTAL FUNDING FOR PREVENT PILLAR	$2,113,239	

*$0 exclusively for Prevent Pillar, and $2,113,239 for programs that cut across Prevent and other pillars.

Monitoring and Evaluation

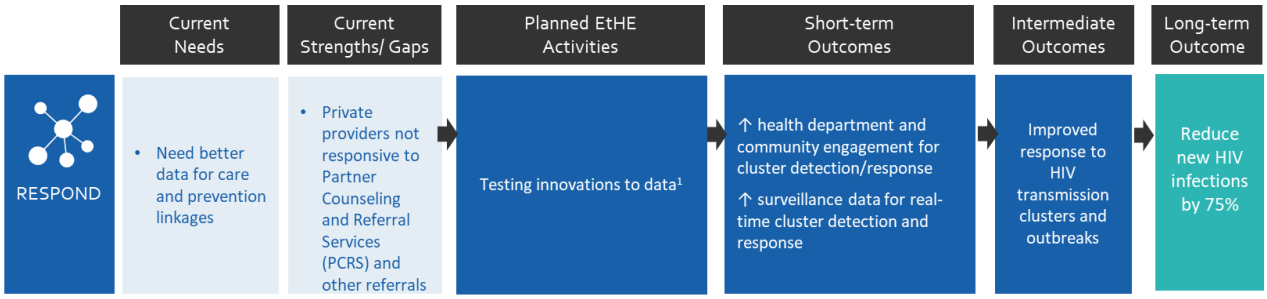
The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[26] Targets will be determined in coordination with CDC as the EPMP is finalized.

Prevent: Orange County	
Outcome Measure	**Data Source**
Percent of persons hired as PrEP detailers*	Hiring records
Number and percentage of clinicians prescribing PrEP within 3 months following detailing visit(s)*	Detailing and prescribing records
Number of HIV-negative clients who are screened for PrEP*	Patient charts
Number and percentage of HIV-negative clients with indications for PrEP who are linked to PrEP*	Patient charts
Number of persons prescribed PrEP among those with indications for PrEP*	Patient charts
Provide trainings and technical assistance to non-clinical CBOs that provide HIV testing services to screen clients	Documentation of trainings and technical assistance

for PrEP indications, support clients in learning about PrEP, and facilitate linkage to PrEP care (e.g., CBOs, SSPs)*	
Number of non-clinical CBO staff provided trainings or TA on PrEP screening and linkage*	Training/TA records
Documentation of supporting client access to existing traditional PrEP care delivery systems and non-traditional PrEP care delivery systems*	Patient charts
Disseminate approaches proven effective to support adherence and persistence. †	Patient charts

*Health Summits for Gay Men and the Transgender Community
†Mental Health Services for PLWH

Respond



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed programs are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Testing Innovations: Mobile Testing, Care, and Referral Services**

Respond: Orange County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response	
Coordination with CDPH-OA	
• County Surveillance Staff will work with the CDPH OA Surveillance Staff to ensure ability to respond when clusters are identified and investigation is needed.	• Sustain communication between surveillance staff and CDPH-OA
Strategy 4B. Investigate and intervene in networks with active transmission **Strategy 4C.** Identify and address gaps in programs and services revealed by cluster detection and response	
Testing Innovations: Mobile Testing, Care, and Referral Services	
• Develop mobile unit program design and protocols • Collaborate with community provider(s) to reach marginalized and hard-to-reach individuals via mobile unit • **Monitor and map new HIV cases** for strategic deployment of mobile unit services • Provide testing, treatment, and referrals to marginalized and hard-to-reach individuals	• Continue to deploy services using the mobile unit • Develop and implement protocols for the mobile unit to engage in a coordinated response to HIV clusters throughout Orange County

HIV Workforce Development Needs

Positions

- **Contracted Testing Service Provider.** The role of the contracted community-based provider(s) is described on page 40.
- **Grants Support Specialist.** The Grants Support Specialist is described on page 40.
- **Program Support Specialist**. The Program Support Specialist is described on page 40.

Capacity-Building

OCHCA will work closely with state and federal partners to respond quickly to a newly identified HIV cluster, utilizing trained County epidemiological staff and Communicable Disease Investigators. OCHCA will leverage resources and expertise of the California State Office of AIDS to tailor local response efforts

Key Partners

Proposed partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of the partners related to this pillar is below

- **Community Providers**
- **CDPH Office of AIDS**
- **Pacific AIDS Education and Training Center (PAETC)**

Funding

Activities proposed under the Respond Pillar will be implemented utilizing CDC PS20-2010 funding as detailed below.

Program/Effort	Total Funding (Requested)	Proposed Funding Source
• Mobile Testing, Care, and Referral Services	$1,263,239	CDC PS20-2010
TOTAL FUNDING FOR RESPOND PILLAR*	$1,263,239	

*$0 exclusively for Respond Pillar, and $1,263,239 for programs that cut across Respond and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[26] Targets will be determined in coordination with CDC as the EPMP is finalized.

Respond: Orange County	
Outcome Measure	**Data Source**
Cluster data is reviewed and prioritized, response is guided and reviewed, procedures are modified to improve responses	Reports of committee and community meetings, after action review meetings
Percent of all persons with diagnosed HIV infection entered into the local surveillance system within ≤30 days of date of diagnosis	Surveillance system
Percent of laboratory results entered into the surveillance system ≤ 14 days after specimen collection	Surveillance system
A data system is developed to rapidly analyze, integrate, visualize, and share data in real time	Data system documentation

A flexible funding mechanism is developed to allow reallocation of resources for a response within one month	Funding mechanism documentation
Implementation of methods to understand the entire network, including people with diagnosed HIV, undiagnosed HIV, or at substantial risk for HIV infection	Methodology documentation
Data analysis and response results for clusters of concern are reported to CDC until investigation and intervention activities are closed	Documentation of submission

Section V: Concurrence

The HIV Planning Council provided concurrence on Orange County's EtHE plan on July 8, 2020. The Council receives regular updates on EtHE Initiative activities. An overview of an early draft of this document was presented at the February 5, 2020 meeting. At this meeting, the group approved the first draft and the process for developing the final EtHE plan. The Council has been an active partner in the development of each of the subsequent drafts. **The criteria of the Council to grant early concurrence of the EtHE plan included**:

- Best efforts for getting community input in the most challenging of circumstances given the COVID-19 epidemic and response; and
- Review of the most recent epidemiological data and subsequent focus on key populations for whom the existing HIV prevention and care services are not sufficient; and
- Included interventions and services to populations and regions in Orange County where few services currently exist; and
- Community engagement will continue to be a vital part of implementation of this plan for the next 5 years.

The Council consists of volunteers including consumers, providers, public health staff, mental health agencies, and community-based organizations. Members of the Council were encouraged to participate in community engagement activities throughout the planning year.

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Appendix 1: Resource Inventory

Exhibit 22 lists the services and programs currently available in Orange County along with their funding sources, by pillar.

Exhibit 22. Orange County Baseline HIV Activities and their Funding Sources

Pillar	Baseline Program/Activity	Funding Sources
DIAGNOSE	• Routine opt-out HIV testing in jails[v,vii] • Focused HIV testing in high-risk populations[ii, xii] • Use of HIV and STD surveillance data to identify candidates for partner services[ii,iii] • HIV testing, including testing and prevention for high-risk individuals and partners of HIV-positive individuals[ii] • Mail to home HIV test kits through community-based provider[xii]	i. AIDS Drug Assistance Program (ADAP) ii. CDC PS-18-1802 (Prevention) iii. HIV Surveillance iv. HRSA Ending the HIV Epidemic 20-078 v. HRSA Ryan White Part A (including Minority AIDS Initiative (MAI)) vi. HRSA Ryan White Part B (including MAI) vii. HRSA Ryan White Part C viii. HRSA Ryan White Part D ix. HRSA Ryan White Part F x. Housing Opportunities for Persons with AIDS (HOPWA) xi. Other - county funded xii. Other – federal, state, or private funding (OCHCA not the Grant Recipient) xiii. PrEP Assistance Program xiv. STD Core xv. PrEP Provider Network xvii. STD Program Management and Collaboration
TREAT	• Assessment of linkage to care barriers[ii, v, vi] • Linkage to Care program[iii, v, vi, vii] • Use of HIV and STD surveillance data to identify candidates for partner services[ii, iii] • Early intervention services for individuals identified via partner services[ii, iii, v, vi] • Training of linkage to care peer navigators and coordinators[ii] • Core medical services (outpatient/ambulatory health services, medical case management, Health Insurance Premium Program, mental health services, oral health care, substance abuse services, early intervention services, medical nutrition therapy, food bank/home delivered meals, nutritional supplements, home health care, and home and community-based health services)[v, vi, vii, x, xii] • Support services (non-medical case management, referral for health care and support services, emergency financial assistance for medications, housing, substance abuse services, medical transportation, outreach services, food bank, legal services, health education/risk reduction (Prevention with Positives), independent skills, psychosocial support services)[v,vi,vii, x, xii] • AIDS Drug Assistance Program (ADAP)[i] • Rapid Anti-Retroviral Treatment (ART) in Orange County clinics and jails[iv] • HIV care to high acuity individuals who do not qualify for the Ryan White Program but are at highest risk of falling out of care[iv] • Expanded housing availability through collaboration with City of Anaheim (Housing and Urban Development Program)[iv] • Rapid ART at community-based HIV services provider[xii]	
PREVENT	• Access to locations for proper syringe disposal[ii] • Training/capacity-building for PrEP Public Health Nurses to improve linkage and retention in PrEP[ii] • PrEP/PEP medication, education, and medical services at County clinic[ii, xii, xv] • Screening and assistance for individuals accessing PrEP (PrEP-AP)[xiii] • Use of HIV and STD surveillance data to identify candidates for partner services[ii,iii] • HIV prevention services (including PrEP) for high-risk individuals, HIV-positive individuals, and partners of HIV-positive individuals[ii]	

 RESPOND	• Use of HIV and STD surveillance data to identify candidates for partner services[ii, iii] • Use of HIV surveillance data to identify high-risk populations and regions[ii, iii] • Use of HIV surveillance data to identify high-priority providers/venues[ii, iii] • HIV cluster investigation[ii,iii]	

Note: Additional resources for HIV services that cannot be quantified or broken down by pillar include Medi-Cal, Medicare, Veterans Administration, and 3rd party reimbursement

Appendix 2: Community Engagement Documentation

Exhibit 23 lists community engagement event dates, descriptions and key voices and partners.

Exhibit 23. Community Engagement Documentation

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
Ending the Epidemics Town Hall 10/18/2019	Orange County and community partners held a town hall to launch community-driven efforts to inform county-wide HIV, HCV, and STI prevention strategies. **Sponsors:** California HIV/AIDS Research Policy Center, Radiant Health Centers, RADAR, The LGBT Center OC, Public Law Center, STI Coalition Orange County, UCI Student Health Center, Shanti Orange County, Orange County's Women's Health Project, Project Youth-Orange County Bar Foundation, and the End the Epidemics Statewide Workgroup.	**New Voices – Priority Populations**: Youth, Hispanic/Latinx MSM, Communities of Color, and PLWH **New Voices – Providers**: Non-HIV/STD service providers
Online Survey[10] 9/30/2020	The County distributed an online survey to key stakeholders to ask for input on how to better engage hard-to-reach populations in HIV prevention and care. A final report summarizing the results will inform implementation.	**New Voices –** Priority Populations **Providers:** HIV providers **Participants:** priority populations, providers, other stakeholders
Integrated Plan Committee (EtHE Steering Committee) Feedback 10/18/2019 2/19/2020 5/20/2020 7/15/2020	At this series of meetings, committee input was solicited on: (1) innovative programs and services to include as part of the county's proposals to HRSA in response to NOFO 20-078; proposals to CDC/CDPH in response to NOFO PS20-2010, community engagement strategies, key stakeholders, and priority populations to be included in EtHE Plan; and (2) the draft EtHE Plan, including assessment of current county HIV related efforts and community providers needed to ensure the successful implementation of proposed programs and services. (3) detailed overview of the EtHE Plan and solicited input from the committee on the situational analysis section of the plan (resources/assets and gaps/challenges) as well	**Participants:** Integrated Plan Committee

EVENT	DESCRIPTION	VOICES & PARTNERS
	as on new voices, key stakeholders, and community engagement strategies.	
CDPH Planning Group Kick-Off Meeting[35] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	**Participants**: Orange County Health Care Agency
EtHE Presentation and Discussion 11/13/2019	CDPH and Facente Consulting were invited to present an overview of CDC 19-1906 accelerated planning year and to solicit preliminary input on the EtHE plan. Sponsors: CDPH, Facente Consulting	**Participants:** Orange County HIV Council and community attendees
EtHE CHIPTS Regional Meeting 01/24/2020	OCHCA attended the CHIPTS regional meeting to plan, coordinate and align the county's draft EtHE plan with the best practices to foment California's regional EtHE response.	**Participants:** County health departments and Planning Council representatives from Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC
EtHE Community Updates 11/13/2019 2/5/2020 3/11/2020 6/10/2020 7/8/2020	Orange County HIV Planning Council Updates and Feedback. Provided detailed overview of the EtHE Plan and solicited additional input from the Council on the draft Plan. Obtained Council concurrence on the EtHE Initiative, Phase I accelerated planning process and plan funded through CDCPS 19-1906.	**Participants:** Orange County HIV Planning Council
HIV/AIDS on the Front Line Conference 9/16/2020	Orange County facilitated a session at the conference to solicit provider input on the County's EtHE initiative and draft plan.	**New Voices – Providers**: Medical providers, including pharmacists. **Sponsors**: PACE, HRSA Region 9, AETC

Appendix 3: Letter of Concurrence

John Paquette
Chair

Keean Kirk
Vice Chair

Fernando Martinez
Vice Chair

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SANTA ANA, CA 92706-0099
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July 8, 2020

Marisa Ramos, Ph.D.
Chief, Office of AIDS
Center for Infectious Diseases
California Department of Public Health (CDPH)
MS 7700, PO Box 997426
Sacramento, CA 95899-7426

Re: Letter of Concurrence from HIV Planning Council Chair

Dear Dr. Ramos,

This letter documents that the Orange County HIV Planning Council (Council) is in concurrence with the Ending the HIV Epidemic in America (EtHE), Phase I accelerated planning process and plan funded through CDCPS 19-1906.

Our planning body has received regular and ongoing updates regarding the EtHE Initiative from the Grant Recipient. The State Office of AID (SOA), in collaboration with Facente Consulting also provided an overview of the EtHE Initiative at the beginning of the CDC PS19-1906 contract year and solicited our input on what is most critical to decrease new HIV infections as we work toward ending the epidemic in Orange County.

The development of Orange County's EtHE Plan is a collaborative process led by the Integrated Plan Committee (IPC), a subcommittee of the Council and the designated EtHE Steering Committee. IPC's input was key in identifying innovative interventions, key stakeholders, and community engagement strategies to ensure the needs of the community are reflected in the Plan.

Orange County's EtHE Plan aligns with existing strategic plans such as the National HIV/AIDS Strategy (Federal), Laying the Foundation for Getting to Zero (CDPH), Integrated HIV Prevention and Care Plan (Orange County), community needs assessments, and other county documents that guide the delivery of HIV prevention and care services, and maintains a surveillance system in collaboration with the SOA.

The selected novel and innovative interventions will expand our reach to underserved populations, increase the availability of testing and Rapid ART, increase use of PrEP, and

will assist more people living with HIV in our county to achieve and sustain viral suppression.

Orange County will use CDC PS 20-2010 funding to implement the EtHE interventions in coordination with HRSA EtHE 20-078 funding.

Our planning body will continue to monitor the implementation of the EtHE Initiative and related interventions and ensure ongoing community engagement so that interventions are executed optimally to meet the needs of the community.

Sincerely,

John Paquette, Chair
Orange County HIV Planning Council

Appendix 4: Planning Council Membership Roster

Orange County HIV Planning Council **Website: https://www.ochealthinfo.com/phs/about/dcepi/hiv/council** **Contact Number: (714) 834-8399**	
Council Members	**Title/ Position**
Adelmo Chan	Council Member
Christopher Ried	Council Member
Fernando Martinez	Council Member
Geeta Gupta	Council Member
Homero Beltran	Council Member
John Conrad	Council Member
John Paquette	Council Member
Keean Kirk	Council Member
Lydia Tran	Council Member
Mark Coleman	Council Member
Michelle Gallardo	Council Member
Narciso Guevara	Council Member
Sandra Boodman	Council Member
Scott Huffman	Council Member
Steven Madrid	Council Member

RIVERSIDE

Riverside County

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

RIVERSIDE COUNTY DEPARTMENT OF PUBLIC HEALTH
RIVERSIDE UNIVERSITY HEALTH SYSTEM—PUBLIC HEALTH

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Introduction

About This Plan

This plan describes Riverside County's bold and innovative plan for ending the HIV epidemic in the county. Riverside County and its northern neighbor, San Bernardino County, make up the Riverside/San Bernardino Transitional Grant Area (TGA) and share a joint HIV Planning Council – the Inland Empire HIV Planning Council. HIV efforts in the county are led by Riverside University Health System—Public Health (RUHS). RUHS, in collaboration with community and clinical partners, has built a strong foundation of HIV prevention, care, and treatment services in the county. These foundational HIV services were built based on the *Inland Empire HIV Planning Council Comprehensive HIV Services Plans*[1,2] and *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan.*[3]

These current baseline activities, and the infrastructure that supports them, are critical for reducing and ultimately eliminating new HIV infections and optimizing the health of people living with HIV (PLWH), but they are not sufficient – hence the need for this Ending the HIV Epidemic (EtHE) plan. However, this EtHE plan does not replace the other plans; instead, this plan, based on the current state of HIV in the county, expands on them and identifies and proposes additional innovative efforts to end the HIV epidemic.

This Plan is organized as follows:

- The **Introduction** provides a high-level overview of 1) the HIV epidemic in the county, 2) the baseline services, activities, and infrastructure that currently exist, and 3) Riverside County's plan to end the epidemic.
- **Section I: Community Engagement** describes Riverside County's completed and planned community, provider, and Planning Council engagement activities and findings to date.
- **Section II: Epidemiologic Profile** presents the latest available data on HIV in Riverside County, including demographics, trends, and disparities across age, race/ethnicity, geography, and more.
- **Section III: Situational Analysis** synthesizes information from the prior two sections and a needs assessment to paint a comprehensive picture of the current state of HIV in the county, including needs, resources, and gaps.
- **Section IV: EtHE Plan** outlines the disruptively innovative activities that the county will implement between now and 2025 across all funding sources, along with key partnerships, workforce development needs, and plans for outcome monitoring.
- **Section V: Concurrence** describes the process for securing Planning Council concurrence.

Current State of HIV in Riverside County

Riverside County has seen a modest 13 percent reduction in new HIV diagnoses from 298 in 2016 to 259 in 2018.[4] In 2018, among those newly diagnosed with HIV, 83 percent were linked to care within 30 days and 75 percent were virally suppressed within 6 months of diagnosis.[4] Men who have sex with men (MSM), people under the age of 30, and people of color are disproportionately affected. Moreover, there are regional differences in the epidemic and available resources. New diagnoses in West, Mid-, and South County are increasing and are more likely to be among younger people and people of color. These trends stand in contrast to those in East County, where new diagnoses are decreasing and are largely among white MSM. Regional disparities in the county also exist in access to care and prevention, with the majority of HIV providers and services located in East County.[5-7] A notable success in Riverside County is with the Hispanic/Latinx population; after years of intensive outreach to and focus on this priority population, rates of linkage to care, viral suppression, and new diagnoses have all markedly improved.[7]

Findings from community engagement efforts offer some insight into the barriers and challenges that are impacting the county's ability to further reduce new HIV infections. Barriers to accessing services are significant in Riverside and include lack of HIV services in some parts of the county; structural inequities, racism, and stigma as well as other social determinants of health (SDoH); being unhoused; mental illness; and substance use (see *Section II: Community Engagement*). These and other barriers limit the ability of some of the most vulnerable and marginalized Riverside residents to access and take advantage of the services and resources that support HIV diagnosis, treatment, prevention, and response efforts.

Current HIV Efforts and Infrastructure

Planning

Riverside County has a long-standing history of planning local HIV prevention, care, and treatment efforts in conjunction with community partners and the local Inland Empire HIV Planning Council. The County HIV work sharpened with the development of the TGA's *2015-2017 Clinical Quality Management (CQM) Plan*[8], which offered a coordinated and systematic approach to assessing and improving the quality of health services for PLWH in the TGA in alignment with National HIV/AIDS Strategy (NHAS) goals. The county has adopted the State's integrated HIV plan—*Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*—as its roadmap to getting to "zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination against people living with HIV (PLWH)."[3]

Services

A number of funding sources support HIV services in Riverside County, including prevention funding from the California Department of Public Health, (CDPH) Office of AIDS (OA) (CDC PS18-1802 and State General Fund); Ryan White Parts A and B, (including Early Intervention Services [EIS] and Minority AIDS Initiative [MAI] funding); CDPH AIDS Drug Assistance Program (ADAP) funding, CDPH Project Empowerment funding, Riverside County General Fund, as well as revenue from third party billing, including Medi-Cal and Medicare.

Collectively, these funding sources support three clinical sites and six community-based organizations (CBOs) to provide services such as HIV testing, PrEP, primary care, mental

health services, dental services, medical case management, and a multitude of wrap-around services for PLWH **(Exhibit 1)**. In addition, this funding supports the RUHS HIV/STD program's direct services (described below). A more extensive resource inventory listing baseline services and programs by funding source and by pillar is included as **Appendix 1**.

Infrastructure

Health Department. RUHS offers a wide range of services and programs, with a staff of over 700 including doctors, nurses, health educators, nutritionists, communicable disease and community program specialists, managers, fiscal, and support staff. The RUHS HIV/STD Branch oversees all health department HIV- and STD-related functions and services including administering much of the funding for direct services previously noted, as well as providing HIV testing, HIV care and wrap-around services via the Early Intervention Program, education and prevention via outreach services, mental health services, partner services, and linkage to care. HIV and STD surveillance programs are also housed here. In addition to these baseline staff, RUHS is hiring a EtHE Coordinator to oversee the implementation of the EtHE Plan and its proposed interventions.

***Exhibit 1**:* Publicly funded clinical and community-based HIV services in Riverside County

Public Health HIV Specialty Care Clinics

- Indio Family Care Center
- Perris Family Care Center
- Riverside Neighborhood Health Center

CBOs Providing HIV Services

- AIDS Healthcare Foundation
- Families Living with AIDS Care Center
- Desert AIDS Project
- Foothill AIDS Project
- TruEvolution

Additional Assets. Riverside County is a collaborator with the National Institutes of Health (NIH)-supported Center for AIDS Research (CFAR) in Southern California. This CFAR is located at the University of California, Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS). The CFAR mission is "to support multidisciplinary research aimed at reducing the burden of HIV both in the United States and around the globe."[9] The CHIPTS EtHE CFAR project is described below.

Riverside County's Plan to End the HIV Epidemic

Exhibit 2 depicts a high-level overview of how Riverside County plans to enhance its current HIV efforts with new, disruptively innovative activities funded with federal EtHE funds. The planned activities will expand and leverage, but not duplicate, the foundational efforts already in place. In particular, in contrast to current activities—which focus on priority populations county-wide—the planned EtHE activities will focus on the regions and populations experiencing high and disproportionate HIV burden, including people under the age of 30, people of color, MSM and those living in West and South County.

The **Exhibit 2** logic model shows the strengths and gaps identified through this planning process (local epidemiologic data, community engagement, and situational analysis) and the new, disruptively innovative activities designed to leverage these strengths and address the gaps. In particular, the growing epidemic among younger people, people of color and MSM in the West and South County regions provides impetus for the proposed EtHE activities, as these regions lack robust HIV-related services and infrastructure.

New EtHE activities will address all four EtHE pillars and will support the short-, intermediate-, and long-term outcomes identified by the CDC in PS-19-1906. The primary activities for Riverside County are listed below. Multiple funding sources (noted in **Exhibit 2)**, including CDC PS-20-2010 and HRSA 20-078, will be leveraged to support these activities, and community partnerships will be strengthened to ensure success. Some activities draw on both funding sources as indicated in Exhibit 2. While the testing interventions below are described in the *Diagnose* pillar, RUHS understands that testing referrals to PrEP and HIV treatment make these relevant interventions for the *Treat* and *Prevent* pillars as well.

- **Testing Initiative for Young MSM of Color** will work with community-based organizations who serve young MSM of color to offer HIV testing, linkage to care, and linkage to PrEP; this strategy will help identify PLWH who are unaware of their HIV status. Key to this model will be partner services and testing services offered though friendship networks. *(Diagnose)*
- **Home HIV Testing** kits mailed to clients. In addition to home HIV testing, RUHS staff will also provide linkage to care and prevention/PrEP referrals. *(Diagnose)*
- The **Sexual Health Provider Education and Incentive Program** will improve offerings of routine HIV testing and PrEP referrals among local providers. Additionally, newly diagnosed individuals will be referred to the Rapid StART program mentioned below. *(Diagnose, Prevent)*
- The **Rapid StART Program** will improve linkage to, retention in, and re-engagement in care by promoting rapid start of antiretroviral therapy (ART) among newly diagnosed individuals and providing more intensive re-engagement support for clients living with HIV who have fallen out of care or who are not virally suppressed. This program will aim for rapid ART initiation within 72 hours of HIV diagnosis. *(Treat)*
- **PrEP expansion through navigation and the CDPH OA PrEP-Assistance Program (AP)** will build the County's first structured PrEP program by training all Communicable Disease Specialist (CDS) staff to become PrEP navigators and certifying the county as a PrEP-AP site. Peer outreach and PrEP linkage services through community-based organizations will also be funded as an Inland Empire TGA-wide activity. (*Prevent)*
- **HIV Network investigation and intervention** will improve identification of HIV transmission networks and targeted intervention by using surveillance data to identify people newly diagnosed with HIV which will allow reaching out to their partner contacts. This team will also work closely with the CDPH Disease Outbreak Intervention and Field Investigation Unit (DOIFI) if an outbreak is detected and exceeds the ability of local response resources to manage. (*Respond)*
- A new **CHIPTS EtHE CFAR project** will support regional data coordination and sharing to guide scale-up of large implementation science projects designed to reduce new HIV infections across the four Southern California counties: Riverside, San Bernardino, Orange and Los Angeles. No CDC PS 20-2010 will be used for this project. *(Respond)*
- The **California Regional Quality Group (CARG),** in which Riverside County participates, will support the EtHE initiative by focusing on quality improvement initiatives for increasing viral suppression rates among populations with disparate viral suppression rates. *(Treat)*

The county's EtHE plan was developed with extensive community and partner engagement and endorsed by the Inland Empire HIV Planning Council. With the new federal EtHE funding,

Riverside County expects to make significant progress over the next 5 years, achieving the EtHE goal of reducing new infections by 75 percent and advancing ending the HIV epidemic in the county.

Exhibit 2. *Logic Model for Ending the HIV Epidemic in Riverside County, organized by pillar. Current county strengths and gaps inform planned EtHE activities, which will impact the short-, intermediate-, and long-term outcomes identified by CDC and the California Department of Public Health.*

1. CDC PS20-2010; 2. HRSA 20-078

Section I: Community Engagement

RUHS used CDC PS-19-1906 as an opportunity to dramatically scale up its capacity for ongoing community engagement **(Exhibit 3)**. Community engagement is an essential component of the county's EtHE efforts. It enhances the understanding of the day-to-day realities of priority populations and sparks discussions about creative ways to harness community strengths, address barriers to accessing HIV prevention, care, and treatment, and dig deeper into the underlying social determinants of health (SDoH). CDPH, the PS19-1906 grantee, has worked very closely with Riverside County and the other five Phase I counties covered under the grant (Alameda, Orange, Sacramento, San Bernardino, and San Diego) to put community engagement front and center. RUHS worked early in the planning year to engage the Inland Empire HIV Planning Council (IEHPC), expand other existing partnerships and create new collaborations with non-HIV providers in education, housing and substance use services before the COVID-19 response.

Exhibit 3. Community Engagement Successes

- Planning Council Engagement
- Engagement of non-HIV providers
- Expanding existing partner relationships
- Pivot to virtual CE due to COVID-19

Community Engagement Activities

The COVID-19 response has affected Riverside County's ability to implement in-person outreach and face-to-face community engagement for most of months allocated for these activities. As a result, RUHS quickly adapted to virtual engagement methods, including Zoom-based presentations and discussions, online surveys, and virtual focus groups. The County's community engagement goals for the accelerated planning year are as follows **(Exhibit 4).**

Exhibit 4. Riverside County Ongoing Community Engagement Outcomes (Year 1)

- Collaborated with Riverside University Health System (RUHS), TruEvolution and other key CBOs to hold a Community Caucus (CC) including PLWH and at-risk individuals. 30 participants from key focus populations, Black/African American (B/AA) and Hispanic/Latinx MSM, Spanish-speakers, unhoused individuals and people who inject drugs (PWID), participated in the CC.
- Collaborated with the San Bernardino County Department of Public Health (SBCDPH), HIV service providers and other key Inland Empire community constituents working in primary and secondary education, health insurance and housing to convene an EtHE summit to discuss key needs and gaps impeding EtHE progress.
- Implemented an online EtHE survey to key providers and focus populations in English and Spanish asking broadly: What should we do to get to zero?
- Conducted an analysis of recent key reports that solicited community input.

Riverside County's EtHE community engagement efforts reengaged Planning Council constituents and brought together new voices—clients, providers, governmental groups and academic institutions—to inform the next best steps to getting to zero. **Exhibits 5 and 6** summarize the completed and planned community engagement efforts for the PS19-1906 accelerated planning year. **Appendix 2** provides more detailed descriptions of these efforts, meeting agendas, meeting notes, and other documentation.

Exhibit 5. Overview of County EtHE Community Engagement Activities, completed and planned

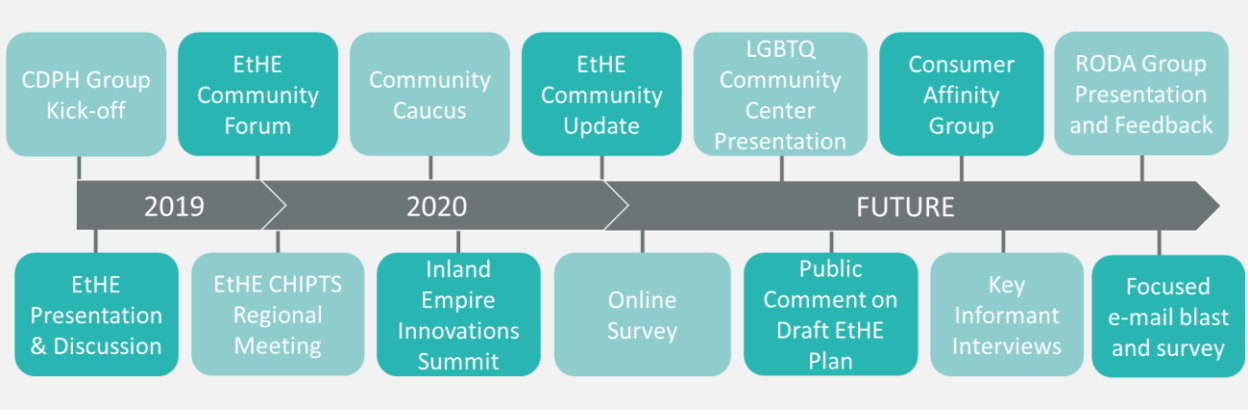


Exhibit 6. Detailed summary of Riverside County's EtHE community engagement activities.

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
CDPH Planning Group Kick-Off Meeting[10] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants:*** *Inland Empire Planning Council Leadership, RUHS HIV/STD Program.*
EtHE Presentation and Discussion[11] 11/14/2019	CDPH/RUHS presented an overview of the EtHE Initiative to glean early input about priorities and process.	***Participants****: Inland Empire Planning Council Leadership and general community.*
EtHE Community Forum[12]	RUHS facilitated a discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	***Participants****: Inland Empire Planning Council, RUHS, SBCDPH, AIDS Health Care Foundation, Desert AIDS*

EVENT	DESCRIPTION	VOICES & PARTNERS
11/14/2019		*Project, FLAAC, Foothill AIDS Project, Housing Authority of Riverside County, HIV + AIDS Research Project Palm Springs, Eisenhower Health.*
EtHE CHIPTS Regional Meeting[13] 01/24/2020	RUHS presented an overview of county's draft EtHE plan and gave input about approaches to the regional EtHE response.	***Participants***: *County health departments and Planning Council representatives from Alameda, Los Angeles, Orange Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.*
Community Caucus I[14] 1/25/2020	TruEvolution convened a gathering of new voices to better understand the experiences of people living with or at risk for HIV. *Sponsors: RUHS, San Bernardino Department of Public Health.*	***New Voices – Priority Populations:*** *Black/African American (B/AA), Hispanic/Latinx, unhoused, Spanish-speakers, the transgender men and women.* ***Other Participants:*** AIDS Healthcare Foundation, Desert AIDS Project, Foothill AIDS Project, FLACC.
Inland Empire EtHE Innovations Summit[15] 1/27/2020	RUHS and SBCDPH convened a summit of providers from different sectors (HIV and non-HIV). They presented the county's EtHE plan and held a discussion on the opportunities & barriers for cross-sector collaboration and improvement in HIV care.	***New Voices – Providers:*** *Education, research institutions, housing, Inland Empire Health Plan, SBCDPH, AIDS Healthcare Foundation, OASH, Families Living with AIDS Care Center, California Workforce Development Board, UC Riverside School of Medicine, Housing Authority of Riverside Count, HRSA, PACE*
Community Caucus II[16] 5/16/2020 10 AM-12 PM	TruEvolution convened a panel of Hispanic/Latinx PLWH to comment and review findings of Community Caucus I. The panel was presented only in Spanish and confirmed and further expanded on the key findings.	***New Voices Participants***: *Hispanic/Latinx PLWH.* *Spanish Speakers.*
Community Caucus III[17]	TruEvolution convened a panel of B/AA and Hispanic/Latinx MSM living with HIV to comment and review findings of Community	***New Voice—Participants***: *B/AA and Hispanic/Latinx MSM living with HIV.*

EVENT	DESCRIPTION	VOICES & PARTNERS
5/16/2020 1 PM- 3 PM	Caucus I. The panel confirmed and further expanded on the key findings.	*English Speakers.*
PLANNED ACTIVITIES (dates TBD)		
Online survey (Ongoing)	RUHS has distributed an online survey that asks for input on how to engage populations not currently reached effectively. Key community leaders volunteered to email the survey to their networks.	***Participants:*** *priority populations, providers, other stakeholders.*
LGBTQ Community Center Presentation and Discussion via Zoom	RUHS will present the draft EtHE plan to the LGBTQ Community Centers via Zoom and solicit their feedback. The Zoom call will be recorded and distributed to obtain additional feedback (see next activity).	***New Voices – Priority Populations:*** *LGBTQ communities.*
EtHE Plan Presentations	A recorded Zoom call outlining the county's draft EtHE plan will be shared with peers via email blast. The public will be asked to provide their feedback and suggestions on the draft plan via email.	***New Voices – Priority Populations****:* Other RUHS-Branches and organizations service priority populations.
Consumer Affinity Group via Zoom	In collaboration with CARG, RUHS plans to facilitate a virtual focus group of women of color to gain a better understanding of their barriers accessing HIV or PrEP care. CARG will be provided quarterly EtHE updates.	***New Voices – Priority Populations:*** Cisgender and transgender women of color
Key Informant Interviews	RUHS will speak with cisgender and transgender women from TruEvolution's existing support group and cisgender and transgender young men of color from CARG's existing peer support groups to gain their input on the county's EtHE plan and intervention.	***New Voices – Priority Populations:*** cisgender and transgender young men of color.
Riverside Overdose Data to Action (RODA) Group Presentation and EtHE Feedback	RUHS will present the draft EtHE plan to the RODA Group and elicit their input on the EtHE plan, especially regarding substance use efforts.	***New Voices – Partners:*** *S*ubstance use providers, behavioral health (RODA Group, Inland Empire Harm Reduction Coalition, Riverside Behavioral Health, Black Infant Health.)
Focused email blast and survey	RUHS will send an email blast and an online survey to participants of the visibiliTy	*New Voices – Priority Populations:* transgender

EVENT	DESCRIPTION	VOICES & PARTNERS
	conference. Participants will be asked to provide feedback on the county's EtHE plan.	community. visibility conference attendees.

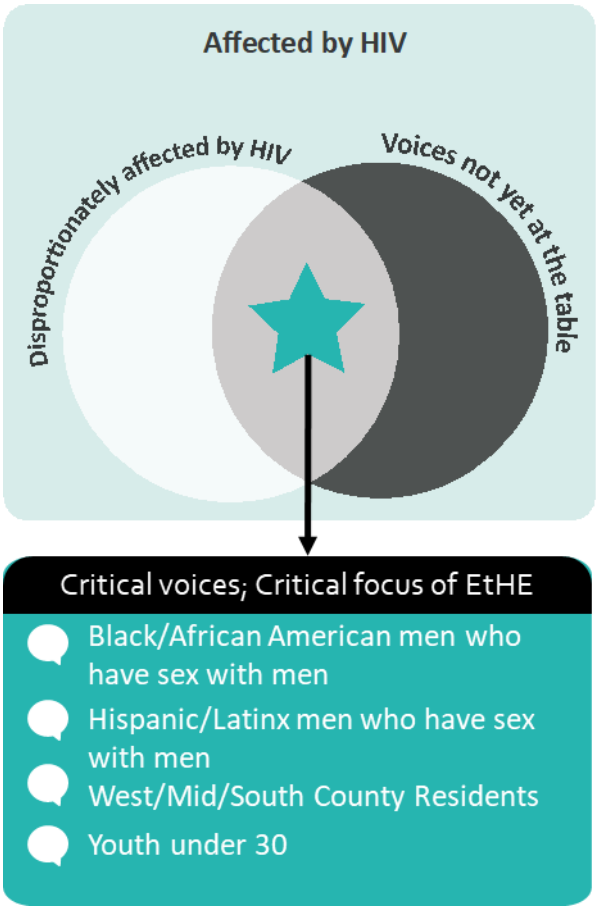
The RUHS HIV/STD Branch oversaw the development and implementation of the community engagement activities. With support from CDPH, they developed strategies for community engagement and then adapted this plan to continue CE during the COVID-19 pandemic. They successfully worked with San Bernardino County to leverage and funnel funding to community groups leading the EtHE work: TruEvolution, AIDS Health Care Foundation (AHF), California Regional Group (CARG), and Families Living with AIDS Care Center (FLACC). These local CBO partners helped plan and implement all community engagement events and were instrumental in successfully engaging new voices representing PLWH, people at risk for HIV, and providers. They helped advertise the events, recruited members from priority populations, and most importantly, helped to build trust between the county's EtHE efforts and community members. In addition, CDPH contracted with Facente Consulting, a California-based public health consulting firm specializing in HIV planning and community engagement to support and build Phase I county capacity to broaden and deepen connections with local priority populations. For Riverside County, Facente Consulting provided support for community engagement events including developing meeting agendas and materials, co-facilitating events, taking meeting notes, and producing summary reports.

New Voices

In addition to deepening the partnerships within current provider and community networks, RUHS will continue to place a special emphasis on including new voices in the implementation of the EtHE Plan.

While all communities affected by HIV are important to serve, most are well served through baseline HIV prevention and care services. Moreover, to end the HIV epidemic, a critical focus must be brought to bear on those groups most affected by the emerging HIV epidemic and who are not now connected to critical services. RUHS used an intentional data-driven process to identify affected populations not currently being reached effectively so they could focus on engaging these new voices. Based on HIV surveillance data, the experience of key stakeholders (e.g., RUHS, the Planning Council, service providers) and an assessment of who is not currently participating in the HIV planning process, RUHS identified the following priority populations as ***critical voices*** and the critical focus of future EHE work.

Exhibit 7. Critical new voices to engage.



- **Black/African American men who have sex with men.** B/AA MSM in Riverside County are disproportionately represented among new HIV diagnoses.
- **Hispanic/Latinx men who have sex with men.** Hispanic/Latinx MSM are disproportionately affected and there is a dearth of culturally and linguistically competent services.
- **Underserved and rural residents of West, Mid and South County.** The majority of new diagnoses occur in West county, and all three geographic areas have limited access to health care and other critical infrastructure and services. People of color and lower income individuals are overrepresented in these areas.
- **Youth under 30.** The emerging HIV epidemic in Riverside county epidemic is among persons under age 30.

The following sections describe the efforts to engage these key focus populations and service providers and community partners experienced working with these populations.

Local Prevention and Care Integrated Planning Bodies

As previously noted, Riverside County and its northern neighbor, San Bernardino County, make up the Riverside/San Bernardino Transitional Grant Area (TGA). The TGA has a joint integrated community planning body called the Inland Empire HIV Planning Council (IEHPC). RUHS continuously seeks the IEHPC's input and guidance when developing HIV prevention, care and treatment strategies and has actively engaged the Council throughout the EtHE planning process.

The Planning Council brings a wealth of knowledge and experience to the EtHE planning process. In accordance with the bylaws of the Planning Council, consumers of Ryan White Part A services must make up at least 33 percent of the membership. The Planning Council has consistently provided a voice to PLWH and has played a lead role in developing the Standards of Care to support PLWH and help ensure that treatment and other resources are available and PLWH are treated with respect and dignity.

In addition, the bylaws identify 13 required membership categories to ensure diversity of representation and perspectives. Examples of the membership categories include people at risk for HIV, health care providers, and mental health and substance use providers. The Council also seeks inclusion of representatives of gender diverse communities, the faith community, and rural and geographically isolated communities. Currently, the Council composition includes 65 percent people of color, 15 percent representatives of the public sector, and 60 percent PLWH; 51 percent are from San Bernardino County and 49 percent from Riverside County. To ensure accessibility, all IEHPC meetings are held in venues that are wheelchair accessible and sign language interpretation services are available upon request.

The IEHPC is a key partner for ensuring that new voices from the priority populations are included in baseline and future EtHE HIV planning efforts. The Council is actively engaged in new member recruitment, with a focus on new voices from the EtHE priority populations. Recruitment strategies include: 1) outreach to health and social service providers serving the priority populations; 2) outreach to HRSA-funded Ryan White Part A and B recipients not already at the table; 3) using Council members' social and professional networks to directly reach out to people from the priority populations; and 4) convening meetings throughout Riverside County's diverse regions for annual priority setting and allocations of Ryan White funds. In 2019, the IEHPC hosted three Consumer Caucuses in the three distinct regions of the TGA, including one in east Riverside County. Having consumers on the committees and the council to inform decisions and provide immediate context to other consumer feedback is invaluable and is a core tool in the community input process for HIV services. The TGA also ensures community input on program design, implementation, and quality through methods such as surveys and through live participation opportunities like town halls, consumer caucus groups, and consumer participation in local and state planning coalitions.[7]

The Planning Council actively engages and develops the leadership of new members through its "HIV University"—a 10 session course about the HIV planning cycle and how to effectively participate to influence funding and policy decisions. This ten-week consumer training program, created and implemented by the IEHPC, is designed to prepare consumers and affected individuals to become organizers and champions in their community. The course is also meant to spark excitement and empower our consumers by partnering with them to learn the skills

necessary to be successful in a planning council role as a self-advocate and peer leader. The ten-session training given over ten weeks begins with basic HIV 101. Other topics addressed include how to run a meeting, cultural humility, orientation to the Planning Council, and how to understand data. This interactive course creates bonds among participants by providing a fun and empowering learning environment with the opportunity to work and grow with others along similar journeys. Throughout the training, participants learn to tell their own story using themes related to the training and at the end they have the opportunity to present their story in front of their cohorts. The course had its inaugural class in October 2019 and held a graduation for seven participants in December 2019. The course is open to all and the Council makes a special effort to recruit priority populations to participate. The HIV University provides an opportunity to interact with and get input from stakeholders who would not normally be at the table.

Local Community Partners

With the exception of a vaccine for HIV, many tools to end the HIV epidemic exist—PrEP, condoms, safer injection equipment, and effective HIV treatment. However, policy barriers, social determinants of health (SDoH), disparities in health care access, stigma, and many other factors create a situation where not all communities benefit equally. With Riverside County's unique epidemiologic profile and disparities in new diagnoses, engagement of affected community members in the planning process is a significant and essential element in EtHE planning.

In addition to the IEHPC's work, RUHS has directly engaged with the identified priority populations as shown in Exhibit 7. The COVID-19 response has limited some face-to-face community engagement, but by the end of the planning year, RUHS engaged every priority population or reviewed key data sources related to each priority population. Direct community engagement will continue in Years 2-5.

Local Service Provider Partners

Service providers, both HIV- and non-HIV-related, are key partners for ending the HIV epidemic in the county. Clinical and community-based providers have a wealth of experience regarding what works and what does not work to reach priority populations and a strong knowledge of the barriers that need to be overcome in order to more effectively serve PLWH and persons at risk. Other partners who may not provide direct services but who have expertise in or connections with priority populations are also key to building a robust, feasible, and sustainable HIV prevention, care, and treatment strategy.

RUHS has pre-existing strong partnerships with the Planning Council, San Bernardino Department of Public Health, and the CBO providers listed in **Exhibit 1** (p. 3, Intro). During the EtHE planning process, RUHS engaged the following new service provider and non-traditional partners:

- **Behavioral Health expertise,** via alignment of the EtHE efforts with Riverside's Behavioral Health Mental Health Services Implementation Plan.
- **California Regional Group (CARG).** Created to as part of the *end+disparities ECHO Collaborative* to increase viral suppression among MSM of color and expanding to EtHE priority populations.

- **Education and research institutions,** including University of California Irvine (UCI); University of California Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS); University of California Riverside (UCR), Loma Linda University (LLU).
- **Faith-based organizations**, including the Center for Faith Based Partnerships initiative.
- **Healthy Stores for Healthy Community.** This program conducts surveys of stores to determine access to items including condoms. One of their goals is to outreach to stores in communities with high STD rates and provide free STD information and condoms.
- **Housing experts,** including HOPWA, Inland Empire Development Corporation, FLACC.
- **Inland Empire Health Plan** that has expanded the definition of allowable medical expenses to include housing costs for people with chronic illnesses.
- **LGBTQ+ Center of Riverside County.** An organization whose vision is to guide and support the local LGBTQ+ community and its allies.
- **Primary care providers,** such as Federally Qualified Health Centers.
- **Riverside Overdose Data to Action Group (RODA)**. A coalition of substance use and mental health providers formed to combat the opioid epidemic in Riverside County.

RUHS is strongly invested in maintaining these new relationships and continuing to forge new partnerships for ending the HIV epidemic.

Selected Findings

The following sections summarize and highlight selected findings from the community engagement efforts related to four domains affecting the HIV epidemic in all California Phase I counties: social determinants of health (SDoH), being unhoused, mental health, and substance use (**Exhibit 8**). These findings represent a synthesis of information gathered from all the activities in **Exhibit 6** completed as of September 30, 2020 (see **Appendix 2** for detailed documentation). The information presented sheds light on some of the prevailing issues and conditions the priority populations are experiencing, serving as an initial indication of how these conditions might influence the county's ability to achieve EtHE goals. These early insights point to potentially impactful strategies and interventions.

Exhibit 8. Key considerations for EtHE in Riverside County, from community engagement processes

Social Determinants of Health, like structural inequality, discrimination, racism, and microaggressions, microinvalidations impact access to HIV-related services.

Secure housing and effective housing services are in short supply, and housing is impacted by chronic disease, mental health, and discrimination.

Mental health services are critically needed, yet lacking, especially among people who are unhoused, people who use substances, and PLWH.

Substance use services and harm reduction services are urgently needed, especially given local rates of opioid and methamphetamine use.

Social Determinants of Health

A common theme across all the completed community engagement efforts was the pervasive effect that social determinants of health (SDoH) have on the well-being of communities. Structural inequality, discrimination, racism, microaggressions, and microinvalidations negatively impact the health of the most vulnerable populations. Community engagement participants shared how SDoH have impacted their experience living with or being at risk for HIV.

Riverside community members spoke about the need for an intervention to respond to stigma and discrimination that occurs because of gender identity, sexuality, and/or HIV status.[14,15] Stigma exists not only at the individual level, but is also in families, communities, cultures, and religious institutions. Persistent stigmatization poses a significant barrier to testing and accessing services. During the Community Caucus event, one member shared their experience attending a family medicine clinic in Riverside. Clients coming in for HIV services were required to register at the opposite end of the waiting room, away from the family medicine registration area.[14] HIV and family medicine services were clearly separated, creating a physical and social divide among clinic patients.

Participants also noted the presence of pervasive systemic racism and other forms of discrimination in the county. A local Housing Opportunities for People with AIDS (HOPWA) coordinator shared an unsettling anecdote that occurred in Hemet, a rural town in the county. One participant reported that during several meetings, City Council members asked “Why are so many Black people moving into our area?”[14] When racism is woven into the policies and institutions meant to protect the well-being of all, it is inevitable that people living with and at risk for HIV are affected.

Being Unhoused

Secure housing is a necessary condition for health and well-being, hence the common mantra "housing is health care." As one Community Caucus participant described, “People are not going to be worried about their health if they are worried about where they are going to sleep.”[14]

Riverside County community members identified three housing issues that pose barriers to achieving the county’s EtHE goals:[14,15] (1) a shortage of affordable housing, (2) lack of coordination of housing services (e.g., HOPWA vouchers are effective for only 2-3 years, but long waitlists prevent swift and responsive housing assistance), and (3) discriminatory policies and actions. For instance, one participant described how a new housing development purposefully hired a private security company to patrol the region, harass people experiencing homelessness, and remove them from the area.

The Riverside County 2019 Point-In-Time Homeless Count and Survey Report identified 2,811 persons who were people experiencing homelessness in January 2019, a 21 percent increase from 2018.[18] The percentage of those experiencing homelessness and being unsheltered was 73 percent of the total count (2,045).[18] Further analysis of the unsheltered subgroup found that 68 percent were cisgender men.[18] In terms of health conditions, 18 percent had experienced mental illness and 24 percent reported current or past substance use.[18] The count further reported 1.3 percent (27 people) were living with HIV but community engagement efforts suggested that HIV among unhoused individuals is underreported due to HIV stigma.[19]

Support is needed not only for people to secure housing but also to maintain housing. Chronic health conditions, mental health disorders, and histories of trauma can make it difficult to maintain employment to get and maintain housing. It is well-recognized that supportive housing services and case management are often necessary to help people maintain and thrive in a stable home,[20] including support for paying rent on time and applying for social benefits or employment opportunities.

Mental Health

The dearth of mental health services in Riverside County is decreasing but there is still a great unmet need. The people in the county who need these services the most cannot easily access them. In community engagement events, PLWH, people experiencing homelessness, and people who use substances were noted as needing more support. Research shows these populations bear a disproportionate burden of trauma and history of childhood adverse events.

Riverside County's Behavioral Health Implementation Plan provides a framework to address mental health and substance use. [21] This framework could be built upon to create a low-threshold, bi-directional pathway between behavioral health and HIV services. A “no wrong door” approach to these services would lower barriers to access care and remove the bureaucratic and timely referral process.[21]

Mental health is closely tied to SDoH, and in Riverside County, which does not have an adequate public transportation system, lack of transportation options is a major barrier, especially for rural residents. Riverside County is geographically large and mental health providers are widely and unequally distributed. People can expect a roundtrip bus commute of at least 8 hours to attend a medical appointment.[14] Long commutes and transportation uncertainties are unnecessary stressors that not only create barriers to accessing services, but also affect mental health, according to community engagement participants.[14] Community engagement efforts also suggest that peer support, peer advocates and family based interventions can be useful mental health support interventions.[14]

Substance Use

In 2018, Riverside County experienced 144 opioid-related overdose deaths, a 23 percent increase from 2016; in addition, the county has witnessed a steady and significant upward trend of deaths attributable to amphetamine overdose since 2011.[22] These trends indicate growing challenges in the county related to addressing substance use. Riverside County community members identified substance use disorders as a prevalent problem in HIV-affected communities. Similar to mental health, substance use highly impacts priority populations, often as a result of trauma and structural inequalities.

Participants expressed a need for harm reduction services for people who use substances. Community caucus participants mentioned the lack of safe injection sites and syringe services programs in the county, especially given the levels of methamphetamine and opioid use in the county.[14] Participants suggested that the county needs a treatment network with low-threshold access points that embrace harm reduction and whole-person care principles. In tandem, a contingency management or cognitive-behavioral intervention is needed to address methamphetamine use across the region.[23] RUHS HIV/STD Branch is partnering with the

Riverside Overdose Data to Action Program to address barriers and the needs of PLWH and those at risk of HIV.

Community Engagement, Years 2-5

Exhibit 9. Community engagement priorities, Years 2-5

1. Include additional new voices through collaborative relationships with CBOs
2. Focusing on workforce development

RUHS will use years 2-5 of EtHE implementation to continuously engage community members in the planning and implementation of services and interventions. Community input was essential in developing the proposed activities outlined in *Section IV: Ending the HIV Epidemic Plan.* Moving forward it will be equally important to keep the Planning Council, community members, and service providers engaged regarding the most effective approaches to implementing services. Future engagement strategies will include working closely with the Planning Council and hosting community forums co-sponsored by RUHS and CBOs. RUHS is prepared to develop alternative and innovative engagement methods if necessary due to COVID-19 or other unanticipated factors. Documentation of all community engagement meetings and outreach efforts will be maintained and reviewed regularly to ensure they are achieving the desired engagement of priority populations.

For years 2-5, RUHS's community engagement priorities are including more new voices through strengthening collaborative relationships with CBOs and focusing on workforce development, as shown in **Exhibit 9**.

Collaboration with Community-Based Organizations

Many priority communities have not been previously reached effectively. As such, many in these communities have a deep-rooted mistrust of large institutions due to historical discrimination that has not only excluded people but has also caused extreme harm. To begin to overcome these barriers, RUHS will prioritize relationships with CBOs grounded in the experiences and cultures of the priority communities. CBOs have the long-standing trust and rapport with those they serve, an invaluable asset that RUHS has yet to fully learn from and leverage. EtHE community engagement would not be possible without the support of CBOs. RUHS and CBO partners will seek technical assistance to implement best practices and innovative strategies for connecting with new voices from the priority populations. In addition to continuing to engage the priority populations identified in year 1, RUHS will also seek to bring the following critical subgroups to the table:

- **Substance users, particularly people who inject drugs (PWID) and people who use methamphetamines.** Reducing substance use in the county through a harm reduction approach could help reduce HIV transmission from injection drug use.
- **Heterosexual women of color.** High-risk heterosexual cisgender women, especially women of color, make up 8 percent of new diagnoses in Riverside County.
- **Transgender community.** Although transgender persons represented only 2 percent of new HIV diagnoses in 2018 and less than 1 percent of PLWH, it is critical to get input on how best to reach this community.
- **Other Substantial-risk County residents, including those who are B/AA, Hispanic/Latinx, uninsured, underinsured, or who have no medical home.** These

are populations who experience systemic barriers to health and are at disproportionate risk for HIV infection.

- **Deaf community.** Current data collection systems do not require client-level data about physical ability differences. There is an active deaf community in Riverside county that has provided helpful resources about making all community engagement events welcoming and accessible. It is critical that all adults who are at substantial risk for HIV have access to prevention and care tools.
- **People newly diagnosed with HIV.** The greatest ability to and benefits from achieving viral suppression are seen in those who link to HIV care within the first 30 days.
- **PrEP-eligible persons.** PrEP expansion is critical to achieving reductions in HIV infections.
- **Non-English speakers.** A number of Spanish-speaking community members came forward to participate in bilingual community forums.

In years 2-5, RUHS will work with CBOs to reduce barriers to participating in community engagement. Hosting events on evenings and weekends or other times when people are not working, providing free childcare during events, and assisting with transportation through vouchers or other means are all feasible strategies for increasing participation.

One mechanism for strengthening partnerships with CBOs is through the PS-20-2010 requirement to subcontract 25 percent of funds to CBOs. RUHS strongly supports this requirement and will develop a request for applications (RFA) to select one or more organizations that will collaborate closely with RUHS to reach the EtHE priority populations. At a minimum, the eligibility criteria for the RFA will include:

- Experience working with and serving one or more of the priority populations or other marginalized communities.
- Knowledge of and ability to apply a health equity framework.
- Having a workforce or clear plans to develop a workforce reflective of the priority populations.

Community members from the priority populations will have input into the services provided under this RFA. In the engagement efforts to date, participants suggested using the funds to hire and train peer navigators to provide PrEP and HIV services across the county.[14] Other options may arise during additional engagement efforts. The RFA will also be an opportunity to build up the county's HIV workforce by providing job opportunities to people from the priority populations.

The RFA process for the EtHE plan will change the way the RUHS HIV/STD Program do business with CBOs to better support them in their EtHE efforts. RUHS will incentivize and provide training on recruiting and hiring people with lived experiences, including people who may not have completed a formal education. As part of a larger plan to build up the county's HIV workforce, RUHS will support the CBOs to access staff development opportunities. RUHS will also seek to reduce administrative barriers and burdens, for example, by accelerating the payment of invoices.

Workforce Development

The success of Riverside County's EtHE plan depends on a highly skilled workforce that reflects the populations served. Riverside County actively seeks to increase the representation of PLWH, transgender persons, and LGBTQ people of color. Hiring people "from the community" addresses at least three needs in the county. First, it will expand culturally competent service provision, leading to increased ability to reach and serve the priority populations as exemplified by discussions during the Community Caucus. Participants shared how there was a lack of services and support groups led by peers with whom they could personally identify.[14] They talked about how having peers as PrEP navigators or advocates creates improved access to services. Second, providing job opportunities and training to people from the priority communities helps reduce the stark economic disparities that contribute to HIV risk and poor health outcomes. Third, hiring people with relevant lived experience shows communities that they are highly valued and needed, helping to break down systemic racism and discrimination. Government created human resource policies and standards often prevent individuals without high school diploma or college degrees from being hired. This is a barrier that no Phase I jurisdiction can easily correct. However, through the goal of workforce development and the identification of this barrier, it is hoped that the federal Ending the HIV Epidemic in America team can work with others to make a path for hiring priority population staff whose education and skills comes from lived experience.

The University of California, Riverside (UCR) School of Medicine has an extensive pipeline program for students from underrepresented minorities (URMs) to increase diversity in the medical and public health fields.[24] This will benefit the county by having an increased number of URMs providing care to the priority populations, raising cultural competence and trust. This program is a model and RUHS will continue to support and develop similar pipeline programs across the county.

Section II: Epidemiologic Profile

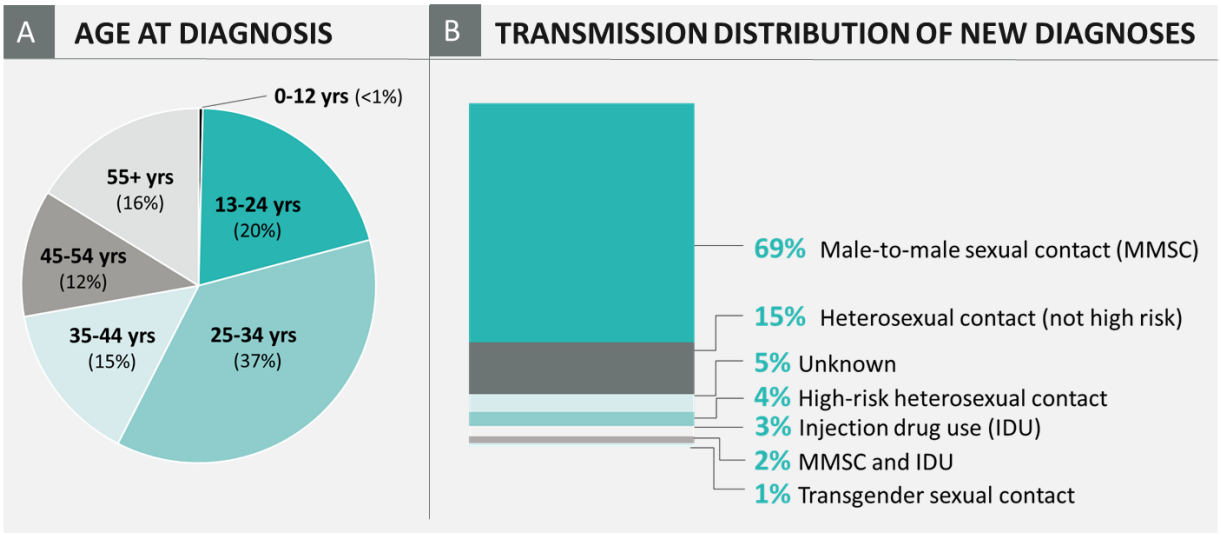
HIV Diagnoses

Riverside County is the fourth most populous county in California[25] and stretches over 7,000 square miles from Orange County to the Arizona border.

In 2018, there were approximately 10,299 people living with HIV in Riverside County. Of those, 9,299 (90.1 percent) had been diagnosed– up from only 75.8 percent diagnosed in 2016 – and 259 were diagnosed within 2018. Of the people diagnosed in 2018, 133 (52 percent) were ages 25 to 44, 179 (69 percent) were infected through male-to-male sexual contact, and 39 (15 percent) were infected through heterosexual contact not typically considered high risk (i.e., not with a partner who was MSM or injected drugs).[4]

Exhibit 10 highlights the age and transmission distribution of new HIV diagnoses in Riverside County in 2018.

Exhibit 10. Age at Time of Diagnosis (A) and Transmission Distribution of New Diagnoses (B), 2018



Overall, age and gender at diagnosis have remained relatively constant between 2014 and 2018 in Riverside County. However, the rates of new infections per 100,000 population by race/ethnicity have changed notably since 2014 as can be seen in **Exhibit 11**. Specifically, the rate of infection among B/AA and Hispanic/Latinx persons peaked in 2016. Since then, rates have declined for both groups, though rates for B/AA remain substantially higher than for other racial/ethnicities groups.[4] It is important to note that when overall numbers of individuals in a group are small, sparklines or other trend analyses should be interpreted with caution.

American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups are not included in the race/ethnicity data tables below due to small to zero numbers reported each year from 2014-2018. This report does not intend to diminish the impact of HIV on American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups. Small numbers are not reported to preserve the confidentiality of PLWH.

Exhibit 11. Rate of Transmission by Race/ethnicity, New HIV Diagnoses, Riverside County

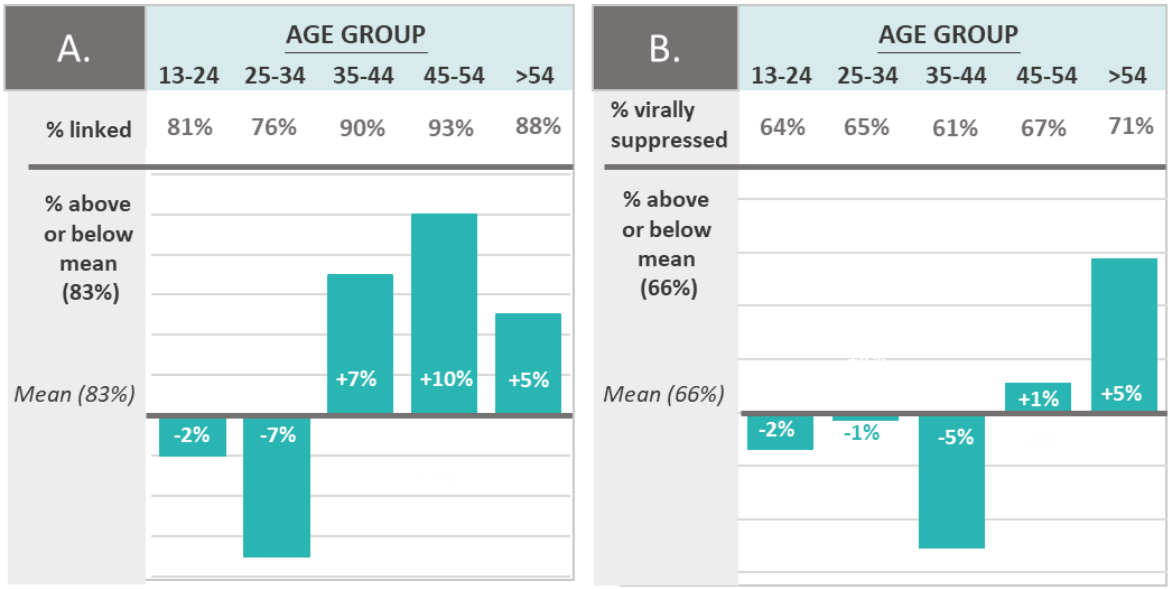
Race/ethnicity	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2014-2018 Sparklines
Black/African American	18.1	27.9	28.3	27.3	21.5	
Hispanic/Latinx	9.5	10.8	12.5	11.8	9.3	
Asian	5.9	2.9	7.8	4.9	4.1	
White	13.5	11.5	11.4	10.2	11.2	

Note: Rates are per 100,000 population.
Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

Linkage to Care and Viral Suppression

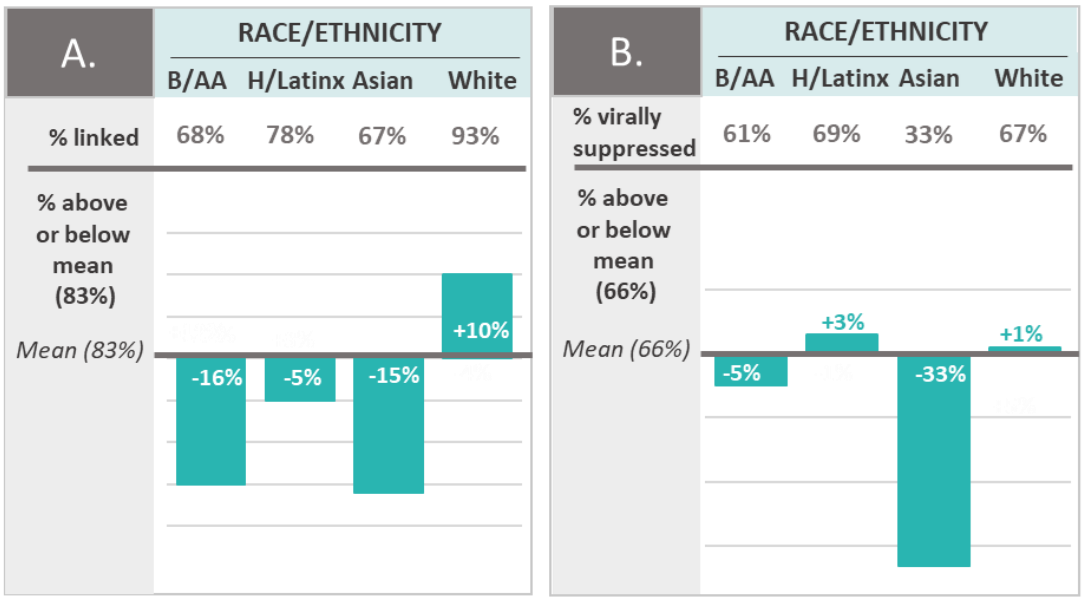
New diagnoses are not the only important piece of HIV epidemiology, however. Also key are the percentages of people who are linked to care within 30 days and who are virally suppressed within six months of diagnosis. Overall, 83 percent of people diagnosed with HIV in Riverside County in 2018 were linked to care within 30 days of diagnosis and 66 percent were virally suppressed within 6 months. However, there were notable disparities; people ages 25-34 had considerably lower rates of linkage to care within 30 days and people ages 35-44 had lower viral suppression rates (**Exhibit 12**).[4]

Exhibit 12. Linkage to Care (A) and Viral Suppression (B) by Age, Riverside County 2018



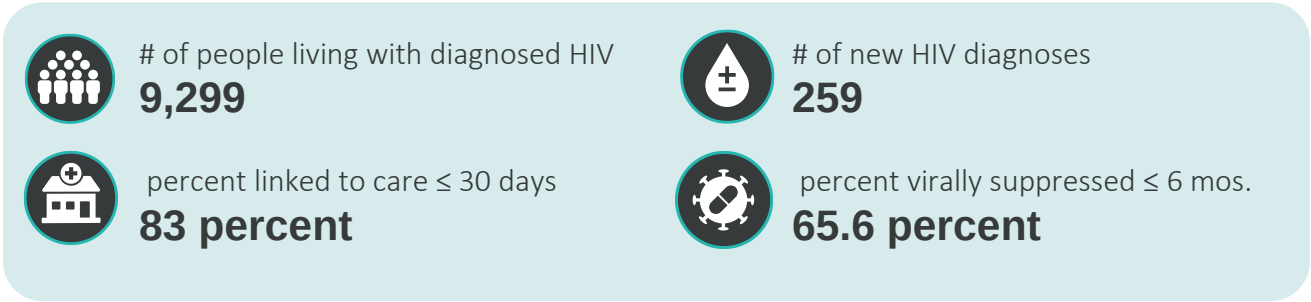
Similarly, disparities in linkage to care and viral suppression were also seen by race/ethnicity, with B/AA, Hispanic/Latinx persons, and Asians having substantially worse outcomes regarding linkage to care within 30 days compared to Whites, and B/AA and Asians having a lower proportion of viral suppression within 6 months of diagnosis compared to Hispanic/Latinx (H/Latinx) and Whites. An impressive 93 percent of White people in Riverside County were linked to care within 30 days of diagnosis in 2018, far higher than people in other racial/ethnic groups (**Exhibit 13**).

Exhibit 13. Linkage to Care (A) and Viral Suppression (B) by Race/ethnicity, Riverside County 2018



In summary, **Exhibit 14** provides a few key features of Riverside County's HIV epidemic in 2018.

Exhibit 14. Key features of Riverside County's HIV epidemic (2018)



Section III: Situational Analysis

This Situational Analysis provides a high-level overview of the strengths, needs, gaps, and barriers related to ending the HIV epidemic in Riverside County. It synthesizes information from the epidemiological profile, community engagement efforts, planning conversations, and consultations with key partners and stakeholders, both HIV and non-HIV.

The Situational Analysis is organized into the following three sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps.

Methods

Riverside County's situational analysis consisted of documenting HIV-related community needs and assets, describing the existing resources to meet those needs (see **Appendix 1: Resource Inventory**), and identifying gaps that must be filled to fully meet the community needs. The situational analysis methods and data sources are described in **Exhibit 15.**

Exhibit 15. Methods and data sources used Riverside County's situational analysis

Method	Description
Needs assessment to ascertain needs, resources, and service gaps	• EtHE community engagement efforts[10-17,26] • County information on existing services • California Directory of Syringe Services Programs[27]
Review of secondary data and reports	• AIDSVu local PrEP estimates[28] • Riverside County Epi Profile 2018[4] • Point in Time homeless count[18] • CA Opioid Surveillance Dashboard[22] • HRSA 20-078 application[7] • CDPH HIV Surveillance Report 2017[29] • HRSA Part C EIS Application • Specialty Mental Health Services Implementation Plan, 2019[21] • Drug Medi-Cal Organized Delivery System Implementation Plan[30] • U.S. Census Population Estimates for Riverside County[25] • Inland Empire Comprehensive HIV Needs Assessment, 2014[31] • Published literature on HIV in Riverside County[5,6]
Community engagement and consultation	• Inland Empire HIV Planning Council • Service providers • Community members representing the priority populations disproportionately impacted by HIV
Review of relevant County and State plans	• Inland Empire Planning Council 2009-2012 Comprehensive HIV Services Plan[1] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan[3] • Riverside County PS 18-1802 Workplan[32] • PS 20-2010 EPMP and Work Plan[33]

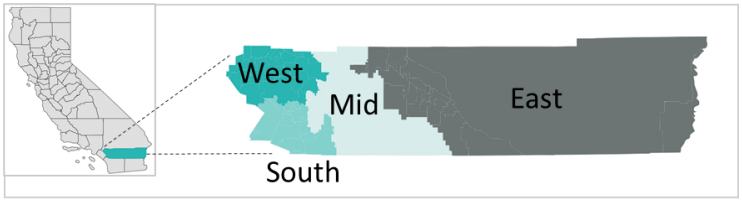
Consultation with key stakeholders	• Local: RUHS staff, Local AIDS service organizations, and others • Regional and State: SBCDPH; CDPH; CARG; Federal Ryan White Program Staff; and AIDS Education and Training Center

Situational Analysis Snapshot

Situational Analysis Summary

Riverside County (**Exhibit 16)** encompasses over 7,000 miles in southern California, bordering Orange County to the west, San Bernardino County to the north, San Diego and Imperial Counties to the south, and the state of Arizona to the east. It is the fourth most populous county in California, with an estimated 2018 population of 2.45 million residents. Riverside County consists of four distinct regions: East County (inclusive of Palm Springs and the greater Coachella Valley area), West County (inclusive of Moreno Valley and Riverside), South County (inclusive of Lake Elsinore and Temecula), and Mid-County (inclusive of Calimesa and Hemet).

Exhibit 16. Map of Riverside County and its main regions



HIV prevention, care, and treatment efforts have resulted in some success. New diagnoses decreased 13 percent between 2016 and 2018, with 259 people newly diagnosed in 2018.[4] In 2018, 83 percent of those newly diagnosed were linked to care within 30 days and 66 percent achieved viral suppression within 6 months of diagnosis. While these successes are heartening, they are tempered by the fact that there is still significant work to be done to improve access to services and health outcomes. Not all in the county have benefited equally from existing services; notably, men who have sex with men (MSM), people under the age of 30, and people of color are disproportionately affected by HIV.

More than two-thirds of PLWH in Riverside County reside in East County, especially Palm Springs, where the prevalence rate (7,300 per 100,000) is more than 20 times higher than California overall (340 per 100,000). PLWH living in East County are primarily white (81 percent) and over 60 (43 percent).[6] However, the newly diagnosed have a different demographic profile than PLWH overall; they reside outside of East County (nearly half of all new diagnoses are in West County) in places where HIV services are limited, further exacerbating the impact of the epidemic. Additionally, those diagnosed in West, Mid-, and South County are more likely to be younger MSM of color.

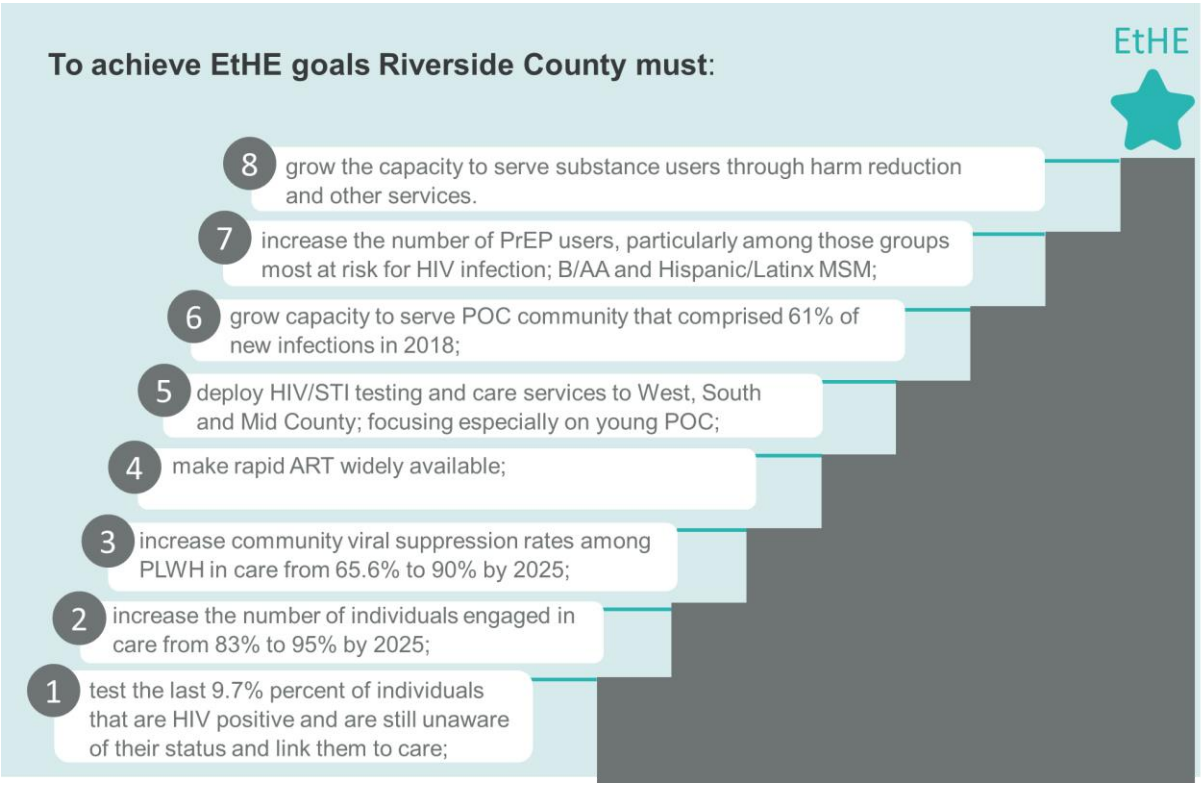
In the 7,000 square miles that make up Riverside County, there are only 11 HIV service providers. RUHS has strong partnerships with all, but the small number of providers for such a large geographic area translates to major access challenges. Because the epidemic was historically centered in East County, the services and infrastructure are concentrated there, which is out of alignment with the current needs.

To end the epidemic in Riverside County, strong programmatic and systems change efforts are needed to bring HIV prevention, care, and treatment services to the populations with disproportionate rates of new diagnoses and limited access to services – specifically B/AA and

Hispanic/Latinx individuals and young people outside of East County. A limitation in Riverside County's current HIV prevention portfolio is a dearth of culturally competent PrEP services, and therefore low PrEP uptake and retention. A focus on PrEP will be critical for making significant progress in reducing new HIV infections. Strengthening the overall HIV infrastructure outside of East County will also be a critical step. Expanding access to services through partnerships with more clinical sites and CBOs, both HIV- and non-HIV-focused, is a high priority.

Exhibit 17 summarizes what is needed to end the HIV epidemic in Riverside County based on 2018 data.

Exhibit 17. High-level summary of what is needed to end the HIV epidemic in Riverside County



Situational Analysis Snapshot by Pillar

Diagnose

In 2018 there were an estimated 1,000 individuals in the County living with HIV who did not know their status.[4] Community engagement data[14] suggests that HIV messaging is lacking and not reaching B/AA and Hispanic/Latinx communities with accurate and culturally appropriate information. This puts these communities at elevated risk for not testing at all, or for testing at later stages of HIV infection.

Today, most people newly diagnosed with HIV are people of color (61 percent). Black/African American individuals are most disproportionately affected, comprising only 6 percent of the population but 12 percent of new HIV diagnoses in 2018.[4] Hispanic/Latinx individuals are a

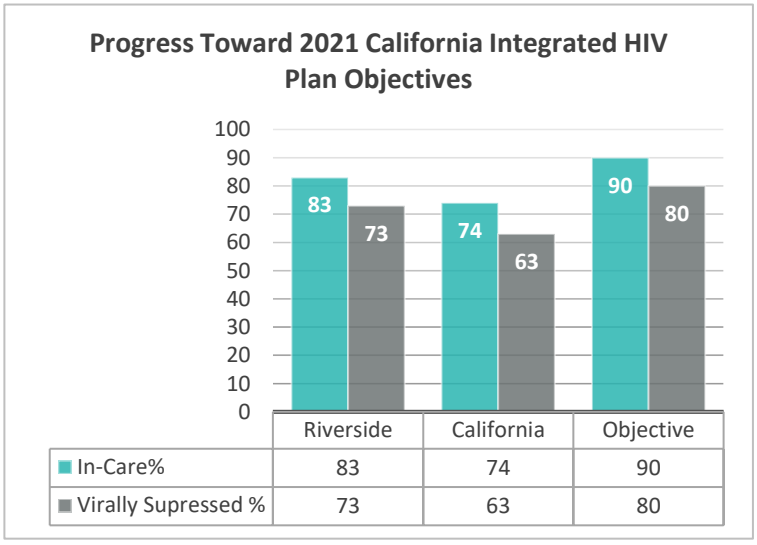
higher proportion of "late testers," or those receiving both an HIV and AIDS diagnosis within 12 months of each other.[34]

RUHS has increased and improved HIV testing through development of routine-opt out testing (ROOT) protocols at community-based clinical sites such as Desert AIDS Project, and federally qualified health centers and has increased outreach to medical providers who test for sexually transmitted infections (STIs) but do not also offer routine HIV testing. However, according to community engagement data, HIV testing is not routine in all non-HIV clinical settings. A forum[14] of people living with and at risk for HIV from Riverside described the common experience of having to advocate for themselves or other family members to access HIV testing. One participant shared that they were offered testing only after they became sick with a secondary infection and had a partner die of complications related to HIV. "We need more advocates," one participant shared.

Treat

Riverside County is doing better than California overall in linking PLWH to medical care within one month and having them achieve viral suppression within six months of HIV diagnosis (**Exhibit 18**). In 2018, among all those newly diagnosed with HIV in the county, 83 percent were linked to care within one month and 66 percent achieved viral suppression within 6 months.[4] However, Blacks/African Americans (-15.3 percent) and Hispanic/Latinx (-4.7 percent) individuals are less likely than other groups to be linked to care within one month, and Blacks/African Americans were less likely to achieve viral suppression within 6 months.[4]

Exhibit 18. Progress toward Integrated Plan objectives



Personal stories offered during community engagement efforts[14] may help to explain these disparities. Community feedback suggested that if you are a person of color in Riverside County, you are more likely to live in West, Mid or South County where housing is cheaper. In these areas, you are not likely to live close to a medical clinic, a pharmacy, a grocery store, a bank or even a gas station. Showing up for a medical appointment may mean a 4-hour bus ride one-way. Your doctor is less likely to look like you, speak your language, or come from a background that could help them understand the challenges you face just to show up to the clinic. Mental health, substance use, and housing security are all cofactors that are more likely to negatively affect your health, but you are less likely to be able to access help for these issues because you live where there are no services.

Prevent

In recent years, there has been a clear shift in the HIV epidemic from being largely among white MSM in East County to one that is largely people of color (especially MSM), those living outside of East County, and those under 30. This is likely, at least in part, a consequence of placing services in East County early on, where the epidemic was, without parallel efforts in other regions. Given the current landscape, it is imperative to, and Riverside County has the opportunity to, scale up HIV and PrEP services to increase utilization in these currently underserved regions and communities.

***Exhibit 19*: 2021 Target and 2018 Estimated PrEP Utilization in Riverside and California**

	Total Users	Rate (per 100,000)
California 2021 target	60,000	152
California 2018	27,283	82
Riverside 2018	1,116	58

While RUHS has moved to improve PrEP utilization via education of PrEP prescribers, PrEP navigators, outreach to priority populations at high risk for HIV, and training for medical providers who were not screening for or prescribing PrEP, there is still much work to be done. Current estimates of PrEP utilization in all areas of California, including Riverside County, fall short of what is needed to achieve the 2021 goal of 60,000 prescriptions for PrEP across the State.[15] As seen in **Exhibit 19**, Riverside lags behind the rest of the state in PrEP uptake.[35] Riverside will have to accelerate uptake of PrEP, especially in communities of color outside of East County, to meet EtHE goals.

Community engagement efforts[14,15] revealed that PrEP information is still not reaching B/AA or Hispanic/Latinx communities with culturally appropriate messaging. Community members suggested that PrEP information must be delivered by peers and must be combined with support and counseling to help manage historical trauma, medical mistrust, and the stigma associated with HIV. RUHS recognizes that expanding this effort through CBO partners and linking it with community engagement strategies will be more effective than working through medical providers alone.

Respond

RUHS's capacity to coordinate between prevention and HIV surveillance has been bolstered with CDC's integrated approach facilitated by PS-18-1802. RUHS is currently working to integrate linkage to care and partner services through cross-training and is developing systems for using surveillance data to identify newly diagnosed individuals yet to be linked to care or received partner services, with the goal that 100 percent of newly diagnosed individuals are offered linkage and partner services.

RUHS coordinates with CDPH's HIV surveillance team for cross-county case coordination and HIV cluster response. When CDPH-OA receives HIV laboratory reports from laboratory facilities and needs to determine if the report is from a new HIV case, it sends an inquiry to the county for confirmation. When a new HIV case from a provider in Riverside County is identified, this case information is also sent to RUHS for follow up, investigation, and case reporting. RUHS receives monthly quality assurance reports from CDPH-OA and has constant contact with an OA-appointed Surveillance Coordinator. If a cluster of new HIV diagnoses is identified that crosses county lines, RUHS works with CDPH-OA and the other jurisdiction's HIV/AIDS Surveillance Coordinators to respond. Information is shared through secure file transfers and by phone calls.

Summary of Resources and Gaps

Resources and Assets

Exhibit 20 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance EtHE planning and implementation. For example, RUHS's EtHE plan builds upon its efforts to expand community-based HIV testing and routinize HIV testing in primary care settings. RUHS has also laid the groundwork for bringing PrEP to communities that have hardly been reached, through provider and navigator education and training, a critical foundation for better serving young MSM of color with PrEP referrals and other prevention services. Additional resources and assets are presented in Exhibit 20 and described in more detail in the narrative that follows.

Exhibit 20: Riverside County Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Strong community-based testing partnerships	●			
Foundation of routine opt-out testing (ROOT)	●			
Robust East County HIV infrastructure		●		
High linkage to care and viral suppression rates among white MSM		●		
Medical training pipeline program		●		
Solid groundwork laid for PrEP scale-up			●	
Good condom access for some populations			●	
Harm reduction services available despite legal barriers to SSPs			●	
HIV surveillance				●
Cross-Pillar				
• Declining new diagnoses • Public health leadership of color • Coordinated planning inclusive of diverse voices • Strong network of providers and support services • RUHS Public Health HIV Specialty Care Clinic (Early Intervention Program) • RUHS Community Health Clinics (CHCs) • Community Action Teams (CAT teams) • Culturally appropriate behavioral health services				

Strong community-based testing partnerships. Riverside plans to leverage the current partnerships and forge new ones with CBOs that have deep knowledge about how to serve communities of color to increase testing services for key populations (young B/AA and Hispanic/Latinx MSM) and regions (West, Mid and South County).

Foundation of ROOT. RUHS has made great strides in promoting ROOT. The sites that have implemented ROOT include: Desert AIDS Project. In California approximately 90 percent of new HIV positives are identified in doctor's offices,[36] and thus, Riverside County will continue its efforts to educate and support providers about the need to adopt routine HIV testing.

Robust East County HIV infrastructure. RUHS has demonstrated that it can build services that are effective in East County for white MSM living with and at risk for HIV. Maintaining that effort will be important, as the majority of PLWH are white MSM living in East County. Lessons learned from these successes can be harnessed to build a similar set of services designed for young MSM of color outside of East County and accelerate EtHE goals.

High linkage to care and viral suppression rates among white MSM. White MSM are more likely to be linked to care within 1 month and virally suppressed within 6 months of HIV diagnosis than other groups. High-quality culturally competent linkage to care services, primary care, and wraparound services, as well as strong services to support enrollment in Patient Assistance Programs (PAP), are likely big factors in this success. Riverside County can now focus on building models that work for people of color, youth, and other marginalized populations.

Medical training pipeline program. Critical to maintaining and expanding HIV medical services is training new providers that are likely to stay in Riverside County. UC Riverside's medical training and residency program has a special emphasis on admitting residents of the Inland Empire who are more likely to stay in their community as practicing physicians. This effort will support the county's HIV infrastructure, especially given the focus on training physicians from the local community.

Solid groundwork laid for PrEP scale-up. RUHS has done initial assessment and education of PrEP providers and PrEP navigators and has begun more focused outreach to populations who have not been previously reached. The county is primed to partner with CBOs to expand this effort, linking these efforts with community engagement strategies, knowing that the priority communities will be more likely to access PrEP if it is promoted by a trusted source. In addition, RUHS is poised to become a PrEP Assistance Program (PrEP-AP) site. In addition, through California Senate Bill 159, pharmacists who complete a specific training can now dispense 60 days of PrEP, increasing access to PrEP initiation.

Good condom access for some populations. Free condoms are widely available through HIV-focused CBOs. RUHS is a *State Clearing House* participant for prevention materials, distributing over 5,000 condoms per year.

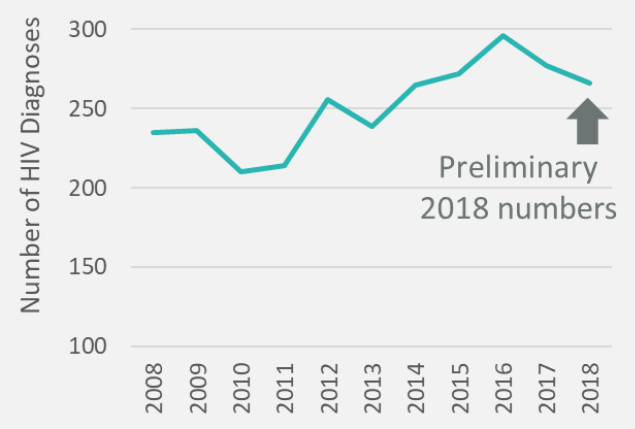
Harm reduction services available despite legal barriers to SSPs. Although there is only one SSP licensed directly through OA, other resources and services for people who use or inject drugs exist, including private pharmacies that sell syringes without a prescription. RUHS

has also equipped its mobile van to accept sharps from community members and the mobile van staff is trained to administer nasal naloxone for opioid overdose.

HIV surveillance protocols. The RUHS Public Health Epidemiology and Program Evaluation Branch provides the latest information on health data, including analysis of HIV trends and issues that impact Riverside County's diverse communities. RUHS is currently strengthening its protocols for linkage to care and for partner services for those diagnosed with HIV and STIs, as part of their integrated surveillance, prevention and care activities.

Declining new diagnoses. Overall HIV diagnoses in Riverside County have fallen 10 percent from a high in 2016 (**Exhibit 21**), primarily fueled by a decrease in HIV diagnoses among older white MSM in East County, where the epidemic has been successfully impacted by ongoing services. In addition, research demonstrates that persons under 25, those in East County, and White cisgender women were at low risk of late testing, improving overall outcomes.[5]

Exhibit 21. New HIV diagnoses in Riverside County



Public health leadership of color. RUHS has people of color and others from affected communities in positions of leadership who understand the need to strengthen the governmental response to prevention and care for B/AA and Hispanic/Latinx communities.

Coordinated planning inclusive of diverse voices. The Inland Empire TGA (San Bernardino and Riverside Counties) engages in coordinated planning that benefits clients living and receiving services in both counties. The Inland Empire HIV Planning Council, whose members focus on a consumer-centered continuum of care, represents both counties. The Planning Council is privileged to have the active and vocal support of individuals who represent the diversity of the community and key populations at risk, including B/AAs, Hispanic/Latinx, and transgender women.

Strong network of providers and support services. In addition to providing HIV care and wrap-around service in its Public Health HIV specialty clinic, RUHS partners with a network of providers and organizations that provide quality HIV-related care and treatment and other resources to patients including Loma Linda Infectious Disease Clinic (youth under 18), Desert AIDS Project, Planned Parenthood, Foothill AIDS Project, and TruEvolution. Some of these partners also provide STI treatment and PrEP. Other partners provide mental health, substance use, housing, transportation, and gender-affirming care services. These CBOs are critical links to the priority populations, especially young MSM of color. Nurturing and supporting the development of these lead organizations to be partners and resources for non-HIV medical providers, can help increase access to services for priority populations.

RUHS Community Health Clinics (CHCs). In addition to its public health arm, RUHS has an integrated system of CHCs offering clinical services. The HIV specialty clinic, which is a separate carved-out clinic within the system, is managed by the HIV/STD Program. With its

broad reach and integrated public health and clinical functions, RUHS has the unique ability to study and report on data obtained from diverse sources, furthering EtHE goals.

Community Action Teams (CAT teams). RUHS has spearheaded a model for community action research through the formation of CAT teams composed of community members. The CAT teams provide leadership opportunities for community members and strengthens data collection through participation in relevant assessments. The CAT teams will be a key resource in leading efforts in underserved regions.

Culturally appropriate behavioral health services. The Riverside University Health System – Behavioral Health Department provides culturally and linguistically competent mental health and substance use services in Riverside County. Their wellness, mental health and prevention programs reach over 50,000 PLWH annually.

Gaps and Challenges

Riverside County has a number of pillar-specific and cross-pillar challenges and gaps that will need to be addressed to reach EtHE goals. For example, current capacity is limited by the fact that there are only a handful of CBOs and clinical providers that provide HIV testing, prevention, and care. Services outside of East County are sparse. Gaps and challenges are summarized in **Exhibit 22.**

Exhibit 22: Riverside County Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Strained community-based testing capacity	●			
Low routine testing in non-HIV clinical settings	●			
Lack of HIV care infrastructure in West, Mid-, and South County		●		
Disparities in linkage to care and viral suppression rates for people of color		●		
No structured community-wide PrEP program			●	
Lack of behavioral interventions for young MSM			●	
Barriers to condom access for youth			●	
No county sanctioned Syringe Services Program (SSP)			●	
Increasing STIs			●	
Lack of real-time HIV surveillance data				●

Cross-Pillar
• Racial equity gaps due to social determinants of health (SDoH) • Insufficient anti-stigma efforts • Uninsured residents • Barriers to health care access • Provider inability to integrate HIV services • Lack of provider cultural competency • Muddled messaging

Strained community-based testing capacity. Current community-based testing efforts are implemented by just a few organizations: AHF, DAP, FLACC, and TruEvolution. No new HIV-focused CBOs have opened in the last 5 years. While these existing organizations can expand, the current economic environment for this expansion is perilous given the COVID-19 pandemic. Current county reimbursement practices require these CBOs to front considerable operational costs, which is also a barrier to recruiting new agencies. RUHS is working within its structure to mitigate this barrier and is close to a resolution.

Low routine testing in non-HIV clinical settings. RUHS has worked hard to establish routine HIV screening in the CHC network, but HIV screening in other non-HIV clinical settings is not a universal routine practice. Individual provider attitudes and behaviors are the main reported barriers to implementing routine testing in primary care and emergency room settings. Community engagement participants shared a number of personal stories about providers being resistant to order an HIV test, even at the direct request of the patient. In some cases, clinicians only ordered testing after patients had progressed to AIDS. Routine testing is an evidence-based strategy that can reduce late testing, which is associated with increases in HIV transmission and HIV-related death.

Lack of HIV care infrastructure in West, Mid-, and South County. There is a gap in access to HIV care due to a lack of HIV providers and other HIV infrastructure in West, South and Mid-County. As a result, patients must travel long distances and multiple hours for medical appointments. Current HIV care services lack the ability to increase their medical appointment capacity to address the increasing new HIV infections in these regions. This jeopardizes fast linkage to care for newly diagnosed individuals and/or sustaining care for those already in care. In addition, community engagement participants noted that culturally and linguistically appropriate care is hard to find.

Disparities in linkage to care and viral suppression rates for people of color. In 2018, B/AA and Hispanic/Latinx individuals had marked disparities in one-month linkage to care rates. B/AAs also have lower 6-month viral suppression rates compared with other race/ethnicities.

No structured community-wide PrEP program. Throughout California, a gap exists between the number of people who are PrEP-eligible and the number of people actually using PrEP. Comments in community engagement sessions suggest that there is not enough PrEP information specifically designed for young MSM of color or enough PrEP navigators to support PrEP retention beyond 6 months. PrEP initiation and retention relies on support for clients that includes contingencies for starting, stopping and re-enrolling in the program.

Lack of behavioral interventions for young MSM. There is a lack of funded behavioral interventions aimed at young MSM and deployed to the key need areas in West, South and Mid-County. These behavioral interventions are needed as part of an overall strategy for reaching and serving this population.

Barriers to condom access for youth. Not all school districts allow condom availability programs. Schools with school-based health centers are more likely to offer comprehensive sexual health education and contraceptives. Limits on condom availability includes not being able to offer them unless a high school student asks for them, has already been pregnant, or has had an STI.

No County-sanctioned Syringe Services Program (SSP). There is only one sanctioned SSP in Riverside County and no county funds support these services. Syringe access is the most effective and most strongly evidence-based intervention available to reduce transmission of HIV and HCV among PWID; therefore, this is a significant gap. Although there are currently low rates of new HIV diagnoses among PWID in Riverside County, this could change rapidly and has been observed recently in other California counties.

Increasing STIs. Upward trends in STIs represent an indicator of condomless sex, which is also a risk factor for acquiring or transmitting HIV in the absence of PrEP use and viral suppression. Increasing syphilis cases among MSM, a trend seen in urban areas across the country are also present in Riverside County. Men make up more than 90 percent of all syphilis cases in Riverside County.[37] In 2018, the overall syphilis rate for Riverside County was 12 per 100,000.[37] That year North Palm Springs had the highest rate of syphilis in Riverside County at 185 cases per 100,000 population, but there have also been recent spikes in Coachella Valley.[37] While Whites make up the highest number of syphilis cases in the Coachella Valley, B/AA have the highest rate of infection at 67.1 per 100,000 population.[37] Increasing repeat STI infections are not only an important indicator of community-level risk, but also a potential missed opportunity to link individuals at substantial risk for HIV to PrEP.[38]

Lack of real-time HIV surveillance data. Without real-time surveillance data, the county is limited in its ability to use the data for client referrals to prevention and care. The State HIV surveillance database eHARS is used to refer clients to prevention or care services in Riverside County, monitoring individuals monthly who do not have lab results in the last 12 months. CalREDIE is currently only used for other STI data tracking. The EtHE Coordinator hired by RUHS will be responsible for guiding and strengthening linkage to care and partner services protocols using surveillance data.

Racial equity gaps due to social determinants of health (SDoH). SDoH are the broader social factors that influence health outcomes. Experiences with racism, discrimination, and trauma can create barriers to services and access for individuals. SDoH associated with poor health outcomes are more prevalent in the regions and populations from which the majority of new diagnoses are occurring. Not coincidentally, most new diagnoses are among people of color who are also more likely to live in the underserved areas of the county and more likely to be impacted by other SDoH such as poverty, homelessness, and substance use. The divide between wealthier, whiter, well-resourced East County, where new HIV diagnoses are declining and the service deserts that are home to many of the county's people of color, where new diagnoses are increasing, is indicative of how systemic racism has impacted HIV in Riverside County.

Insufficient anti-stigma efforts. Community and Planning Council members noted that stigma is a significant barrier to receiving services. Stigma may create barriers to testing—fear of being identified as someone with HIV or at risk for HIV--may prevent people from testing at all, or it may lead them to seek testing or treatment outside their own community. HIV-related stigma may also create a barrier to assessing one's own risk. Outreach and research can help or harm anti-stigma goals and so must be planned and interpreted carefully, with community participation. Education and partnership with faith leaders and use of popular figures such as Magic Johnson were noted as strategies for possible anti-stigma work.

Uninsured residents. The U.S. Census Bureau estimates that in 2019, 9.1 percent of Riverside County residents were uninsured.[39] This lack of insurance creates different tiers of care and affects decisions to access or continue health care. In a review of data from 2009-2014, being uninsured and Hispanic/Latinx were significant risk factors for late HIV testing.[5] Another factor that affects individuals' ability to obtain health care is the inflexibility of insurers and the difficulty of switching between providers and counties. Advocacy from the state could help to mediate this barrier by negotiating more fluid transfers to care with Medi-Cal and other insurers. Riverside will work with the state to lower barriers related to transferring Medi-Cal when moving from one county to another and other impediments experienced on state sponsored insurance plans.

Barriers to health care access. An inequitable distribution of providers and services in Riverside County affects the ability of residents to access health care, particularly in the South and West regions of the county. This is complicated by the county's large geographic area. Services are clustered in the eastern and mid sections of the county, sometimes requiring trips of up to 40 miles to get to a specific provider—leading to missed appointments and falling out of care. The Consumer Caucus cited transportation as the number one priority in their 2019 needs assessment.[14] Other needs, especially for youth, included peer navigators and warm handoffs to link people to services. In some cases, lack of access contributes to people seeking health care only in urgent/emergency situations especially among communities of color who live far from services. Improved cultural competency and patient and provider education are possible approaches to reducing barriers accessing regular and preventive medical care for these populations.

Provider inability to integrate HIV services. Compounding the issues presented by inequitable access to healthcare is the fact that many Riverside County providers do not make HIV education and testing a regular part of the Comprehensive Physical Exam. Increasing routine HIV screening will assist in identifying the thousand individuals estimated to be living with undiagnosed HIV infection. Lack of routine screening limits the potential for education and HIV diagnosis, particularly for young people, and is a potentially contributing factor in the increased incidence of HIV in persons under age 30. This is exacerbated by the lack of peer navigators in clinics to act as guides and advocate for care and to help mediate the relationships between the provider and the patients most likely to fall out of care. RUHS believes that improved provider education could help to improve HIV education and testing, particularly if providers are incentivized through a "report card" or other evidence-based method for achieving quality improvement.

Lack of provider cultural competency. Many providers in Riverside County do not reflect the communities they serve and are not culturally competent. This produces a health care system in which clients feel unwelcome or are uncomfortable accessing. Currently, there are no trainings

or incentives to become culturally competent, nor do private or public insurers such as Medi-Cal require cultural competence.

Muddled messaging. Community engagement data suggest that the messages that substantial risk clients receive from providers in Riverside County contain fear-based rather than sex-positive and destigmatizing messaging. For Riverside County to be successful in expanding PrEP use, especially among communities of color, fear-based messaging will not work. Future PrEP messaging must be consistent, culturally relevant, and thoroughly tested with the intended populations and audiences. Provider education should include how undetectable=untransmissible, often referred to as U=U, can be used in discussions of whole-person health and can be a useful frame for educating and making referrals to PrEP and HIV care.

Section IV: Ending the Epidemic Plan

This section provides a detailed overview of the disruptively innovative activities that Riverside County will implement to End the HIV Epidemic by 2025. The proposed EtHE activities are above and beyond the foundational efforts already in place and are designed to be directly responsive to the needs and gaps identified in *Section III: Situational Analysis.* The proposed EtHE activities are designed to enhance but not duplicate current programs and services and are inclusive of all disruptively innovative activities, regardless of funding source.

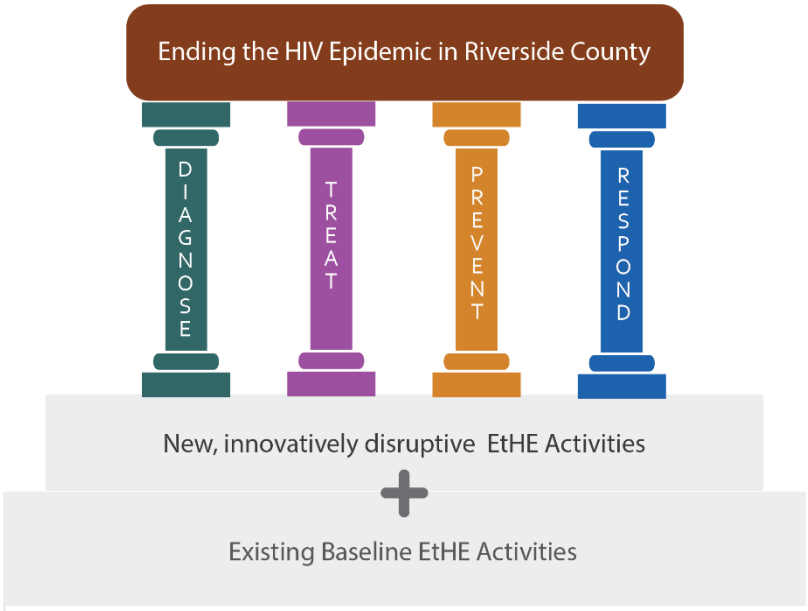


Exhibit 23. Schematic of how new EtHE activities in Riverside County will build upon existing efforts to respond to local needs and gaps not sufficiently addressed to date.

EtHE Programs and Key Partners

Riverside County has identified eight new innovative efforts that will help propel us toward ending the HIV epidemic. These efforts will require close partnership with several existing as well as new partners to be successful. The programs and partners are described below. While the testing interventions below are described in the *Diagnose* pillar, RUHS understands that testing referrals to PrEP and HIV treatment make these relevant interventions for the *Treat* and *Prevent* pillars as well.

Summary of Proposed Programs

- **Testing Initiative for Young MSM of Color.** This activity will work with CBOs who serve young MSM of color to offer HIV testing, linkage to care, and linkage to PrEP. Riverside is experiencing an increase in HIV diagnoses among persons of color and persons under the age of 30 (especially MSM); this strategy will also help us identify people living with HIV who are currently unaware of their HIV status. Use of a social network strategy will be part of the Initiative. The CBOs are a critical factor for success in reaching young men of color, and RUHS is committed to nurturing and growing their capacity. Key to this model will be partner services and testing services offered though friendship networks.[40,41] *(Diagnose Pillar)*
- **Home Testing** kits mailed to clients. The State will provide the test kits in a pilot conducted by Building Healthy Online Communities and NASTAD, and RUHS staff will provide linkage to care and prevention/PrEP referrals. In addition, the county will

purchase home test kits using PS18-1802 funds to expand home testing in Riverside County. *(Diagnose Pillar)*

- **Sexual Health Provider Education and Incentive Program.** This program will educate and incentivize providers to obtain a comprehensive sexual health history from their patients and offer routine testing and PrEP referrals. This will increase use of PrEP to prevent HIV and help patients become aware of their HIV status. In addition, it will provide Riverside with a dedicated staff member to conduct PrEP-related provider trainings and education. (*Diagnose, Prevent)*

- **Rapid StART Program.** This program will promote rapid ART starts to newly HIV diagnosed individuals during their first HIV clinic visit along with a RAPID starter pack with a 30-60 day supply of medication at that same visit. The program will also provide door-to-door transportation from home to the clinic accompanied by an HIV staff member for clients who have fallen out of care or who are not virally suppressed. This will support better viral suppression among PLWH. *(Treat)*
- **PrEP Expansion Through Navigation and PrEP-AP.** RUHS will train all CDS staff—which include STD, prevention, surveillance, and linkage to care staff to become PrEP navigators. This will ensure that all staff are prepared to help PrEP-eligible clients access PrEP. The county will also apply to CDPH OA to become a certified PrEP-AP site. Having the capacity to enroll clients into the new PrEP-AP will expand PrEP access to county clients. (*Prevent)*
- **Network investigation and intervention**. This strategy will use surveillance data to identify people with new HIV diagnoses and interview the newly diagnosed to identify their partner contacts for the purpose of targeting intervention efforts to potential transmission networks. Targeted intervention will result in a more efficient use of funds while slowing transmission between network members. This team will also work closely with the CDPH Disease Outbreak Intervention and Field Investigation Unit (DOIFI) if a detected outbreak exceeds the ability of local response resources to manage. *(Respond)*

- **Collaboration with the California Regional Quality Group (CARG).** Collaboration members include HIV providers across the local region including members from Los Angeles, Orange, San Bernardino, in addition to Riverside County. This group works together to improve HIV care. CARG focuses on increasing viral suppression rates for priority populations through quality improvement initiatives. CARG successfully increased viral suppression rates among MSM of color in 2019. In 2020, some members are focusing are women, and some on young MSM. RUHS participates in meetings and learning sessions for CARG, and regularly reports viral suppression performance data twice a month, among other responsibilities. This initiative began as part of the HRSA funded *end+disparities ECHO Collaborative* at the Center for Quality Improvement & Innovation. *(Treat)*

- **CHIPTS CFAR Project: Regional Response to HIV Eradication Efforts in Southern CA Counties.** Riverside County is participating, along with Los Angeles, Orange, and San Bernardino Counties, in a CHIPTS CFAR study led by Stephen Shoptaw titled *Regional Response to HIV Eradication Efforts in Southern CA Counties.*[26] The proposal is the first effort to build linkages between public health departments, clinicians, researchers, stakeholders, and communities living with or at risk for HIV to address the HIV epidemic in Southern California. It aims to support regional data coordination and sharing that would guide scale-up of large, implementation science projects designed to

reduce new HIV infections across the four counties. This effort has high impact because the four targeted counties represent about half of the population and half of new HIV cases in California. Three specific aims are proposed: (1) to identify barriers and facilitators to HIV surveillance data coordination within the counties (2) to examine techniques for HIV surveillance to identify “hot spots” to guide allocation of prevention resources and trim the outbreak; (3) to engage stakeholders and policy makers to scale-up surveillance tools (such as molecular epidemiology) to control micro-epidemics across the region. (Respond)

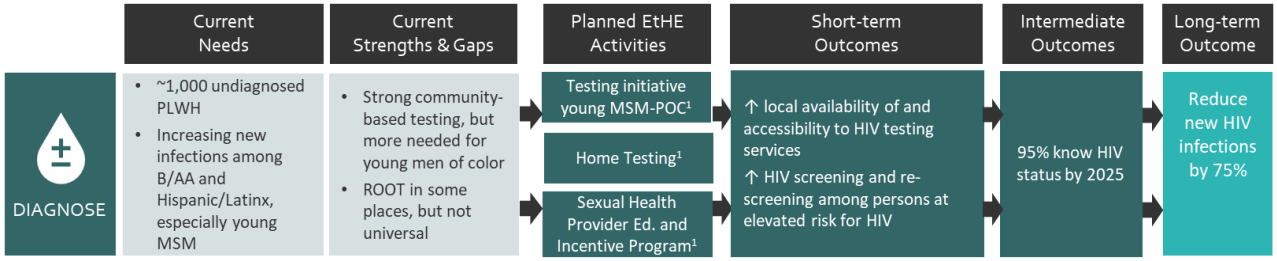
Key Partners

- **Building Healthy Online Communities.** Our collaboration with Building Healthy Online Communities will provide needed capacity and expertise in our efforts to increase access to home testing kits and expand our reach to those seeking sexual health information and testing online, as well as providing messages to young gay/MSM using the various gay dating sites.
- **Desert AIDS Project.** Desert AIDS Project (DAP) is a Federally Qualified Health Center offering HIV prevention and STI treatment services, as well as comprehensive HIV care and wellness services. They have been a part of the Coachella Valley community since 1984.DAP has successfully raised and managed private donations from wealthier MSM. Beginning serving mostly middle- and upper-income white MSM, it is transitioning to serve a majority of low-income, medically-underserved low-income community members. DAP has partnered with RUHS-PH to provide home health and support services for PLWH through Ryan White Care funding for over 20 years.
- **Foothill AIDS Project.** Foothill AIDS Project has offered integrated support services and chronic care management to persons living with or at risk for HIV in western Riverside, San Bernardino, and Los Angeles Counties since 1987. Foothill AIDS Project collaborates with the RUHS HIV specialty care EIP clinic by providing support services.
- **Inland Empire Health Plan.** Inland Empire Health Plan is the largest Medicare-Medicaid plan in the country, with over 1.2 million members and 6,000 providers. Their focus on innovation and quality makes them an ideal partner for collaboration on the development of a PrEP online training program. Incentivizing their providers to learn about and prescribe PrEP will allow us to access their large patient base. The county surveillance team can work with the Inland Empire Health Plan to calculate an overall viral suppression rate for their members living with HIV, as well as any differences seen among different genders, ethnicity and races, ages, and behavioral risks. The health plan may also be able to provide information on the providers who are treating large numbers of PLWH, so partner services can target specific clinics.
- **Other community-based testing partners.** The following partners have also built long-standing relationships in the community by providing key services such as HIV testing, harm reduction, food, housing referrals, alcohol and other drug counseling, and mental health services.
    - Riverside Community Health Foundation
    - Community Health Systems Inc.
    - Planned Parenthood of the Pacific Southwest
    - Riverside/San Bernardino County Indian Health Inc.
    - Sweet Dreams Offender Reentry Program

- **Riverside University Health System CHCs.** Riverside University Health System's Community Health Centers provide primary care at the Riverside Neighborhood Health Center, Perris Family Care Canter, and Indio Family Care center locations, where Public Health HIV care clinics are collocated, as well as other Community Health Centers throughout the county. RUHS Public Health is actively engaging ROOT within the RUHS CHCs.
- **TruEvolution.** TruEvolution has fought for health equity and racial justice since 2008. They currently provide comprehensive HIV health services including testing, PrEP services, linkage to care, mental health services, and case management, as well as emergency supportive housing for PLWH. Their longstanding ties to the western part of the county will be invaluable in reaching out to the community. TruEvolution will continue to provide outreach, testing, psychological support, and access to housing to priority populations.

Riverside County's Plan to End the HIV Epidemic

Diagnose



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed Programs are described in detail in the EtHE Programs and Key Partners section beginning on page 37. A list of programs related to this pillar is below.

- **Testing Initiative for Young MSM of Color**
- **Home Testing**
- **Sexual Health Provider Education and Incentive Program**

Diagnose: Riverside County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities	
Sexual Health Provider Education and Incentive Program	
• Develop a provider detailing plan to encourage providers to obtain a comprehensive sexual health	• Implement provider detailing with 30 providers (Years 2-5) in West County targeted areas.

Diagnose: Riverside County	
Year 1 Activities	**Year 2-5 Activities**
history and **encourage routine HIV testing** and PrEP referrals. • Hire and train PrEP navigator(s) to develop a toolkit for the detailing program with resources for obtaining sexual health history and PrEP education. • Collaborate with Inland Empire Health Plan (IEHP) to develop an incentive program for providers to embrace PrEP and offer PrEP to high-risk individuals. • Develop a MOU with IEHP to offer a CME incentive program to IEHP providers who attend a PrEP education webinar.	• Implement CME training and provider PrEP incentive programs. • Update toolkit as needed.
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non- healthcare settings **Strategy 1C.** Increase to at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings	
Testing Initiative for Young MSM of Color	
• Use epi/surveillance data to determine high morbidity areas. • **Identify CBOs** who serve targeted populations within those areas. • **Develop MOUs** with identified CBOs **to offer/ provide HIV testing** and STD and HCV screening when possible, and train them on HIV testing, linkage to care, and linkage to PrEP protocols. • Identify other locations based on epi data where a mobile unit could be deployed. • Develop outreach materials. • Develop a campaign to promote free to **user at home testing**, partnering with Building Healthy Online Communities (BHOC) to increase access to Home Testing kits through gay dating apps/websites and digital/media campaigns.	• Track outcomes, including number of persons tested, linked to PrEP, linked to HIV care, and number of test kits ordered. • Conduct outreach to young MSM of color to let them know about the new services. • Provide testing in 10 new locations in the Western Region of Riverside County (CBO based or mobile unit) to conduct regular and consistent targeted outreach and testing for Hispanic/Latinx and B/AA MSM. • Implement home testing campaign and provide free test kits.
Home Testing	
• Offer RUHS -STD clinic clients and other EtHE priority populations HIV test kits mailed to their home or preferred location. If home test kits for STDs and/or HCV are available, include those for both HIV and STD clinic clients. • Develop home testing pilot program protocol. • Develop centralized system for HIV test kit ordering, distribution and results. • Forge partnerships with RUHS Divisions to coordinate and fund HIV test kits and system infrastructure. • Create partnerships with CBOs who engage with priority populations and can promote HIV testing to their clients.	• Implement pilot program. • Engage at least 50 patients per year from priority populations.

HIV Workforce Development Needs

Positions

- **Community Outreach Worker/Communicable Disease Specialist (CDS).** A unit of no fewer than five members, including a Senior CDS to act as a team supervisor, is needed. These team members will collect and maintain epi/surveillance data, use the data to determine high morbidity areas, and identify CBOs who serve priority populations within those areas. They will also conduct regular and consistent outreach and testing using the mobile test unit. They are required to complete CDS training through the California Pacific Training Center, who holds the national contract to train disease intervention specialists, or a state training if offered.
- **Health Educators/PrEP Navigators.** These specially trained CDSs will edit and finalize all sexual health history and PrEP tools for providers, build provider relationships, provide training and education, and work with providers to encourage routine testing and ensure appropriate linkage to care.
- **Peer Navigators.** Peer Navigators who share identities with the communities they serve will be positioned in every clinic to increase PrEP awareness and uptake among priority populations. A training program including information about HIV, PrEP, testing, and boundaries and limits will be provided.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, Riverside County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience to increase our capacity to reach these priority populations. Provider education programs will build provider skills and capacity for routine testing and PrEP to all staff described above and follow-up technical assistance will help ensure implementation.

Key Partners

Key Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 41. A list of those related to this pillar is below.

- **Building Healthy Online Communities**
- **Desert AIDS Project**
- **Foothill AIDS Project**
- **TruEvolution**

Funding

Program/Effort	Total Funding	Proposed Funding Source

Testing Initiative-Young MSM-POC	$1,263,239.00	CDC PS20-2010
Sexual Health Provider Ed. and Incentive Program		
Home Testing		
TOTAL FUNDING FOR DIAGNOSE PILLAR*	$1,263,239.00	

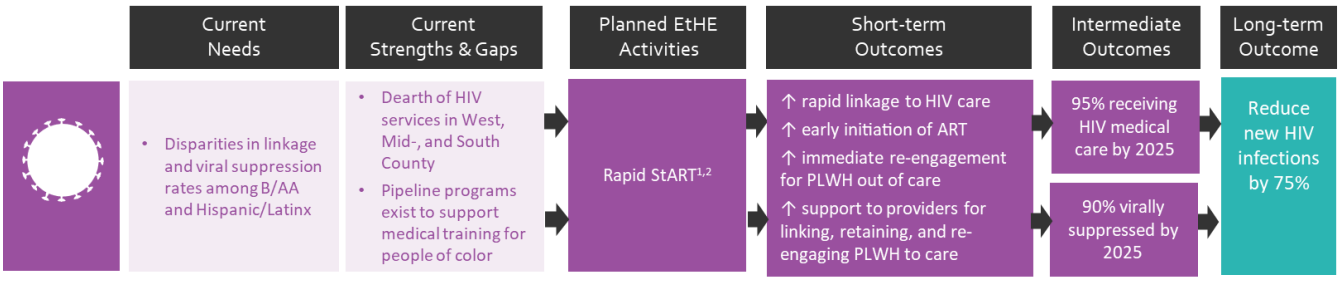
- *$0 exclusively for Diagnose Pillar, and $1,263,239.00 for programs that cut across Diagnose and other pillars. Only RUHS controlled funds.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[33] Targets will be determined in coordination with CDC as the EPMP is finalized.

Diagnose: Riverside County	
Outcome Measure	**Data Source**
Percent of health care facilities identified as priority for routine opt-out HIV screening*	Program reports utilizing Surveillance Data
Percent of HIV tests conducted in healthcare facilities identified as a priority for the EtHE testing services*	ARIES or LEO
Number of non-traditional venues conducting HIV testing†	Records of HIV testing events
Percent of HIV tests conducted in non-traditional venues identified as a priority for the EtHE testing services†	Records of HIV testing events
Number of HIV self-test kits distribution events planned†	Records of HIV self-test kits distribution events
Number of events where HIV testing is bundled with screening for other conditions relevant to the local population†	Records of HIV testing and medical screening events
Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings†	Documentation of strategies utilized
Percent of all persons testing HIV+ in non-traditional test settings linked to HIV medical care within 30 days†	Linkage to care records
Percent of all persons testing HIV- in non-traditional test settings linked to appropriate prevention services†	Linkage records
Systems are developed to routinely identify patients with elevated risk for HIV and order HIV tests at least 4 months†	Documentation of systems and HIV testing orders
Number of “champions” who lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population†	Program reports
Documentation of promoting rapid HIV self-test programs in both healthcare and non-healthcare settings that can offer HIV rapid self-tests to persons at ongoing risk†	Record location sites and type, as well as the number of weeks the promotion took place at each location.

Treat



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed Programs are described in detail in the EtHE Programs and Key Partners section beginning on page 37. A list of programs related to this pillar is below.

- **RAPID StART Pack and Retention Program**

Treat: Riverside County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)	
RAPID StART Pack and Retention Program	
• Train additional Early Intervention Program clinic staff (medical staff, Case Manager, Social Workers, Communicable Disease Specialists, Health Education Assistants and Office Assistants) in **linkage to care** procedures and best practices to start and keep HIV clients in care. • Increase available **walk-in appointment slots** for new HIV diagnosis. • Stock HIV medication **starter packs**. • **Start ART on first visit** to HIV Clinic for newly diagnosed clients and provide a 30-60 day starter pack of medication. • **Provide door to door transportation** accompanied by an HIV staff member for clients who have fallen out of care or are not virally suppressed.	• Develop and track viral load suppression rates for clients who have been previously unsuppressed with an initial goal of 50 percent viral suppression. • Evaluate and refine efforts.
Collaboration with California Regional Quality Group (CARG)*	
• Work with regional providers who are part of CARG to **implement quality improvement strategies** to increase viral suppression rates for patients in care but who do not achieve and sustain viral suppression. • Participate in CARG meetings and learning sessions for CARG. • Report viral suppression performance data twice a month, among other responsibilities.	• Continue to participate in CARG. • Select and implement new quality improvement initiatives.

***** Note: This initiative started as a part of the HRSA funded *end+disparities ECHO Collaborative* at the Center for Quality Improvement & Innovation. It continues independently with TA from CCII, PAETC, PTC and other CBA providers.

HIV Workforce Development Needs

Positions

- **Medical Doctor or Physician's Assistant.** Adding this position will increase the number of available providers to treat clients in RUHS facilities.
- **Communicable Disease Specialist (CDS).** Filling vacant CDS positions and adding new staff will allow for us to provide Linkage to Care and PrEP Navigation services.
- **Linkage to Care Training.** We will provide additional training to medical staff, Case Managers, Social Workers, CDSs, HEAs, and Office Assistants in Linkage to Care procedures to start and keep HIV clients in care.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs

Capacity-Building

When building capacity, Riverside County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience to increase our capacity to reach these priority populations. Provider education programs will build provider skills and capacity for linking HIV clients to care, and follow-up technical assistance will help ensure implementation.

Key Partners

Key Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 41. A list of those related to this pillar is below.

- **Desert AIDS Project**
- **Foothill AIDS Project**
- **Riverside University Health System CHCs**
- **TruEvolution**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Rapid StART Program	$1,290,390.00	CDC PS20-2010
	$1,000,000.00	HRSA 20-078-TGA Wide
TOTAL FUNDING FOR TREAT PILLAR*	$2,290,390.00	

- *$0 exclusively for Treat Pillar, $2,290,390.00 for programs that cut across Treat and other pillars. Only County-controlled funds.

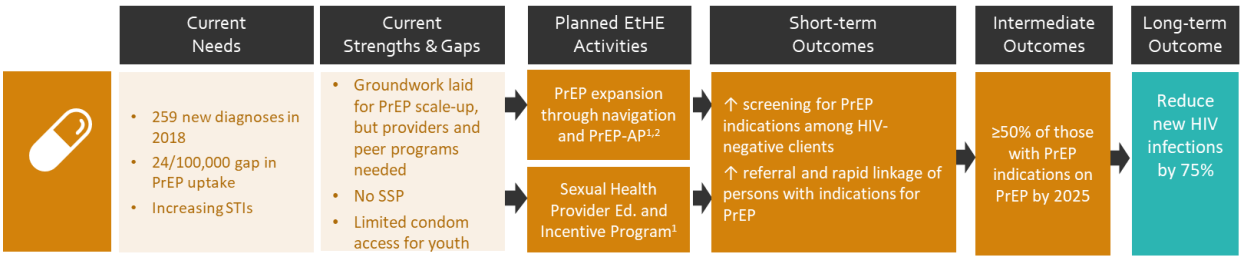
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[33] Targets will be determined in coordination with CDC as the EPMP is finalized.

Treat: Riverside County	
Outcome Measure	**Data Source**
Number of programs supporting and promoting rapid linkage and Rapid ART by providers in non-Ryan White HIV/AIDS Program facilities.	Linkage and ART program documentation.
Number of clients provided with case management and other support services. †	ARIES, Case management and support services records.

†Rapid StART Program

Prevent



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed Programs are described in detail in the EtHE Programs and Key Partners section beginning on page 37. A list of programs related to this pillar is below.

- **Sexual Health Provider Education and Incentive Program**
- **PrEP Expansion Through Navigation and PrEP-AP**

Prevent: Riverside County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	
Sexual Health Provider Education and Incentive Program	
• Develop a provider detailing plan to encourage providers to obtain a comprehensive sexual health history and **encourage** routine HIV testing and **PrEP referrals.** • **Hire and train PrEP navigator(s)** to seek out and/or develop a toolkit for the detailing program with resources for obtaining sexual health history and PrEP education. • Collaborate with Inland Empire Health Plan (IEHP) to develop an **incentive program for providers to** embrace PrEP and **offer PrEP** to high-risk individuals. • Develop a MOU IEHP to offer a **CME incentive program** to IEHP providers who attend a PrEP education webinar.	• Implement provider detailing with 30 providers (years 2-5) in in West County targeted areas. • **Implement CME training and provider PrEP incentive programs.** • Update toolkit as needed.
PrEP Expansion Through Navigation and PrEP-AP	
PrEP Navigation • Develop protocol for **tracking number of patients started on PrEP and maintained on PrEP.** • Recruit and hire new CDS by December 2020. • Train all Communicable Disease Specialists (CDS) staff (STD, prevention, surveillance, and LTC) to become **PrEP navigators**, so that however, and wherever, we encounter persons who are HIV negative, they can quickly be evaluated for and started on PrEP.	**PrEP Navigation** • Assist at least 20 persons with accessing PrEP annually.
PrEP-AP • Apply to **become a PrEP Assistance Program** (AP) enrollment site through the Office of AIDS and become certified.	**PrEP-AP** • Link at least 15 clients to PrEP using PrEP-AP annually.

Prevent: Riverside County	
Year 1 Activities	**Year 2-5 Activities**
• **Hire enrollment worker**. • **Enroll clients in PrEP-AP**.	

HIV Workforce Development Needs

Positions

- **Health Educators/PrEP Navigators.** These specially trained staff will edit and finalize all sexual health history and PrEP tools for providers, build provider relationships, provide training and education, and work with providers to encourage routine testing and ensure appropriate linkage to care.
- **Communicable Disease Specialist (CDS).** Recruit and train one additional STD CDS to allow us to provide referrals to additional PrEP Navigation services.
- **Enrollment Worker.** The enrollment worker will be trained and certified to enroll clients in PrEP-AP.
- **PrEP Navigation Training.** We will provide additional training to all CDSs in PrEP Navigation procedures so persons who are HIV negative can be rapidly evaluated for and started on PrEP, regardless of where they are seen.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, Riverside County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience to increase our capacity to reach these priority populations. Provider education programs will build provider skills and capacity for linking clients with HIV to care. Follow-up technical assistance will be provided to help ensure implementation.

Key Partners

Key Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 37. A list of those related to this pillar is below.

- **Desert AIDS Project**
- **Foothill AIDS Project**
- **Inland Empire Health Plan**
- **Riverside University Health System CHCs**
- **TruEvolution**

Funding

Program/Effort	Total Funding	Proposed Funding Source
PrEP Expansion	$1,290,390.00	CDC PS20-2010
Sexual Health Provider Education and Incentive		
Home-based HIV Testing		
TOTAL FUNDING FOR PREVENT PILLAR*	$1,290,390.00	

- *$0 exclusively for Prevent Pillar, and $1,290,390 for programs that cut across Diagnose and other pillars. Only RUSH controlled funds.

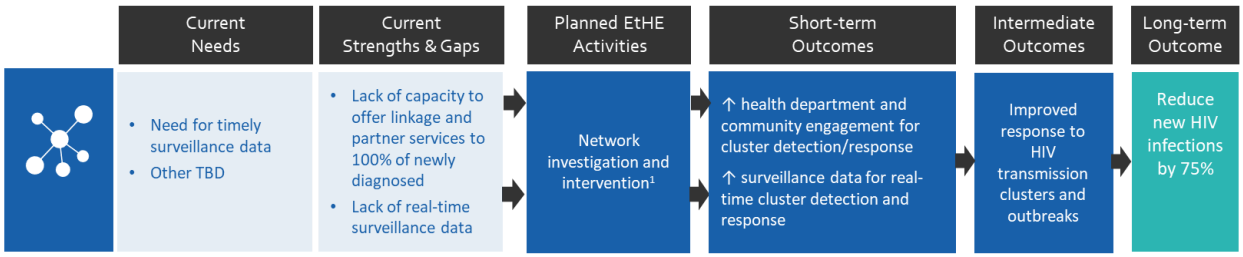
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[33] Targets will be determined in coordination with CDC as the EPMP is finalized.

Prevent: Riverside County	
Outcome Measure	**Data Source**
Percent of persons hired as PrEP detailers. *	Hiring records.
Number of newly-trained PrEP detailers. *	Training records.
Number and percentage of clinicians prescribing PrEP within 3 months following detailing visit(s). *†	Detailing and prescribing records.
Number of HIV-negative clients who are screened for PrEP. *†	Patient charts. and PrEP negative records
Number and percentage of HIV-negative clients with indications for PrEP who are linked to PrEP provider. *†	Patient charts.
Number of persons prescribed PrEP among those with indications for PrEP. *†	Patient charts.
Number of persons who fill the prescription. *†	
Number of persons still taking PrEP after three months	
Implementation of locally-specific insurance and cost-assistance navigation protocols for PrEP patients. †	PrEP Navigation protocols.
Number of clients enrolled in PrEP-AP.†	Patient charts.

*Sexual Health Provider Education and Incentive Program
†PrEP Expansion Through Navigation and PrEP-AP

Respond



1. CDC PS20-2010; 2. HRSA 20-078

Proposed Programs and Efforts

Proposed Programs are described in detail in the EtHE Programs and Key Partners section beginning on page 37. A list of programs related to this pillar is below.

- **Network investigation and intervention**

Respond: Riverside County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response	
Continue to participate in the State Surveillance System, submitting data through the E-HARS system.	Ongoing
Strategy 4B. Investigate and intervene in networks with active transmission	
Network Investigation and Intervention	
• Recruit and hire Office Assistant to support logistics and data entry/management. • Develop **protocol for HIV investigation and follow-up.** • **Assess incoming labs/reports** to determine new diagnoses and refer to case manager for PS/network identification. • Contact providers to identify patients with new HIV diagnoses and refer them to a case manager who will interview the patient to identify contacts for partner services, and to **identify any networks of transmission.** • **DIS shall Interview 80 percent of all newly diagnosed patients** within 30 days of receipt of labs and/or case reports.	• Continue to identify partners and possible transmission networks, and conduct patient follow-up. • Evaluate efforts and use findings to improve process.
Strategy 4C. Identify and address gaps in programs and services revealed by cluster detection and response	
Participate in debrief meetings post cluster investigation	Ongoing

HIV Workforce Development Needs

Positions

- **Office Assistant (OA).** The OA will support logistics and data entry/management.

- **Case Identification Training.** We will provide additional training to all surveillance CDSs on working with providers to identify patients with new HIV diagnoses and referral of those patients to the CDS.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

Provider education programs will build provider skills and capacity for data to care and prevention referrals.

Key Partners

Key Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 37. A list of those related to this pillar is below.

- CDPH Office of AIDS Disease Outbreak Intervention and Field Investigation Unit (DOIFI)
- CDPH Office of AIDS Surveillance Branch
- Pacific AIDS Education and Training Center

Funding

RUHS does not have funding exclusively identified for the RESPOND Pillar, however funding across the other Pillars will support staff, including additional Communicable Disease Investigators, who would play a vital role in cluster response efforts.

Program/Effort	Total Funding	Proposed Funding Source
Network investigation and intervention	$1,290,390.00	CDC PS20-2010
TOTAL FUNDING FOR RESPOND PILLAR*	$1,290,390.00	

- *$0 exclusively for Respond Pillar, and $1,290,390.00 for programs that cut across Respond and other pillars. Only CDPH controlled funds.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[33] Targets will be determined in coordination with CDC as the EPMP is finalized.

Respond: Riverside County	
Outcome Measure	**Data Source**
Cluster data provided by the State Office of AIDS is reviewed and prioritized, response is guided and reviewed, procedures are modified to improve responses.	Reports of committee and community meetings, after action review meetings.
Percent of all persons with diagnosed HIV infection who are entered into the local surveillance system within ≤30 days of date of diagnosis.	Surveillance system.

Percent of laboratory results that are entered into the surveillance system ≤ 14 days after the results are received.	Surveillance system.
A data system is developed to rapidly analyze, integrate, visualize, and share data in real time.	Data system documentation.
A flexible funding mechanism is developed to allow reallocation of resources for a response within one month.	Funding mechanism documentation.
Implementation of methods to understand the entire network, including people with diagnosed HIV, undiagnosed HIV, or at substantial risk for HIV infection or transmission.	Methodology documentation.
Processes and mechanisms are developed to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, for people in cluster networks.	Documentation of processes and mechanisms.
Progress in number of known cluster individuals contacted, number of partners solicited, number of partners tested, and the outcomes will be reported to CDPH OA weekly until the investigation is closed.	Documentation of submission.

Section V: Concurrence

RUHS has chosen the Inland Empire HIV Planning council (IEHPC) as its concurrence body. The IEHPC is comprised of consumers, providers, community members, public health staff, and academic partners. It covers the geographic region (Inland Empire Transitional Grant Area – TGA) of both Riverside and San Bernardino Counties, with the co-chair transitioning between the two County Health Officers on an annual basis.

The mission of the IEHPC is *to maintain the optimum health of all those living with HIV/AIDS in Riverside and San Bernardino Counties through the development and implementation of a comprehensive, consumer-centered continuum of care.* The concurrence process was completed in consultation with the IEHPC and was consistent with the CDC 19-1906 guidance.

The 19-1906 EtHE accelerated planning year was presented to the IEHPC at a general

- Demonstrated best efforts to get community input in the most challenging of circumstances given COVID-19 response; and
- Included a review of the most recent epidemiological data, and subsequent focus on key populations for whom the existing HIV prevention and care services are not sufficient; and
- Included interventions and services to populations and regions in Riverside County where few services currently exist; and
- Assured community engagement will continue to be a vital part of implementation of this plan for the next 5 years.

membership meeting on November 14, 2019. The IEHPC provided early guidance and assistance with community engagement activities in Riverside and San Bernardino Counties, and members also helped interpret the findings of these events. The IEHPC received Draft-3 of the EtHE Plan on June 12, 2020 via email and were allowed a 3-week comment period. Additionally, an overview of the Riverside County EtHE Plan was presented on June 25, 2020 and the IEHPC had the opportunity to ask any clarifying questions and react to the document and the process. At this meeting, the IEHPC voted to approve Draft-3 as their concurrence document. Draft 3 included all essential elements of the plan, including the priority populations, proposed activities, the situational analysis and epi profile. The IEHPC approved the process used to develop the final EtHE plan. They also agreed that the IEHPC had been kept appraised of the progress of EtHE plan and had been an active partner in the development of content. **The criteria the Council used to grant concurrence of the EtHE plan included the following**:

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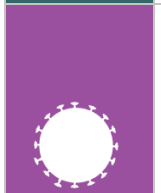
Appendix 1: Resource Inventory

Exhibit 24 lists the services and programs currently available in Riverside County along with their funding sources, by pillar.

***Exhibit 24*:** Riverside County Baseline HIV Activities and their Funding Sources

Pillar	Baseline Program/Activity	Funding Sources
	• Promotion of routine-opt out testing (ROOT) in clinical settings[i] • Testing at community-based organizations (CBOs)[i] • Targeted outreach to link high priority populations to testing • Expanded partner services to support linkage of partners to testing	i. CDC PS-18-1802 ii. HRSA Ryan White Part A iii. HRSA Ryan White Part B (incl MAI) iv. HRSA Ryan White Part C
	• Linkage to care services[i] • Outreach services to link HIV positive minorities to care[ii] • Identify and engage providers not linking clients to care within 30 days[i] • Use of HIV surveillance data to identify candidates for linkage to care[i] • Core care and treatment services (primary care, early intervention services, medical case management, mental health and outpatient substance use services, oral health care, medical nutrition therapy, home and community-based health services)[ii, iv] • Support services (housing, medical transportation, food bank/home-delivered meals, case management, emergency financial assistance, psychosocial support, residential substance use services)[ii] • AIDS Drug Assistance Program (ADAP) Funded partners: Desert AIDS Project [ii], Foothill AIDS Project [ii,iii], AIDS Healthcare Foundation [ii], TruEvolution [iii],	
	• Education of PrEP prescribers and PrEP navigators[i] • PrEP outreach to priority populations at high risk for HIV[i] • Expanded partner services to support linkage of partners to PrEP • Training for medical providers who were not screening for or prescribing PrEP[i] • HIV prevention and support services for people who use drugs (syringe disposal, naloxone training, prevention education)[i] • Condom distribution	
	• Cross-training of linkage workers to provide partner services[i] • Use of HIV surveillance data to identify candidates for partner services[i]	

Note: Additional resources for HIV services that cannot be quantified or broken down by pillar include Medi-Cal, Medicare, Veterans Administration, and 3rd party reimbursement

Appendix 2: Community Engagement Documentation

Exhibit 25 lists community engagement event dates, descriptions and key voices and partners.

Exhibit 25. Community Engagement Documentation

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
CDPH Planning Group Kick-Off Meeting[10] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants:*** *Inland Empire Planning Council Leadership, RUHS HIV/STD Program.*
EtHE Presentation and Discussion[11] 11/14/2019	CDPH/RUHS presented an overview of the EtHE Initiative to glean early input about priorities and process.	***Participants****: Inland Empire Planning Council Leadership and general community.*
EtHE Community Forum[12] 11/14/2019	RUHS facilitated a discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	***Participants****: Inland Empire Planning Council, RUHS, SBCDPH, AIDS Health Care Foundation, Desert AIDS Project, FLAAC, Foothill AIDS Project, Housing Authority of Riverside County, HIV + AIDS Research Project Palm Springs, Eisenhower Health.*
EtHE CHIPTS Regional Meeting[13] 01/24/2020	RUHS presented an overview of county's draft EtHE plan and gave input about approaches to the regional EtHE response.	***Participants****: County health departments and Planning Council representatives from Alameda, Los Angeles, Orange Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.*
Community Caucus I[14] 1/25/2020	TruEvolution convened a gathering of new voices to better understand the experiences of people living with or at risk for HIV. *Sponsors: RUHS, San Bernardino Department of Public Health.*	***New Voices – Priority Populations:*** *Black/African American (B/AA), Hispanic/Latinx, unhoused, Spanish-speakers, and the transgender community.* ***Other Participants:*** AIDS Healthcare Foundation, Desert AIDS Project, Foothill AIDS Project, FLACC.
Inland Empire EtHE Innovations Summit[15] 1/27/2020	RUHS and SBCDPH convened a summit of providers from different sectors (HIV and non-HIV). They presented the county's EtHE plan and held a discussion on the opportunities & barriers for cross-sector collaboration and improvement in HIV care.	***New Voices – Providers:*** *Education, research institutions, housing, Inland Empire Health Plan, SBCDPH, AIDS Healthcare Foundation, OASH, Families Living*

EVENT	DESCRIPTION	VOICES & PARTNERS
		with AIDS Care Center, California Workforce Development Board, UC Riverside School of Medicine, Housing Authority of Riverside Count, HRSA, PACE
Community Caucus II[16] 5/16/2020 10 AM-12 PM	TruEvolution convened a panel of Hispanic/Latinx PLWH to comment and review findings of Community Caucus I. The panel was presented only in Spanish and confirmed and further expanded on the key findings.	***New Voices Participants**:* *Hispanic/Latinx PLWH.* *Spanish Speakers.*
Community Caucus III[17] 5/16/2020 1 PM- 3 PM	TruEvolution convened a panel of B/AA and Hispanic/Latinx MSM living with HIV to comment and review findings of Community Caucus I. The panel confirmed and further expanded on the key findings.	***New Voice—Participants**: B/AA and Hispanic/Latinx MSM living with HIV.* *English Speakers.*

Appendix 3: Letter of Concurrence

Marisa Ramos, Ph.D.
Chief, Office of AIDS
Center for Infectious Diseases
California Department of Public Health
MS 7700, PO Box 997426
Sacramento, CA 95899-7426

Dr. Ramos,

This letter documents that the Inland Empire HIV Planning Council (IEHPC) is in concurrence with the Ending the HIV Epidemic in America, Phase I accelerated planning report submitted by **Riverside County** and funded through Centers for Disease Control and Prevention (CDC), grant number PS 19-1906. The IEHPC covers the geographic region (Inland Empire Transitional Grant Area – TGA) of both Riverside and San Bernardino Counties, with the co-chair transitioning between the two County Health Officers on an annual basis.

At the beginning of the contract year, the IEHPC was provided a presentation by the State Office of AIDS and Facente Consulting, the groups that were contracted to assist in the development of the Riverside County Ending the HIV Epidemic Plan. IEHPC members were asked to disseminate information about the project and seek consumer input on what is most critical to decrease new infections as we work toward ending the epidemic.

We were provided a copy of the draft plan and were part of the community engagement activities that contributed to the final plan. We were also given an overview of the plan at the June IEHPC meeting. IEHPC members had the opportunity to review the materials, offer comments and ask questions.

The plan being submitted is in harmony with the other HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero Plans and other county documents that guide the delivery of HIV prevention and care services, and maintains a surveillance system in collaboration with the State Office of AIDS in Riverside County.

The selected activities in the plan will expand our reach to populations underserved to date, with novel and innovative interventions that will increase testing, provision of rapid ART, and use of PrEP, and will assist more people living with HIV in our county to achieve and sustain viral suppression.

The CDC PS 20-2010 funding to implement the plan will expand services, and will work in unison with the HRSA 20-078 and in partnership with health centers provided Ending the Epidemic funding through HRSA 20-091.

Our planning body will continue to monitor the implementation of the Ending the Epidemic Federal Initiative and its family of interventions. We will also continue to engage the community to assure ongoing, real-time feedback so that the interventions are executed optimally for the populations they are serving.

Signed by the Planning Council Co-Chairs on behalf of the entire Part A Planning Body,

Cameron Kaiser, MD, MPH, FAAFP
Cameron Kaiser, MD, MPH, FAAFP (Dec 15, 2020 15:55 PST)

Cameron Kaiser, MD,

Health Officer Co-Chair

Curtis Smith

Curtis Smith, Community Co-Chair

Appendix 4: Planning Council Membership Roster

Inland Empire HIV Planning Council (San Bernardino/Riverside) **Website: https://www.iehpc.org/** **Contact Number: (909) 501-6512**	
Council Members	**Title/ Position**
Aaron Jacobson	Bylaws Committee Chair, Evaluation of the Administrative Mechanism (EAM) Chair
Cameron Kaiser, MD	Riverside County Health Officer
Claudette Bridges-Cobb	Council Member
Curtis Smith	Empowerment Committee Chair, Grievance Committee Chair, Continuum of Care Committee (CCC)
Curtis White	Secretary
Danielle Huntsman	Council Member
Denise Absher	Council Member
Dr. Cameron Kaiser	Council Member
Executive Committee Representative	Executive Committee Representative
Jeff Taylor	Council Development Committee (CDC) Chair
Jeff Taylor	Council Member
Jerry Chan	Council Member
Jorge Romos Ruiz	Council Member
Justin Goodro	Council Member
Lloyd White	Community Co-Chair, Planning Committee Chair, Standards Committee Chair, Finance Committee Chair
Marjorie Katz	Council Member
Maxwell Ohikhuare, MD	San Bernardino County Health Officer
Zayda Welden	Council Member

SACRAMENTO

Sacramento County

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

SACRAMENTO COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH

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Introduction

About This Plan

This plan describes Sacramento County's bold and innovative plan for ending the HIV epidemic in the County. HIV efforts in Sacramento County are led by the Sacramento County Department of Health Services, Division of Public Health (SCPH). The County is part of the Sacramento Transitional Grant Area (TGA), which includes the urban county of Sacramento, as well as the rural counties of El Dorado and Placer. In collaboration with the HIV Health Services Planning Council, and community and clinical partners, SCPH has built a sophisticated, comprehensive continuum of high-quality HIV prevention, care, and treatment services in the County. These foundational HIV services have evolved over time to address shifts in the epidemic. Sacramento County's *Zero New HIV Infections Together: 2016-2021 Strategic Plan*[1] is aligned with the state's *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*[2] and serves as the guiding framework for the County's HIV efforts. The strategic plan was developed by the local "Zero Together" Coalition, a partnership between SCPH, local HIV/AIDS-related organizations, agencies that serve LGBTQ+ communities, local non-profit organizations, and community-based health and wellness agencies.

Sacramento County's current baseline activities and the infrastructure that supports them are critical for reducing and ultimately eliminating new HIV infections and optimizing the health of people living with HIV, but they are not sufficient—hence the need for this Ending the HIV Epidemic (EtHE) plan. This EtHE plan does not replace the other plans; instead, it expands on them by describing the additional innovative efforts needed based on the state of HIV locally.

This Plan is organized as follows:

- The **Introduction** provides a high-level overview of 1) the HIV epidemic in the County, 2) the baseline services, activities, and infrastructure that currently exist, and 3) Sacramento County's plan to end the epidemic.
- **Section I: Community Engagement** describes Sacramento County's completed and planned community, provider, and Planning Council engagement activities and findings to date.
- **Section II: Epidemiologic Profile** presents the latest available data on HIV in Sacramento County, including demographics, trends, and disparities across age, race/ethnicity, geography, and more.
- **Section III: Situational Analysis** synthesizes information from the prior two sections and a needs assessment to paint a comprehensive picture of the current state of HIV in the County, including needs, resources, and gaps.
- **Section IV: EtHE Plan** outlines the disruptively innovative activities that the County will implement between now and 2025 across all funding sources, along with key partnerships, workforce development needs, and plans for outcome monitoring.
- **Section V: Concurrence** describes the process for securing Planning Council concurrence.

Current State of HIV in Sacramento County

Sacramento's EtHE efforts to date have helped curb the HIV epidemic with the annual number of new HIV infections in Sacramento decreasing by 15 percent (185 cases to 158 cases) between 2008 and 2018.[3,4] However, the County still sees nearly 160 new HIV diagnoses per year (a rate of 10.3 per 100,000), with certain communities disproportionately impacted, including men who have sex with men (MSM), people of color (especially people who are Black/African American [B/AA] or Hispanic/Latinx), transitional age youth (TAY) under 24, and other sub-groups of the aforementioned: substantial risk heterosexuals, substantial risk transgender people, and people who inject drugs (PWID).[2]

A major challenge to ending the HIV epidemic in Sacramento County, as voiced at community engagement meetings, is finding effective ways to address the specific barriers to access these populations face.[5] Community members noted that HIV-related messaging and services are not reaching many people of color (including women), the transgender community, youth, PWID, people experiencing homelessness, Spanish speakers, and other substantial-risk populations. Clinical services delivered through traditional, “four-wall” settings are not always a suitable option for serving some of these communities.[6] These challenges play out in the lower rates of viral suppression among substantial-risk populations, low PrEP uptake, and other disparities.

Current HIV-Related Efforts and Infrastructure

Planning

Sacramento County has a long-standing history of planning local HIV prevention, care, and treatment efforts in conjunction with community partners and the local HIV Health Services Planning Council, which represents the Sacramento TGA. The County's HIV efforts intensified and became more focused with the development of the “Zero Together” Coalition’s *Zero New HIV Infections Together: 2016-2021 Strategic Plan,*[1] which identified the following priorities: testing of people with substantial risk, aggressive linkage and retention in care, use of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), syringe services programs (SSPs), and widespread condom distribution.

Services

Sacramento County and the TGA as a whole have a strong base of service providers dedicated to making a difference in the fight against HIV through providing high quality services that meet consumer needs. A number of public funding sources support these services in Sacramento County, including prevention funding from CDPH (CDC PS18-1802, HIV Prevention and Surveillance Funding and State General Fund); Ryan White Parts A, B, and Minority AIDS Initiative (MAI) funding; HRSA Ending the HIV Epidemic funding; CDPH AIDS Drug Assistance Program (ADAP) funding; as well as PrEP Assistance Program funding, and Sacramento County General Fund. The County is in the process of implementing third party billing, including Medi-Cal and Medicare.

Collectively, these funding sources support SCPH, several clinical providers including Sacramento County Health Center (the County's federally qualified health center [FQHC]), and six CBOs (**Exhibit 1**). One Community Health is the main provider of Ryan White primary HIV care and has built a solid continuum of services for PLWH that includes mental health and substance use services, dental services, medical case management, and a multitude of other services. HIV/STD/HCV testing, harm reduction services, and outreach are also available at various locations throughout the County. A more extensive resource inventory is included in **Appendix 1**.

***Exhibit 1**: Publicly funded clinics and CBOs*

Clinical Providers

- Sacramento County Health Center
- Sacramento County Sexual Health Clinic
- Adult and Juvenile Correctional Health Services
- One Community Health
- UC Davis Pediatrics

Community-Based Organizations

- Gender Health Center
- Golden Rule Services
- Harm Reduction Services
- Safer Alternatives Thru Networking and Education (SANE)
- Sunburst Projects
- Volunteers of America

Infrastructure

Health Department. SCPH has an integrated Sexual Health Promotion Unit (SHPU) consisting of STD/HIV Education and Prevention, STD/HIV Surveillance, and the Ryan White CARE Program. The SHPU oversees all health department HIV- and STD-related functions and services, including administering much of the services funding previously noted, as well as providing HIV/STD/HCV testing, PrEP Navigation, and Linkage to Care as needed. The SHPU has 16 FTE, with approximately half their time devoted to HIV-specific duties.

Additional Assets. In addition, SCPH facilitates the Sacramento Workgroup to Improve Sexual Health (SacWISH). This is a group of community stakeholders that spans the field of sexual health, including staff from community-based organizations, medical providers, school district staff, and representatives from State and local government agencies. SacWISH meets quarterly and has approximately 100 members.

Sacramento County's Plan to End the HIV Epidemic

Exhibit 2 (see p. 6) depicts a high-level overview of how Sacramento County plans to enhance its current HIV efforts with new, disruptively innovative activities funded with federal EtHE funds. The planned activities will expand and leverage, but not duplicate, the foundational efforts already in place. In particular, the new proposed activities will address access barriers for unhoused communities and others for whom traditional "four-walled" clinical settings are not accessible and who include many disproportionately impacted groups (MSM of color, the transgender community, TAY, PWID). In addition, the County will focus on improving outcomes for Ryan White subpopulations who have persistent challenges to achieving and maintaining viral suppression.

The **Exhibit 2** logic model shows the needs, strengths, and gaps identified through this planning process (local epidemiologic data, community engagement, and situational analysis) and the new, disruptively innovative activities designed to leverage these strengths and address the gaps. In particular, this plan focuses on addressing underlying issues that have led to the

highest new HIV infections rates and lag in PrEP uptake among B/AA and Hispanic/Latinx, and the disparities of linkage and viral suppression among B/AA and white MSM and rising STIs among other focus populations. These underlying issues include stigma, a reported barrier accessing STI and HIV-specific services especially for B/AA, Hispanic/Latinx and TAY; traditional clinical settings that can be less flexible at serving unhoused individuals; and a lack of resources and systems to bolster the ability to use surveillance data as a bridge to care and prevention services.

New EtHE activities will work across all four EtHE pillars and will support the short-term, intermediate, and long-term outcomes identified by the CDC in PS-19-1906. The primary activity—Wellness Without Walls—cuts across all four pillars. Multiple funding sources (noted in **Exhibit 2**), including CDC PS-20-2010 and HRSA 20-078, will be leveraged to support components of this activity, and community partnerships will be strengthened to ensure success. Project funded by funding sources outside of CDC PS-20-2010 and HRSA 20-078 are noted as significant to EtHE goals over baseline services and are also aimed at noted priority populations.

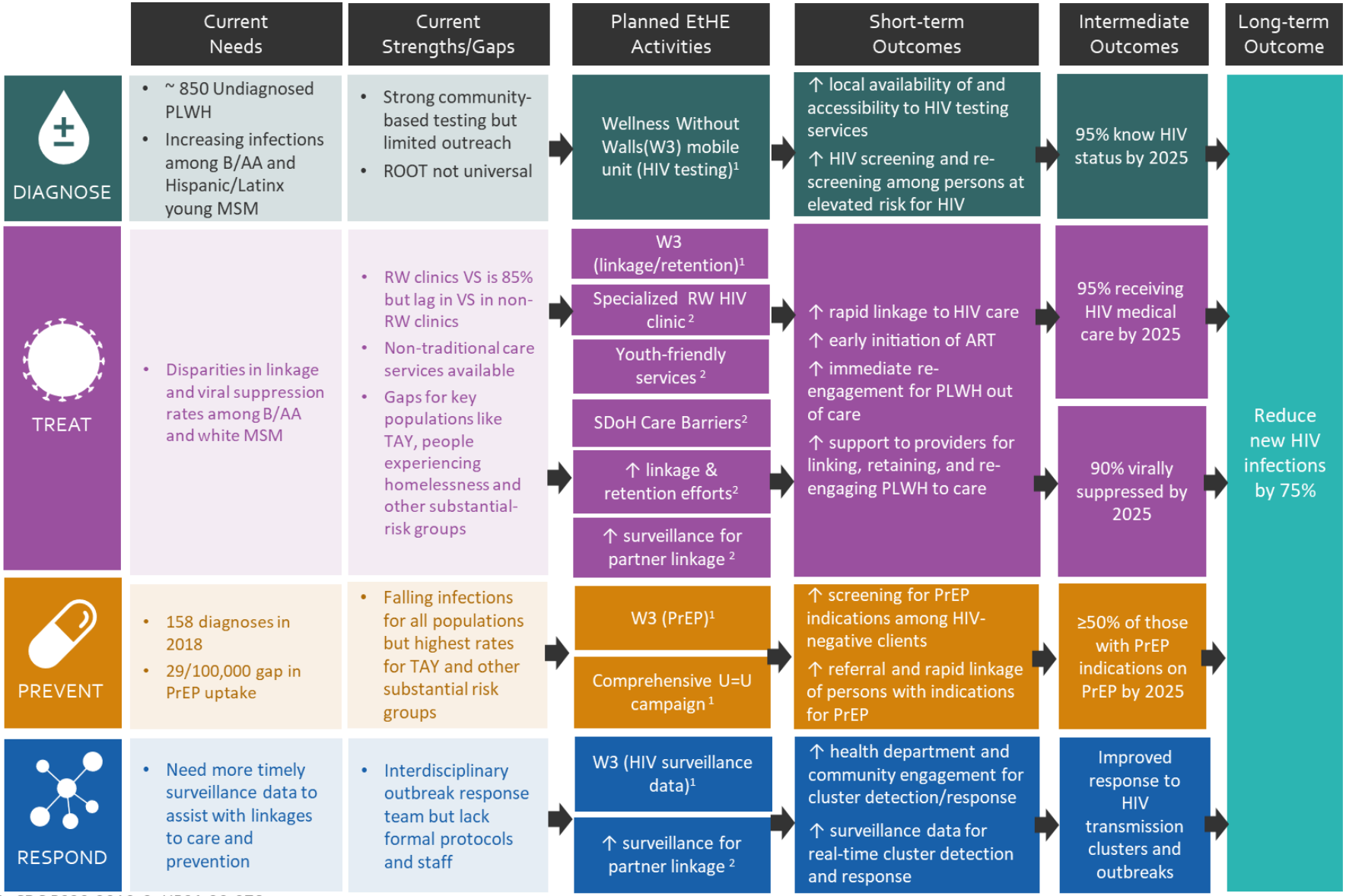
- **Wellness Without Walls (W^3).** For this activity, Sacramento County will establish a mobile unit that directly delivers clinical services—including HIV, sexual health, drug user health, and broader support services (e.g., mental health and substance use counseling)—to unhoused communities and transitional aged youth. Taking sexual health care out of the clinic to meet people where they are will reduce physical, social, and psychological barriers to accessing HIV testing, treatment, and prevention services among unhoused communities, and will accelerate the EtHE response by collecting epidemiologic data about unhoused communities with substantial risks *(Diagnose, Treat, Prevent, Respond)*
- **Comprehensive U=U campaign.** For this activity, SCPH will create a U=U campaign to promote awareness and knowledge about the importance of viral suppression and distribute it using social media and educational materials in waiting rooms. *(Treat, Prevent)*
- **Establish a highly specialized Ryan White HIV care clinic.** SCPH Clinic will expand access to HIV care and treatment for people living with HIV within the Sacramento County TGA, serving at least 125 patients annually. *(Treat)*
- **Youth-friendly services.** SCPH will improve health outcomes for youth under 24 by increasing access to high quality youth friendly sexual health services, lowering barriers to a care, and creating a youth friendly environment for Sacramento County youth to receive HIV services. *(Treat)*
- **Address Social Determinants of Health (SDoH) that create barriers to care.** SCPH will utilize partnerships with community-based agencies to address the complex medical and social needs of patients living with HIV in Sacramento County. *(Treat)*
- **Scale up of linkage and retention efforts.** SCPH will coordinate with community partners and providers to ensure all newly diagnosed individuals and their sex and drug using partners are linked to HIV care within 30 days of diagnosis (with a goal of 7 days) and reengage those lost to care. *(Treat)*
- **Expand Surveillance-Based Partner Services efforts to identify and link partners.** To scale up ability to identify and link partners, a SCPH Communicable Disease

Investigator (CDI) will be embedded in the Sexual Health Clinic to conduct patient interviews, and all CDIs of the HIV/STD Surveillance Unit will conduct expanded Partner Services activities. *(Treat)*

- **Project Empowerment-**The Sacramento LGBT Community Center will improve viral suppression among B/AA people living with HIV (PLWH) and prevent HIV acquisition among B/AA people who are particularly vulnerable to HIV including 1) gay, bisexual, or other MSM, 2) transgender MSM, 3) transgender women, 4) cisgender women, and/or 5) PWID. The intended outcomes include increasing viral suppression, increasing linkage to and retention in HIV care, increasing knowledge of HIV status, and increasing linkage to and uptake of pre-exposure prophylaxis (PrEP). This is State prevention funding directly allocated to the LGBT Community Center and not part of the CDC PS 20-2010 allocation. *(Diagnose, Treat, Prevent)*
- **CFAR-Adapting *Connecting Resources for Urban Sexual Health* for Racial and Ethnic Minority MSM (Adapting CRUSH-MSM)-** This research project is a collaboration between community members, service providers and researchers focused on adapting an evidence-based sexual health services intervention designed to increase PrEP uptake to fit the local HIV epidemic in Sacramento County where racial and ethnic minority populations are disproportionately affected by HIV. The investigators seek to identify how to best adapt a proven-effective sexual health services delivery model called CRUSH: Connecting Resources for Urban Sexual Health to better meet the needs of racial and ethnic minority MSM in the more rural Sacramento County. The CRUSH-MSM model focuses on improving outcomes along the HIV prevention continuum, it also provides support to those living with HIV. This is a CFAR funded research study with no CDC PS 20-2010 funding. *(Diagnose, Treat, Prevent)*

The County's EtHE plan was developed with extensive community and partner engagement and endorsed by the HIV Health Services Planning Council, Sacramento County’s local HIV community planning body. With the new federal EtHE funding, Sacramento County expects to lower new HIV infections by 75 percent over the next 5 years.

Exhibit 2. *Logic Model for Ending the HIV Epidemic in Sacramento County, organized by pillar. Current County needs, strengths, and gaps inform planned EtHE activities, which will impact the short-, intermediate-, and long-term outcomes identified by CDC and the California Department of Public Health.*



1. CDC PS20-2010; 2. HRSA 20-078.

Section I: Community Engagement

SCPH used CDC PS-19-1906 as an opportunity to dramatically scale up its capacity for ongoing community engagement. It enhances the understanding of the day-to-day realities of priority populations and sparks discussions about creative ways to harness community strengths, address barriers to accessing HIV prevention, care, and treatment, and dig deeper into the underlying social determinants of health (SDoH). CDPH, the PS19-1906 grantee, has worked very closely with Sacramento County to put community engagement front and center. Exhibit 3 summarizes community engagement successes to date.

Exhibit 3. Community Engagement Successes

- 2 Community Forums
- Online survey through social networks
- Engagement of the Planning Council
- Pivot to virtual CE due to COVID-19

Community Engagement Activities

The COVID-19 response has affected Sacramento County's ability to implement in-person outreach and face-to-face community engagement for most of the months allocated to the PS 19-1906 accelerated planning year. The County is continuing to adapt to virtual engagement methods, including Zoom-based presentations and discussions, online surveys, virtual focus groups, and telephone key informant interviews which will be methods of ongoing community engagement while implementing the EtHE plan. The County met the following community engagement targets for the accelerated planning year **(Exhibit 4)**:

Exhibit 4. Sacramento County Community Engagement Targets (met in Year 1)

- Community engagement activities to engage new HIV positive/at-risk populations, HIV providers, and non-traditional partners
- Collaborated with key partners in the planning and facilitation of engagement activities and in the review of the findings
- Engage people from each of the priority populations, or their advocates
- Obtained 55 responses to the online survey reaching priority populations
- Examine secondary sources of data for substance users and unhoused persons

Sacramento County's EtHE community engagement efforts reengaged HIV Health Services Planning Council constituents and brought together new voices—clients, providers, governmental groups and academic institutions—to inform the next best steps to end the HIV epidemic. **Exhibits 5 and 6** summarize the completed and planned community engagement efforts for the PS19-1906 accelerated planning year. The completed and proposed activities reflect successful strategies that the SCPH has used in the past to engage community members, such as e-distribution lists, leveraging existing planning efforts, coordinating engagement activities at easily accessible community locations, and providing food during engagement activities. **Appendix 2** provides more detailed descriptions of these efforts. In

addition, the back-up documentation will be kept on file at SCPH to document the planning effort: sign-in sheets, meeting agendas, meeting notes, and other documentation.

Exhibit 5. Overview of County EtHE community engagement activities, completed and planned.

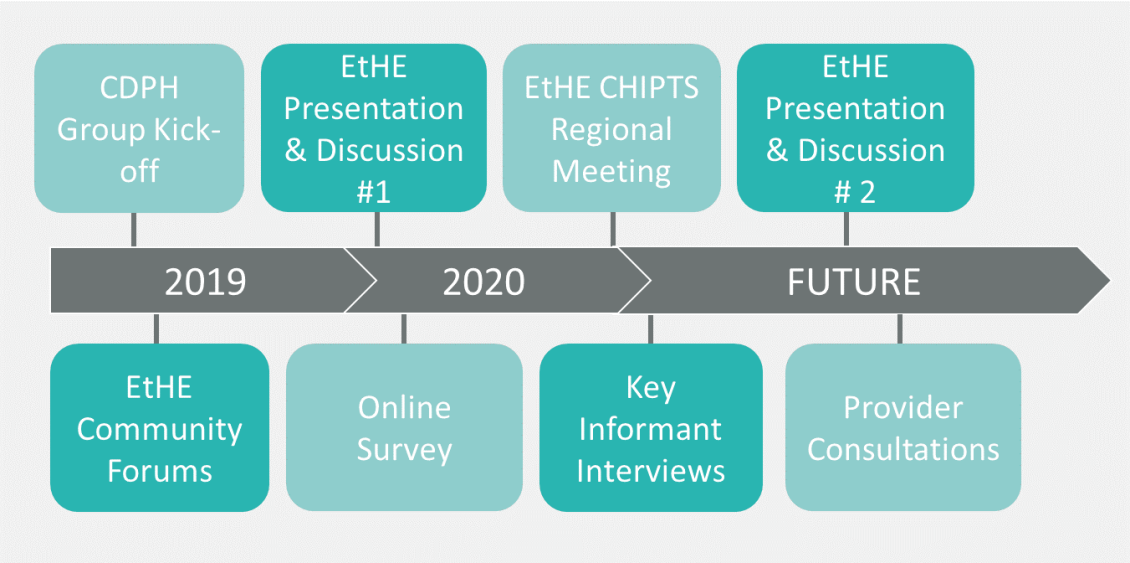


Exhibit 6. *Detailed summary of Sacramento County EtHE community engagement activities*

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
CDPH Planning Group Kick-Off Meeting[7] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants:*** *Sacramento HIV Health Services Planning Council, County of Sacramento Health Department, Gender Health Center, Sierra Foothills AIDS Foundation, and Golden Rule Services*
EtHE Community Forums[5] 11/18/2019,11/21/2019	SCPH presented the County's EtHE initiative then facilitated a group discussion on key strengths, gaps, and ideas for the four EtHE pillars to diagnose, treat, prevent, and respond to HIV.	***New Voices – Providers:*** *harm reduction, youth* *Participants: HIV Health Services Planning Council, clinical providers*
EtHE Presentation and Discussion[8] 01/22/2020	CDPH and Facente Consulting were invited to present an overview of the CDC 19-1906 accelerated planning year and to solicit input on the draft EtHE Plan.	***New Voices – Providers:*** *unhoused* *Participants: HIV Health Services Planning Council,*

EVENT	DESCRIPTION	VOICES & PARTNERS
		clinical providers, members of the public
Online survey[9] 1/22/2020-7/31/2020	SCPH distributed an online survey asking for input on how to engage hardly reached populations in HIV prevention and care. It was sent via email to key leaders with connections to the priority populations, providers, and other stakeholders.	***New Voices – Priority Populations**: TAY, B/AA, Hispanic/Latinx, LGBTQ*
EtHE CHIPTS Regional Meeting[10] 01/24/2020	SCPH attended the CHIPTS regional meeting to plan, coordinate and align Sacramento County's draft EtHE plan with the best practices to foment California's regional EtHE response.	***Participants:** County health departments and Planning Council representatives from Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC*
PLANNED ACTIVITIES (dates TBD)		
Key Informant Interviews	SCPH will speak with current or past substance users to gain their input on the EtHE plan and to gain a better understanding of their barriers in accessing HIV or PrEP care.	***New Voices – Priority Populations**: Current and past substance users*
EtHE Presentation and Discussion via Zoom	SCPH will present the EtHE plan to solicit ongoing feedback and input to the plan and its implementation.	***New Voices – Priority Populations**: B/AA and Hispanic/Latinx MSM, unhoused, TAY, or their advocates*
Provider Consultations	SCPH will present at provider forums, and staff meetings of key providers not traditionally at the HIV care and prevention planning table.	***New Voices – Providers**: substance use, mental health, education, housing, unhoused services, private providers*

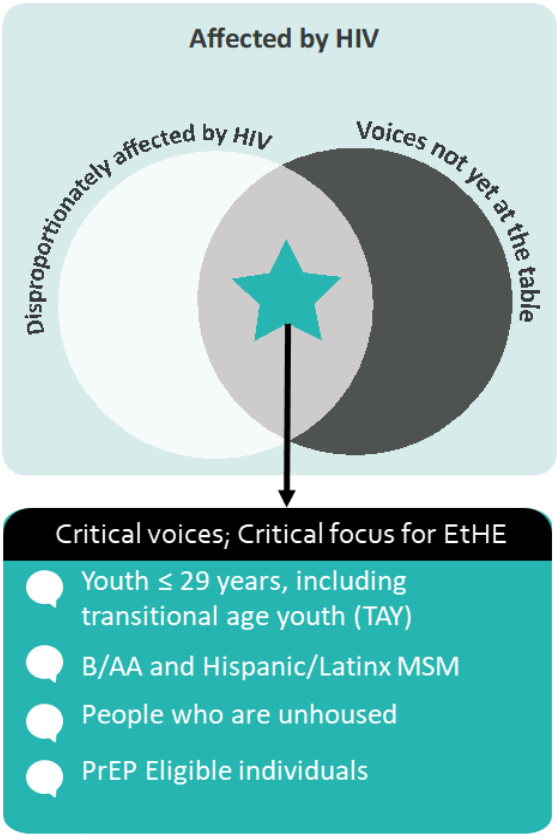
SCPH oversaw the development and implementation of the community engagement plan. In collaboration with CDPH, SCPH led the local Sacramento EtHE Steering Committee that oversaw the planning, implementation, and reporting of 19-1906 activities. Local CBO partners helped plan and implement community engagement events and were instrumental in successfully engaging new PLWH, people at risk for HIV, and provider voices. They helped advertise the events, recruit members from priority populations, and most importantly, helped to build trust between the County's EtHE efforts and community members. In addition, CDPH

contracted with Facente Consulting, a California-based public health consulting firm specializing in HIV planning and community engagement, to support and build Phase I county capacity to broaden and deepen connections with local priority populations. For Sacramento County, Facente Consulting provided support for community engagement events, including developing meeting agendas and materials, co-facilitating events, taking meeting notes, reviewing secondary data sources and producing summary reports.

New Voices

In addition to deepening the partnerships within our current provider and community networks, Sacramento County will continue to place a special emphasis on including critical voices in the implementation of the EtHE plan. The County used an intentional data-driven process to identify affected populations not currently being reached effectively so they can focus on engaging these new voices. Based on HIV surveillance data and the experience of key stakeholders (e.g., the Sexual Health Promotion Unit of SCPH, the HIV Health Services Planning Council, service providers) and an assessment of who is not currently participating in the HIV planning process, the County identified four priority populations as ***critical voices*** that need to be included, shown in Exhibit 7 to the right. These critical focus populations for EtHE work include TAY, B/AA and Hispanic/Latinx MSM, PrEP eligible individuals, and people who are unhoused. In addition, there are a number of subpopulations of these four main focus populations we mentioned: high-risk heterosexuals, PWID, people who are incarcerated or previously incarcerated/re-entering society, negative partners of HIV positive individuals and other substantial-risk groups.

Exhibit 7. Critical new voices to engage.



As described later in this report, Sacramento County will especially emphasize the inclusion of people experiencing homelessness and the agencies that serve them to support Sacramento's innovative initiative of bringing mobile HIV-related services to unhoused communities and the diversity of subpopulations that are represented in them.

As some of these critical focus populations represent communities that have not been reached effectively in the past with baseline prevention and care services, the County will consider innovative ways to promote engagement, including non-cash incentives and engagement settings like focus groups and town hall meetings. SCPH will work with our partners who have relationships with community members, including Gender Health Center (the transgender community), Harm Reduction (unhoused and PWID communities), Safer Alternatives Thru Networking and Education (PWID communities) and Golden Rule Services (MSM of color) to help us recruit participants for the planned stakeholder engagement events.

The following sections describe our efforts to engage new voices prioritized in PS19-1906, with an emphasis toward inclusion of the identified priority populations.

Local Prevention and Care Integrated Planning Bodies

The Sacramento TGA has a joint integrated community planning body called the HIV Health Services Planning Council. SCPH continuously seeks the Planning Council's input and guidance when developing HIV prevention, care, and treatment strategies. SCPH has actively engaged the Council throughout the EtHE planning process, especially regarding the priority populations and proposed interventions.

The Planning Council brings a wealth of knowledge and experience to the EtHE planning process. The Planning Council is composed of stakeholders with diverse personal and professional experiences, including service providers (both HIV and non-HIV related). PLWH make up approximately one quarter (24 percent) of the Planning Council, and additional members include: people at risk for HIV, HIV providers and other individuals who want to work to improve the quality of lives of people living with HIV/AIDS in the Sacramento Transitional Grant Area (El Dorado, Placer, and Sacramento Counties).

The Planning Council is a key partner for ensuring that new voices from the priority populations are included in planning efforts. For example, HIV Health Services Planning Council members who are also PLWH regularly outreach to other PLWH to encourage their participation on the Planning Council.

Local Community Partners

With the exception of a cure for HIV, all the tools to end the HIV epidemic exist—PrEP, condoms, safer injection equipment, and effective HIV treatment. However, policy barriers, SDoH and disparities in health care access, stigma, and many other factors create a situation where all communities do not benefit equally from these tools. Only through engaging affected community members in the planning process can the County ensure the proposed programmatic activities meet community needs and are conducted in ways that resonate with those communities. Therefore, engaging local community members and partners is a significant element in Sacramento County's EtHE planning.

In addition to the Planning Council's work, Sacramento County is engaging with the identified priority populations as shown in Exhibit 7. Direct community engagement will continue in Years 2-5.

Local Service Provider Partners

Service providers, both HIV- and non-HIV-related, are key partners for ending the HIV epidemic in the County. Clinical and community-based providers have a wealth of experience regarding what works and what does not work to reach priority populations and a strong knowledge of the barriers that need to be overcome in order to more effectively serve PLWH and persons at risk. Other partners who may not provide direct services, but who have expertise in or connections with priority populations, are also key to building a robust, feasible, and sustainable HIV prevention, care, and treatment strategy.

SCPH has pre-existing strong partnerships CBO providers listed in **Exhibit 1** (p. 3), as well as with the Sacramento Workgroup to Improve Sexual Health (SacWISH)—a multi-sector group of more than 100 community stakeholders. During the EtHE planning process, SCPH engaged the following new service provider and non-traditional partners:

- **Clinical providers,** including Planned Parenthood
- **Medical insurance,** including Medi-Cal and Covered California
- **Dept. of Health Care Services (DHCS)**
- **Housing providers,** including Loaves and Fishes
- **Pharmacies,** including Pucci's (A pharmacy that has served PLWH for decades)
- **Substance use collaboratives,** including the Opioid Task Force and Meth Coalition

SCPH is strongly invested in maintaining these new relationships and continuing to forge new partnerships for ending the HIV epidemic.

Selected Community Engagement Findings

The following sections summarize and highlight selected findings from the community engagement efforts related to four domains affecting the HIV epidemic in all California Phase I counties: social determinants of health (SDoH), being unhoused, mental health, and substance use (summarized in **Exhibit 8** and described in more detail below). These findings represent a synthesis of information gathered from all the activities in **Exhibit 6** completed as of September 30, 2020 (see **Appendix 2** for detailed documentation). The information presented sheds light on some of the prevailing issues and conditions the priority populations are experiencing, serving as an initial indication of how these conditions might influence the County's ability to achieve EtHE goals. These early insights point to potentially impactful strategies and interventions. Ongoing community engagement work will continue to enrich understanding of these issues.

Exhibit 8. Key considerations for EtHE in the County from community engagement processes

Social Determinants of Health, including HIV provider cultural competency and PrEP-related stigma impact access to services.

Secure housing is key to supporting health and well-being for PLWH; continued efforts to support people who are unhoused are needed.

Mental health services are critically needed, especially given COVID-19. However, availability and quality of services are insufficient.

Substance use, particularly stimulant and opioid use, is on the rise, with substance use treatment as a major unmet need.

Social Determinants of Health

Community engagement participants described the pervasive effect the social determinants of health (SDoH) have on people living with and at risk for HIV in the County. Significant themes[5] derived during community engagement sessions included:

1) Lack of culturally and linguistically appropriate HIV services in other languages, particularly Spanish;
2) Trust is a barrier and is made worse without culturally appropriate services;
3) Practical support like childcare and transportation is necessary;
4) HIV-related "literacy" was also noted as a challenge, such as the ability to understand medical terminology as well as community messaging (e.g., U=U).[5]

Participants also pointed to stigma as a significant issue affecting the ability of priority populations to fully embrace prevention and engage in care. Community members raised the topic of PrEP-related stigma within the gay community, highlighting the term "Truvada whore"—shaming language used to describe people who are on PrEP. Participants suggested that a PrEP speakers bureau/advocates could help address some of these issues.[5]

Other solutions suggested by community engagement efforts[9] included more outreach to the EtHE focus populations, offered in a culturally appropriate manner to build trust over time. Also, offering services in a wellness model to counteract HIV stigma; and taking these services beyond traditional clinic settings.[9]

Being Unhoused

Secure housing is a necessary condition for health and well-being, hence the common mantra "housing is health care." People cannot be expected to prioritize their health without a stable and safe home. Homelessness is a major concern in California, which is home to 53 percent of all unsheltered unhoused people in the country[11], despite making up only 12 percent of the U.S. population.

Sacramento also struggles with addressing homelessness and its ramifications. The County's 2019 point-in-time unhoused count estimated that 5,570 people were experiencing homelessness with 70 percent of those unsheltered. While homelessness increased 19 percent between 2017 and 2019, chronic homelessness appears to have decreased by 7 percent.[12] In April 2020, the County allocated $15 million to implement a COVID-19 Homeless Response Plan, money which helped to fund a multi-agency Homeless Response Team.[13]

Homelessness significantly impacts PLWH. In a 2018 Ryan White Needs Assessment, 18 percent of PLWH respondents were experiencing homeless[14], and local Ryan White data demonstrates that approximately 29 percent of existing Ryan White clients in the TGA report experiencing homelessness or being unstably housed.[6]

EtHE community engagement participants clearly saw people experiencing homelessness as a priority for HIV-related and other services even before the COVID-19 epidemic began. They noted the importance of addressing basic survival needs, such as providing food, blankets, hygiene products, canned food, hotel vouchers, clothes, and cash. They also advocated for support services that bring people experiencing homelessness to their HIV medical appointments (one idea was an encampment-to-clinic shuttle), as well as for mobile treatment services that build upon the successes of the current mobile testing vans operated by Harm Reduction Services and the Sacramento LGBT Center. Pop-up clinics were also suggested.[5]

Mental Health

The 2018 Ryan White Needs Assessment noted an "alarmingly high" proportion of respondents who reported having mental health conditions—46 percent had been prescribed psychiatric medications and 79 percent reported being diagnosed with anxiety, bipolar disorder, dementia, and/or depression.[14] The County makes a significant investment in Ryan White-funded mental health services for PLWH. According to the Needs Assessment, mental health is among the services highest in demand, but also among the highest in unmet need; 81 percent of participants needed mental health services, 63 percent received them, and 18 percent did not

receive them.[14] People experiencing homelessness reported disproportionately high rates of unmet need. PWID had high levels of demand for services and also high levels of unmet need.

Community engagement participants noted that mental health appointment slots are limited and as short as 12 minutes, which is insufficient to meet needs. Anecdotally, as a result of COVID, PLWH are experiencing increased depression and feelings of isolation. Some clients have reported they prefer to meet with their providers in person instead of through telehealth. In response, Sacramento County is providing additional services, such as enhanced case management and the purchase of technology so that providers can complete field visits with clients using the tools that provide better face-to-face mental health services and remain HIPAA compliant.

Community engagement efforts suggest that community mental health can be improved with more community and social support programs that recruit peers as advocates to create or augment existing support groups and services.[9] Community members suggested that support groups should be in a diversity of spaces covering a variety of topics that are meaningful to the priority populations: not just about HIV but about the things that help people connect and thrive.[9]

Substance Use

In Sacramento County, both stimulant- and opioid-related death rates are trending upward. Between 2011 and 2018 there has been an overall upward trend of deaths attributable to amphetamine use with B/AAs dying at twice the rate of whites.[15] In 2018 there were 70 overdose deaths from prescription opioids, heroin, and fentanyl—a 25 percent increase since 2016.[15] This is of concern because it likely indicates an increase in use and these two substances are closely intertwined with HIV risk. Community engagement efforts suggest that substance use should be addressed in the context of providing other services.[9]

In the 2018 Ryan White Needs Assessment, participants were asked about their substance use history. Methamphetamines (15 percent) were the most commonly used of illegally obtained substances in the past 6 months among PLWH participants. Use of prescription opioids in the past 6 months was reported by more than a quarter (26.6 percent); heroin use in the past six months was reported by 4 percent. The percent of participants who self-reported needing substance use treatment was 58 percent (inpatient) and 56 percent (outpatient). However, approximately half of those needing treatment reported that they did not receive it, making this service one of the highest ranked in terms of unmet need. Participants experiencing homelessness had a disproportionately high unmet need for inpatient treatment.[14]

EtHE community engagement participants noted the dearth of alcohol and drug treatment options and that substance use is a major barrier to accessing prevention and care services.[5] Evidence suggestive of substance use as a barrier includes the fact that PWID living with HIV in the County have the lowest rate of viral suppression of any group, except transgender persons, at 60 percent as of 2018.[3]

Community Engagement, Years 2-5

SCPH will use Years 2-5 of EtHE implementation to continuously engage community members in the planning and implementation of services and interventions. Community input was essential in developing the proposed activities outlined in *Section IV: Ending the HIV Epidemic Plan.* Moving forward, it will be equally important to keep the Planning Council, community

members, and service providers engaged in a dialogue around the most effective approaches to implementing services. Future engagement strategies will include working closely with the Planning Council and hosting community forums co-sponsored by the SCPH and CBOs. SCPH is prepared to develop alternative and innovative engagement methods if necessary due to COVID-19 or other unanticipated factors.

For Years 2-5, SCPH's community engagement priorities are including more new voices through strengthening collaborative relationships with CBOs; recruiting new members for the HIV Health Services Planning Council; and focusing on workforce development, as summarized in **Exhibit 9** to the right and described below.

Exhibit 9. Community engagement priorities, Years 2-5

1. Include additional new voices through collaborative relationships with CBOs
2. Recruit new members for the HIV Health Services Planning Council
3. Focus on HIV workforce development

Collaboration with Community-Based Organizations

As described earlier, SCPH has several existing partnerships with CBOs that have trusting relationships with the priority populations: TAY, B/AA and Hispanic/Latinx MSM, people who are unhoused, and PrEP eligible individuals. EtHE community engagement would not be possible without the support of CBOs. SCPH and CBO partners will seek technical assistance to implement best practices and innovative strategies for connecting with new voices from the priority populations. In addition to continuing to engage the communities identified in Year 1, SCPH will also seek to bring the following subsets of the above priority populations and the providers that serve them to the table:

- People newly diagnosed with HIV
- Non-virally-suppressed individuals and virally suppressed individuals
- PrEP-eligible persons
- Non-English speakers
- Transgender community members
- Traditional HIV providers with public and private funds
- Non-traditional providers
- Mental health providers
- Substance use practitioners
- PWID

To improve the County's ability to rapidly reach communities in need, SCPH is examining avenues to expedite the contracting process, potentially by amending agreements with existing CBO providers or utilizing a Letter of Interest process. Funds will be used to enhance testing and provide PrEP. Other potential uses include housing and substance use.

HIV Health Services Planning Council Recruitment

As a community planning body, the HIV Health Services Planning Council is dependent on its members to assess the needs of PLWH in the TGA and establish service priorities. The Planning Council will collaborate with existing and new partners with ties to the community to recruit members who can provide voices from the priority populations. To decrease barriers to participation and advocacy, the Council will make all potential members aware of the Council's

Member Reimbursement policy, which helps to defray the costs associated with Planning Council participation, such as travel and childcare.

Workforce Development

The success of Sacramento County's EtHE plan depends on a highly skilled workforce that reflects the populations served—at SCPH, in clinical settings, and at CBOs. Possible partnerships could include a University of California, Davis (UCD) medical school collaboration with our Sexual Health Clinic and enhancing the existing partnership between UC Davis Medical Center Emergency Department with the SCPH Surveillance Unit to report all newly diagnosed HIV positive patients for immediate linkage to care. Furthermore, SCPH will utilize the AIDS Education and Training Center and the California Prevention Training Center to enhance opportunities for cultural competency training for sexual health providers.

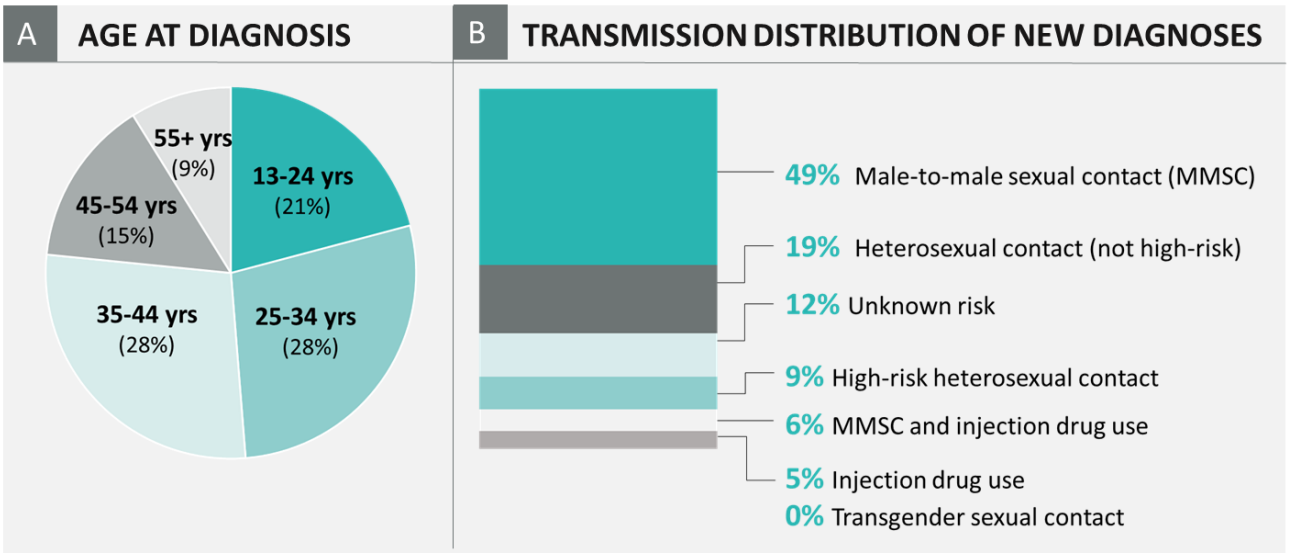
Section II: Epidemiologic Profile

HIV Diagnoses

In 2018, there were approximately 5,253 people living with HIV in Sacramento County. Of those, 4,403 (83.9 percent) people had their infection diagnosed—down from 84.9 percent diagnosed in 2016—and 158 were diagnosed within 2018. Of the people diagnosed in 2018, 88 (56 percent) were ages 25 to 44, 78 (49 percent) were infected through male-to-male sexual contact, and 30 (19 percent) were infected through heterosexual contact not typically considered high risk (i.e., not with a partner who was living with HIV, MSM or injected drugs).[3]

Exhibit 10 highlights the age and transmission distribution of new HIV diagnoses in Sacramento County in 2018.

Exhibit 10. Age at Time of Diagnosis (A) and Transmission Distribution of New Diagnoses (B), 2018



Overall, age and gender at diagnosis have remained relatively constant between 2014 and 2018 in Sacramento County.[3] However, the rates of new infections per 100,000 population have trended notably since 2014 when stratified by race/ethnicity, as can be seen in **Exhibit 11**. Specifically, B/AA and Hispanic/Latinx persons consistently have the highest the rate of transmission, which peaked in 2016. Since then, rates have declined for both groups, though rates for B/AA remain substantially higher than for other ethnic groups.[3] It is important to note that when overall numbers of individuals in a group are small, sparklines or other trend analyses should be interpreted with caution.

American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups are not included in the race/ethnicity data tables below due to small to zero numbers reported each year from 2014-2018. This report does not intend to diminish the impact of HIV on American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups. Small numbers are not reported to preserve the confidentiality of PLWH.

Exhibit 11. Rate of Transmission by Race/ethnicity, New HIV Diagnoses, Sacramento County

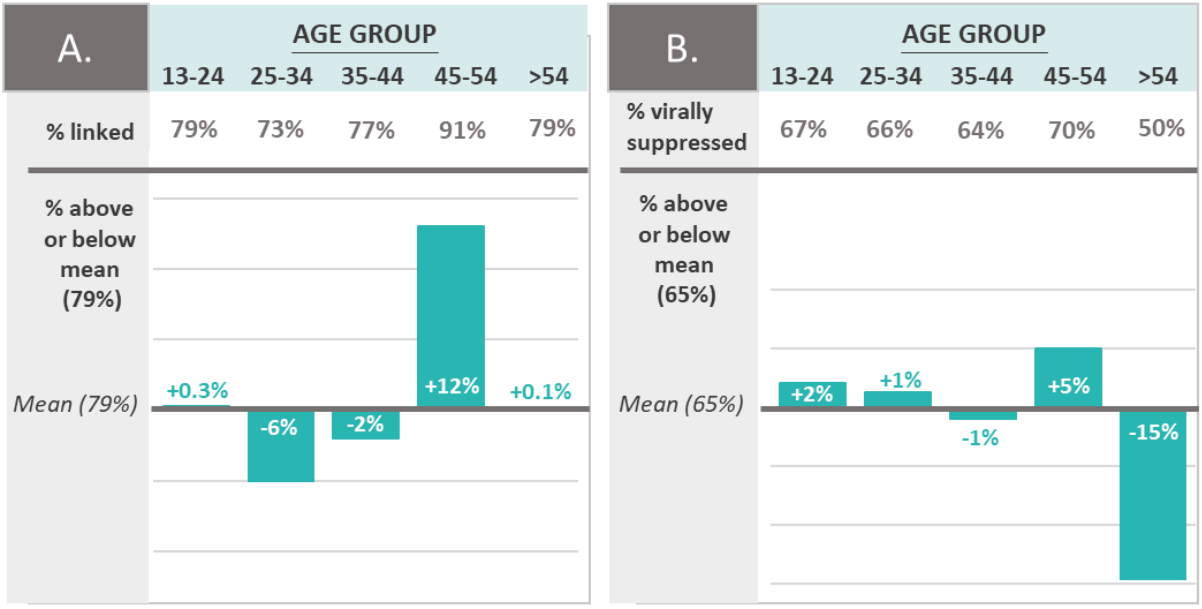
Race/ethnicity	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2014-2018 Sparklines
Black/African American	31.3	22.9	31.4	28.4	25.6	
Hispanic/Latinx	13.7	12.5	16.2	15.3	14.8	
Asian	3.8	1.4	5.5	5.9	5.0	
White	10.4	11.2	9.2	8.3	6.0	

Note: Rates are per 100,000 population.
Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

Linkage to Care and Viral Suppression

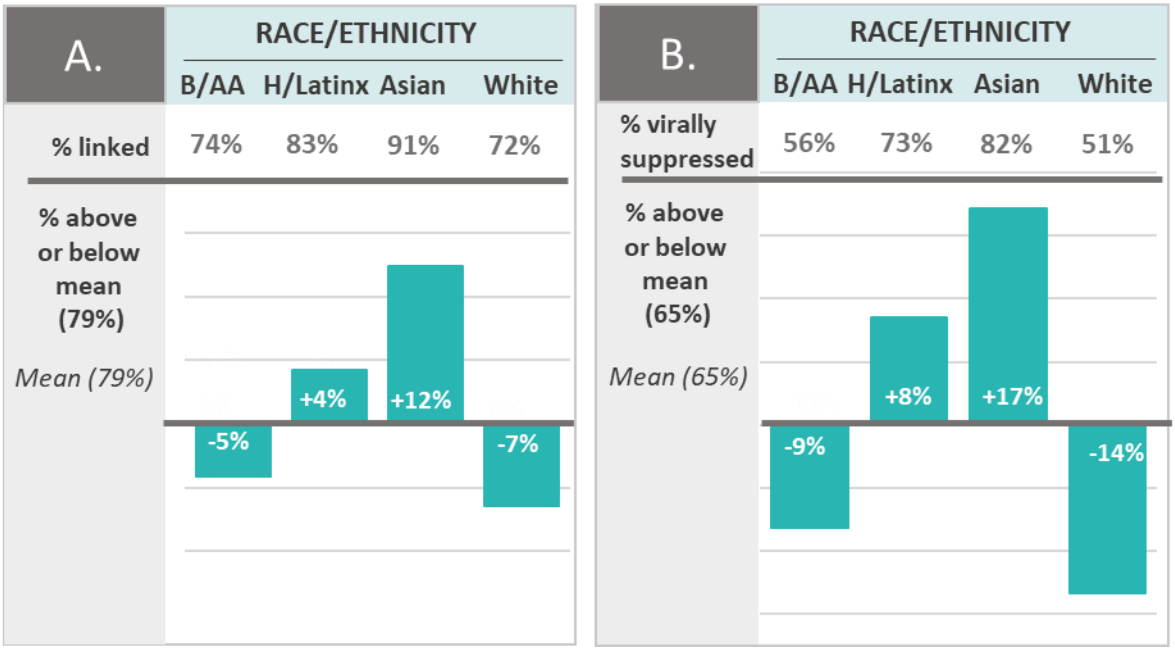
New diagnoses are not the only important piece of HIV epidemiology, however. Also key are the percentages of people linked to care within 30 days, and virally suppressed within six months of diagnosis. Overall, 78.5 percent of people diagnosed with HIV in Sacramento County in 2018 were linked to care within 30 days of diagnosis, and 65 percent were virally suppressed within 6 months. However, there were notable disparities, with people ages 25-34 having considerably worse rates of linkage to care within 30 days, and people older than age 54 having worse viral suppression rates[3] (**Exhibit 12**).

Exhibit 12. Linkage to Care (A) and Viral Suppression (B) by age, Sacramento County 2018



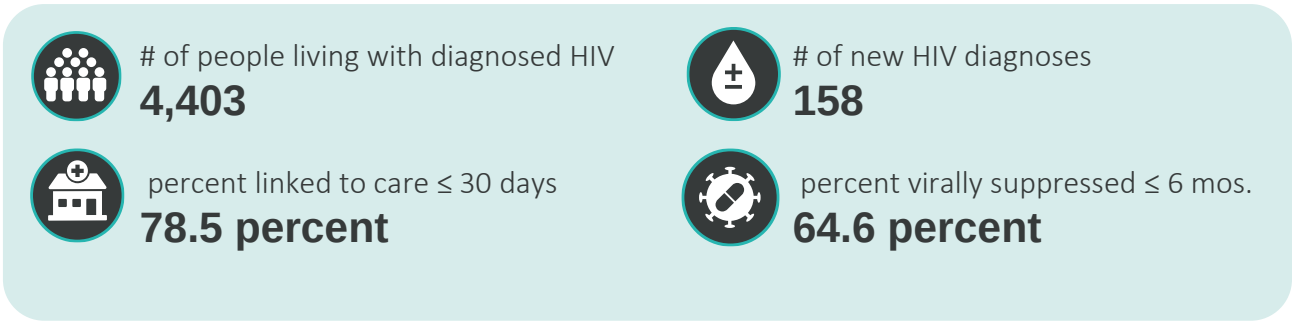
Similarly, disparities in linkage to care and viral suppression were also seen by race/ethnicity, with B/AA and White persons having substantially worse outcomes regarding linkage to care within 30 days and viral suppression within 6 months compared to Hispanic/Latinx and Asians. An impressive 82.7 percent of Hispanic/Latinx(H/Latinx) and 90.9 percent of Asian people in Sacramento County were linked to care within 30 days of diagnosis in 2018, far better than people in other racial/ethnic groups[3] **(Exhibit 13)**.

Exhibit 13. Linkage to Care (A) and Viral Suppression (B) by race/ethnicity, Sacramento County 2018



In summary, **Exhibit 14** provides a few key features of Sacramento County's HIV epidemic in 2018.

***Exhibit 14*.** Key features of Sacramento County's HIV epidemic (2018)



Section III: Situational Analysis

This Situational Analysis provides a high-level overview of the strengths, needs, gaps, and barriers related to ending the HIV epidemic in Sacramento County. It synthesizes information from the epidemiological profile, community engagement efforts, planning conversations, and consultations with key partners and stakeholders, both HIV and non-HIV.

The Situational Analysis is organized into the following three sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps.

Methods

Sacramento County's situational analysis consisted of documenting HIV-related community needs and assets, describing the existing resources to meet those needs (see **Appendix 1: Resource Inventory**), and identifying gaps that must be filled to fully meet the needs (**Exhibit 15**).

Exhibit 15. Methods and data sources used for the County's situational analysis

Method	Description
Needs assessment to ascertain needs, resources, and service gaps	• EtHE community engagement efforts[5,7-10] • 2018 Ryan White Needs Assessment[14] • County information on existing services (such as FY 20 Ryan White Provider Service Matrix[16]) • California Syringe Services Programs[17]
Review of secondary data and reports	• AIDSVu local PrEP estimates[18] • Sacramento County Epi Profile 2018[3] • HIV Infection Fact Sheet[4] • Point in Time homeless count[12] • CA Opioid Surveillance Dashboard[15] • HRSA 20-078 application[6] • Sacramento TGA CQI Plan 2018[19] • 2019 HUD Estimates of Homelessness[11] • Sacramento County Homelessness Report[13] • Harm Reduction Services: Hope Without Limits[20] • Bicillin Access Project presentation[21] • CA HIV Surveillance Report[22] • STI Fact Sheet[23] • HIV in Prisons[24]
Community engagement and consultation	• HIV Health Services Planning Council[8] • Service providers • Community members representing the priority populations disproportionately impacted by HIV
Review of relevant County and State plans	• Zero New HIV Infections Together: 2016-2021 Strategic Plan[1] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan[2] • EPMP and Work Plan[25] • Sacramento County PS18-1802 Work Plan and Logic Model[26]

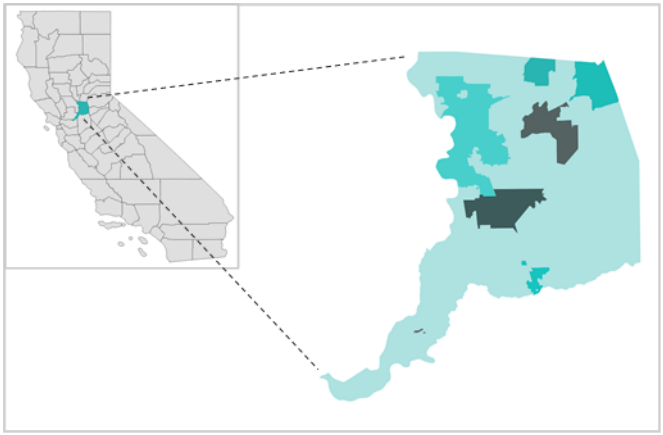
Consultation with key stakeholders	• Local: SCPH staff, Zero Together Collaborative; SacWISH • Regional and State: CDPH; Federal Ryan White Program Staff; and AIDS Education and Training Center

Situational Analysis Snapshot

Situational Analysis Summary

Sacramento County (**Exhibit 16)** is a sprawling, racially diverse urban and suburban community that accounts for more than 90 percent of the HIV cases in the TGA. Thus, the TGA represents both urban and rural trends nationally and presents the challenges for service delivery that are associated with both types of communities. Specialized HIV services are centrally located in Sacramento County and are used by residents from the whole TGA.

Exhibit 16. Map of Sacramento County cities



Sacramento County's EtHE efforts to date have helped curb the HIV epidemic, with the annual number of new HIV infections in Sacramento decreasing by 15 percent (185 cases to 158 cases) between 2008 and 2018.[3,4] However, the County still sees nearly 160 new HIV diagnoses per year (a rate of 10.3 per 100,000), with certain communities disproportionately impacted, including MSM, people of color (especially people who are B/AA or Hispanic/Latinx), transgender women, and people who inject drugs (PWID).[3] People who are B/AA have a rate of new HIV diagnosis more than four times that of people who are White (approximately 26 per 100,000 compared to 6 per 100,000).[3] Women make up 17 percent (n=25), and transgender women make up 2 percent (n=3) of new diagnoses.[3,6] Male-to-male sexual contact (MMSC) made up half of transmissions (49 percent), with the next most common transmission categories being heterosexual contact (not high-risk, 19 percent), high-risk heterosexual contact (9 percent), MMSC/injection drug use (6 percent), and injection drug use (5 percent).[3] There are 4,403 people are living with HIV in Sacramento in 2018,[3,4] with an additional 850 people estimated to be living with undiagnosed HIV.[3] In addition, 78.5 percent of people newly diagnosed with HIV were linked to care within one month, and viral suppression rates improved dramatically, from 46.4 percent of newly diagnosed persons virally suppressed in 2014 to 64.6 percent in 2018.[3]

A major challenge to ending the HIV epidemic in Sacramento County, as voiced at community engagement meetings, is barriers to access.[5] Local needs assessment data collected prior to the EtHE planning process suggested a number of challenges to accessing to HIV-related resources, including a lack of awareness that services are available, not knowing how to get services or where to find them, financial barriers, feeling disrespected by service providers, a lack of convenient appointment times, and concern about the privacy of one's HIV status.[5] In addition to concerns regarding healthcare access, these audiences face various social determinants of health variables which certainly play a role in their health outcomes. Local Ryan White (RW) data indicates that 29 percent of all RW clients report being unhoused or marginally

housed, as compared to a 2019 homelessness rate of 0.30 percent of the general population in the Sacramento TGA.[12] In addition, B/AA are overrepresented among unhoused clients: B/AA made up 26.8 percent of the RW clients who were unhoused, but only 7.4 percent of the TGA's general population in FY18.[6] 18.7 percent of 2018 Sacramento TGA Needs Assessment survey respondents reported being unhoused or unstably housed (living on the street, in a car or in a shelter) in the last two years.[14]

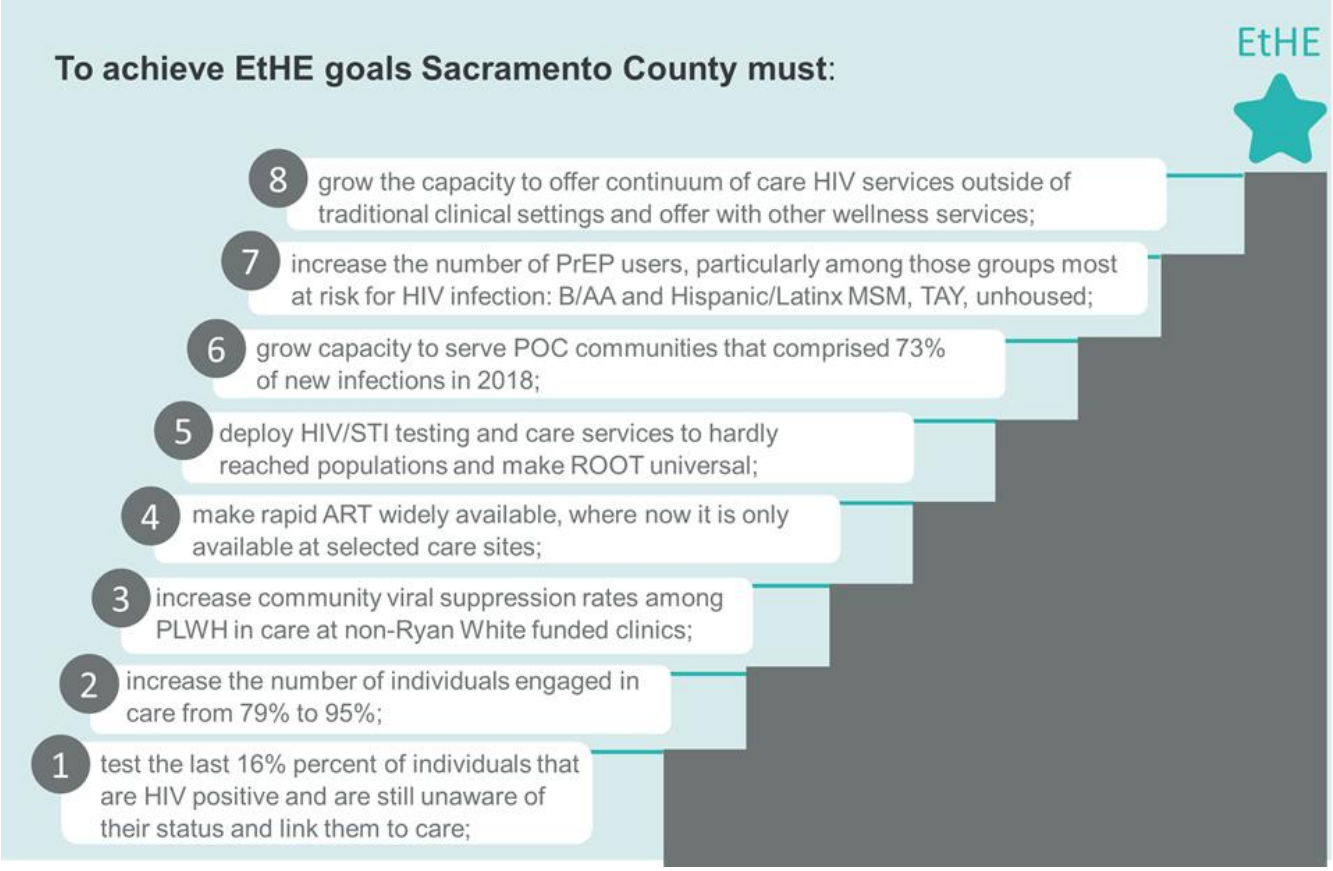
In the 2018 needs assessment, survey respondents that were unhoused reported unmet needs for several RW service categories at higher rates than survey respondents overall. For example, 34 percent of unhoused survey respondents reported an unmet need for AIDS Drug Assistance Program (ADAP) vs. 21 percent of survey respondents overall. 63 percent of unhoused respondents indicated an unmet need for community-based health services vs. 50 percent of respondents overall. Other service categories in which unhoused survey respondents had greater unmet needs than overall respondents include housing (59 percent vs. 48 percent), medical case management (41 percent vs. 29 percent), medical transportation (47 percent vs. 37 percent), oral health care (47 percent vs. 27 percent), referral for healthcare/supportive services (34 percent vs. 21 percent), and inpatient substance use treatment (41 percent vs. 31 percent).[14]

The current configuration of services has wide reach and meets many needs. However, there is a subset of people living with and at risk for HIV for whom these challenges are amplified, according to insights gleaned from recent community engagement efforts. For example, groups such as people experiencing homelessness have particular physical, social, and psychological barriers that the current service networks are not equipped to address.[5] For this and other marginalized populations, clinical services delivered through traditional, "four-wall" settings are inadequate due to physical distance, high costs, fear of stigma, or distrust of the medical system.[5,6]

Current Sacramento County efforts to offer HIV-related services in non-traditional settings are limited in scope, typically consisting of just HIV testing or information distribution. While these efforts are critical, they are not able to meet the need for HIV services or the necessary supportive services—such as mental health counseling, alcohol and drug counseling, and screening for other infections/STDs—to address the social determinants of health that impact the populations most impacted by HIV.[5]

The County is fortunate to have a robust network of HIV-specialized clinical providers and CBOs who have been essential in helping achieve the successes to date. Collectively, the network has experience reaching many marginalized and disproportionately impacted priority populations but does not have the resources for the intensive level of effort it takes to fully engage and serve these groups. With the new EtHE federal funding, SCPH and its partners will be well-equipped to design and implement disruptively innovative strategies for these priority groups using non-traditional approaches and settings.

Exhibit 17. High-level summary of what is needed to end the epidemic in Sacramento County



Situational Analysis Snapshot by Pillar

Diagnose

Today, nearly three-quarters of people newly diagnosed with HIV are people of color (73 percent). MSM (who do not inject drugs) make up only half (49 percent) of new diagnoses in contrast to trends in many other California counties; in Sacramento County, heterosexual contact is the reported mode of transmission for 28 percent of new diagnoses. It is estimated that there are 850 people living with HIV in Sacramento County (16 percent of all PLWH) who are unaware of their HIV status.[3] In 2018, 23 percent (37) were late testers, or those diagnosed with HIV and AIDS simultaneously; of these 48.6 percent were Hispanic/Latinx and 76 percent were cis-male.[3]

Although HIV testing is available in many locations throughout the County, community engagement data suggests that HIV messaging and outreach is not reaching many people of color (including women), the transgender community, youth, PWID, people experiencing homelessness, Spanish speakers, and other vulnerable populations—information may not be reaching them at all, or if it is, it is not resonating.[5] Routine opt-out testing (ROOT) is also not widely practiced, undoubtedly leading to missed opportunities for diagnosing many of those estimated 850 people. There is strong consensus among community engagement participants, SCPH staff, and the Planning Council that community-based testing needs to be widely

accessible in all areas of the County and tailored to the needs of people not currently being reached effectively.

Treat

Sacramento County's one-month linkage to care rate, at 78.5 percent among people newly diagnosed in 2018, falls short of California's goal of 85 percent. Six-month viral suppression rates for newly diagnosed persons have improved dramatically, from 46.4 percent of persons virally suppressed in 2014 to more than 64.6 percent in 2018.[2] The overall viral supression rate among PLWH is 69.9 percent. Deeper examination of these data reveal that: 1) Ryan White patients have good outcomes overall but there has been less success with certain subpopulations, like TAY, B/AA and Hispanic/Latinx[6]; and 2) patients *out* of care are a primary driver of lower than optimal community viral suppression rates.

Commnunity engagement participants highlighted three key needs related to the Treat pillar: 1) expansion of rapid ART; 2) improvement in education and messaging; and 3) removal of access barriers.[5] First, participants expressed that there should be more programs where newly diagnosed persons can start ART within 72 hours of diagnosis. Second, as with testing, participants reported that accurate and culturally appropriate education and messaging about treatment is needed. For example, U=U may not be widely understood, some populations need visuals instead of text-based materials (e.g., people without formal education), youth need youth-friendly mechanisms for communication via apps and other technology, and materials for Spanish speakers are needed. Lastly, community participants noted several barriers to treatment access, including the lack of integrated HCV treatment and services, the limitations inherent in traditional "four-wall" clinic settings, mental illness, substance use, and lack of transportation to and child care options during medical appointments.[5]

Prevent

One of Sacramento County's greatest needs is increased access to and uptake of PrEP. It is estimated that only 657 residents were using PrEP as of 2018, a rate of 53 per 100,000 population, which is substantially lower than California's overall rate, and far short of the state goal of 152 per 100,000 population.[18] The County's CDC PS-18-1802 funds are being used to implement a new initiative called PrEPare Sacramento, as well as increase PrEP navigation services for B/AA, Hispanic/Latinx, and young MSM. Community engagement participants stressed the need to break down PrEP-related stigma and involve people who are on PrEP in promoting PrEP with sex-positive messaging. The current reach of PrEP messaging and services is limited, even more so than testing and treatment messaging and services, as evidenced by the low uptake.

***Exhibit 18*:** 2021 Target and 2018 Estimated PrEP Utilization in Sacramento and California

	Total Users	Rate (per 100,000)
California 2021 target	60,000	152
California 2018	27,283	82
Sacramento 2018	657	53

SCPH, in coordination with the State Office of AIDS, also facilitates condom distribution around the County, including providing condoms to local CBO's. In addition, SCPH coordinates with other condom providers including Essential Access Health's Condom Access Project and the Capitol City AIDS Fund, to distribute condoms and lube through the County.

In addition to PrEP, Sacramento County has a solid, County-sanctioned syringe services program (SSP) and harm reduction services, provided by a local CBO, Harm Reduction Services.[20] In addition to the provision and disposal of syringes and safer injection supplies, the program offers HIV, HCV, and STD testing, specialized medical services (e.g., wound care), education and prevention materials, and overdose prevention services including distribution of naloxone. Harm Reduction Services also operates a mobile van that brings many of these services to PWID. This model of mobile prevention services has been shown to be very effective and could be expanded to reach other populations and to provide additional services.

Respond

SCPH has strong capacity for coordinating between prevention, care, and surveillance because the efforts are all integrated into the Sexual Health Unit. This capacity has been further bolstered with CDC's integrated approach facilitated by PS-18-1802. SCPH is currently working to expand and better coordinate partner services, including developing a surveillance-based partner services protocol. An additional Communicable Disease Investigator (CDI) is being hired with Ryan White early intervention funding, and CDIs are increasingly coordinating with CBOs and other partners.

Sacramento County has not experienced a cluster to date but works closely with the State Office of AIDS to monitor and identify any clusters in the County and coordinate a response. Should a cluster be identified, the California State Office of AIDS (OA) would contact the Sacramento County Health Officer to notify them of the cluster and convene a briefing meeting with the response team, which includes the AIDS Director, STD Controller, HIV/STD Surveillance Program Manager, Epi Unit Manager, STD/HIV Programs Manager, and other key personnel. This team will provide analysis of the cluster and determine the specific activities that will be taken to investigate the cases within the cluster. If the cluster is larger than staff capacity, the OA Prevention Branch Disease Outbreak Intervention and Field Investigation Unit will assist in the response. Throughout the response, Sacramento County will follow the steps outlined in the CDC guidance *"Detecting and Responding to HIV Transmission Clusters: A Guide for Health Departments*" as well as the CDPH OA Cluster Response Plan.

The SCPH Surveillance Unit works closely with other Surveillance coordinators from jurisdictions across the State to ensure that there is no break in services for those living with HIV when transferring to another jurisdiction or even another State.

SCPH has identified a need for community and social network education related to cluster response follow-up. Protocols for this will be developed as part of the implementation of the EtHE plan.

Summary of Resources and Gaps

Resources and Assets

Exhibit 19 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be

leveraged to enhance EtHE planning and implementation. All of the items below can be thought to influence multiple pillars. They are categorized based on how they were discussed during community engagement efforts. One of the County's most valuable resources is its provider and CBO partnerships, whose expertise and experience will be critical as the County branches out to reach new populations living with and at risk for HIV. Additional resources and assets are presented in **Exhibit 19** and described in more detail in the narrative that follows.

Exhibit 19: Sacramento County Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Strong community-based testing services, including 2 mobile testing vans	●			
Robust Ryan White system of care demonstrating success with client viral suppression rates > 85 percent		●		
Wide access to syphilis treatment through the Bicillin Access Project			●	
Recent scale-up of PrEP services and messaging including a PrEP Assistance Program partnership with the State Office of AIDS			●	
Provision of free condoms via partnership with State Office of AIDS			●	
Comprehensive County-sanctioned syringe services program (SSP) offered in community settings			●	
Interdisciplinary SCPH outbreak response team for responding to HIV outbreaks				●
Cross-Pillar				
• **Drop-in and weekend HIV services available, especially for youth** - providing access to on-site clinical services, including HIV testing and care • **Mainstream media visibility** promoting widespread U=U and PrEP messaging • **Free STI Clinic offering comprehensive services** - STI testing/treatment for substantial risk groups, with HIV treatment services coming soon • **Non-traditional medical services** - Some HIV-related and general wellness services offered outside of traditional clinical settings • **Diverse array of service providers** in different sectors who have fostered strong community ties • **Strong partnerships** between organizations that support HIV testing and treatment				

Strong community-based testing services, including 2 small mobile testing vans. Local CBO Harm Reduction Services operates PROJECT REACH, which provides outreach services to unhoused and drug-using populations through the use of a mobile van to distribute risk reduction materials (such as condoms and harm reduction materials, survival supplies (including food, hygiene products, water, and wound care materials), syringe exchange, and HIV/HCV testing. The Gender Health Clinic serves transgender and gender non-conforming persons and SANE serves substance users with HIV testing and clinical referrals to HIV care.

Robust Ryan White system of care. Sacramento County has had a Ryan White system of care operating for more than 20 years to support treatment and care for PLWH. Sacramento's Ryan White program has a high treatment success rate, with more than 85 percent of clients virally suppressed.[6]

Wide access to syphilis treatment. The Bicillin Access Project has been operating in the County since 2007. Its goal is "to facilitate and prioritize timely treatment of symptomatic Early Syphilis infected patients, Late-Latent patient(s), and exposed partners with the objective to promptly and effectively stop the spread of disease in the community."[21] This is an important partnership, not only because it improves access to treatment, but also because it facilitates the connections needed to conduct partner services and follow-up.

Recent scale-up of PrEP services. The County's CDC PS-18-1802 funds are being used to implement a new initiative called PrEPare Sacramento, as well as increase PrEP navigation services for B/AA, Hispanic/Latinx, and young MSM. In addition, contracts for the PrEP Assistance Program (PrEP-AP) are now in place, allowing Sacramento County to be a PrEP-AP provider and enrollment site. This program helps expand access to PrEP for those with financial barriers.

Provision of free condoms. We serve more than 15 sites by providing condoms and lube on a regular basis. **Exhibit 20** to the right shows that 10,610 condoms were distributed in the first quarter of 2020

Exhibit 20. Condom, dental dam, and lube distribution in Quarter 3 of 2020.

Quarterly Data	Condoms	Dental Dams	Lube
Jan-Mar 2020 Quarter 3	10,610	60	5,290

Comprehensive County-sanctioned syringe services program (SSP). Sacramento County has had a strong syringe access program in place for more than two decades. As of 2019, three local community-based organizations offer syringe access services: Gender Health Center, Harm Reduction Services, and SANE (Safe Alternatives Thru Networking and Education).[17] Harm reduction efforts like these have helped prevent HIV/HCV transmission among PWID in Sacramento County, with only 5 percent of new HIV diagnoses among PWID (comparable to California State).[3,22]

Interdisciplinary SCPH outbreak team. The County of Sacramento has an internal team to respond to the HIV epidemic, including public health nurses (PHNs), trained Communicable Disease Investigators (CDIs), epidemiology and prevention staff, and Ryan White staff. The existence of this team enables coordinated responses to combat the HIV epidemic across disciplines.

Drop-in and weekend HIV care services available. Drop-in centers like Wind Youth Services partner with community health organizations (e.g., One Community Health, a Federally Qualified Health Center) to provide HIV testing, care, and other on-site clinical services on a weekly basis. Centers like these create a youth-friendly space where young people can feel comfortable accessing HIV testing and other health services. Saturday clinical hours are available through the UC Davis Medical School (Medical Students under supervision of an attending physician), staffing the Joan Viteri Clinic, with a focus on injection drug users and sex workers. The Sacramento Community LGBT Center also hosts a drop-in center for youth, called the Q-Spot, during evening and weekend hours. Given the challenges reaching many

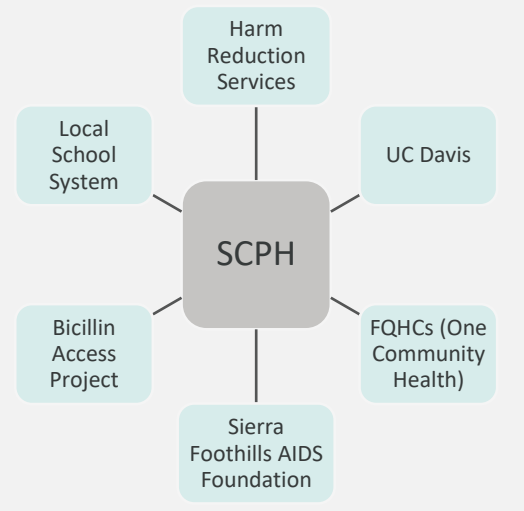
communities due barriers to access offering services outside of traditional 9-to-5 weekday hours is one successful approach that could be expanded.

Mainstream media visibility. Mainstream advertising has increased the visibility of HIV-related treatment and prevention resources, and the County plans to continue this momentum. For example, PrEP commercials on the television and radio have made PrEP more visible. In addition, Sacramento County has proposed to use HRSA EtHE funding to implement a U=U campaign that utilizes social media to promote awareness and knowledge about the importance of viral load suppression.[6] The campaign would reach more than 100,000 residents through social media and would distribute 7,000 educational materials throughout Sacramento County and 30,000 educational materials in waiting rooms. Additionally, the campaign would educate and offer technical assistance to providers regarding U=U.

Free STI clinic. The County's dedicated Sexual Health Clinic supports HIV diagnosis by providing STI testing and treatment (including HIV testing) at no cost to clients. The clinic has been successful in reaching high-risk groups, diagnosing relatively high rates of syphilis and HIV, and experiencing good retention. The clinic will soon be expanding its HIV-related capacity by offering HIV treatment services and started offering PrEP services in May 2020.

Non-traditional medical services. Some community-based organizations in Sacramento offer clinical services (including HIV-related services) outside of traditional medical settings. Examples include mobile/street-based HIV testing by Harm Reduction Services and free Saturday clinics for uninsured and/or undocumented individuals (e.g., Joan Viteri Memorial Clinic). In addition, a number of clinics, including the County Sexual Health Clinic, Sacramento Native American Health Center, and various community-based testing partners offer HIV/STI testing free of cost. Such non-traditional approaches help reduce physical and financial barriers to HIV testing.

Exhibit 21. SCPH partner agencies that support HIV testing and/or treatment



Diverse array of service providers. Sacramento County is home to a number of diverse service providers and organizations that help diagnose, treat, and prevent HIV, including community-based organizations, government agencies, and academic institutions. Many of these service providers have fostered strong ties in the community and displayed knowledge and cultural competence with respect to the populations that they serve. For example, the Sacramento Workgroup to Improve Sexual Health (SacWISH) engages more than 100 community members in its quarterly meetings.

Strong partnerships. SCPH partners with a number of agencies to support quality HIV testing (**Exhibit 21**), including academic institutions like the UC Davis School of Medicine (UCDSOM), Federally Qualified Health Centers (e.g., One Community Health, OCH), community-based organizations like Harm Reduction Services, foundations (e.g., Sierra Foothill AIDS Foundation), local schools, and the Bicillin Access Project mentioned earlier. Among these partners, OCH and the Bicillin Access Project also support quality HIV treatment and care.

Gaps and Challenges

Sacramento County has a number of pillar-specific and cross-pillar challenges and gaps that will need to be addressed in order to reach EtHE goals. Specifically, the County will need to continue to better understand the needs, barriers, and challenges of the groups not currently reached effectively, including TAY, people of color, people experiencing homelessness, and PrEP eligible individuals. This knowledge will help inform the design of services and selection of strategic partnerships. Gaps and challenges are summarized in **Exhibit 22** and detailed below.

Exhibit 22: Sacramento County Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Limits in the reach of community-based testing, resulting in missing many who need it	●			
No enforcement for Routine Opt-Out Testing (ROOT) in medical settings	●			
Clear disparities in viral suppression rates, with both Ryan White subpopulations and non-Ryan White patients affected		●		
Insufficient use of social media/apps to reach youth and make logistics of scheduling appointments easier		●		
Syringe access, city not county-sanctioned			●	
Rising STI rates, indicating increases in condom-less sex and stretching disease investigation resources to their limits			●	
Lack of a protocol for HIV outbreak response making responses less timely and coordinated				●
Cross-Pillar				
• **Stigma** creating barriers to HIV testing, PrEP uptake and accessing HIV care. • **Un- and under-served populations** including unhoused communities, transitional aged youth, and people living with HIV • **Lack of a robust Alcohol and Other Drug (AOD) program** to support high-risk people who use substances • **Lack of cultural competency** resulting in negative patient experiences • **Missing partnerships** including law enforcement, private HIV testing/care organizations, and Medi-Cal • **Provider practices and systems** not fully aligned to support HIV prevention and care • **Lack of non-traditional settings for HIV services** to serve patients who need services in non-clinical spaces or at flexible hours • **Patient health/medical literacy** regarding PrEP/HIV prevention and treatment access • **Insufficient funding/staffing** limiting testing and treatment capacity as well as communicable disease investigation and surveillance				

Limits in the reach of community-based testing. Currently there is no primary care provider going out regularly to rural areas of the County. Mobile primary care services are needed to fill this gap in services.

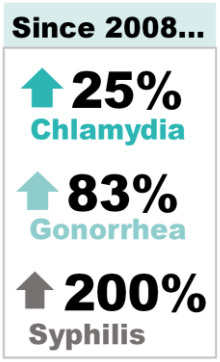
No enforcement for Routine Opt-Out Testing (ROOT). ROOT is happening on a limited basis. The County Sexual Health Clinic has implemented ROOT, and SCPH is working with Corrections to encourage and support ROOT in the juvenile and youth facilities. Since SCPH does not oversee providers, ROOT can only be encouraged and supported, not mandated.

Clear disparities in viral suppression rates. Despite the 85 percent viral suppression rate among Ryan White patients, there are some specific subgroups who have disparately low rates, namely TAY, B/AA and Hispanic/Latinx.[6] In addition, patients *out* of care are a primary driver of the County's lower than optimal viral suppression rates, suggesting a need to work with providers on linkage and retention.

Insufficient use of social media/apps. With respect to treatment, community members indicated that modern communication tools are needed to reach youth (a substantial risk group) and make logistics of seeking care easier for people living with HIV.[5] Examples include social media and apps that make scheduling appointments easier.

Rising STI rates. In Sacramento, the rates of several STIs have increased between 2008 and 2017, with chlamydia rates increasing by 25 percent, gonorrhea rates increasing by 83.1 percent, and syphilis rates more than doubling (**Exhibit 23**).[23] Rates of each STI are approximately 15 percent higher in Sacramento County than in the state of California, with Sacramento ranking 8th highest among all California counties for chlamydia rates, 10th highest for gonorrhea rates, and 12th highest for syphilis rates.[23]

Exhibit 23. Summary of County STI trends



People at higher risk for these STIs in Sacramento County overlap with those at higher risk for HIV due to shared risk factors, yet by default, they are not always tested for HIV when diagnosed with an STI, missing an opportunity to test (and therefore diagnose) people at higher risk for HIV infection.[5] In addition, as the STI caseloads for Sacramento County Communicable Disease Investigators (CDIs) increase, the CDIs have less time to dedicate to HIV response.[5]

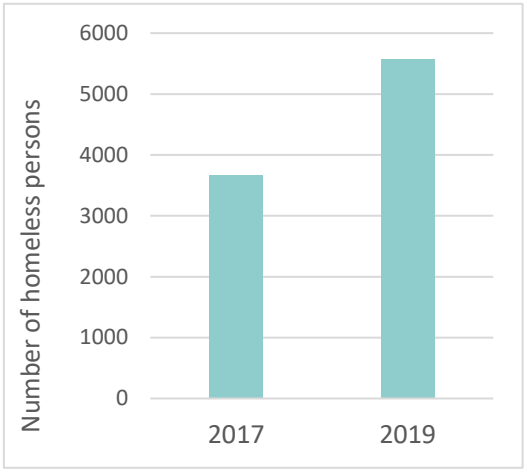
Lack of a protocol for HIV outbreak response. Although the County has an interdisciplinary outbreak team (see p. 25), there is no formal protocol for HIV outbreak response. As a result, responses to the HIV epidemic are not as timely or coordinated as they could be, which could pose challenges to an effective response if a cluster were identified in Sacramento.[5] As the state completes its Outbreak Response Plan, we will follow the guidance for LHJs in that document. We will also utilize the OA Prevention Branch Disease Outbreak Intervention and Field Investigation Unit for technical assistance and additional staffing as needed.

Stigma. Although strides have been made to reduce HIV-related stigma over the past several decades, community members expressed concern that some groups are still experiencing intense HIV-related stigma,[5] especially with regard to PrEP. Community members highlighted the term "Truvada whore"—shaming language used to describe people who are on PrEP. Community members suggested that a PrEP speakers bureau/advocates could help break down this stigma and increase awareness.

Un- and under-served populations. Certain communities are more disconnected than others from resources related to HIV diagnosis and treatment, which makes it difficult to get them tested, linked to care, and retained in care. Two major populations that are hardly reached include people experiencing homelessness and transitional aged youth (TAY). These populations relocate and move frequently, and they may lack access to transportation. These communities often experience high co-morbidity rates (such as mental health or substance use disorders), which exacerbates the challenge of providing them with quality HIV-related care. Members of these communities may perceive the cost of HIV-related services to be high if they do not know about the County's Ryan White program. Moreover, they may not trust traditional medical settings or providers.

Notably, homelessness has been on the rise in Sacramento County (Exhibit 24). An estimated 5,570 people in Sacramento (36 per 10,000) are experiencing homelessness in 2019.[12] Homelessness has increased 52 percent since 2017 (**Exhibit 24**), and almost half of unhoused people are people of color.[12]

Exhibit 24. Homelessness in Sacramento County 2017 vs. 2019



Some community members suggest that prevention efforts have historically focused more on HIV-negative at-risk people than PLWH, and that more prevention efforts with PLWH are warranted, such as U=U and treatment as prevention messaging.

Lack of a robust Alcohol and Drug (AOD) program. Current AOD programs in Sacramento County exist; however, community members noted that they have long wait lists and do not give enough time in the programs for people to develop behavioral skills needed to achieve and maintain their substance use goals. In addition to HIV risk related to injection, the links between non-injection substance use and HIV transmission are well-established, especially among MSM. Further, these programs can help link people to HIV testing and treatment resources. A strong substance use treatment infrastructure is needed for ending the HIV epidemic in the County.

Lack of cultural competency. Community members report that some providers in Sacramento County do not have the skills to deliver an HIV-positive diagnosis effectively, leading to traumatic patient experiences. Providers also sometimes fail to understand the ways that systems are culturally biased, creating barriers for clients from marginalized and under-served populations when they try to access care. Moreover, quality measures for cultural competency are lacking, resulting in little incentive for providers to offer culturally competent care. As a result, a lack of cultural competency sometimes furthers distrust of the medical system due to negative patient experiences.

Missing Partnerships. Despite the critical partnerships described in the Resources and Assets section (see p. 26), certain key partnerships are currently absent in the County EtHE initiative (**Exhibit 25**).

For example, with respect to diagnosis, a lack of partnership with the jail system misses an opportunity to offer HIV testing to adults admitted to jail, where HIV prevalence may be higher than in the general population.[24] Relatedly, strengthening of an existing partnership with the Youth Detention Facility could facilitate STI/HIV testing, linkage to care, and PrEP referrals. Buy-in from law enforcement is also critical to ensure that certain EtHE activities (such as street outreach with condoms or syringe access services) are safe spaces where people will not get penalized for their participation or possession of condoms or injection harm reduction supplies.

Exhibit 25. Missing partnerships for EtHE efforts

Category	Examples
Law Enforcement	• Jail Services • Youth Detention Facility
HIV Testing/ Treatment	• Kaiser • VA
Broader Support Services	• Mental Health Providers • Housing Providers • Substance Use Services
Agencies Serving High-Risk Groups	• Agencies representing/serving B/AA and Hispanic/Latinx MSM • Agencies representing the unhoused • Agencies representing/serving TAY
Insurance Providers	• MediCal/Department of Health Care Services

Examples of other partnerships that are currently missing include relationships with organizations who already conduct HIV and STI testing and/or treatment—such as Kaiser and the VA Medical Center—to support tracking of STI testing rates among patients with HIV; relationships with agencies that serve or represent B/AA and Hispanic/Latinx MSM, the unhoused, and TAY; and relationships with Medi-Cal/Department of Health Care Services.

Provider practices and systems. In community engagement meetings, participants expressed a number of provider-related behaviors that stand in the way of HIV diagnosis, treatment, and prevention.[5] One current provider barrier related to diagnosis is that there is no enforcement for providing routine opt-out testing. In terms of treatment, there is a need for better referrals out of the emergency department to link people to care once they have been identified as HIV-positive. Another treatment barrier is retention in care; patients are often lost to follow-up after being linked to an HIV care provider. With respect to prevention, providers need more training on PrEP, available PrEP-resources, and PrEP-related disparities.

Lack of non-traditional settings for HIV services. Although some organizations offer non-traditional HIV services (e.g., street outreach), these are limited in number and scope. Community engagement insights suggest that Sacramento County lacks physical spaces (such as non-sexual health/STI spaces) and hours of operation (such as late evening hours) that are needed to meet the competing demands of communities and to promote access among marginalized populations.[5]

Patient health/medical literacy. Community input suggests that many patients are lacking concrete knowledge about key HIV prevention concepts.[5] Many patients lack knowledge about PrEP providers/where to get PrEP, and some people think that PrEP is just for gay men. Youth

often use birth control but not condoms, and some patients have a sense of invincibility around HIV. Educational materials are available, but they are often in written format, which may not be accessible to all communities. Health literacy barriers also exist with respect to treatment for HIV, as many people living with HIV do not know about Ryan White services, do not believe they are eligible for Ryan White services, or do not know how to get services, according to a recent County needs assessment.[27]

Insufficient funding/staffing. A lack of funding for HIV-related initiatives was cited widely by community members as an EtHE barrier to diagnosis, treatment, and response efforts.[5] With respect to diagnosis, a lack of staffing and resources county-wide results in insufficient training opportunities for HIV test counselors and community-based organizations, as well as limited hours of operation for key HIV testing sites such as the County's free Sexual Health Clinic. With respect to treatment, there are limited Ryan White providers to support patients living with HIV. Existing providers have long wait lists that prevent newly diagnosed persons from being quickly linked to care, and appointment times are short, leaving insufficient time for patients to fully discuss their needs. With respect to response efforts, although Sacramento County has trained Communicable Disease Investigators (CDIs), they are few in number (due to funding), shared across diseases, and often are responsible for both Sacramento and surrounding counties. The result is that CDI availability to specifically work HIV cases in Sacramento County is limited, reducing the potential for interrupting HIV transmission via partner services and making it difficult to quickly navigate newly diagnosed people into care.

Section IV: Ending the Epidemic Plan

This section provides a detailed overview of the disruptively innovative activities that Sacramento County will implement to End the HIV Epidemic in the County by 2024. The proposed EtHE activities are above and beyond the foundational efforts already in place and are designed to be directly responsive to the needs and gaps identified in *Section III: Situational Analysis.* The proposed EtHE activities are designed to enhance but not duplicate current programs and services and are inclusive of all disruptively innovative activities, regardless of funding source.

Exhibit 26. Schematic demonstrating how new EtHE activities will build upon existing County efforts to respond to local needs and gaps that have not been sufficiently addressed to date.

EtHE Programs and Key Partners

Sacramento County has identified seven new innovative efforts that will help propel us toward ending the HIV epidemic. These efforts will require close partnership with several existing and new partners in order to be successful. The programs and partners are described below.

Summary of Proposed Programs

- **Wellness Without Walls (W^3).** For this activity, Sacramento County will establish a mobile unit that directly delivers clinical services—including HIV, sexual health, and broader support services (e.g., mental health and substance counseling)—to unhoused communities and transitional aged youth. Comprehensive support services are necessary to support HIV diagnosis in these priority populations, but have not previously been available in Sacramento County outside of traditional clinics with walls. Ultimately, taking sexual health care out of the clinic to meet people where they are will reduce physical, social, and psychological barriers to accessing HIV-related services among unhoused communities, and will improve diagnosis through expanded testing. Because W^3 will offer mobile services other than HIV/STI resources, it will allow clients to access services with less stigma. *(Diagnose, Treat, Prevent, Respond)*
- **Comprehensive U=U campaign.** For this activity, Sacramento County will implement a U=U campaign to increase awareness and understanding that PLWH who achieve viral suppression are unable to transmit HIV. Campaign messages will be promoted though

various media including digital advertisements, ads in local publications, posters, and hand cards posted/disseminated at RW provider sites, community agencies, and social venues frequented by targeted audiences, as well as medical provider sites that provide care to PLWH who are not enrolled in RW. To impact the overall viral suppression rates in the TGA, project staff will conduct monthly "provider detailing" with providers who treat PLWH who are non-RW clients. *(Prevent, Treat)*

- **Establish a highly specialized HIV care clinic.** SCPH Clinic will expand access to HIV care and treatment for people living with HIV within the Sacramento County TGA and serving at least 125 patients annually. The clinic will implement strategies to decrease barriers to HIV treatment access, including accessible clinic drop-in hours and expedited HIV treatment. It will also incentivize viral suppression acquisition for audiences having challenges achieving viral suppression, including food assistance, navigation to housing support, and medical transportation. *(Treat)*

- **Youth-friendly services.** SCPH will improve health outcomes for youth ages 13-24 by increasing access to high quality youth friendly sexual health services, lowering barriers to care, and creating a youth friendly environment for Sacramento County youth to receive HIV care. SCPH will use the Positive Peers mobile app to provide sexual health and lifestyle information, peer support through social networking, and disease self-management tools, including appointment and medication reminders and access to personal health information including lab results. In addition, the app facilitates patient communication with their health care team such as doctors, nurses, social workers, and other support service providers. To create a more "youth friendly" environment in our Sexual Health Clinic, we will establish drop-in hours, locate staff trained in adolescent development and trauma-informed approaches, provide snacks and water, cell phone charging stations, risk reduction supplies, and décor with sex positive and motivational images in the lobby. *(Treat)*

- **Address SDoH that create barriers to care.** SCPH will utilize partnerships with community-based agencies to address the complex medical and social needs of patients living with HIV in Sacramento County. SCPH will implement strategies to address barriers to care by using community agencies to expand availability of 90-day residential substance use treatment services and to navigate participants to existing outpatient substance use treatment, and mental health support services upon discharge. A second program will be initiated to provide transitional housing for 4-6 months to unhoused/marginally housed PLWH and to work with community partners to navigate program participants employment and permanent housing. *(Treat)*

- **Scale up of linkage and retention efforts.** SCPH will coordinate with community partners and providers to ensure all newly diagnosed individuals and their sexual/drug using partners are linked to HIV care within 30 days of diagnosis (with a goal of 7 days) and reengage those lost to care. Sacramento County surveillance staff will coordinate with Sacramento County HIV testers and community-based testing partners to ensure newly diagnosed residents are rapidly linked to HIV care with the support of community health workers. Additionally, project staff will work with hospital emergency departments and correctional facilities to ensure PLWH are rapidly linked to care upon release.

Finally, surveillance staff will work with RW and other community providers serving PWLH to re-engage clients who have fallen out of care. *(Treat)*

- **Expand Surveillance -Based Partner Services efforts to identify and link partners.** To scale up ability to identify and link partners, an SCPH Communicable Disease Investigator (CDI) will be embedded in the Sexual Health Clinic to conduct patient interviews, and all CDIs of the HIV/STD Surveillance Unit will conduct expanded Partner Services activities. *(Prevent, Treat)*

- **Project Empowerment.** The Sacramento LGBT Community Center will improve viral suppression among Black/AA PLWH, and prevent HIV acquisition among Black/AA people who are particularly vulnerable to HIV including 1) gay, bisexual, or other MSM, 2) transgender MSM, 3) transgender women, 4) cisgender women, and/or, 5) PWID. The intended outcomes include increased viral suppression, increased linkage to and retention in HIV care, increased knowledge of HIV status, and increased linkage to and uptake of pre-exposure prophylaxis (PrEP). This program is funded by State prevention dollars. *(Diagnose, Treat, Prevent)*

- **Adapting *Connecting Resources for Urban Sexual Health* for Racial and Ethnic Minority MSM (Adapting CRUSH-MSM)-** This research project is a collaboration between community members, service providers and researchers focused on adapting an evidence-based sexual health services intervention designed to increase PrEP uptake to fit the local HIV epidemic in Sacramento County where racial and ethnic minority populations are disproportionately affected by HIV. The investigators seek to identify how to best adapt a proven-effective sexual health services delivery model called *CRUSH: Connecting Resources for Urban Sexual Health* to better meet the needs of racial and ethnic minority MSM in the more rural Sacramento County. The CRUSH-MSM model focuses on improving outcomes along the HIV prevention continuum, it also provides support to those living with HIV. No PS 20-2010 funds will be used on this project. *(Diagnose, Treat, Prevent)*

Key Partners

We will work with key partners to complete these proposed programs, including organizations serving MSM of color and youth, those working with PWID, and those with particular technical expertise. The following agencies are key partners because they have the ability to reach our priority populations, such as MSM of Color, TAY, people experiencing homelessness and PrEP eligible individuals.

- **Golden Rule Services (GRS).** GRS has a 20-year history of providing HIV and STD testing, education, prevention, and risk reduction services to underserved, high-risk, and vulnerable communities in Sacramento County. A current SCPH HIV/STD Prevention Program subcontractor, GRS has maintained a focus on B/AA MSM through County contracts for HIV/STD education and testing services, and providing HIV navigation services including linkage and re-engagement in care.

- **Harm Reduction Services (HRS).** HRS has successfully served individuals who are experiencing homelessness, drug use, and/or in need of behavioral health services. HRS operates Project Reach, which provides outreach services through the use of a mobile van to distribute risk reduction materials (such as condoms and lube), survival

supplies (including food, hygiene products, water, and wound care materials), syringe exchange, overdose prevention and response training, HIV/HCV/STD testing, and targeted education and services for PWID. Their deep experience in mobile service provision will be an invaluable asset in rolling out W^3 services.

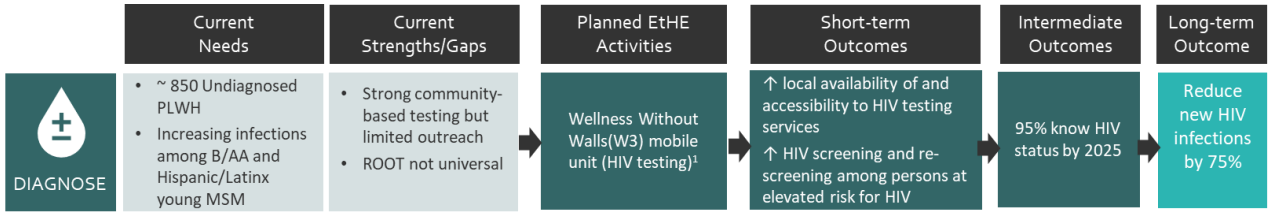
- The **Sacramento LGBT Center** (CENTER) was founded in 1983 and has created a safe space for LGBTQ+ youth called the Q-Spot. The Q-Spot includes a drop-in center, open 7 days a week from 12-6pm, for youth ages 13-24 – serving nearly 250 youth each week. Resources available at the Q-Spot include free HIV testing, counseling, survival supplies, social activities, support groups, housing assistance, and much more.
- **Gender Health Center** (GHC) opened its doors in 2010 and has established the Scripts Hormone Clinic, a free/donation-based Hormone Prescription clinic in collaboration with the UC Davis School of Medicine. GHC also operates a drop-in respite center three days a week for members of the transgender community. Their strong connection to the transgender community will be important for ensuring W^3 services can meet this community's needs.
- **Sacramento County Sexual Health Clinic.** Sacramento Sexual Health Clinic will provide services not available at the W^3 clinic, including administering same-day ART.
- **Sacramento County Department of Health Services, Epidemiology Program** will be instrumental in program evaluation. Program Planners will work in consultation with Epidemiology staff to examine data from a variety of sources, including the California Reportable Disease Information Exchange (CalREDIE), Local Evaluation Online (LEO), the Laboratory Data Entry Tool (LDET), the electronic HIV/AIDS Reporting System (eHARS), and others.
- **Sacramento County Department of Health Services, HIV/STD Surveillance Program** is one of three programs comprising the SCPH Sexual Health Promotion Unit (SHPU). They were integrated into the SHPU to maximize county resources to ensure timely response to contact investigations and to ensure that there was no duplication of efforts. The Surveillance Program is made up of Communicable Disease Investigators (CDIs) who are trained in HIV results notification, linkage to care, Partner Services, and re-engagement of patients who have fallen out of care. They are also responsible for the investigations and reporting of HIV positive individuals, to include those co-infected with syphilis or other STI’s, unhoused populations, people with substance use and mental health disorders, and assist with the linkage to care and warm hand off of those patients to the identified HIV services needed.
- **CDPH Office of AIDS** is a division within the California Department of Public Health, Center for Infectious Diseases, responsible for collaboratively working with state and federal agencies, local health jurisdictions, universities, and CBOs to ensure that efforts to combat the HIV epidemic are targeted and effective. For this project, they will identify, analyze, and monitor clusters and work with SCPH to determine activities to investigate cases within the cluster. The Office of AIDS is also providing oversight and management of CDC PS20-2010.

- **AIDS Education and Training Center (AETC)** is a program of the Ryan White HIV/AIDS program that conducts targeted, multidisciplinary education and training programs for health care providers treating people living with HIV. For this project, SCPH will work with AETC to detail clinics that serve priority populations to improve service outcomes.

Sacramento County's Plan to End the HIV Epidemic

The County's EtHE plan was developed with extensive community and partner engagement and endorsed by the HIV Health Services Planning Council. New EtHE activities will work across all four EtHE pillars and will support the short-term, intermediate, and long-term outcomes identified by the CDC in PS-19-1906.

Diagnose



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Wellness Without Walls (W3)**
- **Project Empowerment**
- **Adapting *Connecting Resources for Urban Sexual Health* for Racial and Ethnic Minority MSM (Adapting CRUSH-MSM)**

Diagnose: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities	
N/A	N/A
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings	
Wellness Without Walls (W3)	
• Conduct three **community engagement meetings**, with an emphasis on including stakeholders who are members of unhoused populations, TAY, and/or the agencies that serve these populations • Collaborate with partners to **develop protocol for mobile services** (services provided, locations served, staffing roles)	• Conduct outreach to promote the mobile services unit and support education/ awareness among unhoused and TAY populations • Increase mobile services unit to 3-4x a week; document challenges and successes; collect data on services provided • Refine protocol for mobile services outreach based on data and lessons learned

Diagnose: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
• Identify an appropriate vehicle that could provide capacity for a mobile services unit • Hire/allocate staff to the mobile services unit • Set up mobile unit with needed **testing materials and supplies** • Train all personnel who will staff the mobile services unit • **Conduct outreach** to promote the mobile services unit and support education/ awareness among unhoused and TAY populations • Pilot the mobile services unit 1-2x a week, for 8 weeks; document challenges and successes; collect data on services provided • Refine protocol for mobile services outreach based on data and lessons learned from pilot period	• Increase staffing to include Medical Case Management Nurse • Issue a competitive bidding process to select community-based service providers such as housing and residential substance use treatment • Initiate subcontracts to provide additional support services such as housing and residential substance use treatment.
Strategy 1C. Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings	
N/A	N/A

HIV Workforce Development Needs

Positions

- **Mobile Services Unit Staff.** The Mobile Services Unit Staff will be responsible for operating the Unit and providing all services, including testing, education, and outreach. They will also be responsible for data collection that will be utilized to improve services in future years.
    - Nurse Practitioner 1.0 FTE – Providing Medical Care / Testing
    - Medical Assistant 1.0 FTE – Providing Medical Care and Testing
    - Communicable Disease Investigator (CDI) 1.0 FTE – Linkage to Care Coordinator
- **Medical Case Management Nurse.** The Medical Case Management Nurse will be added to the staff beginning in year 2, and will be responsible for providing case management services to clients.
- **Mobile Services Unit Training.** As protocols are developed and personnel brought on-line, those personnel will be trained on the services provided, locations served, and staffing roles.

Capacity-Building

When building capacity, Sacramento County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Gender Health Center**
- **Golden Rule Services (GRS)**
- **Harm Reduction Services (HRS)**
- **The Sacramento LGBT Center**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Wellness Without Walls	$760,424	CDC PS20-2010
TOTAL FUNDING FOR DIAGNOSE PILLAR*	$760,424	

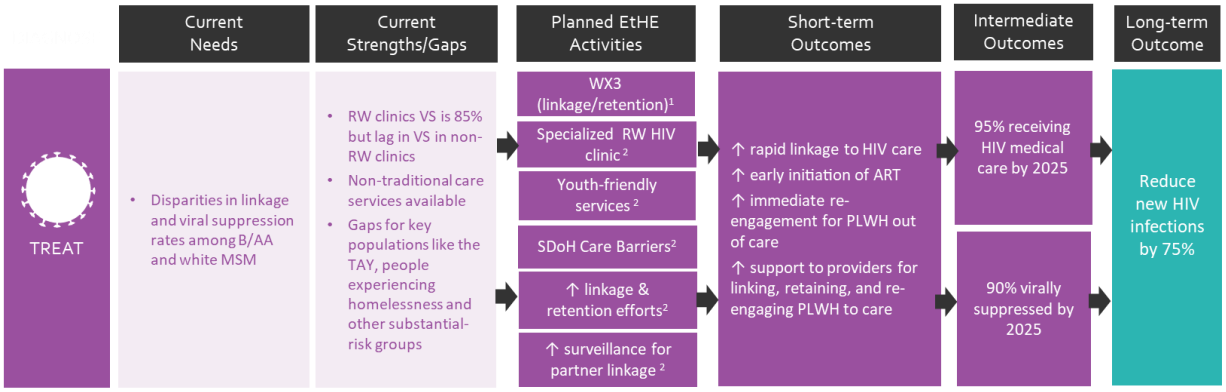
*$0.00 exclusively for Diagnose Pillar, and $760,424 for programs that cut across Diagnose and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[25] Targets will be determined in coordination with CDC as the EPMP is finalized.

Diagnose: Sacramento County	
Outcome Measure	**Data Source**
• **Number** of non-traditional venues where HIV testing is conducted	• Records of HIV testing locations – LEO, (Local Evaluation Online)
• **Percent** of HIV tests conducted in non-traditional venues identified as a priority for the EtHE testing services	• Records of HIV testing events - LEO, (Local Evaluation Online); CBO Quarterly Reports
• **Number** of events where HIV testing is bundled with screening for other conditions relevant to the local population	• Internal SCPH testing log & CBO Quarterly Reports; Electronic Medical Record (Patagonia) for our Sexual Health Clinic
• Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings†	• Documentation of strategies utilized – PrEP navigator logs, Electronic Medical Record, Ryan White Linkage to Care Reports,
• **Percent** of all persons tested in non-traditional test settings that are linked to medical care within 30 days	• Electronic Medical Record (EMR), Ryan White Linkage to Care Reports,
• **Percent** of all persons tested in non-traditional test settings linked to appropriate prevention services	• PrEP navigator logs, EMR

Treat



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Wellness Without Walls (W3)**
- **HIV care clinic**
- **Youth-friendly services**
- **SDoH that create barriers to care**
- **Scale up of linkage and retention efforts**
- **Expand Surveillance – Based Partner Services efforts to identify and link partners**
- **Project Empowerment**
- **Adapting *Connecting Resources for Urban Sexual Health* for Racial and Ethnic Minority MSM (Adapting CRUSH-MSM)**

Treat: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV	
Wellness Without Walls (W3)	
• Staff W^3 Clinic with a 1.0 FTE Communicable Disease Investigator(CDI) who will serve as a **Linkage to Care Coordinator** • **Provide transportation to Sacramento County Sexual Health Clinic** for individuals who receive a Preliminary Positive HIV test result through the W^3 clinic	• Provide transportation to Sacramento County Sexual Health Clinic for individuals who receive a Preliminary Positive HIV test result through the W^3 clinic • Conduct a rapid needs assessment (housing, transportation etc.) for all persons with new HIV diagnoses and link to a disease intervention specialist and/or case manager as needed.

Treat: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
• CDI will perform Partner Services activities with newly diagnosed individuals	
HIV Care Clinic	
• Hire key staff • Train staff on motivational interviewing, adherence counseling, and trauma-informed care • Establish clinic flow and patient referral process • Establish protocol for administering **Same-Day ART** at Sacramento County Sexual Health Clinic • Using HRSA Ending the HIV Epidemic Funding, **extend the Sacramento County Sexual Health Clinic services to include HIV treatment/care** in addition to HIV testing (offered currently) • Pilot intensified, incentivized medical care and support coordination for high need patients	• Administer Same–Day ART service • Expand intensified, incentivized medical care and support coordination for high need patients
Youth-Friendly Services	
• **Provide training to clinic staff** on adolescent development and trauma-informed care • Create a **youth-friendly clinical assessment tool and patient satisfaction surveys** • **Adopt and implement youth-friendly practices** • Secure and utilize the **Positive Peers app** for medication adherence, social support and appointment reminders	• Continue to provide youth-friendly care • Expand use of Positive Peers
Social Determinants of Health	
• **Provide transportation to Sacramento County Sexual Health Clinic** for individuals who receive a Preliminary Positive HIV test result through the W^3 clinic • **Establish partnerships for residential substance use treatment services** • **Establish partnerships for transitional housing and employment services** • Establish partnerships for street-side medical case management services	• Provide transportation to Sacramento County Sexual Health Clinic for individuals who receive a Preliminary Positive HIV test result through the W^3 clinic • Conduct a rapid needs assessment (housing, transportation etc.) for all persons with new HIV diagnoses and link to a disease intervention specialist and/or case manager as needed. • Perform warm hand-off to Ryan White funded medical case manager in Sacramento County
Strategy 2B. Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)	
Scale up Linkage and Retention Efforts	
• Establish partnerships for **street-side medical case management services** • Perform **warm hand-off** to Ryan White funded medical case manager in Sacramento County	• Establish partnerships for street-side medical case management services • Perform warm hand-off to Ryan White funded medical case manager in Sacramento County
Surveillance-Based Partner Services	
• **CDI will perform Partner Services** activities with newly diagnosed individuals	• CDI will perform Partner Services activities with newly diagnosed individuals

HIV Workforce Development Needs

Positions

- **Communicable Disease Investigator (CDI).** The CDI will act as a Linkage to Care Coordinator for W^{3}and perform partner services activities with newly-diagnosed persons.
- **Nurse Practitioner.**
- **Medical Assistant (HRSA ETE Funding).**
- **Public Health Aide / Community Health Worker (HRSA ETE Funding).**
- **Mobile Services Unit Training.** As protocols are developed and personnel brought on-line, those personnel will be trained on the services provided, locations served, and staffing roles.

Capacity-Building

When building capacity, Sacramento County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Gender Health Center**
- **Golden Rule Services (GRS)**
- **Harm Reduction Services (HRS)**
- **Sacramento County Sexual Health Clinic**
- **The CENTER**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Wellness Without Walls	$760,424	CDC PS20-2010
HIV Care Clinic **Youth friendly services** **SDoH that create barriers to care** **Scale up of linkage and retention** **Expand Surveillance – Based Partner Services**	$750,000	HRSA 20-078
TOTAL FUNDING FOR TREAT PILLAR*	$1,510,424	

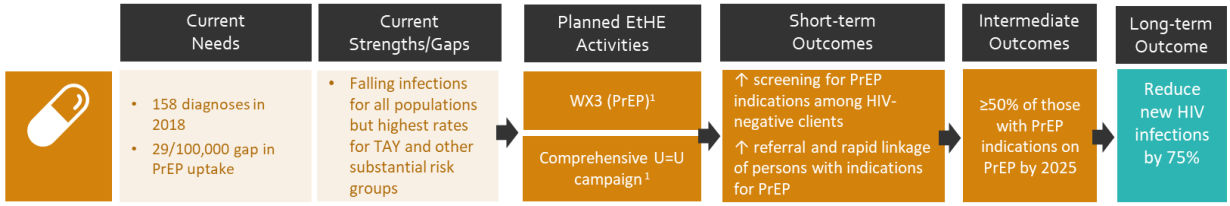
*$0 exclusively for Treat Pillar, and $1,510,424 for programs that cut across Treat and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[25] Targets will be determined in coordination with CDC as the EPMP is finalized.

Treat: Sacramento County	
Outcome Measure	**Data Source**
• **Percent** of all persons with a new HIV diagnosis who receive a rapid needs assessment.	• Case management and support services records in EHR
• **Percent** of all persons with a new HIV diagnosis who receive ART within three days of diagnosis	• Case management and support services records
• **Percent** of all persons with a needs assessment conducted who were linked to a disease intervention specialist and/or case manager as needed	• Case management and support services records
• **Number** of programs supporting and promoting rapid linkage and immediate/as soon as possible ART by providers in non-Ryan White HIV/AIDS Program facilities	• SCPH does not currently have the capacity to conduct this, however we could potentially utilize the AIDS Case Reporting Form (ACRF), and Data to Care Report from CDPH

Prevent



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Wellness Without Walls (W3)**
- **Comprehensive U=U campaign**
- **Project Empowerment**
- **Adapting *Connecting Resources for Urban Sexual Health* for Racial and Ethnic Minority MSM (Adapting CRUSH-MSM)**

Prevent: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	
Wellness Without Walls (W3)	
• **Train CDI to screen W³ clients for PrEP eligibility** • **Establish protocol for linking W³ clients with the Sacramento County PrEP Navigator** (housed at the Sacramento County Sexual Health Clinic) • **Provide transportation to Sacramento County Sexual Health Clinic** for individuals interested in PrEP who receive a negative HIV test result through the W³ clinic • **Enroll eligible participants in** the California PrEP-Assistance Program (**PrEP-AP**) • **Initiate Same-Day PrEP** with eligible clients • Sacramento County PrEP Navigator will schedule **follow-up appointments for PrEP Patients** and assist with medication adherence	• Hire an additional PrEP Navigator • Conduct outreach to promote PrEP services and support education/ awareness among unhoused and TAY populations • Provide transportation to Sacramento County Sexual Health Clinic for individuals interested in PrEP who receive a negative HIV test result through the W³ clinic • Enroll eligible participants in the California PrEP-Assistance Program (PrEP-AP) • Initiate Same-Day PrEP with eligible clients • Sacramento County PrEP Navigator will schedule follow-up appointments for PrEP Patients and assist with medication adherence • Establish protocol for Express Clinic Visits at the Sacramento County Sexual Health Clinic to ensure PrEP patients complete quarterly STI testing and lab work as expediently as possible

Prevent: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
U=U Campaign	
• **Gather messaging data from testing/focus groups** of priority populations • **Determine the most effective local media platforms/venues** for priority populations • **Develop and disseminate** U=U educational materials to County residents • Develop and disseminate U=U waiting room materials for patients • Develop provider detailing materials • Conduct provider detailing	• Continue to disseminate educational materials • Continue U=U media campaign in digital, outdoor, and place-based media • Continue to disseminate waiting room materials • Continue to conduct provider detailing
Strategy 3B. Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs)	
N/A	N/A

HIV Workforce Development Needs

Positions

- **Communicable Disease Investigator (CDI).** The CDI will act as a Linkage to Care Coordinator for W^3, and perform partner services activities with newly-diagnosed persons.
- **PrEP Navigator.** The PrEP Navigator enrolls eligible participants in the California PrEP Assistance Program, initiates same day PrEP for eligible clients, schedules follow-up appointments for PrEP patients and assists with medication adherence. (Position funded with CARES Foundation Funding)

  PrEP Eligibility Training. CDIs will be trained to screen all clients testing negative for HIV for PrEP eligibility.

Capacity-Building

When building capacity, Sacramento County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Gender Health Center**
- **Golden Rule Services (GRS)**
- **Harm Reduction Services (HRS)**
- **Sacramento County Sexual Health Clinic**

- **The CENTER**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Wellness Without Walls **Comprehensive U=U campaign**	$760,424	CDC PS20-2010
TOTAL FUNDING FOR PREVENT PILLAR*	$760,424	

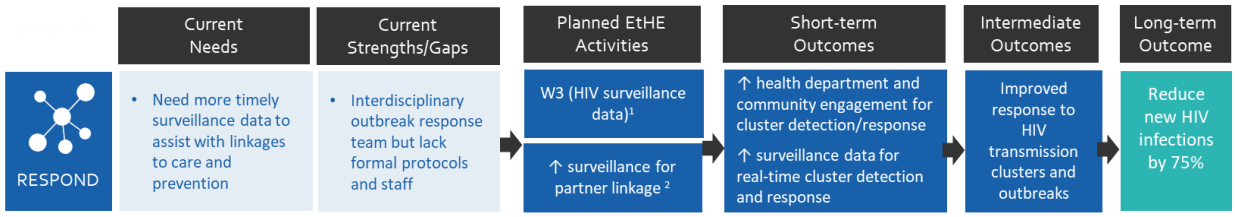
*$0 exclusively for Prevent Pillar, and $760,424 for programs that cut across Diagnose and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[25] Targets will be determined in coordination with CDC as the EPMP is finalized.

Prevent: Sacramento County	
Outcome Measure	**Data Source**
• **Percent** of persons hired as PrEP navigators	• Hiring records
• **Number and percentage** of clinicians prescribing PrEP within 3 months following detailing visit(s)	• Detailing and prescribing records
• **Number** of HIV-negative clients who are screened for PrEP	• Patient charts, Electronic Health Records
• **Number and percentage** of HIV-negative clients with indications for PrEP who are linked to PrEP	• Patient charts, Electronic Health Records, PrEP Navigator Logs
• **Number** of persons prescribed PrEP among those with indications for PrEP	• Patient charts, Electronic Health Records, PrEP Navigator Logs
• Provide trainings and technical assistance to non-clinical CBOs that provide HIV testing services to screen clients for PrEP indications, support clients in learning about PrEP, and facilitate linkage to PrEP care (e.g., CBOs, SSPs)	• Documentation of trainings and technical assistance
• **Number** of non-clinical CBO staff provided trainings or TA on PrEP screening and linkage	• Training/TA records
• **Number** and type of incentives decided upon by the health department	• Incentive program documentation
• Implement locally-specific insurance and cost-assistance navigation protocols for PrEP Patients	• Protocol documentation; PrEP Navigator procedures

Respond



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **Wellness Without Walls (W3)**
- **Expand Surveillance-Based Partner Services**

Respond: Sacramento County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response	
• County Surveillance Staff will work with the CDPH OA Surveillance Staff to ensure ability to respond when clusters are identified and investigation is needed.	• Sustain communication between surveillance staff and CDPH OA
Strategy 4B. Investigate and intervene in networks with active transmission	
• County surveillance staff will provide CID with as much locating information as possible in order that CID can reach out and contact those identified as part of the cluster, as well as the partners identified in the initial interviews. If the number of people to be interviewed is higher than the capacity of the county CID staff, CDPH OA will have their partner services staff deployed to the county. If the cluster response is elevated, CDPH Emergency Response protocols will be followed.	• Continued initiation of Cluster Response activities.
Strategy 4C. Identify and address gaps in programs and services revealed by cluster detection and response	
• A debrief meeting with county staff and CDPH OA staff will happen after each outbreak response in order to refine and ensure the most effective response actions are initiated.	• Post-response debrief meetings will continue to be conducted

HIV Workforce Development Needs

Positions

- SCPH will utilize current Epidemiology staff and Communicable Disease Investigators, in partnership with support of CDPH staff, to respond to potential clusters in Sacramento County
- In collaboration with the CDPH OA Surveillance Branch, policies and protocols will be develop. In addition, the county will follow processes prescribed by CDPH OA Outbreak Response Plan.

Capacity-Building

SCPH will work closely with state and federal partners to respond quickly to a newly identified HIV cluster, utilizing trained County epidemiological staff and Communicable Disease Investigators. SCPH will leverage resources and expertise of the California State Office of AIDS to tailor local response efforts

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 34. A list of those related to this pillar is below.

- **AIDS Education and Training Center (AETC)**
- **California Prevention Training Center (PTC)**
- **CDPH Office of AIDS**
- **Sacramento County Department of Health Services, Epidemiology Program**
- **Sacramento County Department of Health Services, HIV/STD Surveillance Program**

Funding

SCPH does not have funding exclusively identified for the RESPOND Pillar, however funding across the other Pillars will support staff, including additional Communicable Disease Investigators and who would play a vital role in cluster response efforts.

Program/Effort	Total Funding	Proposed Funding Source
Wellness Without Walls	$760,424	CDC PS20-2010
Expand Surveillance-Based Partner Services	$750,000	HRSA 20-078
TOTAL FUNDING FOR RESPOND PILLAR*	$1,510,424	

*$0 exclusively for Respond Pillar, and $1,510,424 for programs that cut across Respond and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[25] Targets will be determined in coordination with CDC as the EPMP is finalized.

Respond: Sacramento County	
Outcome Measure	**Data Source**
• Cluster data is reviewed and prioritized, response is guided and reviewed, procedures are modified to improve responses	• Reports of committee and community meetings, after action review meetings • Post-response debrief notes
• **Percent** of all persons with diagnosed HIV infection entered into the local surveillance system within ≤30 days of date of diagnosis	• LEO, CalREDIE
• **Percent** of laboratory results entered into the surveillance system ≤ 14 days after specimen collection	• CalREDIE
• A data system is developed to rapidly analyze, integrate, visualize, and share data in real time	• Data system documentation
• A flexible funding mechanism is developed to allow reallocation of resources for a response within one month	• Funding mechanism documentation
• Implementation of methods to understand the entire network, including people with diagnosed HIV, undiagnosed HIV, or at elevated risk for HIV infection	• Methodology documentation
• Processes and mechanisms are developed to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, for people in cluster networks	• Documentation of processes and mechanisms
• Data analysis and response results for clusters of concern are reported to CDC until investigation and intervention activities are closed	• Documentation of submission

Section V: Concurrence

SCPH received concurrence from the HIV Health Services Planning Council for the EtHE plan on June 24,2020. The Council has been kept apprised of progress in development of the EtHE plan, including receiving an early draft of this document, which was presented at the January 23, 2020 meeting. At this January meeting, the group approved the first draft and the process of developing the final EtHE plan. The Council has been an active partner in the development of each of the subsequent drafts. **The criteria of the Council to grant early concurrence of the EtHE plan included**:

- Best efforts of getting community input in the most challenging of circumstances given the COVID-19 response; and
- Review of the most recent epidemiological data, and subsequent focus on key populations for whom the existing HIV prevention and care services are not sufficient; and
- Included interventions and services to populations and regions in the Sacramento County where few services currently exist; and
- Community engagement will continue to be a vital part of implementation of this plan for the next 5 years.

The Council consists of volunteers from the three counties that make up the Sacramento Transitional Grant Area: El Dorado, Placer, and Sacramento Counties,[8] including consumers, providers, city representatives, public health staff, mental health agencies, and community-based organizations. Members of the Council were encouraged to participate in community engagement activities throughout the planning year.

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Appendix 1: Resource Inventory

Exhibit 29 lists the services and programs currently available in Sacramento County along with their funding sources, by pillar.

Exhibit 29. Sacramento County Baseline HIV Activities

Pillar	Baseline Program/Activity	Funding Sources
DIAGNOSE	• Community-based HIV testing [i] • Partnerships and technical assistance to promote routine-opt out HIV testing in the jails [i] • HIV/HCV testing specifically for PWID [i]	i CDC PS-18-1802 ii HRSA Ryan White Part A (incl MAI) (Source: Ryan White Service Matrix[16]) iii HRSA Ryan White Part B (incl MAI) iv HRSA Ryan White Part C v CDPH Project Empowerment
TREAT	• Linkage to care [i] • Partner services [i, ii, iii] • Housing navigation services for PLWH [i, ii] • Ambulatory Care [ii, iii] • Child Care [ii] • Emergency Financial Assistance [ii] • Food Bank/Home Delivered Meals [ii, iii] • Health Education and Risk Reduction [ii, iii] • Health Insurance and Cost-Sharing Assistance Program [ii] • Housing [ii, iii] • Medical Case Management (including MAI) [ii, iii] • Medical Nutritional Therapy [iii] • Medical Transportation [ii, iii] • Mental Health [ii, iii] • Non-Medical Case Management [ii, iii] • Oral Health Care [ii, iii] • Outreach Services [ii, iii] • Substance Misuse - Residential and Outpatient [ii] • Program to improve viral suppression among B/AA PLWH [v] • Capacity-building services for improving viral load suppression among B/AA and Hispanic/Latinx PLWH [v] Funded partners: One Community Health [ii, iii, iv], Golden Rule Services [i, iii,v], Harm Reduction Services [i, iii, iii], Sacramento County Sexual Health Clinic [ii], Sacramento LGBT Community Center [v], Sunburst Projects [ii, iii], UC Davis Pediatrics [ii], Volunteers of America [ii, iii]	

PREVENT	• County-wide PrEP Utilization Initiative: PrEPare Sacramento [i] • Community-based PrEP navigation services for B/AA, Hispanic/Latinx, and young MSM [i] • PrEP provider education targeted to sites with high STD diagnosis rates [i] • Syringe Services Programs (SSPs) [i] • HIV Prevention Program for B/AA PLWH [v] • Capacity-building services for HIV prevention among Hispanic/Latinx and B/AA [v] Funded partners: Golden Rule Services [v, i], Harm Reduction Services [i], Sacramento LGBT Community Center [v]	
RESPOND	• Use of HIV surveillance data to determine focus of HIV testing locations [i] • Use of HIV surveillance data to identify candidates for partner services [i]	

Note: Additional resources for HIV services that cannot be quantified or broken down by pillar include Medi-Cal, Medicare, Veterans Administration, and 3rd party reimbursement

Appendix 2: Community Engagement Documentation

Exhibit 30 lists community engagement event dates, descriptions and key voices and partners.

Exhibit 30. Community Engagement Documentation

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
CDPH Planning Group Kick-Off Meeting[7] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative EtHE activities.	**Participants:** Sacramento HIV Health Services Planning Council, County of Sacramento Health Department, Gender Health Center, Sierra Foothills AIDS Foundation, and Golden Rule Services
EtHE Community Forums[5] 11/18/2019,11/21/2019	SCPH presented the County's EtHE initiative then facilitated a group discussion on key strengths, gaps, and ideas for the four EtHE pillars to diagnose, treat, prevent, and respond to HIV.	**New Voices – Providers:** harm reduction, youth Participants: HIV Health Services Planning Council, clinical providers
EtHE Presentation and Discussion[8] 01/22/2020	CDPH and Facente Consulting were invited to present an overview of the CDC 19-1906 accelerated planning year and to solicit input on the draft EtHE Plan.	**New Voices – Providers:** unhoused Participants: HIV Health Services Planning Council, clinical providers, members of the public
Online survey[9] 1/22/2020-7/31/2020	SCPH distributed an online survey asking for input on how to engage hardly reached populations in HIV prevention and care. It was sent via email to key leaders with connections to the priority populations, providers, and other stakeholders. Summarized information informed the situational analysis and chosen interventions.	**New Voices – Priority Populations**: TAY, B/AA, Hispanic/Latinx, LGBTQ
EtHE CHIPTS Regional Meeting[10] 01/24/2020	SCPH attended the CHIPTS regional meeting to plan, coordinate and align Sacramento County's draft EtHE plan with the best practices to foment California's regional EtHE response.	**Participants:** County health departments and Planning Council representatives from Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC

Appendix 3: Letter of Concurrence

HIV Health Services Planning Council
9616 Micron Ave, Suite 930 Sacramento, Ca 95827 (916) 876-5548 Fax (916) 854-9459

June 24, 2020

Marisa Ramos, Ph.D.
Chief, Office of AIDS
California Department of Public Health
MS 7700, PO Box 997426
Sacramento, CA 95899-7426

Dr. Ramos,

This letter documents that our Part A Planning Group is in concurrence with the Ending the HIV Epidemic in America, Phase I accelerated planning report funded through CDC PS 19-1906.

At the beginning of the contract year, our planning body was provided a presentation by the State Office of AIDS and Facente Consulting that was contracted to assist in the development of the Ending the HIV Epidemic Plan. We were asked to disseminate information about the project and seek consumer input on what is most critical to decrease new infections as we work toward ending the epidemic.

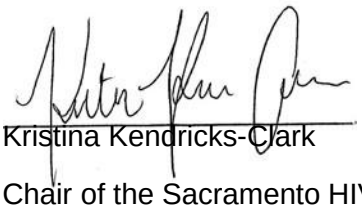
We were provided a copy of the December 2019 draft plan, and were part of the community engagement activities that contributed to the final plan.

The plan being submitted is in harmony with our other HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero Plans and other county documents that guide the delivery of HIV prevention and care services, and maintains a surveillance system in collaboration with the State Office of AIDS.

The selected activities will expand our reach to populations underserved to date, with novel and innovative interventions that will increase testing, provision of rapid ART, and use of PrEP, and will assist more people living with HIV in our county to achieve and sustain viral suppression.

The CDC PS 20-2010 funding to implement the plan will expand services, and will work in unison with the HRSA 20-078 and in partnership with health centers provided Ending the Epidemic funding through HRSA 20-091.

Our planning body will continue to monitor the implementation of the Ending the Epidemic Federal Initiative and its family of interventions. We will also continue to engage the community to assure ongoing, real-time feedback so that the interventions are executed optimally for the populations they are serving.



Kristina Kendricks-Clark

Chair of the Sacramento HIV Health Services Planning Council

Appendix 4: Planning Council Membership Roster

Sacramento Transitional Grant Area-HIV Health Services Planning Council (Sacramento, El Dorado and Placer Counties)

Website: https://www.sacramento-tga.com/

Contact Number: (916) 876-5548 or via email at hiv-hspc@saccounty.net.

Council Members	Title/ Position
Charles McDonald	Council Member
Chelle Gossett	Council Member
David Contreras	Council Member
Dennis Poupart	Council Member
Elizabeth Valentine	Council Member
Judy Vang	Council Member
Kane Ortega	Council Member
Kaye Pulupa	Council Member
Kristina Kendricks-Clark	Council Member
Linda Ryan	Council Member
Matias Castro	Council Member
Melody Law	Council Member
Michael Ungeheuer	Council Member
Michael Wofford	Council Member
Minerva Reid	Council Member
Richard Benavidez	Council Member
Ricky Myers	Council Member
Robyn Learned	Council Member
Ronnie Miranda	Council Member
Steve Austin	Council Member
Susan Farrington	Council Member
Tom Hannon	Council Member
Tracy Jenkins	Council Member
Tracy Thomas	Council Member
Zach Reau	Council Member
Zachary Basler	Council Member

SAN BERNARDINO

San Bernardino County

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

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Continued on next page

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Introduction

About This Plan

This plan describes San Bernardino County's bold and innovative plan for ending the HIV epidemic in the County. San Bernardino County and its southern neighbor, Riverside County, make up the Riverside/San Bernardino Transitional Grant Area (TGA) and share a joint HIV Planning Council – the Inland Empire HIV Planning Council. HIV efforts in the County are led by the San Bernardino County Department of Public Health (SBCDPH), with HIV-related functions embedded in three different divisions—the Division of Clinical Health and Prevention Services, Community Outreach and Education, and the Communicable Disease Section. In collaboration with community and clinical partners, SBCDPH has built a strong foundation of HIV prevention, care, and treatment services in the County. These foundational HIV services were built based on the *Inland Empire HIV Planning Council Comprehensive HIV Services Plans*[1,2] and *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan.*[3]

These current baseline activities, and the infrastructure that supports them, are critical for reducing and ultimately eliminating new HIV infections and optimizing the health of people living with HIV, but they are not sufficient – hence the need for this Ending the HIV Epidemic (EtHE) plan. However, this EtHE plan does not replace the other plans; instead, this plan, based on the current state of HIV in the County, expands on them, and identifies and proposes additional innovative efforts to end the HIV epidemic.

This Plan is organized as follows:

- The **Introduction** provides a high-level overview of 1) the HIV epidemic in the County, 2) the baseline services, activities, and infrastructure that currently exist, and 3) San Bernardino County's plan to end the epidemic.
- **Section I: Community Engagement** describes San Bernardino County's completed and planned community, provider, and planning council engagement activities and findings to date.
- **Section II: Epidemiologic Profile** presents the latest available data on HIV in San Bernardino County, including demographics, trends, and disparities across age, race/ethnicity, geography, and more.
- **Section III: Situational Analysis** synthesizes information from the prior two sections and a needs assessment to paint a comprehensive picture of the current state of HIV in the County, including needs, resources, and gaps.
- **Section IV: EtHE Plan** outlines the innovative activities that the County will implement between now and 2024, across all funding sources, along with key partnerships, workforce development needs, and plans for outcome monitoring.
- **Section V: Concurrence** describes the process for securing Planning Council concurrence.

Current State of HIV in San Bernardino County

San Bernardino County has seen a 21 percent rise in new HIV diagnoses in recent years, from 224 newly diagnosed residents in 2016 to 278 in 2018.[4] When compared to the TGA or the State of California, San Bernardino County has a very different epidemiologic profile, with a higher proportion of HIV cases among people of color, cisgender women (especially cisgender women of color), and heterosexuals, and more transmission fueled by injection drug use.[5]

In 2018, among those newly diagnosed with HIV, 65.5 percent were linked to care within 30 days and 50 percent were virally suppressed within 6 months of diagnosis.[4] Hispanic/Latinx persons represent the majority of new diagnoses; every 3 of 5 new HIV diagnoses are among Hispanic/Latinx people.[4] After years of intensive outreach to and focus on the Hispanic/Latinx population, rates of linkage to care and viral suppression have improved.[6] However, while the majority of new diagnoses are among Hispanic/Latinx people, Blacks/African Americans (B/AA) are the most disproportionately impacted race/ethnicity compared with their population size.[4]

Several factors contribute to San Bernardino County's unique HIV profile. There are many remote areas in the County, particularly the Mountain and Desert Regions,[6] without access to nearby medical services. Poverty, homelessness, drug use, and mental illness are fueling the epidemic. Community engagement efforts conducted during the EtHE planning year revealed that HIV-related stigma, homophobia, housing shortages, methamphetamine use, and several other factors are also impacting PLWH and people at risk for HIV. Finally, despite the robust County infrastructure for HIV prevention, care, and treatment, significant populations are being missed, undoubtedly contributing to high rates of undiagnosed HIV, increasing new diagnoses, and low rates of viral suppression compared with California overall.

Current HIV Infrastructure and Efforts

Planning

San Bernardino County has a long-standing history of planning local HIV prevention, care, and treatment efforts in conjunction with community partners and the local Inland Empire HIV Planning Council. The County HIV work sharpened with the development of the TGA's *2015-2017 Clinical Quality Management (CQM) Plan*, which offered a coordinated and systematic approach to assessing and improving the quality of health services for PLWH in the TGA in alignment with National HIV/AIDS Strategy (NHAS) goals.[7] The Council has also supported and adopted the State's integrated HIV plan—*Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*—as its roadmap to getting to "zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination against people living with HIV (PLWH)."[3]

Services

A number of public funding sources support HIV services in San Bernardino County including prevention funding from the California Department of Public Health (CDPH) (CDC PS18-1802 and State General Fund); Ryan White Parts A, B, C, and F (including Early Intervention Services [EIS] and Minority AIDS Initiative [MAI] funding); CDPH AIDS Drug Assistance Program (ADAP) funding, CDPH Project Empowerment funding, San Bernardino County General Fund, and the Veterans Administration, as well as revenue from third party billing, including Medi-Cal and Medicare. Collectively, these funding sources support several HIV

primary care providers, as well as a number of community-based organizations (CBOs) offering services such as HIV testing, prevention with positives, primary care, mental health services, dental services, medical case management, and a multitude of wrap-around services for PLWH (**Exhibit 1**). In addition, this funding supports the SBCDPH HIV Care, HIV Prevention, and HIV Surveillance teams to provide partner services, linkage to care, outreach, and other HIV prevention and care direct services. A more extensive resource inventory is included as **Appendix 1**.

Infrastructure

***Exhibit 1**:* Publicly funded* HIV services in San Bernardino County

HIV Primary Care

- SBCDPH's FQHCs (3 of 4 sites offer HIV primary care)
- AIDS Healthcare Foundation
- Borrego Health (1 site)
- Jerry L Pettis Memorial Veterans' Medical Center
- Arrowhead Regional Medical Center
- Loma Linda University Medical Center
- Social Action Community Health System (affiliated with Loma Linda University Medical Center

Other HIV Prevention and Care Services

- Foothill AIDS Project
- Loma Linda Promotores Academy (bilingual peer navigators)
- SBC Homeless Partnership
- TruEvolution

*Kaiser Permanente is the main private provider of HIV primary care.

Health Department. Within SBCDPH, HIV-related functions are carried out by three different divisions. The Division of Clinical Health and Prevention Services provides HIV care at three sites and serves as the Ryan White Part A and Part C administrator; the Community Outreach and Education Section administers SBCDPH's HIV Prevention Program; and the Communicable Disease Section oversees HIV Surveillance. Across these divisions, approximately 22 FTE are dedicated to HIV-specific work. SBCDPH is also the main provider of primary HIV care in the County through three of its four federally qualified health centers (FQHCs). In addition, SBCDPH offers a range of assessment, planning, technical assistance, and training countywide.

Additional Assets. SBCDPH maintains connections with academic institutions to support HIV research in the region. For example, the National Institutes of Health (NIH) supported Center for AIDS Research (CFAR) in Southern California, located at the University of California, Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), is a partner. The CFAR mission is "to support multidisciplinary research aimed at reducing the burden of HIV both in the United States and around the globe."[8] SBCDPH has also collaborated with the University of California, Santa Barbara (UCSB) Department of Geography's San Bernardino Mobile Study. UCSB conducted this study to examine the social and structural context of immigration, internal mobility, and HIV risk behavior among Mexican and Central American migrant men who have sex with men (MSM) in the San Bernardino area.

San Bernardino County's Plan to End the HIV Epidemic

Exhibit 2 (see p. 5) depicts a high-level overview of how San Bernardino County plans to enhance its current HIV efforts with new, innovative activities funded with federal EtHE funds. The planned activities will expand and leverage, but not duplicate, the foundational efforts already in place. Thus far, the County's HIV-related efforts have been siloed at the division level, with HIV Care, Prevention, and Surveillance each having its own scope. In contrast, the

proposed innovative activities will bring resources and staff together from across these divisions through extensive collaboration to align objectives and activities to get to zero.

The **Exhibit 2** logic model shows the needs, strengths, and gaps identified through this planning process. Local epidemiologic data, community engagement, and situational analysis as well as the new, innovative activities designed to leverage these strengths and address the gaps are outlined. Overcoming challenges related to access, addressing clinical provider shortages, removing barriers to PrEP uptake, among other issues, will be key to success.

New EtHE activities will address all four EtHE pillars and will support the short-term, intermediate, and long-term outcomes identified by the CDC in PS-19-1906. The primary activities for San Bernardino County are listed below. Multiple funding sources (noted in **Exhibit 2**), including CDC PS-20-2010 and HRSA 20-078, will be leveraged to support these activities and community partnerships will be strengthened to ensure success.

- The **Rapid Response Team** (RRT), which includes deployment of a **Mobile Unit,** will support linkage to care, prevention efforts (e.g., testing, peer-based PrEP navigation), and follow-up for PLWH who have fallen out of care with a focus on people who are unhoused and those living in remote areas of the County. (*Diagnose, Treat, Prevent, Respond)*
- The **Rapid StART Initiative** will link newly diagnosed PLWH to HIV primary care the day they are diagnosed and deliver Antiretroviral Therapy (ART) within 72 hours of their diagnosis. Priority populations for this initiative are B/AA, youth ages 13-24, cisgender women, transgender women of color, and people who inject drugs (PWID). Rapid StART will also be provided as part of the RRT mobile services. *(Treat)*
- The **expansion of HIV prevention services for people who inject drugs (PWID)** will foster partnerships with trusted local harm reduction organizations to provide information about HIV harm reduction, naloxone, and other services to housed and unhoused PWID—an underreached group disproportionately impacted by HIV. (*Prevent)*
- **Home-based HIV testing** mailed to clients. The State will provide the test kits and SBCDPH staff will provide linkage to care and prevention/PrEP referrals. *(Diagnose, Treat, Prevent)*
- The **California Regional Quality Group (CARG),** in which San Bernardino County participates, will support the EtHE initiative by focusing on quality improvement initiatives for increasing viral suppression rates among MSM of color. *(Treat)*
- A new **CHIPTS EtHE CFAR project** will support **regional data coordination** and sharing to guide scale-up of large implementation science projects designed to reduce new HIV infections across the four Southern California counties. *(Respond)*
- A second **CHIPTS EtHE CFAR project** to compare the efficacy of two different interventions aimed at increasing provider skills and capacity to prescribe PrEP: provider detailing/education versus physician-peer comparison (application pending). *(Prevent)*

The County's EtHE plan was developed with extensive community and partner engagement and endorsed by the Inland Empire HIV Planning Council, San Bernardino County's local HIV community planning body. With the new federal EtHE funding, San Bernardino County expects to make significant progress over the next 5 years towards ending the HIV epidemic in the County.

Exhibit 2. Logic Model for Ending the HIV Epidemic in San Bernardino County organized by pillar. Current County strengths and gaps inform planned EtHE activities which will impact the short-, intermediate-, and long-term outcomes identified by CDC and the California Department of Public Health.

1. CDC PS20-2010; 2. HRSA 20-078.

Section I: Community Engagement

Community engagement tailored to San Bernardino's unique community characteristics is an essential component of the County's EtHE efforts. Even though Riverside and San Bernardino Counties share the same TGA, needs assessment data and community engagement efforts show San Bernardino's community needs are distinct from those of Riverside County or California as a whole. San Bernardino is the only Phase I county where the number of new HIV cases are increasing. While this may be in part due to undiagnosed PLWH people migrating from other counties and getting diagnosed in San Bernardino, regardless this trend is worrisome.

For these reasons, community engagement is critically important. The way to end the epidemic is to create programs and services to meet community needs, and the way to meet the needs is by developing a nuanced understanding of what they are through engaging with the priority populations. A few examples of the needs and challenges facing San Bernardino County are worth noting. The County has a large Spanish-speaking Hispanic/Latinx population. Representatives from this group who participated in community engagement efforts reported fewer providers who can respond to their unique linguistic and cultural needs.[9] B/AA are disproportionately affected by new HIV infections relative to their population size and have lower rates of linkage to care and viral suppression than other groups. MSM are disproportionately impacted by the HIV epidemic in San Bernardino County as in most California counties; however, heterosexuals and PWID account for a larger proportion of San Bernardino County cases than in neighboring Riverside County. Needs assessment data suggest that non-gay identified MSM may be a larger group in San Bernardino than in other parts of California.[10] Needs assessment and community engagement efforts also suggest that individuals seeking more affordable housing and a relatively lower cost of living migrate into San Bernardino County which leaves the county chronically under-resourced. Furthermore, according to community members, the rising cost of housing is exacerbating the physical and mental health consequences of living with HIV[9] among a growing population who are experiencing homelessness and critical service gaps. Due to all these factors, B/AA and Hispanic/Latinx MSM, substantial risk heterosexuals, substance users, and people experiencing homelessness have been included as critical new voices during the accelerated planning year for community engagement in years 2-5 of the plan.

The following is a description of SBCDPH's community engagement efforts during the accelerated planning year (Exhibit 3) and a community engagement plan for years 2-5. COVID-19 response efforts by the County have interrupted some of this work and limited the number of in-person engagement activities. Even with these constraints, community input has enhanced SBCDPH's understanding of the priority populations and the circumstances that they face each day. To achieve EtHE goals, community engagement work will be an ongoing and iterative, involving the Planning Council, new voices from the community, HIV providers, and non-traditional partners. SBCDPH will work closely with the CDPH (the PS19-1906 grantee) and the other five Phase I

Exhibit 3. Community Engagement Successes

- Engagement of the Planning Council
- Engagement of non-HIV providers
- Leveraging existing data sources
- Pivot to virtual community engagement due to COVID-19

counties covered under their grants (Alameda, Orange, Riverside, Sacramento, and San Diego) to put community engagement front and center and do together what is necessary to get to zero.

Community Engagement Activities

The COVID-19 response has affected San Bernardino County's ability to implement in-person outreach and face-to-face community engagement for most of months allocated to the PS-19-1906 accelerated planning year. As a result, SBCDPH quickly adapted to virtual engagement methods including Zoom-based presentations and discussions, online surveys, virtual focus groups, and telephone key informant interviews. The County's community engagement outcomes for the accelerated planning year are as follows **(Exhibit 4).**

Exhibit 4. San Bernardino County Community Engagement Outcomes (Year 1)

- Collaborated with Riverside University Health System (RUHS), TruEvolution and other key CBOs to hold a Community Caucus (CC) including San Bernardino PLWH and at-risk individuals. 30 participants from key focus populations, B/AA Hispanic/Latinx MSM, Spanish-speakers, unhoused individuals and PWID, participated in the CC.
- Collaborated with RUHS, TruEvolution, and other key Inland Empire community constituents from primary and secondary education, housing, and health insurance providers to convene an EtHE summit to discuss key needs and gaps impeding EtHE progress.
- Implemented an online EtHE survey to key providers and focus populations in English and Spanish asking broadly: What should we do to get to zero?
- Conducted an analysis of recent key reports that solicited community input.

SBCDPH reengaged Planning Council constituents and brought together new voices, including clients, providers, governmental groups, and academic institutions to inform the next best steps to getting to zero. **Exhibits 5 and 6** summarize completed and planned community engagement efforts for the PS19-1906 accelerated planning year. **Appendix 2** provides more detailed descriptions of these efforts and how the events were documented including meeting agendas, meeting notes, and other documentation.

Exhibit 5. Overview of County EtHE Community Engagement Activities completed and planned.

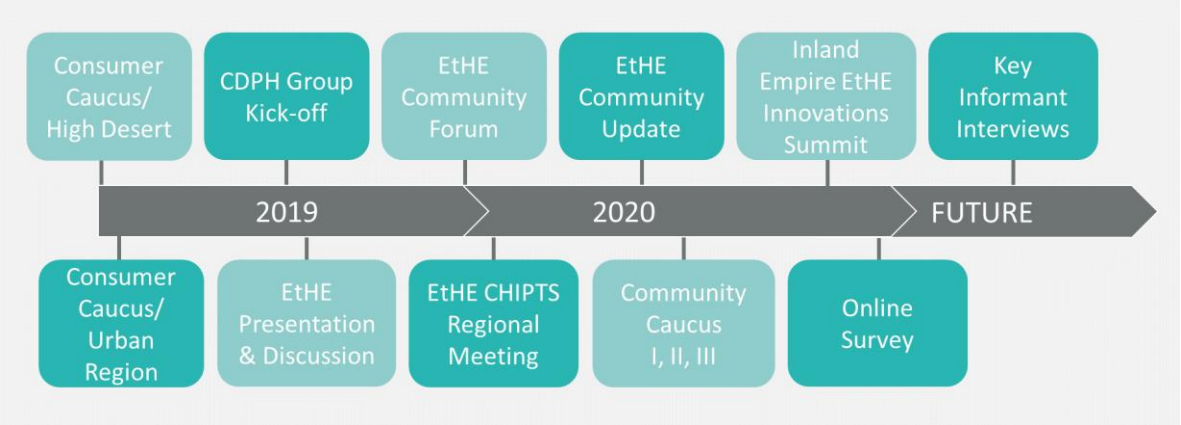


Exhibit 6. *San Bernardino County EtHE Community Engagement Activities, completed and planned*

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
The Consumer Caucus/High Desert San Bernardino[11] 5/21/2019	Part of the Part A priority setting and allocations process. Notes and outcomes reviewed in secondary analysis to inform EtHE planning.	*Participants: PLWH in closed door session. One participant from as far away as Barstow.*
The Consumer Caucus/Urban Region San Bernardino[12] 6/11/2019	Part of the Part A priority setting and allocations process. Notes and outcomes reviewed in secondary analysis to inform EtHE planning.	*Participants: PLWH in closed door session.*
CDPH Planning Group Kick-Off Meeting[13] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	*Participants: Inland Empire Planning Council Leadership, SBCDPH.*
EtHE Presentation and Discussion[14] 11/14/2019	RUHS and SBCDPH facilitated a discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	*Participants: Inland Empire Planning Council and Leadership.*
EtHE Community Forum[15] 11/14/2019	SBCDPH participated in a RUHS facilitated discussion of barriers to ending the epidemic, ways to better	*Participants: Inland Empire Planning Council, RUHS, SBCDPH, AIDS Health Care*

EVENT	DESCRIPTION	VOICES & PARTNERS
	engage people of color in treatment, and ways to increase PrEP utilization.	*Foundation, Desert AIDS Project, FLAAC.*
EtHE CHIPTS Regional Meeting[16] 01/24/2020	San Bernardino County presented an overview of County's draft EtHE plan and gave input about approaches to the regional EtHE response.	*Participants: County health departments and Planning Council representatives from Alameda, Los Angeles, Orange Riverside, Sacramento, San Bernardino, San Francisco, and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.*
Community Caucus I[9] 1/25/2020	TruEvolution convened a gathering of new voices to better understand the experiences of people living with or at risk for HIV. *Sponsors: RUHS, SBCDPH*	*New Voices – Priority Populations: B/AA, Hispanic/Latinx, unhoused, Spanish-speakers, and the transgender community.* *Other Participants: AIDS Healthcare Foundation, Borrego Health, Desert AIDS Project, Foothill AIDS Project, FLACC.*
Inland Empire EtHE Innovations Summit[17] 1/27/2020	RUHS and SBCDPH convened a summit of providers from different sectors (HIV and non-HIV). They presented the county's EtHE plan and held a discussion on the opportunities & barriers for cross-sector collaboration and improvement in HIV care.	*New Voices – Providers: Education, research institutions, housing, Inland Empire Health Plan, RUHS, SBCDPH, AIDS Healthcare Foundation, Borrego, Desert AIDS Project, OASH, Families Living with AIDS Care Center, Foothill AIDS Project, California Workforce Development Board, UC Riverside School of Medicine, Housing Authority of Riverside County.*
Community Caucus II[18] 5/16/2020	TruEvolution convened a panel of Hispanic/Latinx PLWH to comment and review findings of Community Caucus I. The panel confirmed and further expanded on the key findings.	*New Voices Participants: Hispanic/Latinx PLWH.* *Spanish Speakers.*
Community Caucus III[19] 5/16/2020	TruEvolution convened a panel of B/AA and Hispanic/Latinx MSM living with HIV to comment and review findings of Community Caucus I. The panel confirmed and further expanded on the key findings.	*New Voice-- Participants- B/AA and Hispanic/Latinx MSM living with HIV.* *English Speakers.*

EVENT	DESCRIPTION	VOICES & PARTNERS
Online survey[20] 9/30/2020	The County has distributed an online survey that asks for input on how to engage populations not currently reached effectively. Key community leaders volunteered to email the survey to their networks. More of these surveys will be distributed during implementation.	*Participants: priority populations, providers, other stakeholders.*
PLANNED ACTIVITIES (dates TBD)		
Key Informant Interviews	SBCDPH will speak with substance use providers to gain their input on the EtHE plan and to gain a better understanding of their clients' barriers in accessing HIV or PrEP care.	*New Voices: substance users and their providers.*
EHE Plan Implementation CE	Ongoing community engagement during the initial implementation formative phase and to subsequently revise each intervention.	*New Voices – priority populations, providers, and other stakeholders.*

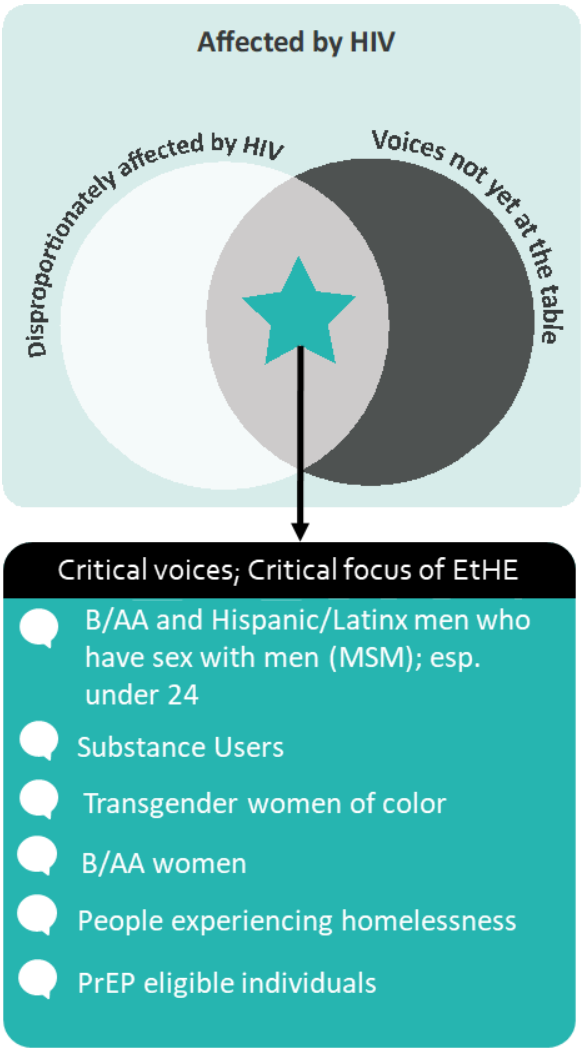
The SBCDPH leadership oversaw the development and implementation of the community engagement activities. With support from CDPH, they developed strategies for community engagement and then they adapted this plan to work to continue during the COVID-19 response. They successfully worked with Riverside County to leverage and funnel funding to community groups leading the EtHE work: TruEvolution, AIDS Health Care Foundation (AHF), Borrego Health, California Regional Group (CARG), and Families Living with AIDS Care Center (FLACC). These local CBO partners helped plan and implement all community engagement events and were instrumental in successfully engaging newly diagnosed PLWH, people at risk for HIV, and providers. They helped advertise the events, recruited members from priority populations, and most importantly, helped to build trust between the County's EtHE efforts and community members. In addition, CDPH contracted with Facente Consulting, a California-based public health consulting firm specializing in HIV planning and community engagement to support and build Phase I county capacity to broaden and deepen connections with local priority populations. For San Bernardino County, Facente Consulting provided support for community engagement events including developing meeting agendas and materials, co-facilitating events, taking meeting notes, and producing summary reports.

New Voices

In addition to deepening the partnerships within our current provider and community networks, SBCDPH placed and will continue to place a special emphasis on including new voices in the implementation of the EtHE Plan.

SBCDPH conducted a data-driven process to identify affected populations not currently being reached and assessed the extent those communities have been represented and involved in the process. Based on HIV surveillance data and the experience of key stakeholders (e.g., SBCDPH, the Planning Council, service providers) and an assessment of who is disproportionately affected and not currently participating in planning processes, SBCDPH identified the following priority populations as ***new voices*** that need to be included:

Exhibit 7. Critical new voices to engage.



- **B/AA and Hispanic/Latinx men who have sex with men (MSM).** MSM of color, including both gay and non-gay identified, are disproportionately represented among new HIV diagnoses in San Bernardino County; especially those under age 24.
- **Substance users.** Substance users, particularly MSM who inject drugs, are at increased risk for HIV infection and transmission and they are underserved by current programs.
- **Transgender women of color.** Substantial risk transgender women, especially transgender women of color, are highly impacted by the HIV epidemic but data is sparse.
- **B/AA women.** B/AA women are disproportionately impacted by HIV in San Bernardino County compared B/AA women in the Inland Empire TGA.
- **People experiencing homelessness,** especially those who have a primary mental health diagnosis. Homelessness and mental health are key factors driving health disparities and remain significant barriers to HIV prevention and care.
- **PrEP eligible individuals.** Includes other at-risk and substantial-risk individuals with a past or recent STI diagnosis, and/or individuals who have one or more sex or needle sharing partners who are living with HIV or of unknown HIV status.

The following sections describe the efforts to engage these key focus populations and service providers and community partners experience working with these populations.

Local Prevention and Care Integrated Planning Bodies

As previously noted, San Bernardino County and its southern neighbor, Riverside County, make up the Riverside/San Bernardino Transitional Grant Area (TGA). The TGA has a joint integrated community planning body called the Inland Empire HIV Planning Council (IEHPC). SBCDPH continuously seeks the IEHPC's input and guidance when developing HIV prevention, care and treatment strategies and has actively engaged the Council throughout the EtHE planning process.

The Planning Council brings a wealth of knowledge and experience to the EtHE planning process. In accordance with the bylaws of the Planning Council, consumers of Ryan White Part A services must make up at least 33 percent of the membership. The Planning Council has consistently provided a voice to PLWH and has played a lead role in developing the Standards of Care to support PLWH and help ensure that treatment and other resources are available and PLWH are treated with respect and dignity.

In addition, the bylaws identify 13 required membership categories to ensure diversity of representation and perspectives. Examples of the membership categories include people at risk for HIV, health care providers, and mental health and substance use providers. The Council also seeks inclusion of representatives of gender diverse communities, the faith community, and rural and geographically isolated communities. Currently, the Council composition includes 65 percent people of color, 15 percent representatives of the public sector, and 60 percent PLWH; 51 percent are from San Bernardino County and 49 percent from Riverside County. To ensure accessibility, all IEHPC meetings are held in venues that are wheelchair accessible and sign language interpretation services are available upon request.

The IEHPC is a key partner for ensuring that new voices from the priority populations are included in baseline and future EtHE HIV planning efforts. The Council is actively engaged in new member recruitment, with a focus on new voices from the EtHE priority populations. Recruitment strategies include: 1) outreach to health and social service providers serving the priority populations; 2) outreach to HRSA-funded Ryan White Part A and B recipients not already at the table; 3) using Council members' social and professional networks to directly reach out to people from the priority populations; and 4) convening meetings throughout San Bernardino County's diverse regions for annual priority setting and allocations of Ryan White funds. In 2019, the IEHPC hosted three Consumer Caucuses in the three distinct regions of the TGA: the High Desert region of San Bernardino County, downtown San Bernardino with neighboring Riverside consumers included, and Palm Springs in Riverside County. Having consumers on the committees and the council to inform decisions and provide immediate context to other consumer feedback is invaluable and is a core tool in the community input process for HIV services. The TGA also ensures community input on program design, implementation, and quality through methods such as surveys and through live participation opportunities like town halls, consumer caucus groups, and consumer participation in local and state planning coalitions.[6]

The Planning Council actively engages and develops the leadership of new members through its "HIV University"—a course about the HIV planning cycle and how to effectively participate to influence funding and policy decisions. This ten-week consumer training program, created and implemented by the IEHPC, is designed to prepare consumers, and affected individuals to become organizers and champions in their community. The course is also meant to spark

excitement and empower our consumers by partnering with them to learn the skills necessary to be successful in a planning council role as a self-advocate and peer leader. The training given over 10 weeks begins with basic HIV 101. Other topics addressed include, for example, how to run a meeting, cultural humility, orientation to the Planning Council, and how to understand data. This interactive course creates bonds among participants by providing a fun and empowering learning environment with the opportunity to work and grow with others along similar journeys. Throughout the training, participants learn to tell their own story using themes related to the training and at the end they have the opportunity to present their story in front of their cohorts. The course had its inaugural class in October 2019 and held a graduation for seven participants in December 2019. The course is open to all and the Council makes a special effort to recruit priority populations to participate. The HIV University provides an opportunity to interact with and get input from stakeholders who would not normally be at the table.

Local Community Partners

With the exception of a vaccine for HIV, all the tools to end the HIV epidemic exist—PrEP, condoms, safer injection equipment, and effective HIV treatment. However, policy barriers, social determinants of health (SDoH), disparities in health care access, stigma, and many other factors create a situation where not all communities benefit equally. With San Bernardino County's unique epidemiologic profile and increasing new diagnoses, engagement of affected community members in the planning process is a significant and essential element in EtHE planning.

In addition to the IEHPC's work, SBCDPH has directly engaged with the identified priority populations as shown in Exhibit 8. The COVID-19 response has limited some face-to-face community engagement, but by the end of the planning year, SBCDPH engaged every priority population or reviewed key data sources related to each priory population. Direct community engagement will continue in Years 2-5.

Exhibit 8: *Engagement of priority populations.*

B/AA and Hispanic/Latinx MSM	Community Caucus I (1/25/2020) Community Caucuses II, III (5/16/2020)
Substance Users	California Opioid Dashboard Report (4/23/2020); Provider consultations (ongoing), PWID focus group (TBD)
Transgender women of color	EtHE online survey to VisibiliTy Conference registrants (TBD) Transgender women of color focus group (TBD)
B/AA women	Cisgender women of color focus group (TBD)
People experiencing homelessness	Community Caucus I (1/25/2020)

PrEP eligible individuals	Community Caucus I (1/25/2020)

Local Service Provider Partners

Service providers, both HIV- and non-HIV providers, are key partners for ending the HIV epidemic in the County. Clinical and community-based providers have a wealth of experience regarding what works and what does not work to reach priority populations and a strong knowledge of the barriers that need to be overcome in order to more effectively serve PLWH and persons at risk. Other partners who may not provide direct services, but who have expertise in or connections with priority populations, are also key to building a robust, feasible, and sustainable HIV prevention, care, and treatment strategy.

SBCDPH engaged the following service provider and non-traditional partners:

- **California Regional Group (CARG),** a collaborative of the national end+disparities Collaborative focused on viral suppression among MSM of color.
- **Educational institutions,** including school-based health centers, Pacific High School, and the Riverside Unified School District.
- **Faith-based organizations** such as Inland Empire Praise Gospel Group that has participated in HIV testing and World AIDS Day events in San Bernardino.
- **Housing experts,** including HOPWA providers, Inland Empire Development Corporation, TruEvolution and FLACC.
- **Inland Empire Health Plan** that has participated in EtHE community meetings and is working on innovative approaches to health care reimbursement.
- **Primary care providers,** such as AIDS Health Care Foundation (East Valley), Social Action Community Health System (East Valley), Loma Linda University Medical Center (East Valley) Foothill AIDS Project (East Valley, West Valley, Desert).
- **Researchers,** including the University of California, Riverside, Center for Health Disparities Research.
- **Substance use providers,** including medication-assisted treatment (MAT) clinics and harm reduction providers, VARP Inc. residential treatment, Cedar House Life Change Center treatment center, and Mental Health Systems Inc. rehabilitation services.
- **TruEvolution,** a community-based non-profit that provides advocacy and HIV prevention and care services for LGBTQ+ people. TruEvolution has played a lead role in several community engagement efforts to date.

SBCDPH is strongly invested in maintaining these new relationships and will continue to forge new partnerships critical to EtHE goals.

Selected Findings

The following sections present selected findings from community engagement efforts. They are organized under the following headings and summarized in **Exhibit 9**:

- Social Determinants of Health
- Being Unhoused
- Mental Health
- Substance Use

These were key domains discussed in the CDC 19-1906 guidance. SBCDPH and its clinical and community partners continue to learn from community voices about the interconnectedness and complexity of these and other issues, as they represent critical focal points for ending the HIV epidemic. Community engagement efforts in San Bernardino have begun to reveal potentially impactful strategies and interventions. These valuable early insights demonstrate the importance of continuing to explore how broader social factors affect the physical and mental health outcomes of San Bernardino residents.

Exhibit 9. Key considerations for EtHE in San Bernardino County, from community engagement processes

Social Determinants of Health, such as socioeconomic inequality, access to health insurance, and discrimination, impact access to HIV-related services.

Secure housing is in short supply and many people who are unhoused are also experiencing mental health issues, substance use, and stigma.

Mental health services are critically needed, yet lacking, especially among people who are unhoused and people living with HIV.

Substance use services and harm reduction services are urgently needed, especially given local rates of opioid and methamphetamine use.

The findings described below represent highlights from the community engagement activities in Exhibit 6 that were completed as of September 30, 2020 although community engagement is ongoing.

Social Determinants of Health

Social determinants of health (SDoH), including income inequality, lower educational attainment, and health insurance access, negatively affect health. At the end of 2018, 14.9 percent of residents living in San Bernardino were living in poverty—2.2 percent higher than those living in neighboring Riverside County.[21] In 2018, median household income was $3,784 less than in Riverside.[21] In 2018, 9.3 percent of San Bernardino residents were uninsured, which is also slightly higher (by 0.2 percent) than Riverside residents.[21,22] A key finding of community engagement activities was that economic disparities themselves obstruct upward mobility and maintain cycles of worsening poverty. Underlying these issues are many forms of oppression that are more difficult to quantify, including discrimination, racism, misogyny, homophobia, and HIV-related stigma. Community engagement participants shared how SDoH have impacted their experience living with or being at risk for HIV. These accounts have been summarized in longer reports[9,23,24] but a few examples are mentioned below.

Stigma. San Bernardino County community members spoke about the negative perception and stigma they suffer because of their gender identity, sexuality, or HIV status.[9,17] Stigma affects not only at the individual level, but is also in families, communities, cultures, and religious institutions. Persistent stigmatization poses a significant barrier to testing and accessing services. Information gathered from community engagement efforts suggested that stigma may be more prevalent in certain populations in the County due to a warping of indigenous culture which is more accepting of fluid sexualities by religiosity imposed on colonized individuals. Unlearning and healing from trauma may mean that most interventions must have a mental health component as a starting place. A key finding of community engagement work was that that HIV stigma persists in San Bernardino County and continues to be a barrier to HIV testing, accessing HIV care and PrEP usage.[9] Community members suggested that targeted education about HIV/AIDS in a culturally appropriate manner is still needed because of this.[9]

> "PrEP is not just a drug you give to someone to take once a day. It's an ongoing effort to heal daily so that you can engage in the behaviors that will help you instead of hurt you."
>
> *-Gabriel Maldonado, CEO, TruEvolution*

Homophobia. During the Community Caucus event, members discussed the persistent stereotype of HIV being a "gay disease" which acts as a further barrier for non-gay identified HIV positive or at-risk individuals accessing testing, prevention, and other HIV services.[9] San Bernardino County has more substantial-risk heterosexuals impacted by HIV than the TGA or the state,[6] making homophobia and stigma pressing issues in the county. The problem is further compounded by the dearth of support services for people, particularly men, who identify as straight. One member shared his experience of finding out he was HIV positive in the emergency room and subsequently experiencing depression because of his diagnosis.[9] While he was linked to care, he could not find support services for straight men that were easily accessible.

Being Unhoused

A key finding of community engagement efforts suggested that housing is a foundational need and, often, people prioritize their housing over their health.[9] The San Bernardino Office of Homeless Services 2019 Point-In-Time Homeless Count and Survey Report identified 2,607 persons who were unhoused on January 24, 2019, a 23.1 percent increase over 2018.[25] Further analysis of the subgroups identified in the count found that 71.6 percent of those unhoused were male. In terms of health conditions, 10 percent of persons unhoused experienced mental illness and 9 percent were chronic substance users. The count further reported that less than 1 percent were living with HIV but community engagement efforts suggested that HIV among unhoused individuals is underreported due to HIV stigma.[25]

Housing shortages. Inland empire community members identified four housing issues that pose barriers to achieving the county's EtHE goals:[9,17] (1) a shortage of affordable housing, (2) a shortage of housing vouchers, (3) lack of coordination among housing services (e.g., HOPWA vouchers are effective for only 2-3 years, but long waitlists prevent swift and responsive housing assistance), and (4) discriminatory policies and actions. For instance, one San Bernardino participant shared a story of applying for and getting a rental. However, once the landlord found

out that they had been homeless due to illness, they were required to increase their deposit to twice what they were originally quoted, adding a considerable barrier to housing.

Housing support. Ongoing support services are needed not only for people to secure housing but also to maintain housing. Chronic health conditions, mental health disorders, and histories of trauma can make it difficult to maintain housing. It is well recognized that supportive housing services and case management are often necessary to help people maintain and thrive in a stable home. [26] Needed support includes support for paying rent on time and applying to social benefits or employment opportunities.

Testimony from the Inland Empire Health Plan (IEHP) members at the EtHE Community Innovations Summit highlighted the importance of housing, both to improve health outcomes of PLWH and to avoid more costly care of these clients in emergency rooms.[17] The IEHP is seeking a federal waiver to reimburse housing expenses directly: security deposit, moving expenses and rent subsidy. Secure housing is a necessary condition for health and well-being, hence the common mantra "housing is health care." As one Community Caucus participant described, “People are not going to be worried about their health if they are worried about where they are going to sleep.”[9]

Mental Health

There is a dearth of mental health services in San Bernardino County. The people in the county who need these services the most cannot easily access them. In community engagement events, it was noted that PLWH, people experiencing homelessness, and people who use substances are all populations that have a high need for mental health services, often as a result of experiencing high levels of trauma.

Mental health is closely tied to SDoH, and in San Bernardino County which does not have an adequate public transportation system, lack of transportation options, especially for rural residents, is a major barrier to mental health care and services. San Bernardino County is geographically large and mental health providers are widely and unequally distributed. Mental health was ranked in the top 5 of core issues of PLWH by the Inland Empire Community Caucus.[9] A key finding of community engagement efforts suggested the peer support and peer advocacy can be a vital mental health resource for PLWH in San Bernardino.[9]

Substance Use

Both San Bernardino and Riverside County community members identified substance use disorders as a TGA- wide problem for communities affected by HIV. In 2018, San Bernardino County experienced 106 opioid-related overdose deaths, a 190 percent increase from 2016; in addition, since 2011, the county has witnessed a steady and significant upward trend of deaths attributable to amphetamine overdose.[27] Furthermore, the TGA’s 2014 Needs Assessment found that 21.7 percent of San Bernardino County PLWH reported a need for outpatient substance abuse services and 17.4 percent stated a need for either outpatient or inpatient substance abuse services in the preceding 12 months.[5] Similar to mental health, substance use highly impacts priority populations, often as a result of trauma and structural inequalities. Substance use treatment and EtHE strategies must go hand in hand to reduce HIV transmission.

Community Caucus participants expressed a need for harm reduction services for people who use substances. Participants mentioned the lack of safe injection sites and syringe exchange

services in the county, especially given the levels of methamphetamine and opioid use in the county.[9] Participants suggested that the county needs a treatment network with low-threshold access points that employ harm reduction and whole-person care principles. In tandem, a contingency management or cognitive-behavioral interventions are needed to address methamphetamine use across the region.[28]

Community Engagement, Years 2-5

SBCDPH will use years 2-5 of EtHE implementation to continuously engage community members in the planning and implementation of services and interventions. Community input was essential in developing the proposed activities outlined in *Section IV: Ending the HIV Epidemic Plan.* Moving forward, it will be equally important to keep the Planning Council, community members, and services providers engaged regarding the most effective approaches to implementing services. Future engagement strategies will include working closely with the Planning Council and hosting community forums co-sponsored by SBCDPH and CBOs. SBCDPH is prepared to develop alternative and innovative engagement methods if necessary due to COVID-19 or other unanticipated factors. Documentation of all community engagement meetings and outreach efforts will be maintained and reviewed regularly to ensure they are achieving the desired engagement of priority populations.

Exhibit 10. Community engagement priorities, years 2-5

1. Include additional new voices through collaborative relationships with CBOs
2. Focusing on workforce development

For years 2-5, SBCDPH's community engagement priorities are including more new voices through strengthening collaborative relationships with CBOs and focusing on workforce development, as summarized in **Exhibit 10,** and described below.

Collaboration with Community-Based Organizations

Many priority communities have not been previously reached effectively. As such, many in these communities have a deep-rooted mistrust of large institutions due to historical discrimination that has not only excluded people but has also caused extreme harm.[29,30] To begin to overcome these barriers, SBCDPH will prioritize relationships with CBOs grounded in the experiences and cultures of the priority communities. CBOs have the long-standing trust and rapport with those they serve; an invaluable asset that SBCDPH has yet to fully learn from or leverage. EtHE community engagement would not be possible without the support of CBOs. SBCDPH and CBO partners will seek technical assistance to implement best practices and innovative strategies for connecting with new voices from the priority populations because community engagement efforts have confirmed that these groups continue to be hardly reached and hardly served by baseline HIV work.[9]

In years 2-5, SBCDPH will work with CBOs to reduce barriers to participating in community engagement. We plan to hold informal meetings in the field at point of care settings (e.g., mobile testing unit van) to engage new voices. Informal meetings may also be held with constituent organizations, service providers, and non-traditional partners, such as the Sheriff and Probation, in order to reach people who are unaware of their HIV status and allow access to the care continuum from a variety of avenues. Hosting events on evenings and weekends or other times when people are not working, providing free childcare during events, and assisting with

transportation through vouchers or other means are all feasible strategies for increasing participation. Some of these new voices represent communities that we have less experience reaching. Therefore, the county will consider innovative ways to promote engagement in the planned activities, such as social media for youth, media campaign targeting Spanish-speakers, family-based interventions, and partnering with nontraditional partners that have further, or non-governmental, reach into the community.

One mechanism for strengthening partnerships with CBOs is through the PS-20-2010 requirement to subcontract 25 percent of funds to CBOs. SBCDPH strongly supports this requirement and will develop a request for proposals (RFP) to select organizations to implement strategies funded through both Ryan White and CDC EtHE funds. The RFP will establish criteria for applicants related to:

- Experience working with and serving one or more of the priority populations or other marginalized communities.
- Knowledge of and ability to apply a health equity framework.
- Having a workforce or clear plans to develop a workforce reflective of the priority populations.
- Having a culturally and linguistically appropriate workforce, and other criteria.

Community members from the priority populations will have input into the services provided under this RFP. In the engagement efforts to date, participants suggested using the funds to hire and train peer navigators to provide PrEP and HIV services across the county.[9] Other options may arise during additional engagement efforts. The RFA will also be an opportunity to build up the county's HIV workforce through providing job opportunities to people from the priority populations.

The RFP process for the EtHE plan will change the way the SBCDPH does business with CBOs to better support them in their EtHE efforts. SBCDPH will incentivize and provide training on recruiting and hiring people with lived experiences, including people who may not have completed a formal education. As part of a larger plan to build up the county's HIV workforce, SBCDPH will support the CBOs to access staff development opportunities. SBCDPH will also seek to reduce administrative barriers and burdens, for example, by accelerating the payment of invoices.

Workforce Development

> "Many programs do not think about the long term. They are not meant to build up the community. We need poverty work, education work, economic sustainability, jobs."
>
> *Participant-Community Caucus*

The success of San Bernardino County's EtHE plan depends on a highly skilled workforce that reflects the populations served. Hiring people "from the community" expands culturally competent service provision, leading to increased ability to reach and serve the priority populations, as exemplified by discussions during the Community Caucus. Participants shared how there was a lack of services and support groups led by peers with whom they could personally identify.[9] They talked about how having peers as PrEP navigators or advocates creates improved access to services; when hiring these navigators, San Bernardino County will seek members of the priority populations to fill the roles.

Hiring community members also provides job opportunities and training to people from the priority communities, helping reduce the stark economic disparities that contribute to HIV risk and poor health outcomes. Making community hiring a priority demonstrates to communities with lived experience that they are highly valued and needed, helping to break down systemic racism and discrimination.

The University of California, Riverside (UCR) School of Medicine has an extensive pipeline program for underrepresented minorities (URMs) to increase diversity in the medical and public health fields.[31] This program is a model and the TGA will continue to support and develop similar pipeline programs across the region.

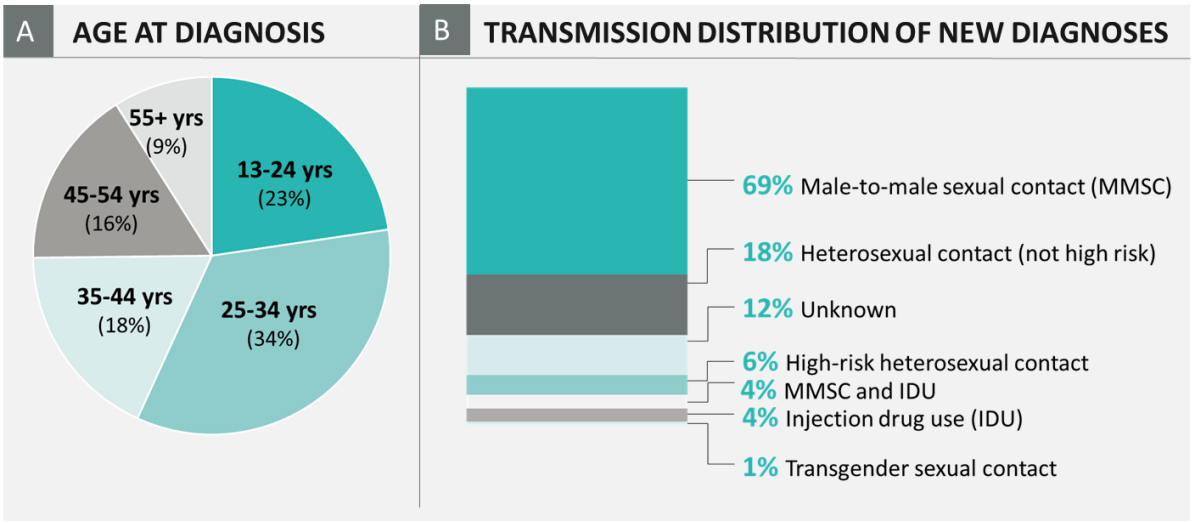
Section II: Epidemiologic Profile

HIV Diagnoses

In 2018, there were approximately 5,558 people living with HIV in San Bernardino County. Of those, 4,568 (82.2 percent) had been diagnosed – up from only 74.8 percent diagnosed in 2016 – and 278 were diagnosed within 2018. Of the people diagnosed in 2018, 145 (52 percent) were ages 25 to 44, 193 (69 percent) were infected through male-to-male sexual contact, and 50 (18 percent) were infected through heterosexual contact not typically considered high risk (i.e., not with a partner who was MSM or injected drugs).[4]

Exhibit 11 highlights the age and transmission distribution of new HIV diagnoses in San Bernardino County in 2018.[4]

Exhibit 11. Mode of Transmission, New HIV Diagnoses, San Bernardino County 2018



Overall, age and gender at diagnosis have remained relatively constant between 2014 and 2018 in San Bernardino County. However, the rates of new infections per 100,000 population by race/ethnicity have changed notably since 2016 as can be seen in **Exhibit 12**. Specifically, the rate of infection among Black/African Americans, Hispanic/Latinx persons, and white persons has been steadily rising since 2016 (this trend started earlier in 2015 for B/AA) and rates continue to be substantially higher for Black/African Americans in all years than for other race/ethnicities. It is important to note that when overall numbers of individuals in a group are small, sparklines or other trend analyses should be interpreted with caution.[4]

American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups are not included in the race/ethnicity data tables below due to small to zero numbers reported each year from 2014-2018. This report does not intend to diminish the impact of HIV on American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups. Small numbers are not reported to preserve the confidentiality of PLWH.

Exhibit 12. Rate of Transmission by Race/ethnicity, New HIV Diagnoses, San Bernardino County

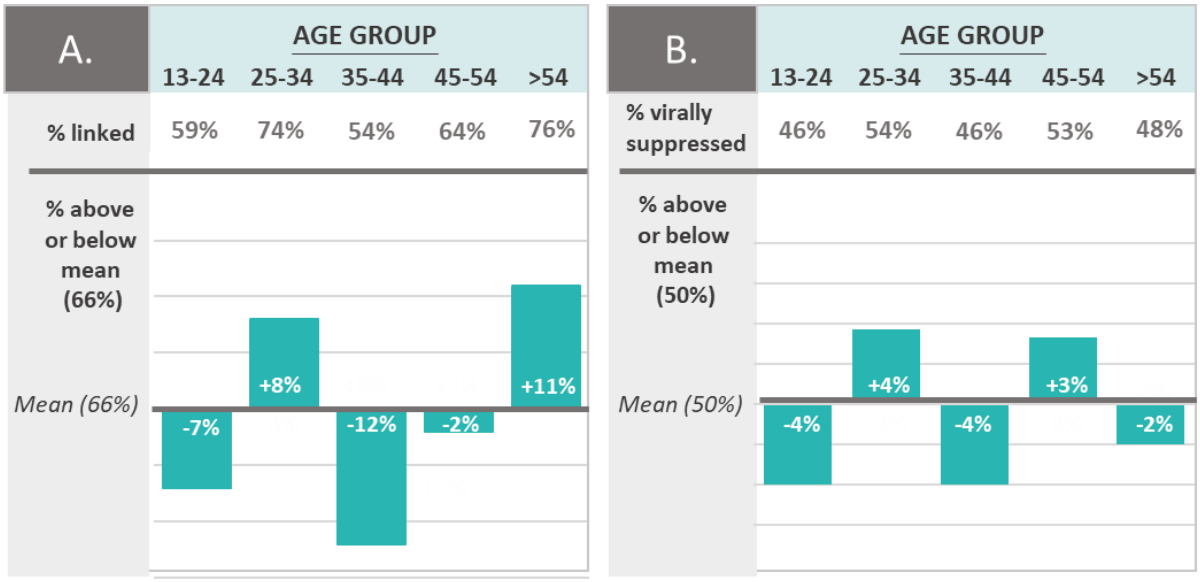
Race/ethnicity	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2014-2018 Sparklines
Black/African American	19.1	25.6	22.7	24.8	25.2	
Hispanic/Latinx	10.9	9.4	11.3	13.3	14.7	
Asian	6.9	5.3	5.3	5.2	5.8	
White	6.7	4.7	6.6	7.2	8.3	

Note: Rates are per 100,000 population.
Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

Linkage to Care and Viral Suppression

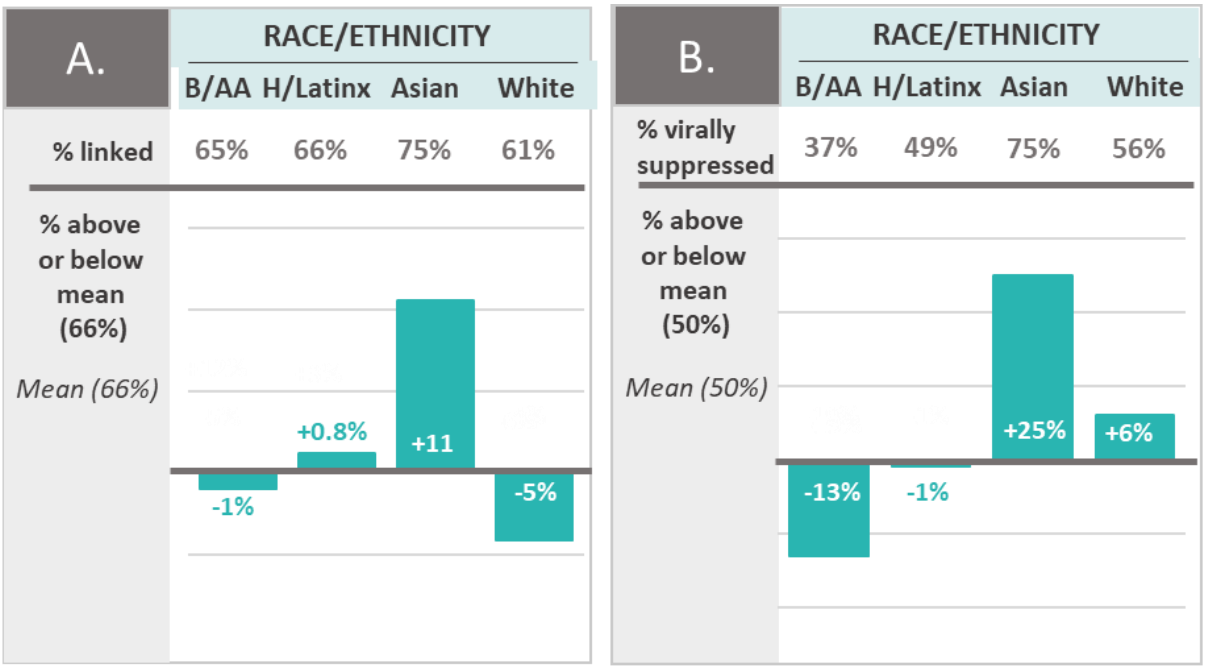
New diagnoses are not the only important piece of HIV epidemiology, however. Also, key are the percentages of people who are linked to care within 30 days and who are virally suppressed within six months of diagnosis. Overall, 65.5 percent of people diagnosed with HIV in San Bernardino County in 2018 were linked to care within 30 days of diagnosis, and 50 percent were virally suppressed within 6 months. However, there were notable disparities; people ages 13-24 and 35-44 had considerably worse rates of linkage to care within 30 days and people ages 13-24, 35-44, and 55 and older had worse viral suppression rates (**Exhibit 13**).[4]

Exhibit 13. Linkage to Care (A) and Viral Suppression (B) by Age, San Bernardino County 2018



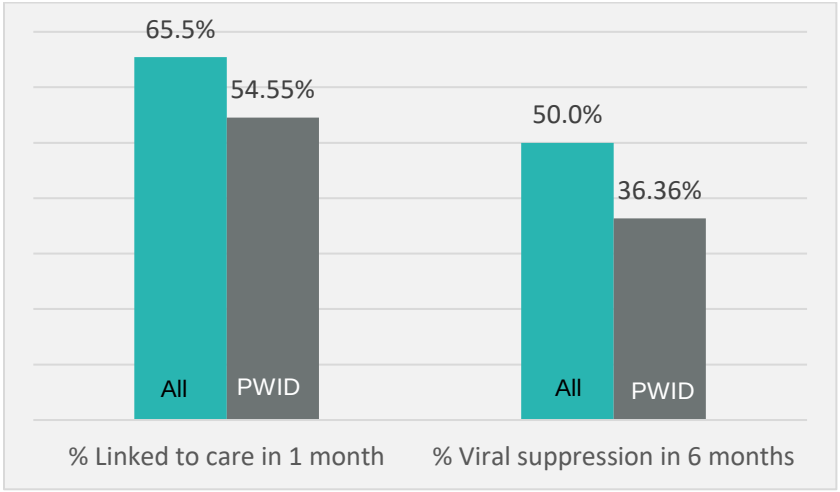
Similarly, disparities in linkage to care and viral suppression were also seen by race/ethnicity, with whites having a substantially lower rate of linkage to care within 30 days and Black /African Americans having a lower rate of viral suppression within 6 months compared to other race/ethnicities including Hispanic/Latinx (H/Latinx). (**Exhibit 14**).[4]

Exhibit 14. Linkage to Care (A) and Viral Suppression (B) by Race/ethnicity, San Bernardino County 2018



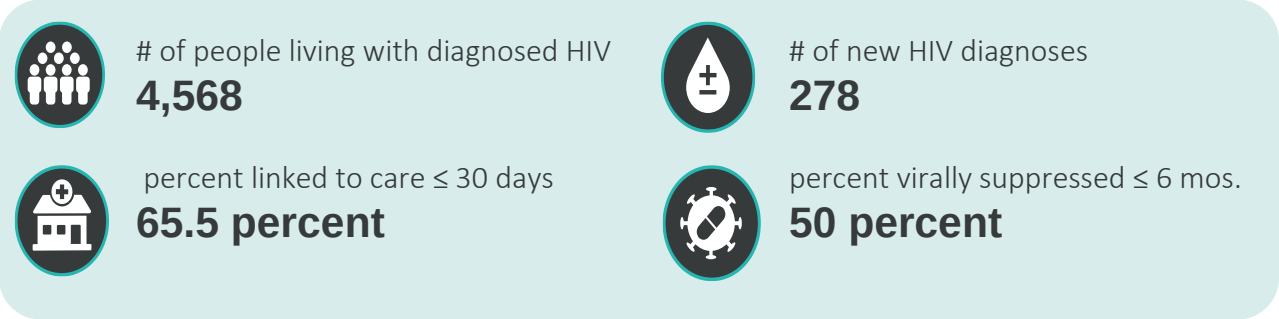
Lastly, disparities in linkage to care and viral suppression are also seen by transmission category, with persons who inject drugs substantially less likely to be linked to care in one month or achieve viral suppression in six months than the overall county average.[4]

Exhibit 15. Linkage to Care and Viral Suppression by Injection Drug Use, San Bernardino County 2018



In summary, **Exhibit 16** provides a few key features of San Bernardino's County's HIV epidemic in 2018.

Exhibit 16. Key features of San Bernardino County's HIV epidemic (2018)



Section III: Situational Analysis

This Situational Analysis provides a high-level overview of the strengths, needs, gaps, and barriers related to ending the HIV epidemic in San Bernardino County. It synthesizes information from the epidemiological profile, community engagement efforts, planning conversations, and consultations with key partners and stakeholders, both HIV and non-HIV.

Methods

San Bernardino County's situational analysis consisted of documenting HIV-related community needs and assets, describing the existing resources to meet those needs (see **Appendix 1: Resource Inventory**), and identifying gaps that must be filled to fully meet the community needs. The situational analysis methods and data sources are described in **Exhibit 17.**

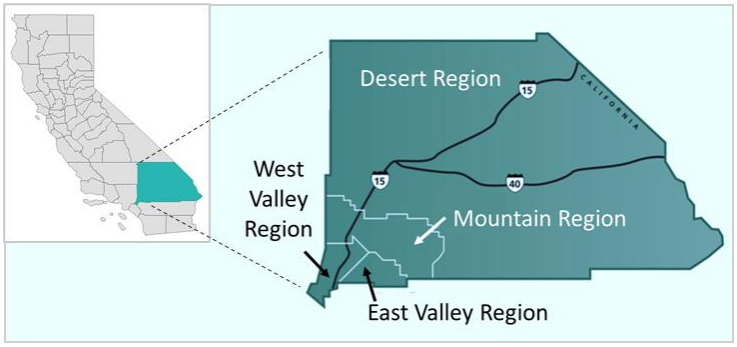
Exhibit 17. Methods and data sources used for the County's situational analysis

Method	Description
Needs assessment to ascertain needs, resources, and service gaps	• EtHE community engagement efforts[9,11-20] • County information on existing services • Getting to Zero Think Tank[24] • Inland Empire Comprehensive Needs Assessment[10]
Review of secondary data and reports	• AIDSVu local PrEP estimates[32] • 2018 San Bernardino County Epi Profile[4] • San Bernardino Community Indicators Report[23] • San Bernardino County Homeless Count and Survey[25] • CA Opioid Surveillance Dashboard[27] • Riverside/San Bernardino TGA HRSA 20-078 Application[6] • San Bernardino CQM Plan[7] • CDPH HIV Surveillance Report[33]
Community engagement and consultation	• Inland Empire HIV Planning Council • Service providers • Community members representing the priority populations disproportionately impacted by HIV
Review of relevant County and State plans	• Inland Empire HIV Planning Council Comprehensive HIV Services Plans[1,2] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan[3] • EPMP and Work Plan[34] • San Bernardino County PS18-1802 Work Plan and Logic Model[35]
Consultation with key stakeholders	• SBCDPH staff from all HIV Divisions • Riverside University Health System – Public Health • CDPH • Federal Ryan White Program Staff

Situational Analysis Snapshot

Situational Analysis Summary

Exhibit 18. San Bernardino County Planning Regions



San Bernardino County, in the inland portion of Southern California, has an area of 20,053 square miles making it the largest county in the contiguous United States. The county is divided into 4 planning regions: 1) Desert, 2) West Valley, 3) East Valley, and 4) Mountain **(Exhibit 18)**.[36] The county is part of the Inland Empire, which is made up of the Riverside, San Bernardino and Ontario metropolitan statistical areas. Much of the county's land (81 percent) lies outside of the control of county or city governments. Only 5 percent of land is used for housing, utilities, agriculture, and municipal parks; 13 percent is used by the military and 82 percent is vacant. The desert region comprises 93 percent of all land area in the county.

With a population of 2,171,938, it is the 5th most populous county in California and the 14th most populous in the U.S. The population is clustered mostly in the West Valley Region.[22] Population density in the county as a whole is 108 persons per square mile versus 3,072 persons per square mile[23] in the East and West Valley Regions alone.

San Bernardino County is culturally diverse with only 31.5 percent of the population being comprised of non-Hispanic whites. B/AAs, Hispanic/Latinx and other race/ethnic groups comprise 8.4 percent, 51.1 percent and 9 percent of the population respectively.[22] Over 40 percent of residents speak a language other than English at home and approximately 21 percent of all residents are born outside of the U.S.[21] According to the U.S. Census Bureau, an estimated 14.9 percent of county residents live in poverty,[21] which is somewhat lower than the TGA as a whole, but a staggering 50.4 percent of PLWH in the county are living in poverty.[5]

The geographic and demographic uniqueness of San Bernardino County represents a mix of challenges and opportunities for ending the HIV epidemic. The high cost of living in California has drawn individuals to San Bernardino County in search of less expensive housing. Homelessness and poverty have been noted as cofactors in HIV acquisition so the County's relative housing affordability should offer an opportunity for lower income individuals to not have to choose between health care and housing. However, these affordable unincorporated regions are remote, with little infrastructure, and are considered medically underserved. Less urban density can offer some protective factors in the spread of certain communicable diseases, but since HIV is sexually transmitted, the low density is not a significant protective factor. Regional diversity across San Bernardino is taken into account through the ongoing evaluation of health strategies and resource distribution across four distinct health planning regions 1) East Valley, 2) West Valley, 3) Mountain and the 4) Desert Region. There have been some noted successes in local EtHE efforts, other aspects of the HIV epidemic are worsening in San Bernardino.[23]

There are eight principal providers of primary medical care for PLWH in San Bernardino County. They are SBCDPH (via three of its four FQHCs), Jerry L. Pettis Memorial Veterans' Medical Center, Kaiser Permanente (private), Loma Linda University Medical Center, AIDS Healthcare

Foundation, Borrego Health, Arrowhead Regional Medical Center, and the Social Action Community Health System (SACHS), affiliated with Loma Linda University Medical Center.

A number of hopeful trends make this a strategic moment to engage with getting to zero planning and implementation within the county. Now, and for many years since the implementation of antiretroviral therapy (ART), deaths among PLWH have declined and the number of PLWH has increased. Between 2016 and 2018 there was a 16 percent increase of the number of PLWH in the County (from 3,949 to 4,563 cases). Also promising was that between 2014 and 2018 viral suppression within 6 months, among people newly diagnosed with HIV, increased from 42 percent to 50.0 percent (**Exhibit 19**).[4] However, if this viral suppression trend continues, it will fall short of 2021 targets that call for 75 percent of all newly diagnosed PLWH to be virally suppressed within 6 months.

***Exhibit 19*. percent** Virally Suppressed Among People Newly Diagnosed with HIV in San Bernardino County

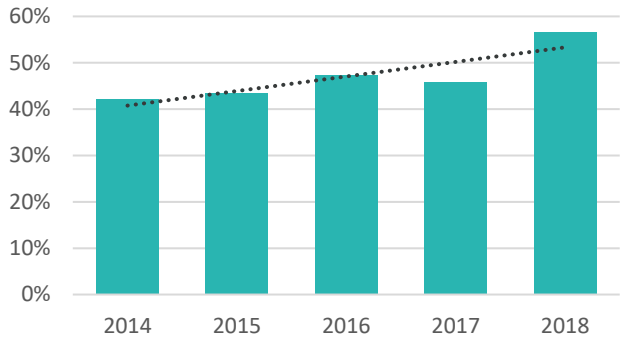
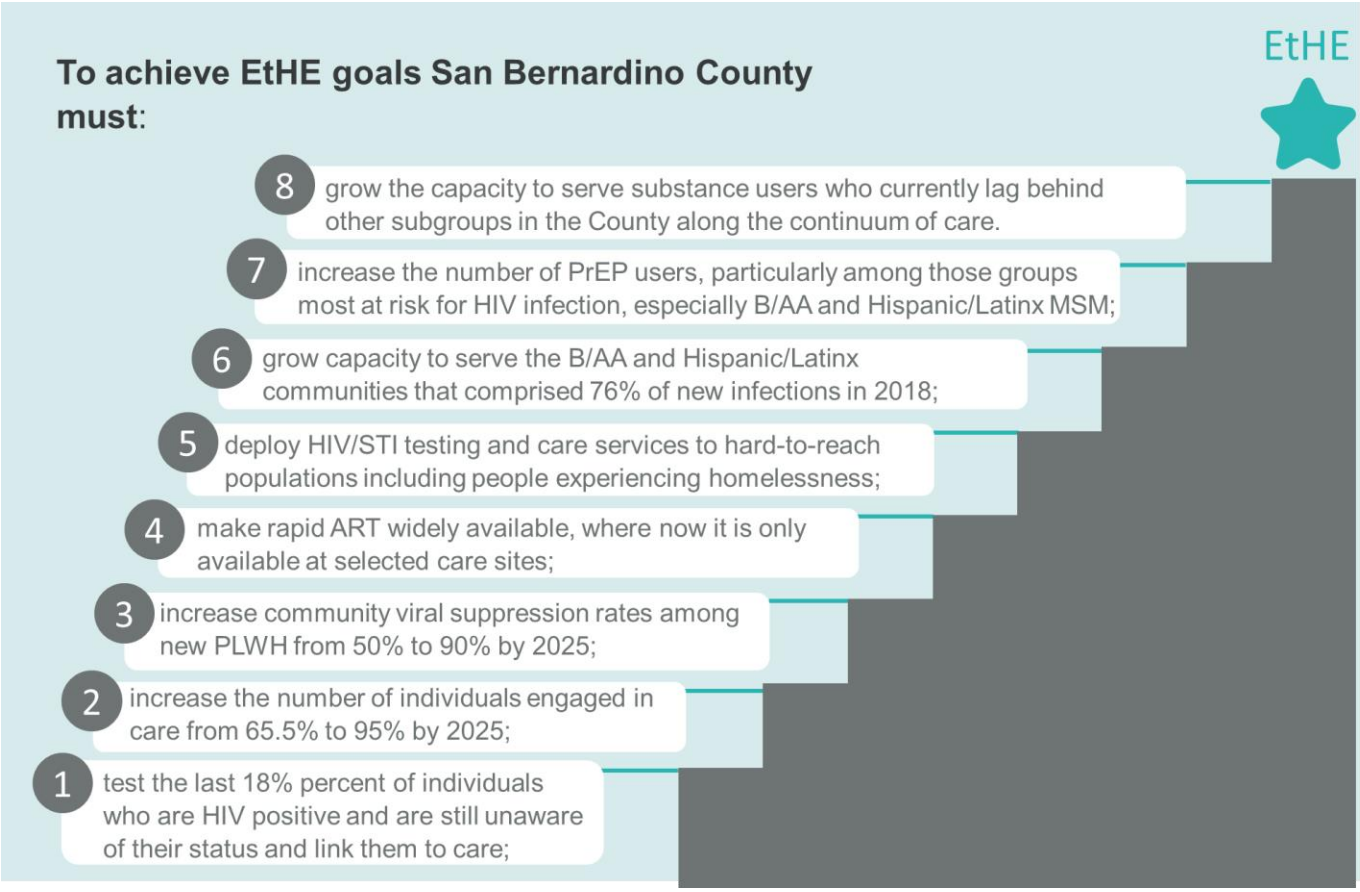


Exhibit 20 summarizes what the County must do to reach EHE goals.

***Exhibit 20*.** High-level summary of what is needed to end the HIV epidemic in the San Bernardino County



Situational Analysis Snapshot by Pillar

Diagnose

There are troubling trends that make this a critical moment to accelerate EtHE strategies. As of 2018, an estimated 18 percent (n=990) of all people with HIV remain undiagnosed. Since 2011 the annual number of incident HIV cases increased by 25 percent.[4] MSM, people under 34, and people of color (B/AA and Hispanic/Latinx) are affected disproportionately. Community engagement efforts[9] suggest that stigma continues to be a barrier to HIV testing and other health seeking behaviors underlying the persistent discrimination and fear in these communities across San Bernardino. Fear of being identified as someone who might be at risk for HIV can keep individuals from testing. Fear and stigma can also lead to individuals denying their risk to their medical providers and their conscious self. Education can be a great equalizer; however, community engagement efforts also revealed that culturally appropriate HIV information is not reaching the B/AA and Hispanic/Latinx communities or other populations such as people under 34, PWID, or people experiencing homelessness who are at substantial risk for HIV.

Treat

Among those newly diagnosed in 2018, 65.5 percent were linked to care within one month and 50 percent achieved viral suppression within 6 months, indicating a need for substantial efforts to improve linkage and retention. Newly diagnosed B/AA were less likely than other race/ethnicities to be linked to care or virally suppressed.[4]

Poverty is still a major factor affecting the health of PLWH in the county. Thus, despite affordability of housing, a lack of low-income housing and homelessness are still major risk factors for PLWH and affect their ability to maintain their linkages to health care. Racism, trauma, and stigma-related stressors lead to an increased incidence of mental illness which can also affect the ability of PLWH to navigate through the health care system. In 2016 an estimated 36 percent of all PLWH had an unmet need for primary HIV care.[6] New strategies, and especially new resources, need to be deployed across the county to end the HIV epidemic in San Bernardino and support those most negatively impacted by the costs of discrimination.

Prevent

The emerging epidemic in the San Bernardino County is predominately among people of color (79 percent) and the county has more infections attributed to heterosexual contact (24 percent), injection drug use (IDU) (8 percent) and diagnoses among cisgender women (14 percent) when compared to the TGA or California as a whole.[4,6] In 2018, B/AA persons made up 17 percent of new infections, but only 9.4 percent of the general population.[4,22] Also, Hispanic/Latinx persons account for 59 percent, or 3 out 5 of all new diagnoses. By age, young people under 34 made up more than half of new diagnoses.[4]

SBCDPH has led recent efforts to improve PrEP utilization throughout the county and TGA[6] via education of PrEP prescribers, PrEP navigators, outreach to priority populations at substantial risk for HIV, and training for medical providers who were not screening for HIV or prescribing PrEP; however there is still much work to do. Current estimates of PrEP utilization[22,32] in all areas of California, including San Bernardino , fall short of what is needed to achieve the 2021 goal of 60,000 prescriptions for PrEP across the state.[3] As seen in **Exhibit 21**, San Bernardino County lags behind the rest of the state in PrEP uptake.[37] San Bernardino will have to accelerate uptake of PrEP, especially in communities of color, young people under 24, MSM, at-risk heterosexuals and PWID, to meet EtHE goals.

***Exhibit 21*:** 2021 Target and 2018 Estimated PrEP Utilization in San Bernardino and California

	Total Users	Rate (per 100,000)
California 2021 target	60,000	152
California 2018	27,283	82
San Bernardino 2018	593	35

Community engagement efforts suggest why the epidemic might be affecting more people of color. Lack of culturally appropriate information, shortages of HIV providers, long waits for referrals to care, lack of transportation, lack of affordable housing, and the high prevalence of substance use and other mental health conditions were all raised as significant barriers that must be addressed in order to achieve progress on EtHE goals.

Respond

SBCDPH's capacity to coordinate between prevention and HIV surveillance has been bolstered with CDC's integrated approach facilitated by PS-18-1802. However, the lack of real-time surveillance data that hampers all counties affects San Bernardino more dramatically. Needs assessment data[6] found that San Bernardino County's epidemic is increasing faster than the general population size, which suggests a migration pattern of PLWH into San Bernardino County who may have been infected and/or diagnosed in other areas. These cases are not taken into account when distributing funds.[6] Compounding this funding issue are decreases in funding over the years that have left HIV services chronically under-resourced;[10] for example, SBCDPH's Ryan White Part C EIS funding alone was cut 6.6 percent between 2016 and 2018, while new HIV diagnoses increased 21 percent during the same period.[4,5] The Desert and West Valley Regions are critically underserved. Community engagement efforts documented housing as a fundamental need that may drive PLWH to settle in areas of the County that have cheaper housing costs but few health services or other vital infrastructure.[9] Community engagement efforts further revealed that even in relatively affordable San Bernardino, people are driven to homelessness through a combination of poverty, mental health, substance use, and other broader social factors. According to homeless PLWH, the chances of maintaining care in a homeless encampment are very low without intervention.

The county surveillance team works closely with the State HIV Surveillance Branch on all aspects of HIV reporting activities, including potential cluster investigations involving San Bernardino County cases. San Bernardino's surveillance team has developed supportive and reciprocal relationships with teams in neighboring counties to address cross-jurisdictional matters.

Summary of Resources and Gaps

Resources and Assets

Exhibit 22 highlights selected resources and assets that were identified during the process of the needs assessment activities. SBCDPH has a number of pillar-specific resources and assets that can be built upon to enhance EtHE goals. SBCDPH currently funds strategic partnerships with organizations that have links to B/AA and Hispanic/Latinx populations at risk for HIV and offer services in neutral spaces that serve the diversity of communities present in San Bernardino County. These partnerships can be expanded and linked to additional supportive services like the InnRoads Project (discussed in more detail below), which focuses on unhoused individuals and will be a valuable partner for achieving EtHE goals. Community-based HIV testing can be expanded as well as working to help build and expand testing programs in the major hospitals in San Bernardino like Arrowhead Regional Medical Center, already a leader in emergency department (ED) testing. Loma Linda University Medical Center is also poised to expand testing and other HIV services on site and remotely. The end+disparities ECHO Collaborative/CARG has demonstrated that it can increase viral suppression in a key focus population for SBCDPH: MSM of color. All of these resources and more will be leveraged to help San Bernardino reach its EtHE goals.

Exhibit 22: San Bernardino County Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Community-based Testing	●			
Emergency Room Testing	●			
Foundation for Rolling Out Rapid Linkage to Care		●		
end+disparities ECHO Collaborative/CARG		●		
Minority AIDS Initiative (MAI) funding		●		
SB 159 Pharmacy Syringe Sales			●	
PrEP Initiatives			●	
Cross-Pillar				
• Regional approach • Public health staff • More supportive administration • Coordination between SBCDPH Surveillance, Prevention, and Care • InnROADS Services for people experiencing homelessness				

Community-based Testing. SBCDPH plans to increase testing services to key populations through community-based testing partners that are poised to expand services and have deep knowledge about how to serve communities of color. These organizations include AHF, Borrego Health, FLACC, and TruEvolution.

Emergency Department Testing. Arrowhead Regional Medical Center is currently a leader in implementing ED testing. Loma Linda University hospital is poised to expand ED based testing and will be another key partner to reaching EtHE goals in San Bernardino.

Foundation for Rolling Out Rapid Linkage to Care. The HIV Prevention and HIV Care teams currently facilitate linkage to care connections at SBCDPH FQHCs—the foundation on which the proposed Rapid StART Initiative will be built. Rapid StART will reduce the time between diagnosis and ART initiation.

End+Disparities ECHO Collaborative/CARG. The end+Disparities ECHO Collaborative California Regional Group is a national model aimed at increasing viral suppression in key populations, strengthening, and building local partnerships, and increasing the local quality improvement capacities of HIV providers and consumers. SBCDPH joined the ECHO Collaborative to implement these strategies and focus on MSM of color. The model includes in-clinic drill downs of data, process mapping, and flow mapping to target clients who are not virally suppressed and who had not previously been identified through other mechanisms. This approach is helpful because virally unsuppressed individuals are “invisible” when looking at quality measures that show overall high rates of viral suppression.

Minority AIDS Initiative Funding. The SBCDPH is allocating money to innovative partners who have shown they can implement effective strategies. An ongoing MAI-funded program at TruEvolution offers testing, linkage to care, and early intervention services. The diverse staff reflects the populations in the county that need services the most: Blacks/African Americans, Hispanic/Latinx, and the transgender community. Their strategies of community-building, outreach, and social networking are well suited to the suburban and rural areas underserved in San Bernardino County.

Senate Bill 159. When Senate Bill (SB) 159 went into effect on January 1, 2020, California became the first state in the nation to authorize pharmacists to furnish a 30- to 60-day supply of pre-exposure prophylaxis (PrEP) and a complete course of post-exposure prophylaxis (PEP) without a physician’s prescription. The legislation also prohibits insurance companies from requiring “step therapy” or prior authorization for anti-retroviral drugs, including PrEP and PEP. The bill is a key step in California’s work to eliminate HIV. This bill also represents an opportunity to expand education and partnerships with pharmacies about how they can best serve key populations in San Bernardino County.

PrEP Initiatives. SBCDPH has a number of baseline PrEP initiatives funded through PS-18-1802 designed to address the lag in PrEP uptake: 1) enhanced collaboration with the SBCDPH Communicable Disease Section for better referrals to PrEP after STI/HIV exposure; 2) facilitation of a new PrEP/PEP navigator collaborative for coordination, training, and support; 3) initiating case conferences using CBA providers as needed to detail and improve PrEP case outcomes; and 4) promote PrEP using CDC developed materials.

Regional Approach. The SBCDPH is the major provider of HIV primary care services in the county. SBCDPH delivers these services through three geographically distinct sites located in

each of the Health Planning Regions: 1) East Valley, 2) West Valley, and 3) Desert. SBCDPH is the Grantee for Ryan White Parts A, B, and C funding to provide HIV primary medical care and support services to low-income PLWH who have no other resources to pay for care. The county operates four FQHCs including those in Adelanto, Hesperia, Ontario, and San Bernardino. The AIDS Health Care Foundation, located in West Valley, is funded through Part A funds administered by San Bernardino County on behalf of the RSBTGA. The Loma Linda University Children's Hospital provides both inpatient and outpatient HIV primary care to children through the age of 21 years, funded through the California Children's services. The Veterans Administration Medical Center is also located in San Bernardino County, providing HIV primary medical care to veterans living throughout southern California.[5] As part of the RSBTGA, the SBCDPH and Riverside County coordinate with each other to serve clients that may be receiving care and prevention services in both counties. In addition to direct primary care, the SBCDPH offers a range of assessment, planning, technical assistance, and training across the three regions. In 2018, SBCDPH implemented regional cultural sensitivity trainings in the FQHCs.

Public Health Staff. SBCDPH staff are engaged in ongoing EtHE-focused work and actively searching out data on how race, ethnicity, socioeconomic status, substance use, homelessness, and mental health interact with the HIV epidemic. The recent Getting to Zero Think Tank is an example of this effort.[24] The SBCDPH works with academic partners and technical assistance providers locally, statewide, and nationally to learn and share about getting to zero outcomes.

More Supportive Administration. SBCDPH administration has increased capacity to support the full functioning of HIV care, prevention, and surveillance using a more coordinated and integrated approach. The EtHE initiative is an opportunity to increase cross-division collaboration.

Coordination Between SBCDPH Surveillance, Prevention, and Care. The Prevention team has developed a more cohesive and collaborative relationship with their Communicable Disease Section partners responsible for HIV Surveillance activities in the county. This has allowed for complementary and cooperative procedures related to making connections with syphilis/HIV co-infected individuals for providing partner services and PrEP/PEP navigation. This collaborative partnership has grown to more effectively involve the Ryan White Part A Grantee and the Clinic Operations Section to coordinate the Ending the Epidemic strategy and delivery of more comprehensive services. The Prevention team works collaboratively with the Surveillance team to obtain surveillance data to inform local testing efforts, helping the team to target testing services in largely high prevalence zip codes throughout the County. The Prevention team will establish new testing sites by analyzing data from the year end reports and STI surveillance reports and using new data regarding activities of high HIV risk from the LEO system.

InnROADS. In July 2019, a new and innovative family of programs established a collaboration to provide outreach and engagement that allows for real-time multi-agency problem solving and referrals for those experiencing homelessness in San Bernardino County. This project creates a field-based engagement treatment model that will provide services in the field targeting all regions of the county. Services include HIV/STI/HCV testing, case management, alcohol, and other drug (AOD) counseling, and mental health services delivered by behavioral health nurses in coordination with other providers. This multidisciplinary/multi-agency collaboration includes the SBCDPH HIV Prevention program, Communicable Disease Section (which includes HIV

Surveillance), the Department of Behavioral Health (DBH), Department of Aging and Adult Services (DAAS), the Sheriff's Department, and Probation.

Gaps and Challenges

SBCDPH has a number of pillar-specific challenges and gaps that will need to be addressed in order to reach EtHE goals. Lag time in linkage to care (LTC) has been a persistent problem that is fomented by an overall shortage of resources and trained staff. Low PrEP uptake as compared to all-county averages must also be addressed. Data gaps due to migration of PLWH into San Bernardino will be addressed though more collaboration across SBCDPH with surveillance to prevention and care being a driving force of these collaborations. While brick and mortar facilities do need to be part of the EtHE expansion of activities, mobile services will also be vital to PWID, homeless, B/AA, Hispanic/Latinx MSM, and at-risk heterosexuals. Gaps and challenges are summarized in **Exhibit 23**.

Exhibit 23: San Bernardino County Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Limits to Health Care Access	●			
Barriers to Collaboration with Prisons/Jails	●			
Shortages of HIV Clinical Providers		●		
Delays for Linkage to Care		●		
Lack of Transportation		●		
High Prevalence of Substance Use and Mental Health Issues		●		
Lack of Evidence Based Practices and Approaches			●	
Low PrEP Initiation			●	
High STI Rates			●	
Data Gaps/Lack of a Protocol for HIV Outbreak Response				●
Cross-Pillar				
• Social determinants of health (SDoH) • Organizational barriers and staff turnover • Migratory patterns • Housing and homelessness				

Limits to Healthcare Access. Healthcare access in San Bernardino County is impeded by a lack of providers and services for primary care, mental health, and HIV specialty care. The county is a designated Health Professional Shortage Area (HPSA). In this service desert, SBCDPH has become a major provider of HIV care services for three health care planning areas: 1) East Valley, 2) West Valley and 3) Desert regions. The county directly operates three FQHCs that provide HIV care – Hesperia, Ontario, and San Bernardino Health Centers – and most local providers refer their HIV patients to one of these sites. Most of these services are concentrated in the East Valley, leaving the other areas severely under-resourced. The Mountain and Desert regions of the County have major gaps in resources and infrastructure. Also, apart from the FQHCs, AIDS Healthcare Foundation, Loma Linda University Children's Hospital, and the Veterans Administration, there is a dearth of HIV medical care in the county for low-income PLWH.[5]

Barriers to Collaboration with Prisons and Jails. There are intermittent challenges relating to SBCDPH collaborating with and influencing the HIV prevention and treatment work within prisons and jails. Staff turnover often influences the timeliness of collaborative efforts. Limited resources are also a barrier to routine testing. SBCDPH staff meets with jail staff on a regular basis to mitigate barriers and collectively seek outside funding to accomplish HIV work. However, it should be noted that there is a need for sustained, ongoing funding for this work, to ensure it is maintained beyond the limitations of various grant cycles.

Shortages of HIV Clinical Providers. In San Bernardino County, there are too few HIV specialty providers to treat PLWH. Among the few providers in place, many are poised to retire in the coming years, leaving a gap in the HIV medical workforce. There is an immediate need to train new providers in HIV subspecialty care and recruit more providers of color to serve the changing demographics of the epidemic. Training must be provided on a flexible schedule and deployed over a wide geographical area in order to prevent clinics from closing during regular business hours and limiting services. Creating a hybrid in-person/online approach might work best to ensure all regions are served without the need for providers or clients to travel as often.

Delays for Linkage to Care. Currently, many people newly diagnosed with HIV are experiencing lengthy delays in being linked to care. Reported linkage to care within 30 days fluctuates and is related to both the lack of providers and client insurance status. For newly identified clients who are insured it can be difficult for them to establish linkage-to-care, as they must see their assigned primary care provider. For uninsured clients, SBCDPH is able to provide a warm hand-off to one of its own health centers, however recent staff turnover within the specialty care team has made it challenging to provide appointments within 10 days. Ryan White data show that while many clients may not be linked to care within 30 days, most are being linked to care within 3 months.

Lack of Transportation. Transportation has been noted as a barrier for those trying to access services across the county. San Bernardino spans 20,053 square miles, making it the largest county in the U.S. by area; similar in size to the state of West Virginia and larger than the state of Connecticut. The county is composed of different terrains, including mountains, valleys, and deserts, making transportation across this large area an issue for residents. Transportation was cited as a priority by the Consumer Caucus. Services and providers are spread widely across the county, making it difficult for patients to access these services and more likely that they will fall out of care.

Substance Use and Mental Illness Among PLWH. PLWH are much more likely to experience mental health or substance use disorders than the general population. PLWH who struggle with these issues may be more likely to engage in condomless sex and needle sharing, increasing the risk of HIV transmission. The 2014 Needs Assessment found that 25 percent of all PLWH used an illicit drug in the past month (including cannabis).[10] Harm reduction efforts need to be put in place to prevent any further HIV infection from injection drug use. Thirty-seven percent (37 percent) of HIV program clients, as documented in ARIES, have a need for mental health services, further showcasing the mental, emotional, and social support that this population requires. People experiencing homelessness also report high rates of chronic substance use (20.4 percent) and mental illness (19.7 percent).[25]

Evidence Based Practices and Approaches. The current gaps in the county have highlighted the need for appropriate and specific prevention interventions and strategies that reach at-risk populations effectively.

Low PrEP Initiation. Despite the strong PrEP efficacy evidence, many at-risk populations are not initiating PrEP use**.** Multiple barriers can hinder PrEP uptake, including barriers related to health insurance coverage, providers failing to discuss HIV with their patients, lack of low-barrier PrEP access services, stigma, and lack of PrEP knowledge**.** Specific to San Bernardino County, there is a lack of staffing dedicated to PrEP services and peer navigation. The county would benefit from using a community health worker model to initiate connections to services such as testing, PrEP, and care. This model would work well for the at-risk communities of color who may not feel comfortable accessing standard clinic-based services.

Exhibit 24. Comparison of infection rates between the total population of SB County and PLWH

	Infection Rates per 100,000	
	Total Population	PLWH
Syphilis	35.3	6986.6
Gonorrhea	157.5	4291.7
Chlamydia	535.7	2580
HCV	214.1	4291.7

High STI Rates. The rates of STIs in San Bernardino County have increased from 2010 to 2016 and the county is within the top 6 of California's 61 jurisdictions for the number of reported cases of chlamydia and gonorrhea. People with STIs are more vulnerable to acquiring HIV. It is a missed opportunity when someone diagnosed with an STI is not tested for HIV. In addition, the rates of chlamydia, syphilis, gonorrhea, and hepatitis C are higher for PLWH (**Exhibit 24**). A PLWH in San Bernardino County is 27 times more likely to be infected with gonorrhea compared to the rate of gonorrhea in the overall population. The syphilis rate among PLWH is alarmingly high, and the chancre sore that characterizes syphilis increases the likelihood of HIV transmission.

Data Gaps/Lack of a Protocol for HIV Outbreak Response. Although the County has an interdisciplinary outbreak team (see p. 25), there is no formal protocol for HIV outbreak response. As a result, responses to the HIV epidemic are not as timely or coordinated as they could be, which could pose challenges to an effective response if a cluster were identified in San Bernardino. As the state completes its Outbreak Response Plan, we will follow the guidance for LHJs in that document. We will also utilize the OA Prevention Branch Disease Outbreak Intervention and Field Investigation Unit for technical assistance and additional staffing as needed.

Social Determinants of Health. San Bernardino's HIV epidemic is characterized by a higher proportion of people of color compared with the epidemics of the TGA and California. Thus, systemic racism and its effect on health outcomes may be more of a burden for San Bernardino than in the TGA or in California as a whole. Reducing the HIV epidemic in San Bernardino County is hampered by social determinants of health (SDOH), which are structural conditions that communities experience daily. Five SDOH stand out in the county: poverty, education, unemployment, lack of insurance, and cultural competency.

- **Poverty** affects half of all PLWH in the county defined as living below 100 percent of the federal poverty level.[6]
- **Education** disparities exist in the county and play a role in economic mobility and well-being. Overall, 18.1 percent of county residents have not completed high school.[21] However, among PLWH in San Bernardino County, that rate is significantly higher at 27.8 percent.[6]
- **Unemployment** rates are high in the PLWH population – 70.4 percent of PLWH in San Bernardino are unemployed or disabled[6] compared with only 10.5 percent in the county overall.[21] Unemployment and income are noted as significant barriers to prevention and care in San Bernardino.
- **Uninsured/underinsured** people are less likely to access care. The rates of uninsured individuals are higher in the county than in the TGA as a whole. Among San Bernardino County residents ages 18-64, 19.2 percent are uninsured[21] compared to 15.6 percent of all TGA residents.[6] The 2014 TGA Needs Assessment revealed that 12.2 percent of all PLWH in San Bernardino County were uninsured.[10]
- **Cultural competency and language barriers** must be addressed, given the increases in new diagnoses among Hispanic/Latinx MSM in the county. Outreach, information, and services need to be provided in a culturally and linguistically appropriate manner in order to make sure all clients are treated with respect and that they have the ability to understand and participate in their care.

Organizational Barriers and Staff Turnover. There are two main current organizational challenges within SBCDPH. First, HIV Care Services, Prevention, Surveillance, and the Ryan White Program are in different divisions within the department and they are physically located in different buildings. This organizational and physical division creates a delay in the coordination and planning of HIV activities across the county. Given these circumstances, enhanced communication and collaboration across divisions are needed to ensure strategies are aligned and effective. Second, within SBCDPH a high number of positions will be vacant soon due to staff retirements. It is necessary to fill those positions with similarly trained and qualified staff. To achieve this, additional resources for transition planning and a process for knowledge transfer will be required.

Migratory Patterns. San Bernardino residents are likely to migrate and relocate between neighboring counties. Since some areas of the county are adjacent to up to three other counties, migration between counties is common for residents. Data from the 2014 TGA Needs Assessment collaborated these migration trends. Many people are moving from Los Angeles County to San Bernardino County in the pursuit of cheaper, more affordable housing. However, migration between counties creates a problem in maintaining up-to-date surveillance data and poses a problem for residents during their Medi-Cal insurance re-enrollment process. The

Enhanced HIV/AIDS Reporting System (eHARS) surveillance database may not capture the actual numbers of PLWH in the county if they were initially reported in another jurisdiction, but later moved to San Bernardino County.[5] This only occurs if information about new residence is provided to the state Surveillance Unit. This creates a gap in the data, providing an incomplete picture of the epidemic and limiting the scope of knowledge required to develop appropriate interventions. For clients, Medi-Cal regulations pose additional barriers because they must re-enroll each time they move to another county, something many recipients are not aware of until they try and utilize their Medi-Cal in the new county.

Housing and Homelessness. PLWH identified housing as the number one issue in the 2019 Consumer Caucus.[9] Noted in the HRSA 20-078 application is that the loss of housing is linked to deteriorating health status. High-quality, safe, and affordable housing is needed to make sure that PLWH can live healthy lives and engage in health-positive behaviors. However, many people in the county lack housing, forcing them into encampments, onto a friend's couch, or into their cars. The 2019 Point in Time Homeless Count Survey identified 2,607 people who are experiencing homelessness in San Bernardino County. Among that population, 2.2 percent were identified as living with HIV, which is likely an undercount;[25] in the TGA's 2014 Needs Assessment, 14.8 percent of PLWH reported being homeless.[5] PLWH experiencing homelessness are likely to prioritize daily shelter and food over medical care; when forced to choose among priorities, basic needs will nearly always prevail. Therefore, positive health outcomes are conditional on the county's ability to meet housing and other basic needs.

Section IV: Ending the Epidemic Plan

This section provides a detailed overview of the disruptively innovative activities San Bernardino County will implement to End the HIV Epidemic by 2024. The proposed EtHE activities are above and beyond the foundational efforts already in place and are designed to be directly responsive to the needs and gaps identified in *Section III: Situational Analysis.* The proposed EtHE activities are designed to enhance but not duplicate current programs and services and are inclusive of all innovative activities, regardless of funding source.

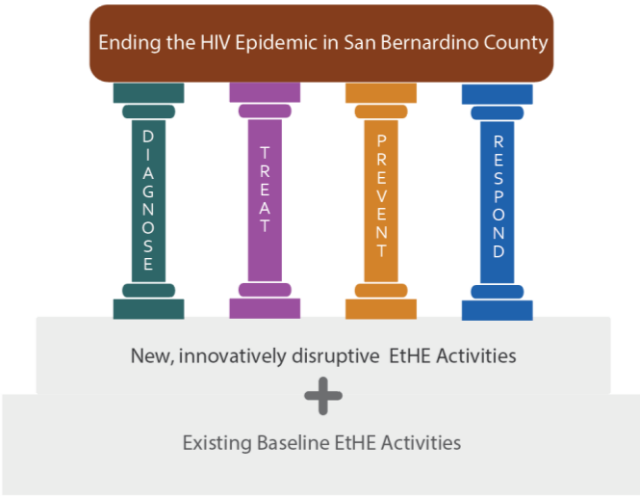


Exhibit 25. Schematic of how new EtHE activities will build upon existing efforts to respond to local needs not sufficiently addressed to date.

EtHE Programs and Key Partners

San Bernardino has identified four new innovative efforts that will help propel us toward ending the HIV epidemic. These efforts will require close partnership with several existing as well as new partners to be successful. The programs and partners are described below.

Summary of Proposed Programs

- **Rapid Response Team (RRT) and Mobile Clinic.** To better meet the needs of populations not currently being reached effectively, SBCDPH will develop a Rapid Response Team with an accompanying mobile van. The RRT will use multiple outreach methods, including the van, to build the county's capacity to bring HIV-related and other critical services to populations with severe barriers to access, including people who are unhoused and PLWH living in the high desert areas where there are no care sites. The RRT will also serve PLWH who are out of care and people who want or need PrEP.
    - "Diagnose" pillar services: RRT will provide HIV, HCV, and STI testing. The RRT will scale up outreach to people of color and MSM under the age of 34, where recent new infections are concentrated, in order to diagnose those currently unaware of their HIV infection. Regarding STI diagnoses, there will be a particular focus on identifying syphilis and rectal gonorrhea infections among MSM.
    - "Treat" pillar services: The HIV Prevention Team and Peer Educators/Navigators assigned to the RRT will support re-engagement and retention in HIV medical care for PLWH who are in danger of falling out of care and those who have fallen out of care. RRT will be a key facilitator of the Rapid StART program (see below), with its capacity to outreach outside the clinic walls to promote timely ART initiation. It will also follow up with newly diagnosed individuals after their first medical appointment to encourage treatment adherence and provide retention support. STD treatment will also be provided through the RRT.

  - "Prevent" pillar services: The RRT will provide peer-based PrEP education, outreach, and navigation. As part of services for PWID, RRT will also provide harm reduction services.
  - "Respond" pillar services: Using surveillance data, the RRT will identify partners of newly-diagnosed individuals and offer testing, linkage to care, linkage to PrEP.
  - Cross-pillar services: The RRT will develop partnerships with a variety of community providers, especially those serving the unhoused, to ensure access to housing assistance, food, and mental health services. Hepatitis A outreach and education will also be integrated into mobile services.

- The **Rapid StART Initiative** will link newly diagnosed PLWH to HIV primary care the same day they are diagnosed and deliver antiretroviral therapy (ART) within 72 hours of that diagnosis. Priority populations for this initiative are B/AA, youth 13-24, women, transgender women of color, and PWID. Rapid StART will also be provided as part of the RRT mobile services and the expanded service for PWID (see below). Funded by both PS 20-2010 and HRSA 20-078 grants.*(Treat)*

- **Expand HIV Prevention Services for Persons who Inject Drugs (PWID).** This program will foster partnerships with local harm reduction organizations to provide information about HIV harm reduction, naloxone, and other services. Through these trusted community channels, we will support increased access to HIV prevention among unhoused PWID. *(Prevent)*

- **Home-based HIV testing** mailed to clients, with the State providing the test kits and SBCDPH staff providing linkage to care and prevention/PrEP referrals. *(Diagnose, Treat, Prevent)*

- The **California Regional Quality Group (CARG),** in which San Bernardino County participates, will align with EtHE initiative by focusing on quality improvement initiatives for increasing viral suppression rates among MSM of color. *(Treat)*

- **CHIPTS CFAR Project: Regional Response to HIV Eradication Efforts in Southern CA Counties.** San Bernardino County is participating, along with Los Angeles, Orange, and Riverside Counties, in a CHIPTS CFR study led by Stephen Shoptaw titled *Regional Response to HIV Eradication Efforts in Southern CA Counties.*[8] The proposal is the first effort to build linkages between public health departments, clinicians, researchers, stakeholders, and communities living with or at risk for HIV to address the HIV epidemic in Southern California. It aims to support regional data coordination and sharing that would guide scale-up of large, implementation science projects designed to reduce new HIV infections across the four counties. This effort has high impact because the four targeted counties represent about half of the population and half of new HIV cases in California. Three specific aims are proposed: (1) to identify barriers and facilitators to HIV surveillance data coordination within the counties (2) to examine techniques for HIV surveillance to identify “hot spots” to guide allocation of prevention resources and trim the outbreak; (3) to engage stakeholders and policy makers to scale-up surveillance tools (such as molecular epidemiology) to control micro-epidemics across the region. No PS 20-2010 is allocated to this project. *(Respond)*

- A second **CHIPTS EtHE CFAR project** to compare two interventions for increasing provider skills and capacity to prescribe PrEP—provider detailing/education or peer comparison (application pending). No PS 20-2010 is allocated to this project. *(Prevent)*

Key Partners

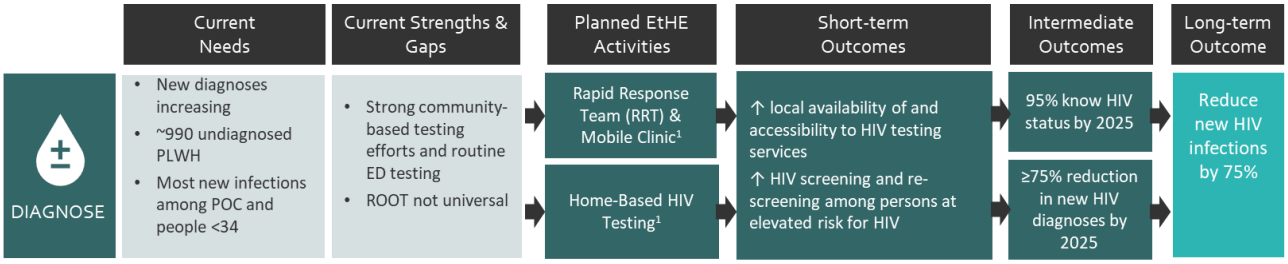
We will work with key partners to complete these proposed programs, including organizations serving young persons of color, those working in the West Valley or Desert regions, and those with particular technical expertise. These include:

- **Borrego Health.** Borrego Health is a Federally Qualified Health Center (FQHC) providing comprehensive HIV and HCV treatment and care at two locations in San Bernardino County, in an under-served areas with a documented need for accessible medical care. Other services under their Specialty Clinics include PrEP/PEP and Transgender Health. They also have sites in Riverside and San Diego Counties.
- **Community-based testing partners.** These partners have built long-standing relationships in the community by providing key services such as harm reduction, food, housing referrals, alcohol and other drug counseling, and mental health services. The RRT will be deployed with these partners to identify partners of newly-diagnosed individuals and offer testing, linkage to care, and linkage to PrEP.
    - AIDS Healthcare Foundation
    - Borrego Community Health Foundation
    - Community Health Systems Inc.
    - Foothill AIDS Project
    - Planned Parenthood of the Pacific Southwest
    - Riverside/San Bernardino County Indian Health Inc.
    - Social Action Community Health System
    - Sweet Dreams Offender Reentry Program
    - TruEvolution
- **Hepatitis A Outbreak Response Teams.** SBCDPH Hepatitis A Outbreak Response Teams are experienced in contact tracing and outbreak investigation among priority populations including those experiencing homelessness and PWID.
- **Inland Empire Harm Reduction.** Inland Empire Harm Reduction is a local, community-based public health project that provides naloxone, education, harm reduction kits, and access to recovery options to PWID.
- **Loma Linda Promotores Academy.** Loma Linda Promotores Academy trains bilingual peer navigators. Among the many training topics, trainees receive comprehensive Behavioral Health training that will prepare them to provide harm-reduction mental health aid and understand and apply the foundations of behavior change. Working with this agency will enhance the county's capacity to offer culturally- and linguistically-competent services to clients.
- **San Bernardino County Homeless Partnership.** Housing security increases the likelihood of HIV treatment adherence. San Bernardino County Homeless Partnership provides an inclusive and coordinated system of care to all residents who are homeless

or at risk of becoming homeless. The RRT will partner with their Street Outreach and Engagement Services.

San Bernardino County's Plan to End the HIV Epidemic

Diagnose



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 38. A list of programs related to this pillar is below.

- **Rapid Response Team (RRT) and Mobile Clinic**
- **Home-Based HIV Testing**

Diagnose: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities	
N/A	N/A
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non- healthcare settings	
Rapid Response Team and Mobile Clinic	
RRT and Mobile Clinic • Develop and implement protocols in collaboration with the HIV Surveillance Team to assign newly diagnosed HIV cases. • Develop Request for Proposal (RFPs) for Peer Educators and Mental Health/Case Management teams to work directly as part of RRT. • **Train Peer Educators** in RRT operating procedures and HIV basic counseling skills. • **Hire additional RRT staff** as needed (e.g., PrEP Navigator, nursing personnel). • **Train staff** on DIS and HIV/PrEP Navigation best practices. • RRT will identify partners of newly diagnosed individuals and **offer testing,** partner services and	• Continue services. • Evaluate protocols and services and track outcomes.

Diagnose: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
linkage to care; identify syphilis cases and/or rectal gonorrhea cases, with emphasis on MSM, and follow up with PrEP education and navigation services; and follow up with newly diagnosed individuals after first medical appointment for treatment adherence and retention support. • RRT staff will **staff the mobile clinic.** • HIV Prevention Team will support re-engagement and retention in HIV medical care for PLWH in danger of falling out of care and those who have fallen out of care. • Acquire mobile medical vehicle. • Operate weekly in each health planning region of the county and **offer rapid HIV, HCV, and STD (syphilis/GC/CT) testing;** hepatitis A vaccination; dispense medication (STD treatment and/or PrEP/PEP) per physician order; offer Rapid ART for confirmed newly diagnosed individuals; offer PrEP to clients who tested with preliminary negative results and were assessed to be at substantial risk.	
Home-Based HIV Testing	
• Offer San Bernardino HIV/STD clinic and other EtHE priority populations HIV test kits mailed to their home or preferred location. • Develop pilot program protocol. • Develop centralized system for HIV test kit ordering, distribution, and results. • Forge partnerships with other SBCDPH divisions to coordinate and fund HIV test kits and system infrastructure. • Create partnerships with CBOs who engage with priority populations and can promote HIV testing to their clients.	• Implement pilot program. • Engage at least 50 patients per year from priority populations.
Strategy 1C. Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings	
N/A	N/A

HIV Workforce Development Needs

Positions

- **HIV / PrEP Navigators.** HIV / PrEP Navigators are the primary contacts for linkage and referrals. They also do STI follow-up, offer partner services, and relink PLWH who have fallen out of care.
- **Peer Navigators.** Peer Navigators with shared identities to the communities they serve will provide continuous outreach to homeless encampments to provide referrals to the Mobile Clinic and other needed services. They may also accompany HIV / PrEP Navigators as they provide direct patient services.

- **Communicable Disease Investigation (CDI) Staff.** CDI Staff will be responsible for collecting and analyzing surveillance data to identify partners of newly-diagnosed HIV and STI patients for follow-up. CDI Staff will also use surveillance data to identify potential disease hot spots.
- **HIV Care, Prevention, and Surveillance Training.** Anticipated turnover in these SBCDPH divisions will require training staff to maintain departmental qualifications.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, San Bernardino County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

We will work with key partners to complete these proposed programs, including organizations serving young persons of color, those working in the West Valley or Desert regions, and those with particular technical expertise. These include:

- **Borrego Health**
- **Community-based testing partners**
- **Hepatitis A Outbreak Response Teams**
- **Inland Empire Harm Reduction**
- **Loma Linda Promotores Academy**
- **San Bernardino County Homeless Partnership**

Funding

Program/Effort	Total Funding	Proposed Funding Source
RRT and Mobile Clinic	$1,003,464	CDC PS20-2010
Home-based HIV Testing		
TOTAL FUNDING FOR DIAGNOSE PILLAR*	$1,003,464	

- *$0 exclusively for Diagnose Pillar, and $1,003,464 for programs that cut across Diagnose and other pillars. Only SBCDPH controlled funds.

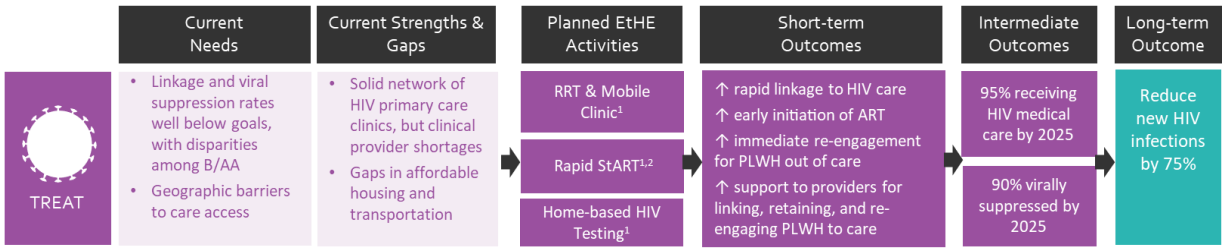
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[34] Targets will be determined in coordination with CDC as the EPMP is finalized.

Diagnose: San Bernardino County	
Outcome Measure	**Data Source**
Number of events where HIV testing is bundled with screening for other conditions relevant to the local population*†	Records of HIV testing events
Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings*†	Documentation of strategies utilized
Percent of all persons testing HIV+ in non-traditional test settings linked to HIV medical care within 30 days*†	Linkage to care records
Percent of all persons testing HIV- in non-traditional test settings linked to appropriate prevention services*†	Linkage records

*Rapid Response Team
†Mobile Clinic

Treat



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 38. A list of programs related to this pillar is below.

- **Rapid Response Team (RRT) and Mobile Clinic**
- **Rapid StART**
- **Home-Based HIV Testing**

Treat: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)	
Rapid Response Team and Mobile Clinic	
RRT and Mobile Clinic • **Acquire mobile medical vehicle** • Operate weekly in each health planning region of the county and offer rapid HIV, HCV, and STD (syphilis/GC/CT) testing; hepatitis A vaccination; dispense medication (STD treatment and/or PrEP/PEP) per physician order; **offer Rapid ART** for confirmed newly diagnosed individuals; offer PrEP to clients who tested with preliminary negative results and were assessed to be at substantial risk. • Develop and implement protocols in collaboration with the HIV Surveillance Team to assign newly diagnosed persons. • Develop Request for Proposal (RFPs) for Peer Educators and Mental Health/Case Management teams to work directly as part of RRT. • Train Peer Educators in RRT operating procedures and HIV basic counseling skills. • Hire additional RRT staff as needed (e.g., PrEP Navigator, nursing personnel). • Train staff on DIS and HIV/PrEP Navigation best practices. • RRT will **identify partners** of newly diagnosed individuals and offe**r** testing, partner services and **linkage to care**; identify syphilis cases and/or rectal gonorrhea cases, with emphasis on MSM, and follow up with PrEP education and navigation services; and follow up with newly diagnosed individuals after first medical appointment for **treatment adherence and retention support.** • RRT staff will staff the mobile clinic. • HIV Prevention Team will **support re-engagement and retention in HIV medical care** for PLWH in danger of falling out of care and those who have fallen out of care.	• Continue services. • Evaluate protocols and services and track outcomes.
Rapid StART	
• Link 90 percent of newly diagnosed persons to HIV primary care within 72 hours of diagnosis. • Prescribe ART to 100 percent of linked newly diagnosed persons within 72 hours of HIV diagnosis.	• Continue to provide Rapid StART, lost-to-care re-engagement, HIV Prevention referrals and education, and improve access to care for PWLH. Work to achieve 100 percent linkage within 72 hours. • Ongoing evaluation of program efficacy and quality improvement.

Treat: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
• Provide Patient Transportation eligible patients to/from medical, dental, and other medical and support visits. • Provide Mobile Medical Care to eligible PLWH living in rural/frontier areas of the high desert and other remote locations in the TGA. • Provide in-person linkage and warm-handoffs to 100 percent of newly diagnosed persons to ensure linkage to and retention in care. • Establish and execute evaluation activities to ensure efficacy of adopted methodologies.	
Home-Based HIV Testing	
• Activities TBD – linkage to care referrals.	

HIV Workforce Development Needs

Positions

- **Peer Educators.** Peer educators will provide basic HIV counseling and risk reduction and prevention education to clients and partners. They may also refer clients for medical and support services as appropriate.
- **Mental Health/Case Management Team.** The mental health team will provide mental health services and referrals to clients. Case Managers will help to coordinate services with other members of the treatment and services team and follow up with newly diagnosed individuals to provide treatment adherence and retention support.
- **HIV / PrEP Navigators.** HIV / PrEP Navigators are the primary contacts for linkage and referrals. They also provide STI follow-up, offer partner services, and relink PLWH who have fallen out of care.
- **RRT and HIV Counseling Training.** We will provide training to peer educators on RRT operating procedures and HIV basic counseling skills.
- **DIS and HIV / PrEP Navigation Training**. We will provide training to ensure that staff are well equipped to provide disease intervention and PrEP navigation services.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, San Bernardino County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

- **Borrego Health**
- **Community-based linkage to care partners**
- **Loma Linda Promotores Academy**
- **San Bernardino County Homeless Partnership**

Funding

Program/Effort	Total Funding	Proposed Funding Source
RRT and Mobile Clinic	$1,003,464	CDC PS20-2010
Home-based HIV Testing		
Rapid StART	$1,000,000	HRSA 20-078
TOTAL FUNDING FOR TREAT PILLAR*	$2,003,464	

- *$1,000,000.00 exclusively for Treat Pillar, and $1,003,464 for programs that cut across Treat and other pillars. Only County-controlled funds.

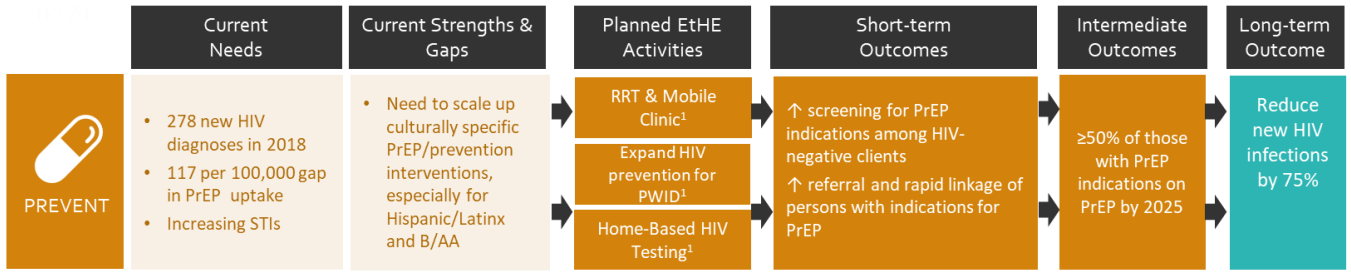
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[34] Targets will be determined in coordination with CDC as the EPMP is finalized.

Treat: San Bernardino County	
Outcome Measure	**Data Source**
Number of programs supporting and promoting rapid linkage and immediate/as soon as possible ART by providers in non-Ryan White HIV/AIDS Program facilities. *†	Linkage and ART program documentation.
Number of clients provided with case management and other support services*.	Case management and support services records.

*Rapid Response Team
†Mobile Clinic

Prevent



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 38. A list of programs related to this pillar is below.

- **Rapid Response Team (RRT) and Mobile Clinic**
- **Expand HIV Prevention Services for persons who inject drugs (PWID)**
- **Home-Based HIV Testing**

Prevent: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	
Rapid Response Team and Mobile Clinic	
RRT • Develop and implement protocols in collaboration with HIV Surveillance Team to assign newly diagnosed HIV cases. • Develop Request for Proposal (RFPs) for Peer Educators and Mental Health/Case Management teams to work directly as part of RRT. • Train Peer Educators in RRT operating procedures and HIV basic counseling skills. • Hire additional RRT staff as needed (e.g., **PrEP Navigator,** nursing personnel). • Train staff on DIS and HIV/**PrEP Navigation best practices.** • RRT will identify partners of newly diagnosed individuals and offer testing, partner services and linkage to care; **identify syphilis cases and/or rectal gonorrhea cases**, with emphasis on MSM, and **follow up with PrEP education and navigation services**; and follow up with newly diagnosed individual after first medical appointment for treatment adherence and retention support. • RRT staff will staff the mobile clinic. • HIV Prevention Team will support re-engagement and retention in HIV medical care for PLWH in danger of falling out of care and those who have fallen out of care.	• Continue services. • Evaluate protocols and services and track outcomes.

Prevent: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
Mobile Clinic • Acquire mobile medical vehicle. • Operate weekly in each health planning region of the County and offer rapid HIV, HCV, and STD (syphilis/GC/CT) testing; hepatitis A vaccination; **dispense medication** (STD treatment and/or **PrEP**/PEP) per physician order; offer Rapid ART for confirmed newly diagnosed individuals**; offer PrEP to clients** who tested with preliminary negative results and were **assessed to be at substantial risk.**	
Home-Based HIV Testing	
• Activities TBD – PrEP referrals	
Strategy 3B. Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs)	
Expand HIV Prevention Services for Persons who Inject Drugs (PWID)	
• Develop partnerships with Inland Empire Harm Reduction and similar community-based groups working with injecting drug users. • Develop a plan and timeline to increase awareness of services targeting people who inject drugs. • Work with existing Department hepatitis A outbreak response teams to provide people experiencing homelessness with information on HIV harm reduction, naloxone, and other services.	• Evaluate services and track outcomes

HIV Workforce Development Needs

Positions

- **HIV / PrEP Navigators.** HIV / PrEP Navigators are the primary contacts for linkage and referrals. They also provide STI follow-up, offer partner services, and relink PLWH who have fallen out of care. The PrEP Navigators will foster partnerships with local organizations and work with them to provide information to PWID.
- **Peer Educators.** Peer educators will provide basic HIV counseling and risk reduction and prevention education to clients and partners. They may also refer clients for medical and support services as appropriate.
- **Mental Health/Case Management Team.** The mental health team will provide mental health services and referrals to clients. Case Managers will help to coordinate services with other members of the treatment and services team and follow up with newly diagnosed individuals to provide treatment adherence and retention support.
- **PrEP Navigation Training**. We will provide training to ensure that staff are well equipped to rapidly evaluate HIV- persons so that they can be rapidly evaluated for PrEP and started on it, regardless of where they are seen.

- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs

Capacity-Building

When building capacity, San Bernardino County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations. Provider education programs will build provider skills and capacity for linking clients with HIV to care. Follow-up technical assistance will be provided to help ensure implementation.

Key Partners

- **Hepatitis A Outbreak Response Teams**
- **Inland Empire Harm Reduction**

Funding

Program/Effort	Total Funding	Proposed Funding Source
RRT and Mobile Clinic	$1,003,464	CDC PS20-2010
Expand Services for PWID		
Home-based HIV Testing		
TOTAL FUNDING FOR PREVENT PILLAR*	$1,003,464	

- *$0 exclusively for Prevent Pillar, and $1,003,464 for programs that cut across Diagnose and other pillars. Only SBCDPH controlled funds.

Monitoring and Evaluation

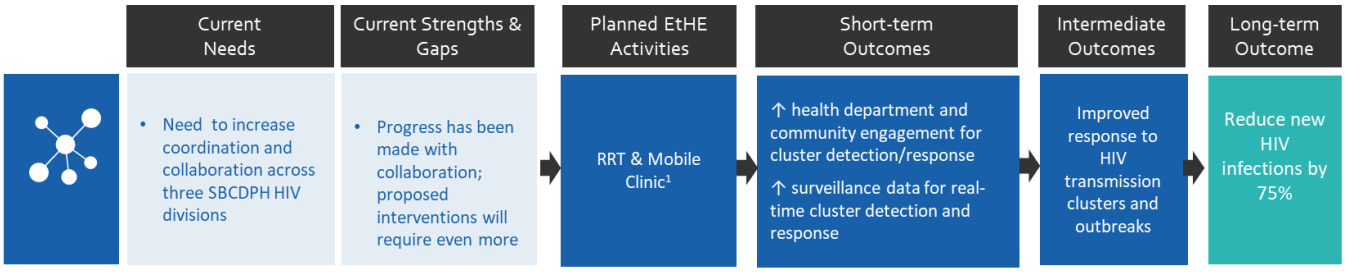
The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[34] Targets will be determined in coordination with CDC as the EPMP is finalized.

Prevent: San Bernardino County	
Outcome Measure	**Data Source**
Number of HIV-negative clients who are screened for PrEP.*†	Patient charts.
Number and percentage of HIV-negative clients with indications for PrEP who are linked to PrEP.*†	Patient charts.
Number of persons prescribed PrEP among those with indications for PrEP.*†	Patient charts.
Number and percentage of syringe service programs (SSPs) offering standard services.#	SSP records.
Number and percentage of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment,#	SSP records.

Number and percentage of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment.#	SSP records.
Number and percentage of SSPs with direct provision of or formal active referral arrangements to essential support services.#	SSP records.

*Rapid Response Team
†Mobile Clinic
#Expand HIV Prevention Services to PWID

Respond



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 38. A list of programs related to this pillar is below.

- **Rapid Response Team (RRT) and Mobile Clinic**

Respond: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time cluster detection and response	
• **Coordination with CDPH**-The county Surveillance Staff will work with the CDPH OA Surveillance Staff to ensure ability to respond when clusters are identified and investigation is needed.	• **Coordination with CDPH**-Sustain communication between surveillance staff and CDPH OA.
Strategy 4B. Investigate and intervene in networks with active transmission	
Rapid Response Team and Mobile Clinic	
• Develop and implement protocols in collaboration with HIV Surveillance Team to assign people newly diagnosed with HIV to services. • Develop Request for Proposal (RFPs) for Peer Educators and Mental Health/Case Management teams to work directly as part of RRT. • Train Peer Educators in RRT operating procedures and HIV basic counseling skills. • Hire additional RRT staff as needed (e.g., PrEP Navigator, nursing personnel). • **Train staff on DIS** and HIV/PrEP Navigation best practices. • RRT will identify partners of newly diagnosed individuals and offer testing, **partner services** and linkage to care; identify syphilis cases and/or rectal gonorrhea cases, with emphasis on MSM, and follow up with PrEP education and navigation services; and follow up with newly diagnosed individual after first medical appointment for treatment adherence and retention support. • RRT staff will staff the mobile clinic	• Continue services. • Evaluate protocols and service outcomes.

Respond: San Bernardino County	
Year 1 Activities	**Year 2-5 Activities**
• HIV Prevention Team will support re-engagement and retention in HIV medical care for PLWH in danger of falling out of care and for those who have fallen out of care. • **Coordination with CDPH-** County surveillance staff will provide CID as much locating information as able in order that CID can reach out and contact those identified as part of the cluster, as well as the partners identified in the initial interviews. If the number of people to be interviewed is higher than the capacity of the county CID staff, CDPH OA will have their partner services staff deployed to the county. If the cluster response is elevated, CDPH Emergency Response protocols will be followed.	• **Coordination with CDPH-** Continued initiation of Cluster Response activities.
Strategy 4C. Identify and address gaps in programs and services revealed by cluster detection and response	
• **Coordination with CDPH-** A debrief meeting with county staff and CDPH OA staff will happen after each outbreak response in order to refine and ensure the most effective response actions are initiated.	• **Coordination with CDPH-** Post-response debrief meetings will continue to be conducted

HIV Workforce Development Needs

Positions

- **Office Assistant (OA).** The OA will support logistics and data entry/management.
- **Case Identification Training.** We will provide additional training to all surveillance CDSs on working with providers to identify patients with new HIV diagnoses and referral of those patients to case managers.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

- DIS training.
- Continued collaboration with CDS surveillance team.
- Strengthen regional collaboration with neighboring counties.

Key Partners

- **CDPH Office of AIDS**
- **Foothills AIDS Project**
- **Neighboring County Public Health Departments**
- **SBCDPH CDS surveillance team**

- **SBCDPH Ryan White D2C data**

Funding

SBCDPH does not have funding exclusively identified for the RESPOND Pillar, however funding across the other Pillars will support staff, including additional Communicable Disease Investigators, who would play a vital role in cluster response efforts.

Program/Effort	Total Funding	Proposed Funding Source
RRT and Mobile Clinic	$1,003,464	CDC PS20-2010
TOTAL FUNDING FOR RESPOND PILLAR*	$1,003,464	

- *$0 exclusively for Respond Pillar, and $1,003,464 for programs that cut across Respond and other pillars. Only CDPH controlled funds.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[34] Targets will be determined in coordination with CDC as the EPMP is finalized.

Respond: San Bernardino County	
Outcome Measure	**Data Source**
Cluster data is reviewed and prioritized, response is guided and reviewed, procedures are modified to improve responses.	Reports of committee and community meetings, after action review meetings.
Percent of all persons with diagnosed HIV infection who are entered into the local surveillance system within ≤30 days of diagnosis.	Surveillance system.
Percent of laboratory results that are entered into the surveillance system ≤ 14 days after specimen collection.	Surveillance system.
A data system is developed to rapidly analyze, integrate, visualize, and share data in real time.	Data system documentation.
A flexible funding mechanism is developed to allow reallocation of resources for a response within one month.	Funding mechanism documentation.
Implementation of methods to understand the entire cluster network, including people with diagnosed HIV, undiagnosed HIV, or at substantial risk for HIV infection or transmission.	Methodology documentation
Processes and mechanisms are developed to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, for people in cluster networks.	Documentation of processes and mechanisms.

Data analysis and response results for clusters of concern are reported to CDC until investigation and intervention activities are closed.	Documentation of submission.

Section V: Concurrence

SBCDPH has chosen the Inland Empire HIV Planning council (IEHPC) as its concurrence body. The IEHPC is comprised of consumers, providers, community members, public health staff, and academic partners. It covers the geographic region (Inland Empire Transitional Grant Area – TGA) of both Riverside and San Bernardino Counties, with the co-chair transitioning between the two County Health Officers on an annual basis.

The mission of the IEHPC is *to maintain the optimum health of all those living with HIV/AIDS in Riverside and San Bernardino Counties through the development and implementation of a comprehensive, consumer-centered continuum of care.* The concurrence process was completed in consultation with the IEHPC and was consistent with the CDC 19-1906 guidance.

The 19-1906 EtHE accelerated planning year was presented to the IEHPC at a general membership meeting on November 14, 2019. The IEHPC provided early guidance and assistance with community engagement activities in San Bernardino and Riverside Counties. Members also helped interpret the findings of these events.

The IEHPC received Draft-3 of the EtHE Plan on June 12, 2020 via email and was provided a 3-week comment period. Additionally, an overview of the San Bernardino County EtHE Plan was presented on June 25, 2020 and the IEHPC had the opportunity to ask any clarifying questions and react to the document and the process. received concurrence for the San Bernardino EtHE plan. At this meeting, the IEHPC voted to approve Draft-3 as their concurrence document. They also agreed that the IEHPC had been kept appraised of the progress of EtHE plan and had been an active partner in the development of content. **The criteria the Council used to grant concurrence are below.**

- Demonstrated best efforts to get community input in the most challenging of circumstances given COVID-19 response; and
- Included a review of the most recent epidemiological data, and subsequent focus on key populations for whom the existing HIV prevention and care services are not sufficient; and
- Included interventions and services to populations and regions in San Bernardino County where few services currently exist; and
- Assured community engagement will continue to be a vital part of the implementation and updating of this plan for the next 5 years.

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Appendix 1: Resource Inventory

Exhibit 26 lists the services and programs currently available in San Bernardino County along with their funding sources.

Exhibit 26: San Bernardino County Baseline HIV Activities and their Funding Sources

Pillar	Baseline Program/Activity	Funding Sources
DIAGNOSE	• Routine opt-out HIV testing program at SBCDPH FQHC's, the County Medical Center Emergency Room, and efforts to re-establish HIV testing at SBC jails [i] • Targeted outreach to link high priority populations to testing [i] • Expanded partner services to support linkage of partners to testing [i] • HIV testing planning with law enforcement and other key stakeholders [i] • Rapid HIV/HCV testing to priority populations via mobile van outreach in non-clinical settings [i] • Community and court-ordered classes on HIV prevention, testing, care, and treatment [i] • Testing at community-based organizations (CBOs) [i] • STD Awareness Month Media Campaigns to increase testing and linkage to care [i]	i CDC PS-18-1802 ii HRSA Ryan White Part A iii HRSA Ryan White Part B (incl MAI) iv HRSA Ryan White Part C
TREAT	• Expanded partner services to support linkage of partners to care [i] • Linkage to care system that identifies newly diagnosed PLWH and referral to a medical provider within 30 days, with confirmation of linkage to care [i] • Regular meetings with care and surveillance teams to support linkage to and retention in care [i] • Train PrEP navigators to assist with linkage to care and insurance [i] • Identification of people who have fallen out of HIV care in ARIES [ii] • Retention in Care and MAI outreach team field visits to re-engage people in care [iii] • STD Awareness Month Media Campaigns to increase testing and linkage to care [i] • Outreach services to link populations in areas of high HIV incidence to care [iii] • Core care and treatment services (primary care, early intervention services, medical case management, mental health and outpatient substance use services, oral health care, medical nutrition therapy, home, and community-based health services) [ii, iv] • Support services (housing, medical transportation, food bank/home-delivered meals, case management, emergency financial assistance, psychosocial support, residential substance use services) [ii] • AIDS Drug Assistance Program (ADAP) Funded partners: Desert AIDS Project [ii], Foothill AIDS Project [ii, iii], AIDS Healthcare Foundation [ii], TruEvolution [iii], Borrego Community Health Foundation [iii], Social Action Community Health Systems [ii]	
PREVENT	• Education for PrEP prescribers and PrEP navigators [i] • Linkage of HIV-negative individuals with STD/HIV exposure and other substantial risk populations to PrEP services [i] • Expanded partner services to support linkage of partners to PrEP [i] • Promote PrEP information and awareness to community via social media [i] • Promote PrEP information and education of screening guidelines to primary care providers via toolkits and detailing sessions [i] • Education of pharmacies and substance use facilities on non-prescription syringe sales [i] • Community assessment on expanding syringe access [i] • Non-prescription pharmacy syringe sales	

	• Communication with local law enforcement to discuss syringe possession laws specific to HIV prevention or care services specific to PWID [i] • Distribute condoms through partnerships with local venues [i]	
RESPOND	• Use of HIV surveillance data to determine focus of HIV testing locations [i] • Use of HIV surveillance data to identify candidates for partner services [i]	

Note: Additional resources for HIV services that cannot be quantified or broken down by pillar include Medi-Cal, Medicare, Veterans Administration, and 3rd party reimbursement

Appendix 2: Community Engagement Documentation

Exhibit 27 lists community engagement event dates, descriptions and key voices and partners.

Exhibit 27. Community Engagement Documentation

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
The Consumer Caucus/High Desert San Bernardino[11] 5/21/2019	Part of the Part A priority setting and allocations process. Notes and outcomes reviewed in secondary analysis to inform EtHE planning.	*Participants: PLWH in closed door session. One participant from as far away as Barstow.*
The Consumer Caucus/Urban Region San Bernardino[12] 6/11/2019	Part of the Part A priority setting and allocations process. Notes and outcomes reviewed in secondary analysis to inform EtHE planning.	*Participants: PLWH in closed door session.*
CDPH Planning Group Kick-Off Meeting[13] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	*Participants: Inland Empire Planning Council Leadership, SBCDPH.*
EtHE Presentation and Discussion[14] 11/14/2019	RUHS and SBCDPH facilitated a discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	*Participants: Inland Empire Planning Council and Leadership.*
EtHE Community Forum[15] 11/14/2019	SBCDPH participated in a RUHS facilitated discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	*Participants: Inland Empire Planning Council, RUHS, SBCDPH, AIDS Health Care Foundation, Desert AIDS Project, FLAAC.*
EtHE CHIPTS Regional Meeting[16] 01/24/2020	San Bernardino County presented an overview of County's draft EtHE plan and gave input about approaches to the regional EtHE response.	*Participants: County health departments and Planning Council representatives from Alameda, Los Angeles, Orange Riverside, Sacramento, San Bernardino, San Francisco, and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.*
Community Caucus I[9] 1/25/2020	TruEvolution convened a gathering of new voices to better understand the experiences of people living with or at risk for HIV. *Sponsors: RUHS, SBCDPH*	*New Voices – Priority Populations: B/AA, Hispanic/Latinx, unhoused, Spanish-speakers, and the transgender community.* *Other Participants: AIDS Healthcare Foundation, Borrego Health, Desert AIDS Project, Foothill AIDS Project, FLACC.*

EVENT	DESCRIPTION	VOICES & PARTNERS
Inland Empire EtHE Innovations Summit[17] 1/27/2020	RUHS and SBCDPH convened a summit of providers from different sectors (HIV and non-HIV). They presented the county's EtHE plan and held a discussion on the opportunities & barriers for cross-sector collaboration and improvement in HIV care.	*New Voices – Providers: Education, research institutions, housing, Inland Empire Health Plan, RUHS, SBCDPH, AIDS Healthcare Foundation, Borrego, Desert AIDS Project, OASH, Families Living with AIDS Care Center, Foothill AIDS Project, California Workforce Development Board, UC Riverside School of Medicine, Housing Authority of Riverside County.*
Community Caucus II[18] 5/16/2020	TruEvolution convened a panel of Hispanic/Latinx PLWH to comment and review findings of Community Caucus I. The panel confirmed and further expanded on the key findings.	*New Voices Participants: Hispanic/Latinx PLWH.* *Spanish Speakers.*
Community Caucus III[19] 5/16/2020	TruEvolution convened a panel of B/AA and Hispanic/Latinx MSM living with HIV to comment and review findings of Community Caucus I. The panel confirmed and further expanded on the key findings.	*New Voice-- Participants- B/AA and Hispanic/Latinx MSM living with HIV.* *English Speakers.*
Online survey[20] 9/30/2020	The County has distributed an online survey that asks for input on how to engage populations not currently reached effectively. Key community leaders volunteered to email the survey to their networks. More of these surveys will be distributed during implementation.	*Participants: priority populations, providers, other stakeholders.*

Appendix 3: Letter of Concurrence

Marisa Ramos, Ph.D.
Chief, Office of AIDS
Center for Infectious Diseases
California Department of Public Health
MS 7700, PO Box 997426
Sacramento, CA 95899-7426

Dr. Ramos,

This letter documents that the Inland Empire HIV Planning Council (IEHPC) is in concurrence with the Ending the HIV Epidemic in America, Phase I accelerated planning report submitted by **San Bernardino County** and funded through Centers for Disease Control and Prevention (CDC) grant number PS 19-1906. The IEHPC covers the geographic region (Inland Empire Transitional Grant Area – TGA) of both Riverside and San Bernardino Counties, with the co-chair transitioning between the two County Health Officers on an annual basis.

At the beginning of the contract year, the IEHPC was provided a presentation by the State Office of AIDS and Facente Consulting, the groups that were contracted to assist in the development of the San Bernardino County Ending the HIV Epidemic Plan. IEHPC members were asked to disseminate information about the project and seek consumer input on what is most critical to decrease new infections as we work toward ending the epidemic.

We were provided a copy of the draft plan and were part of the community engagement activities that contributed to the final plan. We were also given an overview of the plan at the June IEHPC meeting. IEHPC members had the opportunity to review the materials, offer comments and ask questions.

The plan being submitted is in harmony with the other HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero Plans and other county documents that guide the delivery of HIV prevention and care services, and maintains a surveillance system in collaboration with the State Office of AIDS in San Bernardino County.

The selected activities in the plan will expand our reach to populations underserved to date, with novel and innovative interventions that will increase testing, provision of rapid ART, and use of PrEP, and will assist more people living with HIV in our county to achieve and sustain viral suppression.

The CDC PS 20-2010 funding to implement the plan will expand services, and will work in unison with the HRSA 20-078 and in partnership with health centers provided Ending the Epidemic funding through HRSA 20-091.

Our planning body will continue to monitor the implementation of the Ending the Epidemic Federal Initiative and its family of interventions. We will also continue to engage the community to assure ongoing, real-time feedback so that the interventions are executed optimally for the populations they are serving.

Signed by the Planning Council Co-Chairs on behalf of the entire Part A Planning Body,

Cameron Kaiser, MD, MPH, FAAFP
Cameron Kaiser, MD, MPH, FAAFP (Dec 15, 2020 15:55 PST)

Cameron Kaiser, MD,

Health Officer Co-Chair

Curtis Smith

Curtis Smith, Community Co-Chair

Appendix 4: Planning Council Membership Roster

Inland Empire HIV Planning Council (San Bernardino/Riverside) **Website: https://www.iehpc.org/** **Contact Number: (909) 501-6512**	
Council Members	**Title/ Position**
Aaron Jacobson	Bylaws Committee Chair, Evaluation of the Administrative Mechanism (EAM) Chair
Cameron Kaiser, MD	Riverside County Health Officer
Claudette Bridges-Cobb	Council Member
Curtis Smith	Empowerment Committee Chair, Grievance Committee Chair, Continuum of Care Committee (CCC)
Curtis White	Secretary
Danielle Huntsman	Council Member
Denise Absher	Council Member
Dr. Cameron Kaiser	Council Member
Executive Committee Representative	Executive Committee Representative
Jeff Taylor	Council Development Committee (CDC) Chair
Jeff Taylor	Council Member
Jerry Chan	Council Member
Jorge Romos Ruiz	Council Member
Justin Goodro	Council Member
Lloyd White	Community Co-Chair, Planning Committee Chair, Standards Committee Chair, Finance Committee Chair
Marjorie Katz	Council Member
Maxwell Ohikhuare, MD	San Bernardino County Health Officer
Zayda Welden	Council Member

SAN DIEGO

San Diego County

CALIFORNIA CONSORTIUM FOR CDC PS19-1906

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS

COUNTY OF SAN DIEGO, HEALTH AND HUMAN SERVICES
AGENCY, PUBLIC HEALTH SERVICES

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Introduction

About This Plan

This plan describes San Diego County's bold and innovative plan for ending the HIV epidemic. The County of San Diego, Health and Human Services Agency (HHSA) leads the HIV efforts in San Diego County, in collaboration with the San Diego HIV Planning Group (HPG). In conjunction with community and clinical partners, the San Diego County has built a strong foundation of HIV prevention, care, and treatment services even in the face of a multitude of complexities unique to the county. These foundational HIV services were built based on *Getting to Zero: San Diego's Plan for HIV Care, Prevention, Testing, and Surveillance (2017-2021)*,[1,2] which aligns with the federal Ending the Epidemic (EtHE) initiative[3] and *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan.*[4]

These current baseline activities, and the infrastructure that supports them, are critical for reducing and ultimately eliminating new HIV infections and optimizing the health of people living with HIV, but they are not sufficient – hence the need for this EtHE plan. This EtHE plan does not replace the other plans; instead, it expands on them by describing the additional innovative efforts needed, based on the current state of HIV in the county.

This Plan is organized as follows:

- The **Introduction** provides a high-level overview of 1) the HIV epidemic in the county, 2) the baseline services, activities, and infrastructure that currently exist, and 3) San Diego County's plan to end the epidemic.
- **Section I: Community Engagement** describes San Diego County's completed and planned community, provider, and planning group engagement activities and findings to date.
- **Section II: Epidemiologic Profile** presents the latest available data on HIV in San Diego County, including demographics, trends, and disparities across age, race/ethnicity, geography, and more.
- **Section III: Situational Analysis** synthesizes information from the prior two sections and a needs assessment to paint a comprehensive picture of the current state of HIV in the county, including needs, resources, and gaps.
- **Section IV: EtHE Plan** outlines the disruptively innovative activities that San Diego County will implement between now and 2025, across all funding sources, along with key partnerships, workforce development needs, and plans for outcome monitoring.
- **Section V: Concurrence** describes the process for securing concurrence with the San Diego HIV Planning Group (HPG).

Current State of HIV in San Diego County

San Diego County has seen a 25 percent decrease in new HIV diagnoses in recent years, from 502 newly diagnosed residents in 2016 to 379 in 2018.[5] The number of new diagnoses in 2018 was the lowest number of new diagnoses recorded annually since 1984—a major milestone for the county. In 2018, among those newly diagnosed with HIV, 83 percent were linked to care within 30 days and 61 percent were virally suppressed within 6 months of diagnosis.[5] Despite these successes, there are still groups that are disproportionately affected by HIV. These include Black/African American (B/AA) men who have sex with men (MSM), Hispanic/Latinx MSM, the transgender community, and people who inject drugs (PWID).

Findings from community engagement efforts offer some insight into the barriers and challenges that are impacting the county's ability to further reduce new HIV infections, especially among the populations disproportionately affected. Among B/AA MSM, racism, discrimination, trauma, stigma, and the historical impact of marginalization and inequity create barriers to accessing services. Among Hispanic/Latinx MSM, stigma, distrust in the medical system, immigration status, and cultural and linguistic barriers impact access to HIV testing and care. Among the transgender community, stigma as well as a lack of robust epidemiological data pose barriers to effective service delivery. Among PWID, distrust of the healthcare system, a general lack of health services specifically serving this population, and overlapping epidemics of HIV and substance use pose barriers to reducing HIV infections. *Section II: Community Engagement* describes in more detail how these and other barriers are limiting the ability of many living with and vulnerable to HIV to seek and access resources and services that support HIV diagnosis, treatment, prevention, and response efforts.

Current HIV Efforts and Infrastructure

Planning

HHSA has a long-standing history of planning local HIV prevention, care, and treatment efforts in conjunction with community partners and the HPG. San Diego County's prevention and care planning groups integrated in 2015 and the HPG now has a special role in directly advising the County Board of Supervisors on HIV-related health policy. The HPG published its first integrated plan in September of 2016: *Getting to Zero: San Diego's Plan for HIV Care, Prevention, Testing, and Surveillance (2017-2021)*.[1] The Plan was updated in 2019[2] and it closely follows the requirements of the Integrated HIV Prevention and Care Plan Guidance[6] released by HRSA and CDC in June 2015, and aligns with the more recent federal Ending the Epidemic (EtHE) initiative.[3]

Services

A number of public funding sources support HIV services in San Diego County, including prevention funding from CDPH (CDC PS18-1802, State General Fund, and Project Empowerment); Ryan White Parts A, B, C, D, and F (including Early Intervention Services [EIS] and Minority AIDS Initiative [MAI] funding); Housing Opportunities for Persons with AIDS (HOPWA), Special Projects of National Significance (SPNS), San Diego County General Fund, Veterans Administration, private donations, as well as revenue from third party billing, including Medi-Cal and Medicare.

Collectively, these funding sources support a number of clinical and community-based HIV service providers (**Exhibit 1**) that offer services such as HIV testing, prevention with positives, primary care, mental health services, dental services, medical case management, and a multitude of wrap-around services for PLWH. In addition, this funding supports HHSA's testing, partner services, linkage to care, outreach, and other HIV prevention and care direct services. A more extensive resource inventory is included in **Appendix 1**.

***Exhibit 1**: Publicly funded clinics and CBOs providing HIV services in San Diego County*

Clinical Providers

- AIDS Healthcare Foundation
- Family Health Centers of San Diego, Inc.
- North County Health Project
- San Diego American Indian Health Center
- San Ysidro Health
- UCSD Mother, Child, & Adolescent Program
- UCSD Owen Clinic
- Vista Community Clinic

Community-Based Organizations

- Christie's Place
- Mama's Kitchen
- Neighborhood House Association
- San Diego LGBT Community Center
- San Diego Volunteer Lawyer Program
- Stepping Stone of San Diego, Inc.

Infrastructure

Health Department. The HHSA HIV, STD, and Hepatitis Branch (HSHB), whose mission is "to improve health outcomes in communities disproportionately impacted by HIV and STDs"[7] is responsible for administering and overseeing publicly funded HIV and STD programs and services. In addition to being a direct service provider, HSHB provides leadership and coordination for HIV efforts in what is a large, complex, and diverse county. The Epidemiology and Immunization Services Branch houses the county's HIV surveillance program, and this program works closely with the HSH Branch.

Additional Assets. HHSA is a collaborator with the National Institutes of Health (NIH)-supported San Diego Center for AIDS Research (CFAR). This CFAR, located at the University of California, San Diego (UCSD), "promotes scientific and clinical studies in HIV and fosters researchers using innovative strategies to optimize HIV care, remove health disparities, support vaccine development and find a cure for HIV."[8] In addition, HHSA is a collaborator with the NIH-supported Center for AIDS Research (CFAR) in Southern California, located at the University of California, Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS). The mission of the CHIPTS CFAR is "to support multidisciplinary research aimed at reducing the burden of HIV both in the United States and around the globe."[9]

San Diego County's Plan to End the HIV Epidemic

Exhibit 2 (see p. 6) depicts a high-level overview of how San Diego County plans to enhance its current HIV efforts with new, disruptively innovative activities funded with federal EtHE funds. Some of the proposed activities utilize multiple funding sources that will be noted for each activity. The planned activities will expand and leverage, but not duplicate, the foundational efforts already in place. Importantly, the planned activities will focus on priority populations currently underreached by HIV efforts, including B/AA and Hispanic/Latinx MSM, the transgender community, and PWID. San Diego County has made great progress since it launched its Getting to Zero initiative in 2016, and this EtHE initiative offers a timely opportunity to accelerate that progress.

The **Exhibit 2** logic model shows the strengths and gaps identified through this planning process (local epidemiologic data, community engagement, and situational analysis, and the new, disruptively innovative activities designed to leverage these strengths and address the gaps). In particular, disparities in new HIV diagnoses among B/AA, Hispanic/Latinx and youth; linkage and viral suppression disparities for PWID, B/AA and young adults 20-39; and the need for better and more timely data.

New EtHE activities will work across all four EtHE pillars and will support the short-term, intermediate, and long-term outcomes identified by the CDC in PS19-1906. The primary activities for the County of San Diego are listed below. Multiple funding sources, including CDC PS20-2010 and HRSA 20-078, will be leveraged to support these activities, and community partnerships will be strengthened to ensure success.

- **Wrap Around Services for Persons who Inject Drugs** will provide comprehensive testing (HIV, HCV, STDs), status-neutral health care navigation for PrEP or antiretroviral therapy (ART), and linkage to substance use disorder treatment and mental health resources for persons who inject drugs. *(Diagnose, Treat, Prevent)*

- **Peer-based Mobile PrEP** will hire Black and Hispanic/Latinx MSM and transgender women and men who are currently utilizing PrEP to become PrEP champions to support outreach and education efforts connected with mobile PrEP clinics that offer PrEP-related medical evaluation, including comprehensive testing (HIV, HCV, STDs and safety labs), ongoing PrEP medical care, linkage to Benefits Navigation, and prescriptions for PrEP. *(Diagnose, Prevent)*

- **Competitive Routine HIV Testing Implementation Grants** will be given to local community health centers and other non-profit health care providers to implement routine HIV testing in primary care, urgent care and emergency departments. Other testing innovations may be added as implementation activities progress. *(Diagnose)*

- **Benefits Navigation** will employ trained benefits counselors who can help clients enroll in necessary benefits programs, including Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs, etc. *(Diagnose, Treat, Prevent)*

- The **Getting to Zero App and Resource Guide** will provide information and resources regarding medical and support services for persons living with or vulnerable to HIV in the form of a mobile application and printed guide. *(Diagnose, Treat, Prevent)*

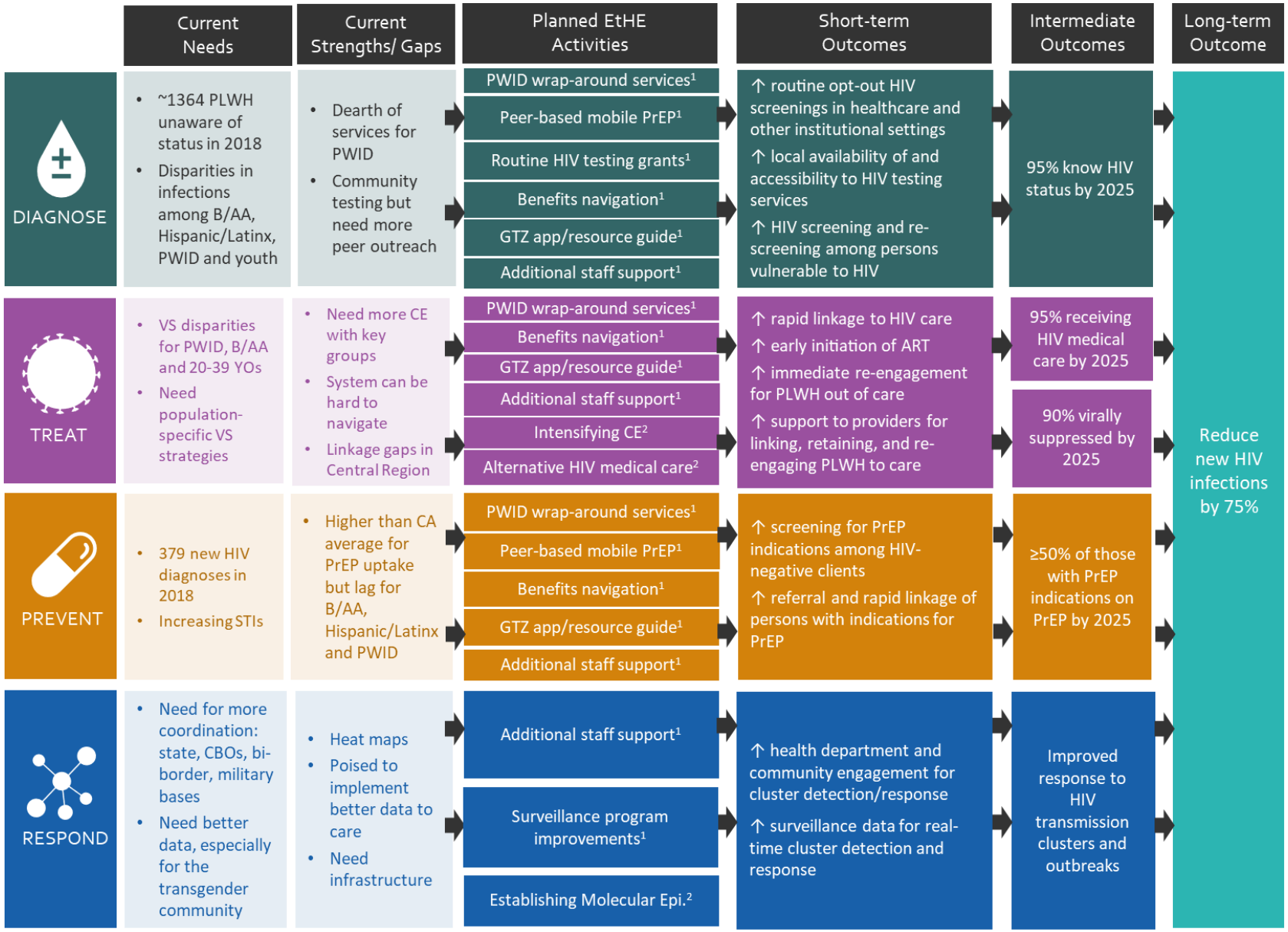
- **Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee** will provide additional staff support to the HPG to augment the group's ability to effectively plan for and evaluate HIV prevention efforts in alignment with the County of San Diego's Getting to Zero initiative and the federal Ending the HIV Epidemic initiative. *(Diagnose, Treat, Prevent, Respond)*

- **Surveillance Program Improvements** will increase the ability of the County of San Diego's HIV Epidemiology Surveillance Program to detect potential HIV clusters and ensure prompt response by the HIV, STD and Hepatitis Branch and its contracted providers. *(Respond)*

- Intensifying ***community engagement*** activities, including community forums, education and outreach, and leadership training. *(Treat)*
- Establishing ***alternative forms of HIV medical care***, namely more drop-in clinics to create options for persons who have not been successfully retained in more conventional forms of medical care. *(Treat)*
- Establishing ***molecular epidemiology***, including a substantial community readiness and education effort, to interrupt high-transmission clusters of HIV, reduce new infections and ensure that persons living with undiagnosed HIV can be identified and linked to care and other support services. *(Respond)*
- A San Diego CFAR project led by Dr. Davey Smith entitled **TRANS(ending) the HIV Epidemic: Planning a Mobilized Community-delivered Response with Transgender Communities at High Risk for HIV Transmission** will address HIV among transgender persons affected by sex work, violence, and substance use through evaluation of evidence-based practices. *(Diagnose, Treat, Prevent, Respond)*
- A **CHIPTS EtHE CFAR project** will support regional data coordination and sharing to guide scale-up of large implementation science projects designed to reduce new HIV infections across four Southern California counties. *(Respond)*

The County of San Diego's EtHE plan was developed with extensive community and partner engagement and endorsed by the HPG. With the new federal EtHE funding, HHSA expects to make significant progress over the next 5 years towards ending the HIV epidemic in the county.

Exhibit 2. *Logic Model for Ending the HIV Epidemic in San Diego County, organized by pillar. Current County strengths and gaps inform planned EtHE activities, which will impact the short-, intermediate-, and long-term outcomes identified by CDC and the California Department of Public Health.*



1. CDC PS20-2010; 2. HRSA 20-078.

Section I: Community Engagement

The County of San Diego used CDC PS19-1906 as an opportunity to evaluate and assess capacity needs for community engagement resources. Community engagement is an essential component of the county's public health efforts, including the Getting to Zero and EtHE initiatives. Community engagement enhances the understanding of the day-to-day realities of priority populations and sparks discussions about creative ways to harness community strengths, address barriers to accessing HIV prevention, care, and treatment, and dig deeper into the underlying social determinants of health.

Exhibit 3. Community Engagement Successes

- Planning Council Leadership
- EtHE Community Summit
- PrEP Listening Session
- Community Consumer Survey

Since its inception in 2016, the County of San Diego's Getting to Zero initiative has resulted in significant progress toward ending the HIV epidemic in no small part due to its emphasis on community engagement. The 2016 GTZ plan and its November 2019 update continues to be the organizing framework for the County of San Diego efforts, and the Plan has engagement as a central "pillar." The GTZ plan's definition of *engage* is conceptualized as a multifaceted mobilization of community efforts to achieve collective impact by:

1. Partnering with communities disproportionately impacted by HIV;
2. Developing and deploying media campaigns to promote awareness, encourage testing and treatment, and promote use of PrEP;
3. Reducing stigma;
4. Developing action plans for reducing disproportionalities; and
5. Refining referral and linkage systems to address co-factors that lead to disproportionate outcomes.

The County of San Diego longstanding efforts are compatible with the CDC 19-1906 goal of making community input a critical part of EtHE activities. Through a variety of resources, HRSA funding in particular, the County of San Diego has been involved in an iterative process to narrow in on key populations that have not benefited from the improved HIV outcomes that subgroups such as gay white MSM have seen. These key focus populations are B/AA and Hispanic/Latinx MSM, PWID, the transgender community, persons in their 20s and 30s, and residents of the Central Region. The County of San Diego is committed to working with community in substantive and meaningful ways that put assumptions aside and begin to build understanding about what getting to zero means outside of public health programs.

Community Engagement Activities

The COVID-19 pandemic and response has affected San Diego County's ability to implement in-person outreach and face-to-face community engagement for most of the months allocated to the PS 19-1906 accelerated planning year. However, HHSA implemented and partnered with others to implement substantive community engagement activities before the onset of COVID-19 by leveraging multiple sources of funding including HRSA 19-034. Those activities are

leveraged for this planning process. Given that the COVID-19 response will limit the possibility of face-to-face meetings for the foreseeable future, HHSA is also evaluating the utility of adapting some of its community engagement work to virtual methods including Zoom-based presentations and discussions, online surveys, virtual focus groups, and telephone key informant interviews. The County of San Diego's community engagement goals for the 2020 accelerated planning year are listed below **(Exhibit 4)**:

Exhibit 4. The County of San Diego Community Engagement Goals (Year 1)

- **Regional Efforts**: Hold a minimum of 5 community listening sessions in each of the regions of the county with an emphasis on the Central region.
- **New Voices**: Engage new people vulnerable to and living with HIV and the HIV providers and non-traditional partners who serve them.
- **Community Driven**: Collaborate with communities in the planning and implementation of community engagement.
- **Capacity:** Ensure that efforts build the capacity of the health department to work meaningfully and authentically with communities.
- **Coordination:** Ensure a coordinated response that integrates activities across funding sources and programs.

HHSA partnered with HPG leadership and constituents and brought together new voices—clients, providers, governmental groups, and academic institutions—to inform the next best steps to get to zero. **Exhibits 5 and 6** summarize the completed and planned community engagement efforts for the PS19-1906 accelerated planning year and beyond. The completed and proposed activities reflect successful strategies that the county has used in the past to engage community members: GTZ community forums (November 2018, February 2020), a PWID community scan (2019), provider forum (PrEP, 2020) and completing the data analysis for the 2017 HIV Impact Survey. **Appendix 2** provides more detailed descriptions of these efforts, and meeting agendas, meeting notes, and other documentation are kept by HHSA for audit.

***Exhibit 5*.** Overview of County EtHE community engagement activities

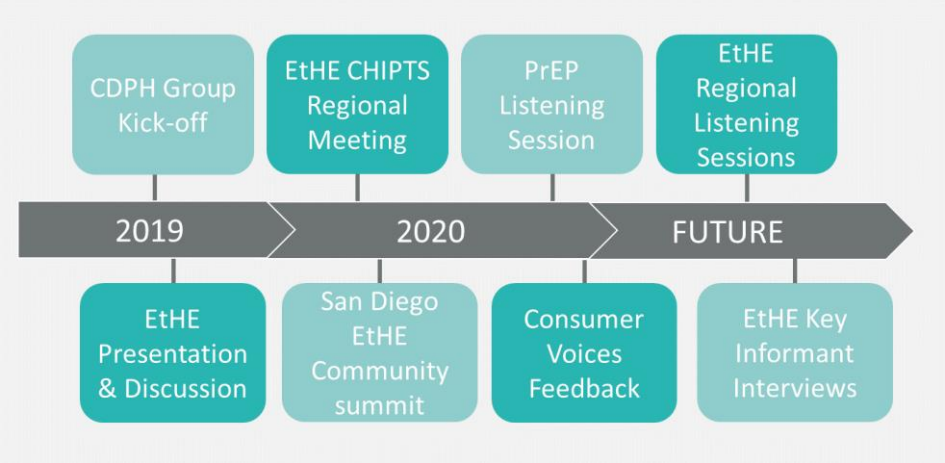


Exhibit 6. *San Diego County EtHE community engagement activities, completed and planned*

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
CDPH Planning Group Kick-Off Meeting[10] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants****: San Diego HPG, County of San Diego Health and Human Services Agency. All CA Phase 1 counties, CDPH.*
EtHE Presentation and Discussion[11] 11/12/2019	The San Diego HPG Steering Committee facilitated a discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	***Participants****: San Diego HPG, HSHB staff, public*
EtHE CHIPTS Regional Meeting[9,12] 01/24/2020	HHSA presented an overview of the county's draft EtHE plan and gave input about approaches to the regional EtHE response.	***Participants****: County health departments and Planning Council representatives from Alameda, Los Angeles, Orange Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.*
San Diego Ending the HIV Epidemic Community Summit[13] 02/29/2020	HHSA and the Summit co-sponsors presented the country's EtHE initiative and then facilitated a group discussion of barriers to ending the epidemic, methods to better engage new voices, and ways to increase the utilization of HIV and PrEP services. Nathan Fletcher, County Board of Supervisor, invited participants to sign a petition and attend the Board of Supervisors meeting on March 10, 2020 to reverse the County of San Diego policy against needle exchange.	***New Voices – Priority Populations****: Hispanic/Latinx MSM, the transgender community, PWID* ***New Voices – Providers****: research* ***Participants:*** *Board of Supervisors, people vulnerable to and living with HIV, Spanish-speakers, clinical providers, CBOs, new HIV-positives, peer advocates, pharmaceutical company representatives, San Diego HPG members.* ***Sponsors:*** *San Diego Center for AIDS Research (CFAR), San Diego HPG, County of San Diego HIV, STD and Hepatitis Branch of Public Health Services*

EVENT	DESCRIPTION	VOICES & PARTNERS
PrEP Listening Session[14] 02/29/2020	County of San Diego and Gilead held a listening session to discuss methods to better engage new voices, barriers to PrEP utilization, and recommendations to improve PrEP access and utilization.	***New Voices – Providers****: PrEP navigators* ***Participants****: Prevention through Active Community Engagement (PACE), San Diego HPG, clinical providers, pharmacy providers, PrEP navigators, people vulnerable to and living with HIV.* *Sponsors: Gilead*
Consumer Voices Feedback[15] **02/29/2020-05/312020**	The Getting to Zero Project and Ending the HIV Epidemic efforts collected feedback from 100+ consumers (living with and vulnerable to HIV including those who have utilized Ryan White funded services in San Diego County.	***New Voices-Priority populations:*** *B/AA MSM, Hispanic/Latinx MSM, the transgender community*
PLANNED ACTIVITIES (dates TBD)		
Key Informant Interviews	County of San Diego will speak with new voices to gain their input on the EtHE plan and to gain a better understanding of their barriers in accessing HIV or PrEP care.	***New Voices –*** *Priority Populations* ***New Voices – Providers****: substance use*
EtHE Listening Sessions via Zoom or in-person as COVID-19 response allows	The County of San Diego will hold virtual listening sessions with new voices from each noted part of the county (Central, Southeast, and Southern) since each area has a high proportion of the priority populations. The county will collect community input on the EtHE plan and barriers to PrEP and HIV services utilization.	***New Voices – Priority Populations****: B/AA MSM, Hispanic/Latinx MSM, the transgender community, PWID*

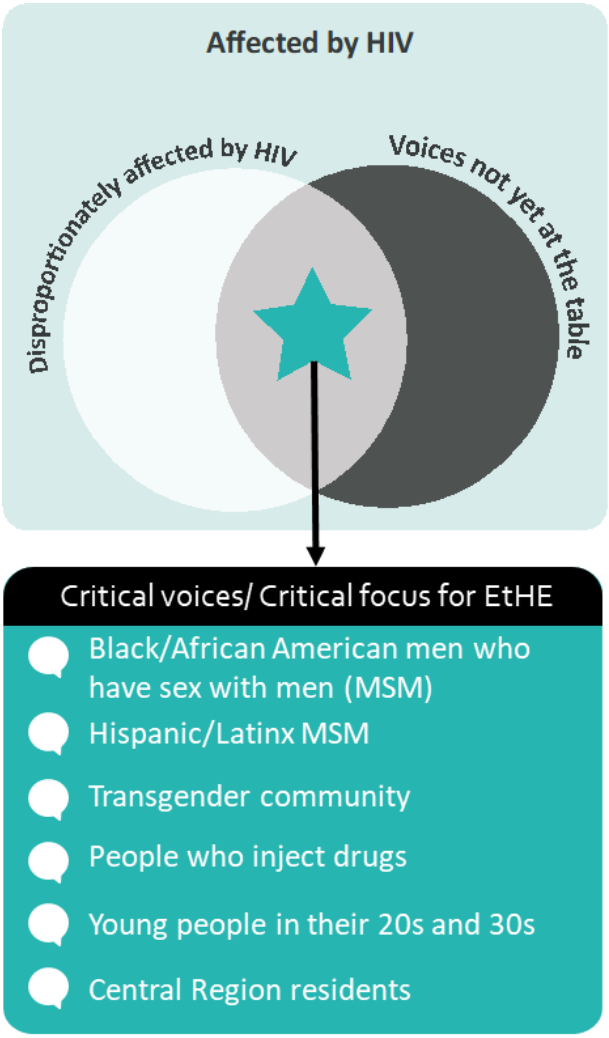
The San Diego CFAR, with support from HSHB, headed the local San Diego EtHE Steering Committee that oversaw the planning, implementation, and reporting of 19-1906 activities. The Steering Committee successfully leveraged funding from other sources to augment 19-1906 work. An example of their leadership is their coordination of the HPG and the San Diego CFAR to implement the successful San Diego Ending the Epidemic Summit. Gleaning community wisdom was a key outcome of the summit, where new voices and long-term survivors came together to vote on priorities for future EtHE work. Participants acknowledged that this was just a beginning, and commitments were made to continue the work. A future summit will focus on developing further action plans for key groups.

New Voices

In addition to deepening the partnerships within current provider and community networks, HHSA will continue to place a special emphasis on including new voices in the development and implementation of the EtHE plan.

HHSA used an intentional data-driven process to identify affected populations not currently being reached effectively so they could focus on engaging these new voices. HHSA conducted an environmental scan to assess the needs of persons who inject drugs, services available, and service needs. The report includes local data and a thorough review of the literature regarding injection drug use and harm reduction services. Experiences of persons who inject drugs are shared throughout the report. In addition, based on HIV surveillance data and the experience of key stakeholders (e.g., the HIV, STD and Hepatitis Branch of Public Health Services, the HPG, service providers) and an assessment of who is not currently participating in the HIV planning process, HHSA identified the following priority populations as ***new voices*** that need to be included (summarized in **Exhibit 7** and described below):

Exhibit 7. Critical new voices to engage.



- **Black/African American (B/AA) men who have sex with men (MSM).** B/AA MSM experience stark HIV health disparities, particularly regarding retention in care and viral suppression.
- **Hispanic/Latinx MSM.** Hispanic/Latinx MSM experience similar HIV health disparities, and are a large proportion of late HIV diagnoses.
- **Transgender community.** There is a lack of robust data for the transgender population. Therefore, the transgender community should be further engaged by the county, especially those who participate in behaviors that may make them vulnerable to acquiring HIV, in order to gain an understanding of their current situation and needs.
- **People who inject drugs (PWID).** PWIDs are a population that is hardly reached in the county and they are vulnerable to not only HIV infection, but also STI and HCV infections.
- **Young people in their 20s and 30s.** Young adults in their 20s and 30s make up a large proportion of new HIV diagnoses in the county, experience disparities in viral suppression and are not currently at the HIV planning table.
- **Central region residents.** Residents of the county's Central Region are statistically less likely to be linked to care or achieve viral suppression than other county residents.[16]

The following sections describe our efforts to engage critical voices prioritized in PS19-1906 with an emphasis for inclusion of the identified priority populations.

Local Prevention and Care Integrated Planning Bodies

The San Diego eligible metropolitan area (EMA) community planning body is called the San Diego HIV Planning Group (HPG). This formation of the integrated prevention and care planning group is a legislative requirement for HRSA RW Part A funding and was approved in December 2015 by the County Board of Supervisors (BOS), codifying the special role of the HPG in advising the BOS on health policy related to HIV/AIDS. Most recently the HPG provided leadership by presenting data through public comment to the BOS on the likely outcomes of expanding harm reduction services for PWID. The San Diego County continuously seeks the HPG's input and guidance when developing HIV prevention, care, and treatment strategies. The county has actively engaged the HPG throughout the EtHE planning process, especially regarding the priority populations and proposed interventions.

The HPG brings a wealth of knowledge and experience to the EtHE planning process. Planning group membership is composed of stakeholders with diverse personal and professional experiences, including both HIV and non-HIV related service providers. People living with HIV are required to make up at least 33 percent of the planning group, and additional members include people vulnerable to acquiring HIV, HIV service providers, community based organizations, research partners and other members of the public.

The HPG is a key partner for ensuring that new voices from the priority populations are included in planning efforts and within the HPG. In addition, the HPG is actively engaged in developing the leadership of members vulnerable to and living with HIV (consumers). The following are the key subcommittees of the HPG and descriptions of their important work as it relates to EtHE activities:

> ***Steering Committee*** oversees the governance of the HPG including planning and coordinating EtHE activities.
>
> ***HIV Consumer Group*** is charged with increasing and representing consumer participation throughout the HPG process. While current consumer representation on the HPG is primarily made up of long-term HIV survivors, community engagement efforts suggested that younger people, both vulnerable to and living with HIV, are an untapped resource, especially about issues like substance use and mental health needs.
>
> ***CARE Partnership*** facilitates the collaboration between consumers, providers and community members to empower consumers, share resources, educate the community, advocate for public policy plans and services for women, children, youth and families living with and affected by HIV/AIDS.
>
> ***Getting to Zero Strategies and Standards Committee*** oversees the Getting to Zero Plan to direct objectives, strategies, and activities to get to zero new infections and continue to support those vulnerable to and living with HIV in San Diego. This committee updates and approves all standards for HIV services. Service standards are developed by the non-medical and medical working groups.

Priority Setting and Resource Allocation Committee *is* charged with reviewing, analyzing and considering available data, and making recommendations to the HIV Planning Group based upon that data regarding service priorities, service delivery and funding allocation by service category. This committee also oversees the needs assessment process.

Local Community Partners

As is evident from their track record of engaging communities, HHSA believes and is committed to ensuring that the proposed programmatic activities meet community needs and are conducted in ways that resonate with those communities. This is a primary focus of engagement with the EtHE priority populations.

In addition to the Planning Group's work, the County of San Diego is directly engaging with the identified priority populations as shown in **Exhibit 7** (p.11)**.** By the end of the planning year, the county expects to engage every priority population at least once directly or through the review of secondary sources of data that were developed with community input. Direct community engagement will continue in Years 2-5.

Local Service Provider Partners

Service providers, both HIV- and non-HIV-related, are key partners for ending the HIV epidemic in San Diego County. Clinical and community-based providers have a wealth of experience regarding what works and what does not work to reach priority populations and a strong knowledge of the barriers that need to be overcome in order to more effectively serve people vulnerable to and living with HIV. Other partners, who may not provide direct services but who have expertise in or connections with priority populations, are also key to building a robust, feasible, and sustainable HIV prevention, care, and treatment strategy.

The County of San Diego has pre-existing strong partnerships with the HPG and the CBO and clinical providers listed in **Exhibit 1** (p. 3, Introduction). The county also supports ongoing collaborations between consumers, providers, and the public health department as described in the GTZ 2016 plan. In addition, during the EtHE planning process, the County of San Diego engaged the following new service providers and non-traditional partners:

- **Primary care providers**: including Federally Qualified Health Centers and other primary care providers from the major health systems, military and community-based clinics.
- **Research partners**: CFAR funded San Diego Center for AIDS Research, National HIV Behavioral Survey.
- **Substance use providers:** including substance use disorder counselors, Stepping Stone San Diego, Choices in Recovery, Josue House, FQHCs and others.
- **Housing:** County Housing and Community Development, Townspeople.
- **Mental Health:** County Behavioral Health Services, the LGBT Center, UCSD, FQHCs.

The County of San Diego is strongly invested in maintaining these relationships and continuing to forge new partnerships for ending the HIV epidemic. Also, the COVID-19 pandemic has resulted in new partnerships and services models, many of which will continue to better serve people vulnerable to and living with HIV.

Selected Findings

The following sections summarize and highlight selected findings from the community engagement efforts. These findings represent a synthesis of information gathered from all the activities in **Exhibit 6** completed as of September 30, 2020 (see **Appendix 2** for detailed documentation). The findings are organized into four domains representing barriers that are facing most communities across the U.S. as they work to end the HIV epidemic: social determinants of health, being unhoused, mental health, and substance use (**Exhibit 8**). The information collected sheds light on the prevailing issues and conditions the priority populations are experiencing, serving as an initial indication of how these conditions might influence the county's ability to achieve EtHE goals. These early insights point to potentially impactful strategies and interventions.

Exhibit 8. Key considerations for EtHE in San Diego County, from community engagement processes

Social Determinants of Health like structural inequality and discrimination—especially among people who are undocumented—hinder progress.

Secure housing is needed to help people experiencing homelessness and housing insecurity meet basic needs and prioritize their health.

Mental health services that are culturally and linguistically appropriate are critically needed to support viral suppression.

Substance use services are urgently needed to support HIV prevention and care efforts, especially given local rates of heroin, fentanyl and methamphetamine use.

Social Determinants of Health

A common theme across all the completed community engagement efforts was the pervasive effect that social determinants of health have on the well-being of communities. Structural inequality, discrimination, racism, HIV related stigma and oppression negatively impact the health of the most vulnerable populations. Community engagement participants shared how these factors have impacted their experience living with or being vulnerable to HIV. Providers also suggested that mistrust of the healthcare system compounded with institutional trauma and racism is real and presents barriers to hardly served communities.

Immigration status and federal immigration policies hinder vulnerable communities from achieving health equity. San Diego County shares a border with Mexico, so immigration-related barriers, especially for Hispanic/Latinx people, are extremely relevant. Two main immigration barriers were identified as preventing the county from achieving their EtHE goals:[17] (1) fear of immigration consequences for participating in programs, and (2) and fear that undocumented status disqualifies people from accessing public benefits (e.g., Medi-Cal). Current federal immigration policies have created a heightened sense of fear and uncertainty for the undocumented community. Ending the epidemic in San Diego County is not possible without providing direct support and advocacy for undocumented communities.

PrEP utilization in the county is also impacted by these factors. In 2018, at least 87 out of every 100,000 people were PrEP users, which is good progress towards the county's target of 152 PrEP users per 100,000 people.[18] However, community members identified the following

barriers to higher PrEP utilization:[19] (1) not all medical providers are actively prescribing PrEP to vulnerable populations; (2) current PrEP services have limited operation hours and location; and (3) stigma, particularly in the military, prevents military personnel from seeking PrEP and HIV prevention services on base or in VA medical centers.

Being Unhoused/Unsheltered

The 2018 WeAllCount Homeless point in time count identified 8,576 people experiencing homelessness living in San Diego County. The majority are between the ages of 25-54, and 70 percent are male. Despite making up only 5.5 percent of the county's population, 23 percent of the people experiencing homelessness persons are B/AA. Among respondents, 2 percent reported living with HIV, 43 percent reported having a mental health diagnosis, and 23 percent reported alcohol or substance use.[20] HIV is thought to be under-reported in the homeless point in time count. Analysis of the 2017 Community Survey of HIV Impact gives a clearer picture of unstably housed PLWH. PLWH and unstably housed respondents of the 2017 Community HIV Impact Survey (n=175) were mostly male (89 percent), gay/bisexual (81 percent), and people of color: Hispanic/Latinx (49 percent) and B/AA (12 percent).[21] Community engagement efforts and program data suggest the people experiencing homeless are significantly undercounted.

San Diego community residents also shared their personal struggles of balancing their health and housing needs. A long-term HIV survivor revealed the exorbitant cost their partner must pay for their medical insurance and often "either he pays that or pays rent."[17]

Support is needed not only for people to secure housing but also to maintain housing. Chronic health conditions, mental health disorders, and histories of trauma can make it difficult to maintain housing. It is well-recognized that supportive housing services and case management are often necessary to help people maintain and thrive in a stable home,[22] including support for paying rent on time and applying to social benefits or employment opportunities. Community engagement efforts suggest that the COVID-19 pandemic has resulted in a housing crisis on top of an existing housing crisis.

Mental Health

Mental health is a critical part of health care services for people vulnerable to and living with HIV. At the San Diego Ending the HIV Epidemic Community Summit, a long-term HIV survivor described how an HIV-positive disclosure was a common traumatic experience that all PLWH share. A young, recently diagnosed Hispanic/Latinx participant at the summit shared the need for daily support to be hopeful and to help educate their family about HIV.[17] There is an additional need to create awareness and address any mental health barriers to accessing PrEP.

There is a need for culturally and linguistically appropriate mental health services in San Diego County for all populations. Paying for these services can be even more of a challenge than paying for primary medical services. "You need a PhD in health insurance to understand how to get care sometimes," one participant of the Summit shared. Also shared was the fact that San Diego County lacks a substantive bilingual mental health workforce to meet the mental health needs of a large and growing Spanish-speaking population. A Spanish-speaking transgender woman said, "I need to talk to my therapist with a translator on my phone. People are not able to talk about all their emotions and feelings with someone that does not understand their language."[17] Even though mental health providers offer language interpretation services,

Spanish speakers may not get the therapeutic benefit of a direct relationship with their provider because of the language barrier.

The mental health problem in the county can be further compounded by the lack of culturally appropriate services.[17] Through ongoing community engagement efforts, HHSA is committed to growing its understanding of what it means to offer culturally responsive and appropriate mental health care.

Substance Use

San Diego County community members identified substance use disorders as a prevalent problem in communities affected by HIV. Like mental health, substance use highly impacts priority populations, often because of trauma and structural inequalities.

From 2011-2018, there has been a steady and significant upward trend of deaths attributable to amphetamine use in San Diego County, from 2.55 deaths/100,000 population to 5.84/100,000. In addition, there were 268 opioid-related overdose deaths in 2018, a 5 percent increase from 2016. Deaths from overdoses of both heroin and fentanyl rose sharply during this time.[23] These data serve as indicators for the unmet needs of people who use opioids and stimulants, many of whom inject these substances.

Community members expressed a need for harm reduction services for people who use substances. Community Summit participants mentioned the need for safe injection sites and syringe services programs (SSPs) in the county.[17] The County of San Diego currently prohibits the establishment of needle exchange programs.[24] Only one FQHC and one pharmacy in the City of San Diego are allowed to offer limited syringe exchange services, hindering access to treatment services.[17,25,26] However, the HPG harm reduction advocates and County Board of Supervisor Nathan Fletcher put forward an initiative on March 10, 2020 to overturn the SSP ban and the Board of Supervisors voted to move forward with a local assessment of expanding syringe service programs and a review of the research.[17] Low-threshold, harm reduction strategies are needed to address substance use and achieve the San Diego County's EtHE goals.

Community Engagement, Years 2-5

The County of San Diego will use Years 2-5 of EtHE implementation to continuously engage community members in the planning and implementation of services and interventions. Community input was essential in developing the proposed activities outlined in *Section IV: Ending the HIV Epidemic Plan.* Moving forward, it will be equally important to keep the HPG, community members, and service providers engaged in a dialogue around the most effective approaches to implementing services. Future engagement strategies will include working closely with the HPG and hosting community forums co-sponsored by the HHSA, CBOs, and the HPG. The County of San Diego is prepared to develop alternative and innovative engagement methods if necessary due to COVID-19 or other unanticipated factors.

For Years 2-5, San Diego County's community engagement priorities are to include more new voices through strengthening collaborative relationships with CBOs and focusing on workforce development, as shown in **Exhibit 9** and described below. Documentation of all community engagement meetings and outreach efforts will be maintained and reviewed regularly to ensure they are achieving the desired engagement of priority populations.

Exhibit 9. Community engagement priorities, Years 2-5

1. Including additional new voices through collaborative relationships with CBOs
2. Focusing on workforce development

Collaboration with Community-Based Organizations

Many of the communities that have not been reached effectively have a deep-rooted mistrust of large institutions due to historical discrimination that has not only excluded people but has also caused extreme harm. To begin to overcome these barriers, the San Diego County will prioritize relationships with CBOs grounded in the experiences and cultures of the priority communities. CBOs have the long-standing trust and rapport with those they serve, an invaluable asset that San Diego County continues to learn from. EtHE community engagement would not be possible without the support of CBOs. The county and CBO partners will seek technical assistance to implement best practices and innovative strategies for connecting with new voices from the priority populations. In addition to continuing to engage the communities identified in Year 1, the County of San Diego will also seek to bring the following new voices to the table:

- B/AA and Hispanic/Latinx MSM
- PWID and harm reduction advocates
- Transgender community members
- Young persons in their 20's and 30's
- Central region residents
- Antiracism advocates

In Years 2-5, the county will work with CBOs to reduce barriers to participating in community engagement. Hosting events on evenings and weekends or other times when people are not working, providing free childcare during events, and assisting with transportation through vouchers or other means are all feasible strategies for increasing participation. To further engage young people, the county will provide virtual engagement options and use technology and social media to create innovative outreach methods. All community engagement events must be conducted in a way that destigmatizes HIV and empowers, not disenfranchises, vulnerable populations. Engaging priority populations should be done more than once to build community and engage the trust of the populations most impacted by the epidemic.

One mechanism for strenghtening partnerships with CBOs is through the PS-20-2010 requirement to subcontract 25 percent of funds to CBOs. The County of San Diego strongly supports this requirement and will issue a solicitation(s) for funding to local CBOs to collaborate closely with the county to reach and serve the EtHE priority populations. Additionally, the county will collaborate with CBOs directly funded by the California Department of Public Health and the Centers for Disease Control and Prevention. A newly formed High Impact Prevention Navigators Collaborative will engage front line staff and their supervisors in sharing best practices for navigation services and these practices will be documented.

Workforce Development

Community engagement efforts can be used to bolster the county's HIV workforce by building economic opportunies and creating a pipeline of critical workers to help reach EtHE goals. Testimony at the San Diego Ending the HIV Epidemic Community Summit suggested that EtHE funds be used to hire and train peers from the most affected groups.[17] The County of San Diego will fund and provide training to assist HIV-focused CBOs expanding their lay workforce; HRSA 20-078 funding will be used to provide leadership training for the CBO workforce. Hiring people with lived experience shows that community experience is valued and needed. Providing job opportunities and training to people from the priority communities helps reduce the stark economic disparities that contribute to HIV risk and poor health outcomes. In addition to leadership training, the County of San Diego recognizes the need to train mentors and mentorship as succession planning for the old guard to transfer knowledge to the new generation. The workforce must be tranformed by welcoming the leadership of those living with and most vulnerable to HIV

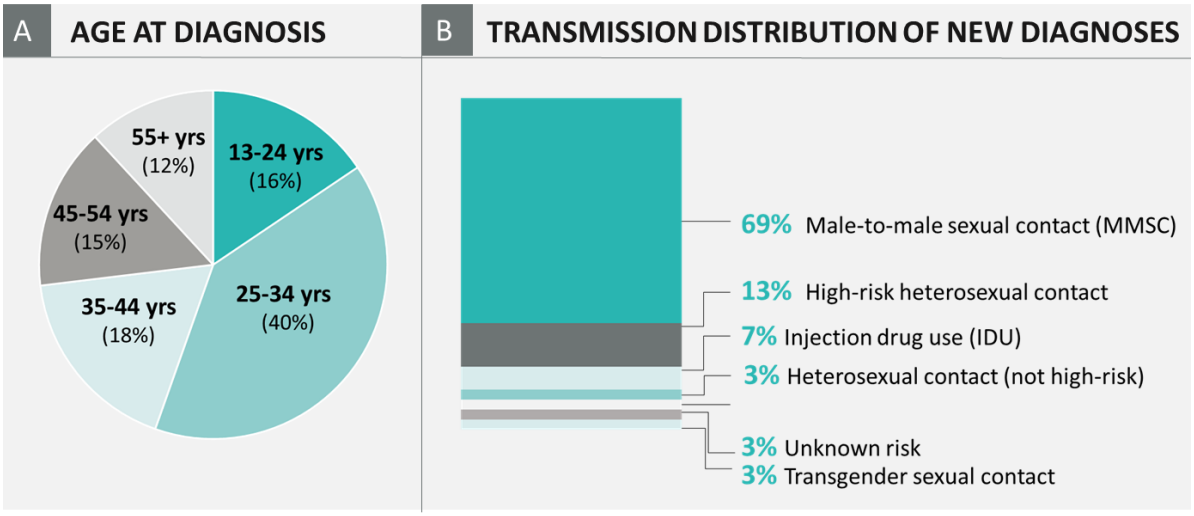
Section II: Epidemiologic Profile

HIV Diagnoses

In 2018, there were approximately 13,688 people living with HIV in San Diego County and aware of their status. Of those, 379 were diagnosed within 2018. Also, in 2018 there were an estimated 1,364 people living with HIV that were unaware of their HIV status.[27] Of the people made aware of their status in 2018, 220 (58 percent) were ages 25 to 44, 261 (69 percent) were infected through male-to-male sexual contact, and 49 (13 percent) were infected through heterosexual contact typically considered high risk (i.e., with a partner who was MSM or injected drugs).[5] Unless otherwise indicated, these tables were developed from epidemiological data provided by CDPH-OA for 2018.

Exhibit 10 highlights the age and transmission distribution of new HIV diagnoses in San Diego in 2018.

Exhibit 10. Age at Time of Diagnosis (A) and Transmission Distribution of New Diagnoses (B), 2018



Overall, age and gender at diagnosis have remained relatively constant between 2014 and 2018 in San Diego County. However, the rates of new diagnoses per 100,000 population when stratified by race/ethnicity have fluctuated notably since 2014, as can be seen in **Exhibit 11**. Specifically, Black/African Americans and Hispanic/Latinx persons consistently have the highest rate of diagnosis, which peaked in 2016. Since then, rates have declined for both groups, though following a steep decline in 2017, rates for Black/African Americans bounced back up somewhat and remain substantially higher than other ethnic groups.[5] It is important to note that when overall numbers of individuals in a group are small, sparklines or other trend analyses should be interpreted with caution.

American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups are not included in the race/ethnicity data tables below due to small to zero numbers reported each year from 2014-2018. This report does not intend to diminish the impact of HIV on American Indian/Native Alaskan and Native Hawaiian/Pacific Islander groups. Small numbers are not reported to preserve the confidentiality of PLWH.

Exhibit 11. *Rate of Transmission by Race/ethnicity, New HIV Diagnoses, San Diego County*

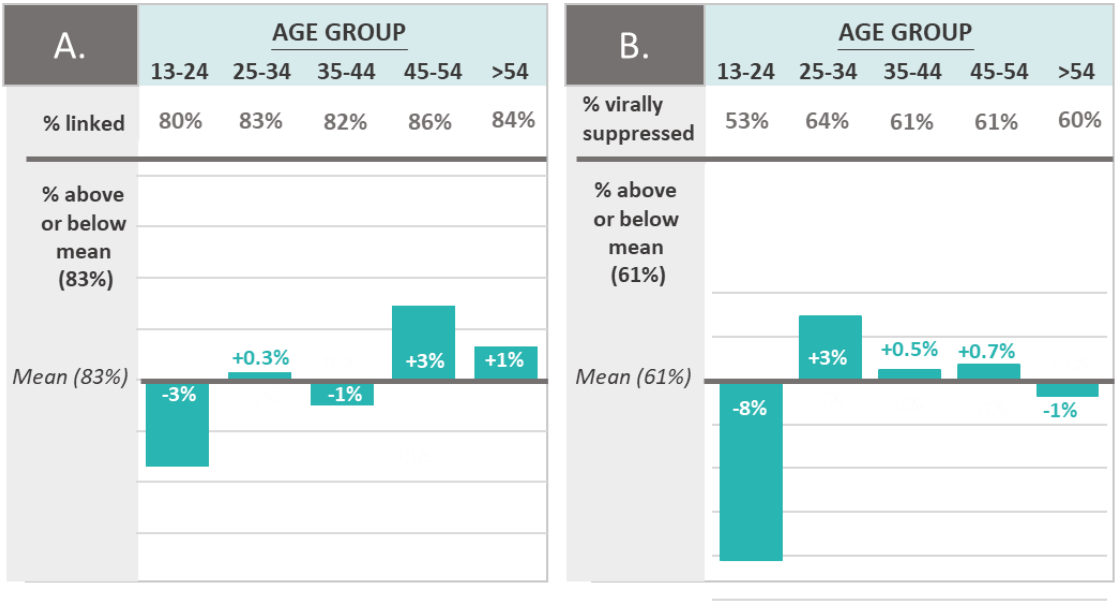
Race/ethnicity	2014 Rate	2015 Rate	2016 Rate	2017 Rate	2018 Rate	2014-2018 Sparklines
Black/African American	35.4	38.9	38.7	29.0	31.9	
Hispanic/Latinx	20.2	19.1	21.8	17.9	14.5	
Asian	9.5	10.0	7.6	8.4	6.1	
White	12.2	10.8	11.1	8.2	8.4	

Note: Rates are per 100,000 population.
Data Source: California Department of Public Health, Office of AIDS, Surveillance Section

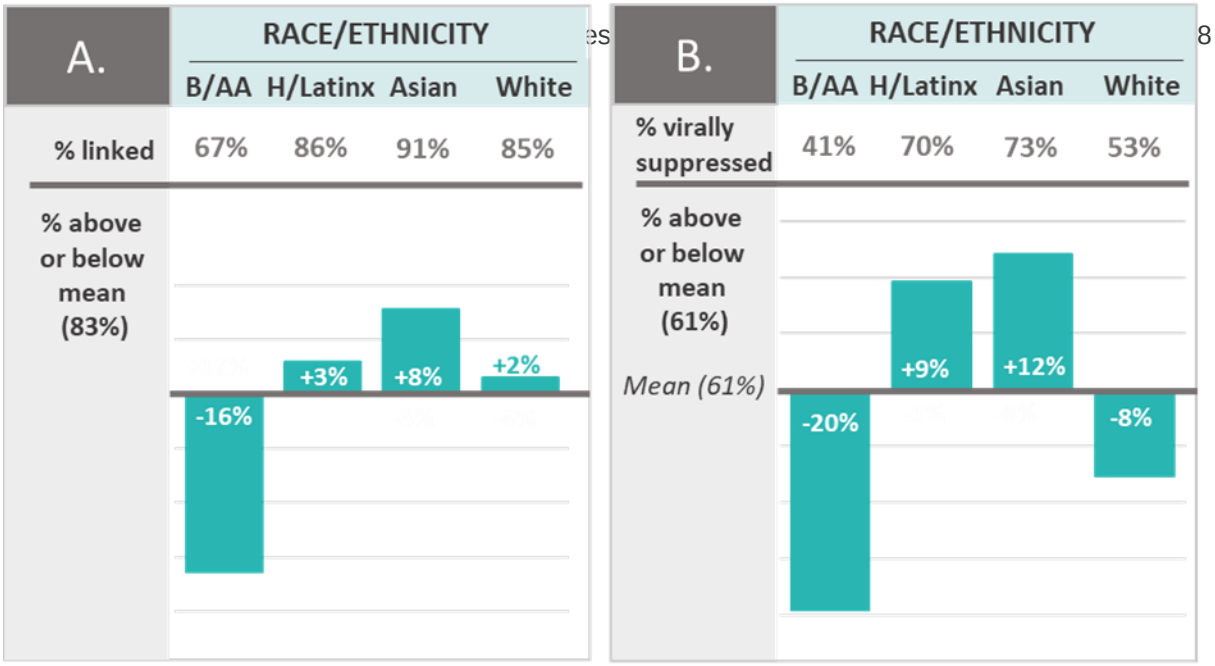
Linkage to Care and Viral Suppression

New diagnoses are not the only important piece of HIV epidemiology, however. Also, key are the percentages of people linked to care within 30 days, and virally suppressed within six months of diagnosis. Overall, 83.1 percent of people diagnosed with HIV in San Diego County in 2018 were linked to care within 30 days of diagnosis, and 60.7 percent were virally suppressed within 6 months. However, there were notable disparities, with persons 13-24 years of age – having considerably worse rates of linkage to care within 30 days, and worse viral suppression rates (**Exhibit 12**).[5]

Exhibit 12. Linkage to Care (A) and Viral Suppression (B) by Age, San Diego County 2018



Similarly, disparities in linkage to care and viral suppression were also seen by race/ethnicity, with Black/African Americans (B/AA) having substantially worse outcomes than other racial/ethnic groups in both linkage to care within 30 days and viral suppression. Hispanic/Latinx (H/Latinx) and Asian persons exceeded the mean in both categories. (**Exhibit 13**).[5]



In summary, **Exhibit 14** provides a few key features of San Diego County's HIV epidemic in 2018.[5]

Exhibit 14. Key features of San Diego County's HIV epidemic (2018)

Section III: Situational Analysis

The Situational Analysis offers a high-level overview of the strengths, needs, gaps, and barriers related to ending the epidemic in San Diego County. It synthesizes data from community engagement efforts, the epidemiological profile, planning conversations, and consultations with partners implementing work through multiple HIV and non-HIV funding sources.

The Situational Analysis is organized into the following three sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps.

Methods

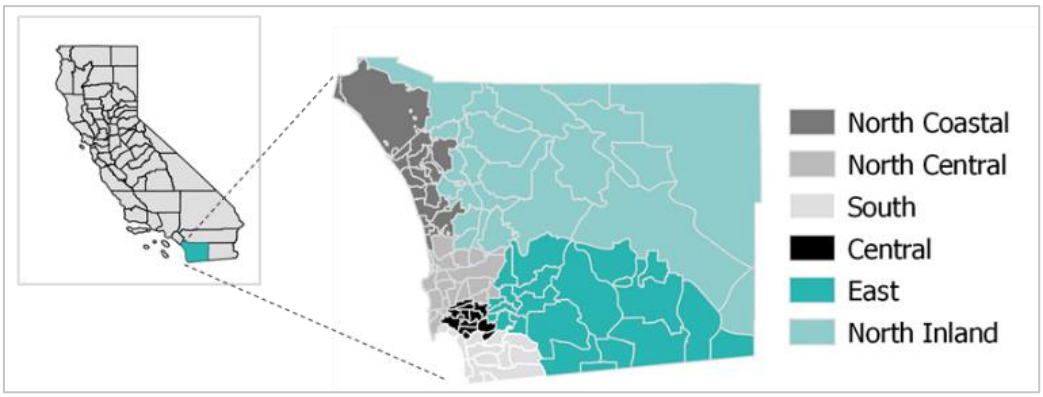
San Diego County's situational analysis consisted of documenting HIV-related community needs and assets, describing the existing resources to meet those needs, and identifying gaps that must be filled to fully meet the needs (**Exhibit 15**).

Exhibit 15. Methods and data sources used for the County's situational analysis

Method	Description
Needs assessment to ascertain needs, resources, service gaps	• EtHE community engagement efforts[8-12,14] • County information on existing services • California Directory of Syringe Services Programs[26]
Review of secondary data and reports	• AIDSVu local PrEP estimates[18] • San Diego County Epi Profile 2018[5] • 2017 Community Survey of HIV Impact[21] • 2018 Point in Time homeless count[20] • CA Opioid Surveillance Dashboard[23] • HIV Care Continuum, San Diego County 2018[27] • CDPH HIV Surveillance Report 2017[28] • U.S. Census Population Estimates for San Diego County[29]
Community engagement and consultation	• San Diego County HIV Planning Group • Service providers • Community members representing the priority populations disproportionately impacted by HIV
Review of relevant County and State plans	• Getting to Zero: San Diego's Plan for HIV Care, Prevention, Testing and Surveillance[1] • Getting to Zero 2019 Update to San Diego County's Integrated Plan for HIV Care, Prevention, and Surveillance[2] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan[4] • PS 18-1802 Workplan[30] • HRSA 19-034 application[31] • HRSA 20-078 application[16] • PS 20-2010 Evaluation Performance Measurement Plan[32]
Consultation with key stakeholders	• Local: HHSA staff, HIV Planning Group, HIV Providers, CBOs • Regional and State: CDPH; CARG; CFAR; HRSA Region 9 group; Federal Ryan White Program Staff

Situational Analysis Snapshot

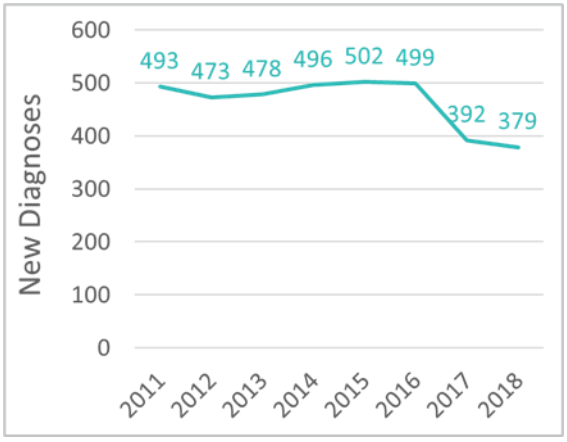
Exhibit 16. Map of San Diego County Health Services Areas



Situational Analysis Summary

San Diego County (**Exhibit 16**) reaches over 4,200 square miles with urban, suburban, and rural communities. With a population of 3.3 million, it is the second most populous county in California and the fifth most populous county in the United States.[29] There are 18 incorporated cities, over 30 unincorporated communities, 10 military installations, and 18 federally recognized Indian reservations within the county. Adding to its geographic and regulatory complexity, San Diego County shares the world's most active international land border crossing with Baja, Mexico; the combined population of San Diego and Tijuana, Mexico is over 5 million.

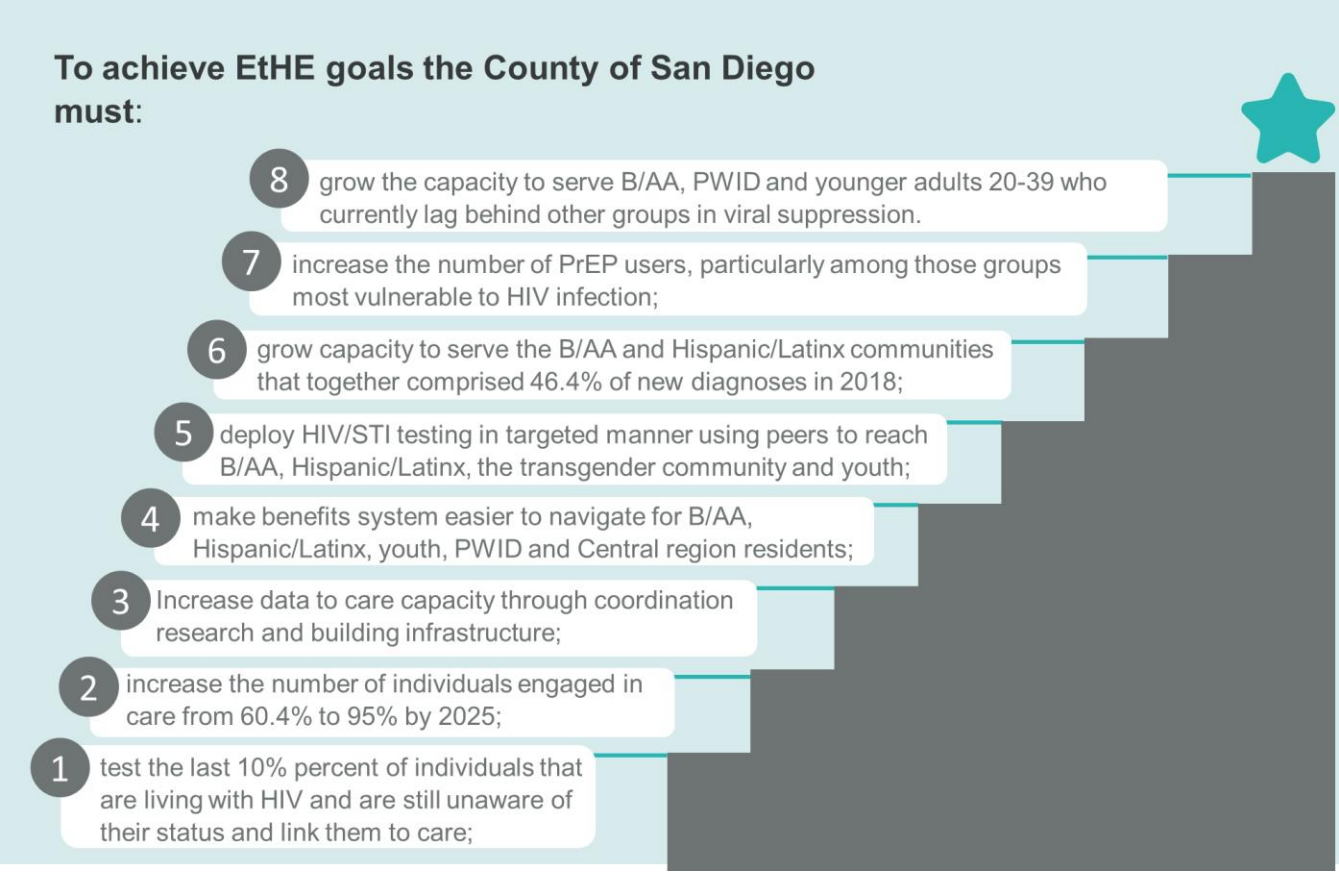
***Exhibit 17*:** Number of Annual New Diagnoses, San Diego County, 2011-2018



Since its inception in 2016, San Diego County's Getting to Zero initiative has made significant progress as evidenced by data on new diagnoses (**Exhibit 17**), viral suppression, and mortality as described in *Section III: Epidemiologic Profile.* In 2018, the 379 cases in San Diego County represented the lowest number diagnosed since 1984, which was a significant success. Viral suppression rates have more than doubled in the last decade (31 percent in 2011 to 63 percent in 2018), and the number of HIV-related deaths has decreased from 136 in 2011 to 72 in 2017. In 2018, among all new HIV diagnoses, 83.1 percent were linked to care within 6 months.[5] However, there are some key groups that continue to be impacted disproportionately by HIV: B/AA and Hispanic/Latinx MSM, the transgender community, PWID, young people in their 20's and 30's, and residents of the Central region.[5,21]

Exhibit 18 summarizes what the county must do to reach EtHE goals. The situational analysis by pillar (next section) will discuss key aspects of these key populations and explain why they must be a focus of EtHE efforts.

Exhibit 18. High-level summary of what is needed to end the HIV Epidemic in San Diego County



Situational Analysis Snapshot by Pillar

Diagnose

In 2018 there were 13,688 individuals in San Diego County living with diagnosed HIV infection.[5] Additionally, there were an estimated 1364 individuals living with HIV who were unaware of their status.[27] With the proportion of diagnosed HIV cases estimated at close to 90 percent, those not identified through baseline testing efforts need new and innovative strategies to reach them. Community engagement data suggest that this last 10 percent are more likely to be from disproportionately impacted groups like B/AA and Hispanic/Latinx MSM.[17]

Data from the local HPG's Survey of HIV Impact indicates that many B/AA MSM do not pursue testing, primarily because they are distrustful of the service delivery system, they worry that getting tested might be perceived as an admission of engaging in stigmatized behavior, or they do not prioritize sexual health.[21] For these reasons, program materials designed for gay men overall may not be accessed by B/AA MSM. The additional co-factor of economic inequality means many of these men lack adequate health coverage and prioritize more immediate needs, such as food and housing, over health needs. Other long-standing, unaddressed physical

health, mental health, and substance use needs often exist that prevent these men from prioritizing HIV risk or HIV testing.

Hispanic/Latinx MSM are too often diagnosed with HIV late in their illness. This population is the most likely to progress from HIV to AIDS within one year of diagnosis and has the highest rate of AIDS diagnosis within 30 days of diagnosis with HIV. Men in this population may fear accessing HIV testing and/or medical care services. Those living in the U.S. with undocumented immigration status may be concerned that seeking services or confirming HIV-positive status will result in deportation, loss of employment, or other legal problems. These men may be unaware of available services or might not understand that they may be eligible to receive services. Anecdotal information indicate there is distrust of medical systems and fear that information collected in medical settings will be shared with other government agencies. Moreover, stigma related to HIV and homosexuality is common in many traditional families, communities, and religious institutions.

Given the complex socio-cultural barriers that exist for B/AA and Hispanic/Latinx MSM, traditional HIV-focused CBO-based HIV testing services may not reach them. Indeed, as the number of new HIV diagnoses have declined by 26 percent from 2016 to 2018, the positivity rate in focused HIV testing programs has declined below 1 percent in some regions of San Diego County. Positivity rates well below 1 percent means that testing agencies will fall short of CDPH's funding requirement of 1 percent positivity even as prevention efforts become more successful. Routinizing HIV testing across a broader cross-section of primary care providers and clinical settings will free up testing resources for more culturally targeted strategies. While the County of San Diego has been able to work with several FQHCs to implement routine HIV testing as a component of primary care, there are still some that have not implemented this federal and local best practice. More incentives are needed for some FQHCs to make this transition.

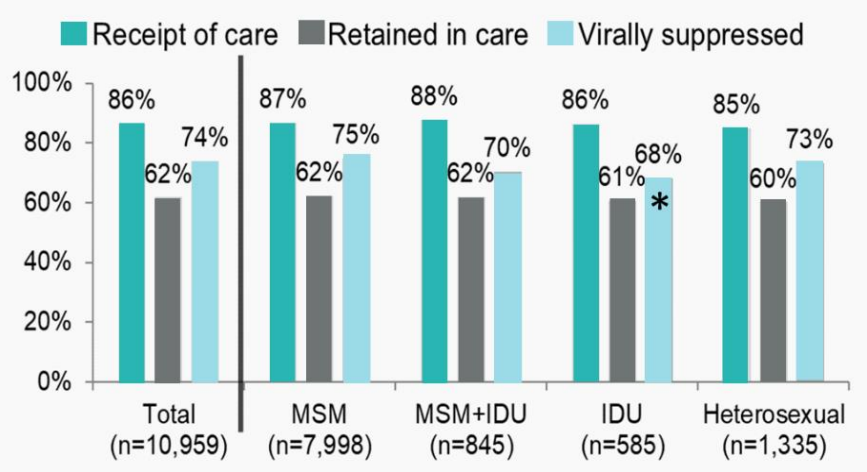
Treat

B/AA communities are not experiencing the benefits of treatment equal to the successes seen by other groups, particularly regarding retention in care and viral suppression. According to 2018 continuum of care data, 71.5 percent of all PLWH were engaged in care and 60.4 percent were virally suppressed. B/AAs were substantially less likely than other groups to be engaged in care (-6.5 percent) and achieve viral suppression (-12.4).[5] For B/AA MSM, racism, discrimination, and trauma create barriers to accessing services and the stigma that is associated with same-sex sexual behavior in many segments of B/AA communities creates further impediments to acknowledging risk. Moreover, a history of disenfranchisement, marginalization, and health inequity lead to low self-efficacy and low levels of health literacy that can impede the ability of these men to seek or receive accurate health information and services.[31]

According to 2018 data, Hispanic/Latinx PLWH were also somewhat less likely to be engaged in care compared with other groups (-0.8).[5] Community engagement data suggest that Hispanic/Latinx PLWH are undercounted. Studies of Hispanic/Latinx MSM show that they are more likely to report concerns about loss of familial support or basic needs such as housing or employment if members of the community become aware of their risk for HIV or their sexual behavior. They may be less likely to access services in agencies that are LGBTQ+-centered,

opting for services that are more family-centered. As a result, they often do not access medical services until they are sick, delaying early diagnosis of HIV. Hispanic/Latinx MSM also experience language and/or cultural barriers. They may be monolingual Spanish-speaking or prefer to receive health information in Spanish. Ensuring bilingual and culturally responsive services is challenging, given that the entire service delivery system in San Diego County is challenged to recruit bilingual and culturally proficient staff. Concerns regarding confidentiality translate into not disclosing risk information to service providers, and as a result, Hispanic/Latinx MSM may not receive services that address their needs.

Exhibit 19. Continuum of Care Outcomes by Population



When the San Diego County's HIV surveillance data is analyzed after application of HRSAs method for de-duplicating reported cases, the data indicate that PWID do not achieve viral suppression at rates seen by other transmission categories, and this difference is statistically significant (**Exhibit 19)**. Further, an environmental scan of PWID conducted by the County of San Diego indicated several areas for potential improvements, including increased testing, increased support for life-saving supplies (naloxone, fentanyl test strips), and increased support for linkage to services.

PWID have multiple barriers to care including distrust of the healthcare system. This population has not been prioritized for HIV prevention services in many years and is considered underserved in San Diego. San Diego County is developing a policy initiative focusing on PWID to increase their access to harm reduction education, HIV/STI/HCV testing, and case management. In San Diego County, approximately 13 percent of persons living with HIV are PWID or MSM and PWID.[5] In addition, California has long been struggling with the parallel epidemics of opiates and crystal methamphetamine use. These epidemics also overlap with the STI risks[33] for MSM.

Community engagement efforts also suggest that the complicated safety net of payers and services is a barrier to maintaining care. The benefits landscape in California has changed substantially since the implementation of the Affordable Care Act. With the addition of numerous program augmentations designed to expand the safety net for persons living with or vulnerable to HIV, there are now a myriad of sometimes intersecting programs. While these developments are positive in that they further buttress the safety net, navigating these complicated systems has become more challenging and has inadvertently created a disincentive for clients who are not able to successfully navigate these systems on their own. As a result, persons living with or vulnerable to HIV are not able to access the care and benefits they need, thus decreasing the access to and success of ART or PrEP.

Prevent

In 2018, there were 379 new HIV diagnoses in San Diego, the lowest number reported since 1984. From 2011 to 2018, there was a 30 percent decrease in new HIV diagnoses community wide with white MSM seeing some of the steepest declines. However, local epidemiology indicates that Black and Hispanic/Latinx MSM face disproportionate vulnerability to HIV. Among new diagnoses during the period of 2014 to 2018, B/AAs accounted for 11.8 percent of new diagnoses, but as a group B/AAs make up only 5.5 percent of San Diego County's population.[29] Similarly, Hispanic/Latinx comprise 44.1 percent of new diagnoses, but as a group make up 34.1 percent of the county's population.[29]

In 2018, transgender persons made up 2.6 percent of new HIV diagnoses and 1.3 percent of all persons living with diagnosed HIV.[5] While these numbers are comparatively small, community engagement efforts and past programs dedicated to serving the transgender community suggest that this population is at elevated risk. Transgender people experience multiple systems barriers to care and, due to a lack of data specifically on transgender health and HIV, are likely under-represented in local epidemiological data. This lack of data hampers the county's ability to understand and address their needs. For instance, there are not currently accepted size estimates for the transgender population. Using a methodology devised by the Williams Institute at the University of California, Los Angeles[34] that estimated that transgender persons account for 0.76 percent of the population in California, there is an estimated 19,073 to 24,993 transgender persons living in San Diego County. Another data challenge is that transgender status is not collected in a uniform manner across all health care and government systems, and in many cases, it is not collected at all. As a result, there are no reliable estimates of number of persons living with HIV who are transgender in San Diego County. The county and the HPG obtained the input of trans persons in the 2017 Community Survey of HIV Impact. The results must be interpreted with caution, as there were only 30 survey respondents who indicated they were transgender, all of whom reported living with HIV. However, the data point to the need to further engage this population to ensure that service planning and delivery incorporates their needs. Over half of the respondents indicated multiple sexual partners during the prior 12 months. Respondents indicated that the Internet, coupled with smart phone apps, were the primary method used to connect to sexual partners. Almost one-third of respondents indicated not disclosing their HIV status in sexual networking profiles. Over half of respondents indicated that they sometimes or never disclose their HIV status to sexual partners.[21]

***Exhibit 20*:** 2021 Target and 2018 Estimated PrEP Utilization in San Diego and California

	Total Users	Rate (per 100,000)
California 2021 target	60,000	152
California 2018	27,283	82
San Diego 2018	2,390	87

San Diego is doing better than CA for PrEP utilization[18] as seen in **Exhibit 20**. Beginning in 2015 the county participated in a 3-year CDC-funded demonstration project to improve PrEP utilization for MSM and the transgender persons (Project PrIDE) at high-risk for acquiring HIV. Results from Project PrIDE indicates an ongoing need for a comprehensive approach to health and well-being that includes PrEP as well as other vital resources, particularly gender-responsive and trauma-informed medical care and other services. For all populations, stigma related to sexual activity remains a significant barrier to PrEP. Developing and deploying teams of PrEP champions from the populations of interest, can mitigate the barriers of stigma.

Respond

The importance of surveillance data in understanding and responding to the HIV epidemic has grown substantially during the past five years in San Diego County. While much of the data use has been retrospective (looking at a prior year to identify HIV incidence, receipt of HIV care, and viral suppression), there is a growing need to have access to more real-time data, particularly regarding new HIV diagnoses. Some surveillance enhancements will require considerable resource and technology investments as described in implementing the "black box" process for deduplicating HIV cases across the border with Mexico (see *Plan* section). Some surveillance gaps are complex to solve due to jurisdictional barriers. For example, military bases report communicable disease through military health infrastructure and not the local health department. This is a gap in local data for San Diego that HHSA has been able to mediate through negotiated agreements. Other gaps are low tech, and easier to solve with strategically funded support positions such as improving manual data entry surge capacity to support, for example, transitions from eHARS to CalREDIE as described below.

Finally, while HIV clusters are rare in San Diego County, the county works closely with the State HIV Surveillance Branch on all aspects of HIV reporting activities and has a plan for collaboration on cluster investigations involving San Diego County cases should they occur. San Diego's surveillance team has developed supportive and reciprocal relationships with teams in neighboring counties to address cross-jurisdictional matters.

Summary of Resources and Gaps

Resources and Assets

Exhibit 21 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance EtHE planning and implementation. For example, San Diego has begun to use data more effectively by publishing STI hotspot data to allow for better planning and implementation of data-to-care activities. PrEP utilization is above state averages, thanks in part to the implementation of Project PrIDE, other demonstration projects and CDC PS 12-1201 and PS 18-1802. The county is looking to build on this success through the development of an ongoing PrEP collaborative to support frontline workers and problem-solve barriers to PrEP uptake. In addition, the county has completed a community scan to assess the needs of PWID, which will inform the expansion of wrap-around services for people vulnerable to and living with HIV that are also substance users. Lastly, HHSA is well-practiced in the community engagement strategies that are core to EtHE.

Exhibit 21: San Diego County Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Good to Go Clinic- Sex positive serving MSM and Transgender Women	●			
STI Heat Maps- deploy targeted HIV testing	●			
Capacity for early HIV diagnoses		●		
Same day ART adopted by most providers		●		
Ryan White clinic viral suppression rates		●		
Project PrIDE, demonstration projects and CDC funded programs			●	
Decreasing HIV infections			●	
CalREDIE for HIV data				●
Cross-Pillar				
• **Political will** exists with Board of Supervisors supporting the Getting to Zero Initiative • **HIV Planning Group** is engaged, promoting diverse community participation • **Public health staff** are skilled and diverse • **Strong foundation for community engagement** established with the past two Getting to Zero Summits • **Tribal communities** in San Diego County have resources and infrastructure for collaboration				

Good to Go Clinic. Providing sex positive services for MSM (cis and trans) and transgender women. This is a University of California at San Diego program established in 2018 and is intended to encourage younger, sexually active individuals to have regular sexual health checks-ups for STI's and HIV. The clinic features "the total test," which combines the latest tests for conditions such as gonorrhea, chlamydia and syphilis, hepatitis B and C with testing for HIV. All testing is free to participants. The program is funded by a grant from the National Institutes of Health.[35]

STI Heat Maps. HHSA publishes STI heat maps highlighting STI incidence geographically to allow providers to deploy targeted HIV testing resources.

Capacity for early HIV diagnosis. The county is engaged in an ongoing technical assistance effort to build the capacity of providers to identify those at the earliest stage of HIV infection. As early infection is also the time when HIV is most transmissible, this strategy will be important to achieving continuing declines in HIV incidence.

Same day ART. San Diego stands out in its capacity to deliver same day ART. Many of the key providers of HIV testing have adopted the goal of linking newly diagnosed individuals to HIV primary care within one week of diagnosis, and ideally on the same day. From January 2017 through July 2018, almost eight out of ten individuals newly diagnosed with HIV were linked to care within 30 days, and almost 9 out of 10 were linked to care within 90 days. The effort to adopt same day ART services began as part of the CDPH Strategic HIV Prevention Project and was then taken up as a quality improvement project overseen by the Ryan White Clinical Quality Management Committee.

Ryan White clinic viral suppression rates. In 2018 HHSA reported that the average viral suppression among Ryan White clinics was 91 percent. By comparison, community-level viral suppression was 63 percent.

Project PrIDE. A three-year demonstration project that increased PrEP usage. (see *Situational Analysis, Prevent,* page 27 for a more detailed description of this program).

Decreasing HIV infections. As stated in the data presented above**,** the 379 diagnoses in 2018 in San Diego County represented the lowest number since 1984, which was a significant success. New diagnoses have been falling each year since 2015. The County of San Diego's EtHE plan focuses on increasing and maintaining viral suppression and PrEP access to populations experiencing HIV related health disparities, which will in turn lead to a decrease in HIV infections.

CalREDIE for HIV data. The California Reportable Disease Information Exchange (CalREDIE) is a secure system that the CDPH has implemented for electronic disease reporting and surveillance.[36] Today, all 61 Local Health Departments (LHDs) in California use CalREDIE in some capacity, but not all local health jurisdictions (LHJ's) use the system for surveillance of all notifiable communicable diseases. LHJs and CDPH have access to disease and laboratory reports in near real-time for disease surveillance, public health investigation, and case management activities. San Diego County already uses CalREDIE for data collection and reporting for sexually transmitted infections (STIs) other than HIV. San Diego is poised to begin using the CalREDIE system for HIV data collection in 2020, which will improve the ability to implement data-to-care efforts as a strategy to improve linkage rates and re-engagement in care.

Political Will. On March 1, 2016, the County of San Diego's Board of Supervisors adopted the Getting to Zero Initiative. Support of Ending the HIV Epidemic (EtHE) activities at this level represents an opportunity to implement new interventions along the full range of the HIV continuum including healthier policies. This initiative includes five overlapping strategies: Test, Treat, Prevent, Engage, and Improve. In addition, the county is developing a major policy initiative to expand services to PWID. San Diego County does not currently sanction syringe services programs (SSP); however, there is a FQHC in the City of San Diego that has a City sanctioned SSP and the San Diego Harm Reduction Coalition has applied to set up another SSP in the City of San Diego. These efforts are a critical step to building the capacity and collect the data needed to increase political will to support eventual SSPs Countywide.

Planning Council. The CDC 19-1906 project guidance cites "planning council engagement" as a key step to accelerating the progress toward EtHE. The San Diego HPG is engaged and actively focused on discussing issues that will be key to EtHE. HPG leadership would like to use the accelerated EtHE planning year to promote consumer involvement in activities that will

improve services and recruit new voices to the planning table. HPG leadership envisions using the current committee structure to organize general community engagement and to be a hub of recruitment and data collection activities linked to EtHE planning.

Public Health Staff. Public health staff are partnering with the HPG to develop and implement leadership training and focus groups with the aim of expanding the capacity of the HPG to gain input for new and critical voices for EtHE planning. Leadership within HHSA is highly skilled, diverse, and actively engaged in EtHE planning along the spectrum of services that have impacted key indicators of the epidemic for all groups. The public health staff are a resource to help draft, refine, and support evidence-based health policy to the San Diego County Board of Supervisors, and as a result, the county has grown healthier and more able to respond to the HIV epidemic overall.

Strong Foundation for Community Engagement. The first ever (November 2018) Getting to Zero Summit (GTZ) in San Diego County was attended by over 130 individuals including approximately 40 consumers. This forum represents the gold standard for what is hoped for in the EtHE 19-1906 planning year. A second GTZ Summit (February 2020) with over 100 consumers helped to focus and inform EtHE goals for PrEP and linkage to care. The COVID-19 pandemic and response has altered what can be done in face-to-face methods of community engagement. Therefore, the intention is to continue to engage the community through a series of telephone or other remote key informant/stakeholder interviews.

Tribal Communities. In San Diego there are 18 recognized Native American tribes. There are health centers co-located in tribal areas. Current funding for these health centers is approximately $25 million.[10] These health centers are a formidable resource but they need technical assistance to improve and increase HIV prevention, care, and surveillance activities.[10] The County of San Diego health department is a logical entity to provide this technical assistance, but will require technical assistance of its own to expand these partnerships.

Gaps and Challenges

San Diego County has several pillar-specific and cross-pillar challenges and gaps that will need to be addressed to reach EtHE goals. For example, while the county has been able to work with several FQHCs to implement routine HIV testing as a component of primary care, there are still some that have not implemented this federal and local recommendation. Rapid ART is a hallmark of care in San Diego for most populations, but incarcerated persons are still not able to receive medication immediately upon entry. Given the overlap of substance use and incarceration, lack of rapid access to ART in jail may be contributing to the lower viral suppression rates among detained people living with or vulnerable to HIV, particularly PWID. The county has made great strides in implementing data-to-care but gaps in capacity for manual data entry still exist. While PrEP uptake in San Diego has been a success relative to many other California counties, long-term maintenance on PrEP by some clients has been challenging and there is still a lag in uptake and persistence among key populations such as B/AA and Hispanic/Latinx MSM.

Exhibit 22: San Diego County Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
By Pillar				
Low volume of routine testing in non-HIV clinical settings	●			
Gaps in HIV treatment for incarcerated populations		●		
Disparities in viral suppression rates for PWID		●		
No County-wide SSP services			●	
PrEP Barriers			●	
Increasing STIs			●	
Manual data entry needs for surveillance data				●
Incomplete surveillance data				●
Cross-Pillar				
• Social determinants of health • Bi-border issues • Lack of community building/community organizing infrastructure • Geographic and regulatory complexity • Military organizations • Language barriers • Involvement of new and younger voices in planning				

Low routine testing in non-HIV clinical settings. HIV testing should be routine like any other chronic diseases (i.e., diabetes, hypertension). Many providers have adopted HIV testing in routine/wellness check exams. Increasing routine testing in all HIV clinical settings, particularly in the emergency departments of the large healthcare systems, will save vital resources for a more focused testing effort on EtHE focus populations. By providing funding to support this transition, the County of San Diego will be able to increase the number of providers who have implemented this recommendation.

Incarcerated Populations. The county detention facilities do not give HIV medication upon entry and there is often a delay of up to two weeks. The amount of time it takes depends on the facility (there are 7 detention facilities in San Diego), on whether the person has been incarcerated previously, and whether they have a medical record showing prior medications taken. If the person has not been previously incarcerated, they must first be seen by the Sheriff's Medical Unit before beginning any medication regimen.

Disparities in viral suppression rates for PWID. PWID are connecting to care at rates comparable to other groups but are not realizing the same viral suppression outcomes. HIV testing in this population is also low for San Diego County.[37]

Lack of County-wide SSP Services. The County Board of Supervisors does not currently sanction syringe services. However, the Board of Supervisors has recently revisited this position and is reviewing data to guide future action.

PrEP Barriers. PrEP has been most successfully deployed to white MSM populations. Addressing barriers particular to certain other populations may make it more accessible to those who need it. The following approaches have been discussed[10] to reduce barriers to PrEP:

- Do not make screening a barrier: if a person is asking for PrEP, they need it.
- Provide PrEP or linkage to PrEP in substance use treatment settings.
- Develop culturally specific PrEP marketing, such as including images of people of color and multi-lingual messaging (especially Spanish).
- Using peer PrEP navigators as intermediaries to clinics and pharmacies.
- Provide same-day PrEP without waiting for insurance enrollment/approvals.
- Address ongoing Medi-Cal cuts to small pharmacies, which limit implementation of and access to PrEP.

Incomplete Surveillance Data. San Diego may be closer to viral suppression goals than the current surveillance data indicate. Some people living with HIV are classified as “out of care” even when many may be in care, due to the lag time in data processing. There is a need for a central repository that San Diego and Tijuana could use to identify and clean duplicate reports using what is called “Black Box” technology,[38] in which cases are de-duplicated without either jurisdiction having direct access to the other’s data. There is a need to deduplicate HIV cases without clients being made ineligible for treatment in the U.S.

HIV Messaging. Some people do not respond to the “standard” or traditional HIV messaging used in previous efforts. Messaging is not a “one size fits all” endeavor; population-specific messages are needed. If messages and campaigns are not developed for the populations with a cultural lens, large segments of the population will not see the messages as relevant to them. One example is lower uptake of PrEP among people of color, which calls for developing campaigns tailored to B/AA and Hispanic/Latinx MSM. While previous campaigns did contain images of B/AA and Hispanic/Latinx there were issues such as level of acculturation and regional placement of appropriate images. An example of “what not to do” cited at a community meeting[10] described an English language advertisement for PrEP on a billboard placed in a predominately Spanish-speaking Hispanic/Latinx community in San Diego.

Social Determinants of Health. Racism, discrimination, trauma, and the stigma associated with same-sex sexual behavior and substance use particularly for PWID and disclosing this behavior or acknowledging its risk, all create barriers for accessing services. This affects a myriad of health-seeking behaviors for B/AA and Hispanic/Latinx MSM, transgender people, PWID, and other populations vulnerable to and living with HIV. This is then reflected in disparities in HIV incidence and other health outcomes. For example, while 11.8 percent of newly diagnosed cases in 2014 – 2018 were among B/AAs, this group constitutes only 5 percent of the population in the county, demonstrating the disproportionate burden of HIV in this community. Likewise, Hispanic/Latinx persons make up 34 percent of the population yet

comprise 44 percent of those newly diagnosed. Transgender people represent 2 percent of new diagnoses and just over 1 percent of persons living with HIV.

Bi-Border Issues. HIV does not discriminate by geography. An estimated 60 million north-bound crossings every year occur from Mexico into San Diego County. The fluidity of movement across the border means that functionally San Diego and Tijuana are really one health jurisdiction of 5 million people. Without HIV surveillance data for those living on the other side of the border, the county's surveillance data for almost half of this health jurisdiction is incomplete. Additionally, due to San Diego's proximity to the border, there is a sizeable population that does not have legal documentation for U.S. residency, creating unique challenges in accessing care and therefore a likely driving force in health disparities. Hispanic/Latinx MSM may be living in the U.S. with undocumented status and be concerned that seeking services will result in deportation, loss of employment or other legal problems. These men may be unaware of available services or not understand that they may be eligible to receive services without fear of being deported.

Lack of Community Building/Community Organizing Infrastructure. There is a need to have substantive and impactful community engagement, particularly from those priority populations who have not seen the benefits of a generally descending incident HIV infection curve. Resources and staffing currently are too overextended to meaningfully increase the public health department's use of a community building/community organizing model. These activities should not be about checking a box but rather should be participatory with the communities most impacted and implemented for the long-term (not just in this EtHE planning year). This will require additional dedicated staff and resources. Another benefit of engaging in this work is the opportunity to develop a workforce pipeline whereby people from affected communities can receive education, training, and support to move into public health careers, thus helping to strengthen the county's health workforce infrastructure.

Geographic and Regulatory Complexity. As described earlier, San Diego County is a complex web of urban, suburban and rural communities; tribal reservations; and military installations. The border crossings between Mexico and San Diego County add to its geographic and regulatory complexity. With such diversity, it is a major challenge to create HIV prevention, care, and treatment approaches that are tailored to the myriad of different needs, not to mention the sheer volume of services that would be required to fully address HIV in the county. In addition, there is frequent migration between residents of San Diego County and the neighboring counties of Orange, Riverside, and Imperial. This can cause difficulty in maintaining up-to-date surveillance data and pose a problem for residents during the Medi-Cal insurance re-enrollment process. The Enhanced HIV/AIDS Reporting System (eHARS) does not capture the actual numbers of PLWH in the county if they were initially reported in another jurisdiction, but then moved to San Diego County. This creates a gap in the data, yielding an incomplete picture of the epidemic and limiting the scope of knowledge required to develop appropriate interventions. For clients, Medi-Cal regulations pose additional barriers because they must reenroll each time they move to another county.

Military Organizations. San Diego is home to the largest number of active duty personnel in the nation and has a large concentration of retired military personnel. Currently cases of HIV are not required to be reported to the State or the local health department from military bases, and instead are required to be reported to the Department of Defense, contributing to an incomplete understanding of the county's HIV epidemic. There are 10 military installations in San Diego

County. A single base can house over 20,000 individuals and a base composition can shift radically from year to year due to student and recruit training.

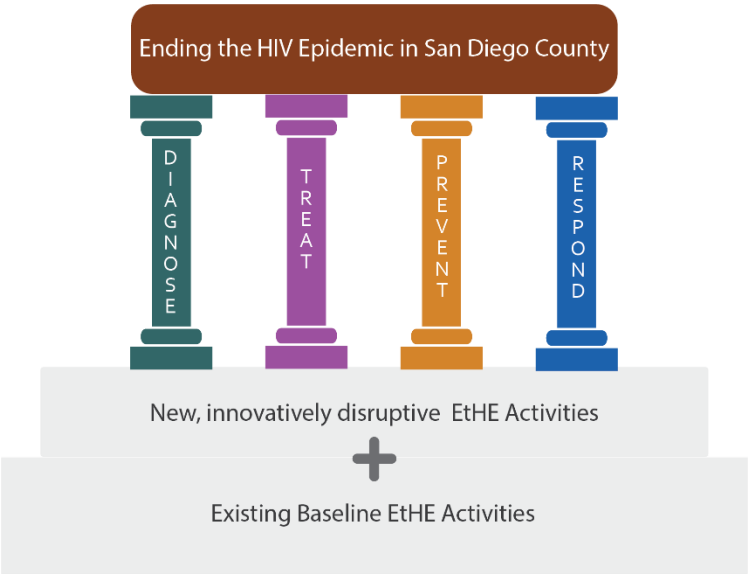
Language Barriers. As discussed earlier, Hispanic/Latinx are affected by language and/or cultural barriers to accessing and engaging in services (see *Situational Analysis, Key Populations* for a more detailed description of this issue).

Involvement of new and younger voices in planning. Community engagement efforts highlight the need for new and younger voices at the planning table.[15]

Section IV: Ending the Epidemic Plan

This section provides a detailed overview of the disruptively innovative activities that San Diego County will implement to End the HIV Epidemic by 2025. The EtHE activities are above and beyond the foundational efforts and are designed to be directly responsive to the needs and gaps identified in *Section III: Situational Analysis.* The proposed EtHE activities are designed to enhance but not duplicate current programs and services and are inclusive of all disruptively innovative activities, regardless of funding source.

Exhibit 23. Schematic of how new, disruptively innovative EtHE activities in San Diego County will build upon existing efforts to respond to local needs and gaps not sufficiently addressed to date.



EtHE Programs and Key Partners

The County of San Diego has identified 12 innovative efforts that will help propel the county toward ending the HIV epidemic. These efforts will require close partnership with several existing as well as new partners to be successful. The programs and partners are described below.

Summary of Proposed Programs

- **Wrap Around Services for Persons who Inject Drugs.** This activity will provide comprehensive testing (HIV, HCV, STDs), status-neutral health care navigation for PrEP or ART, and linkage to substance use disorder treatment and mental health resources for persons who inject drugs. In San Diego County, persons who inject drugs do not achieve viral suppression at the same high rates seen by other transmission groups; early diagnosis and linkage to substance use disorder treatment and mental health resources will help to increase viral suppression in this population. *(Relevant pillar(s): Diagnose, Treat, Prevent)*

- **Peer-based Mobile PrEP.** This activity will recruit Black and Hispanic/Latinx MSM and transgender persons who are currently utilizing PrEP to become PrEP champions to support outreach and education efforts connected with mobile PrEP clinics. The mobile clinics will provide PrEP-related medical evaluation, including comprehensive testing (HIV, HCV, STDs and safety labs), ongoing PrEP medical care, linkage to Benefits Navigation, and prescriptions for PrEP. Previous work indicates that Black and Hispanic/Latinx MSM face disproportionate vulnerability to HIV, and transgender

persons have an ongoing need for gender-responsive and trauma-informed medical care and other services. For all groups, stigma related to sexual and substance use activity remains a significant barrier to PrEP. Developing and deploying teams of PrEP champions from the populations of interest will help to mitigate stigma as a barrier. *(Relevant pillar(s): Diagnose, Prevent)*

- **Routine HIV Testing Implementation Grants.** San Diego County will provide competitive start-up grants for local community health centers and other non-profit health care providers to implement routine HIV testing in primary care, urgent care and emergency departments. The recent declines in new HIV diagnoses requires a move from focused to routine HIV testing as a component of primary care. By providing funding to support this transition, the County of San Diego will be able to increase the number of providers who have implemented this recommendation. *(Relevant pillar(s): Diagnose)*

- **Benefits Navigation.** This activity will provide trained benefits counselors who can help clients enroll in necessary benefits programs, including Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs, etc. Since the implementation of the Affordable Care Act, navigating complicated benefit systems has become more challenging for clients. Through this intervention, the County of San Diego seeks to ensure that there are highly trained navigators who can provide the enrollment assistance necessary to ensure that clients are able to access all benefits program for which they are eligible, increasing the likelihood of success accessing and maintaining use of PrEP or ART. (*Relevant pillar(s): Diagnose, Treat, Prevent)*

- **Getting to Zero App and Resource Guide.** Develop a mobile application that provides information and resources regarding medical and support services for persons living with or vulnerable to HIV. Once developed, conduct ongoing maintenance of all resources and information to ensure that it remains up-to-date, comprehensive, and accurate. Create printed versions of the resource guide, as well, to ensure accessibility by a large proportion of the residents of San Diego County. Creating a mobile application guidebook would serve the residents of and visitors to the county by creating an easy means of finding information and providers. *(Relevant pillar(s): Diagnose, Treat, Prevent)*

- **Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee.** This activity will provide additional staff support to the HIV Planning Group to augment the group's ability to effectively plan for and evaluate HIV prevention efforts in alignment with the County of San Diego's Getting to Zero initiative and the federal Ending the HIV Epidemic initiative. *(Relevant pillar(s): Diagnose, Treat, Prevent, Respond)*

- **Surveillance Program Improvements.** Increase the ability of the County of San Diego's HIV Epidemiology Surveillance Program to detect potential HIV clusters and ensure prompt response by the HIV, STD and Hepatitis Branch and its contracted providers. The importance of surveillance data in understanding and responding to the HIV epidemic has grown substantially during the past five years in San Diego County. There is a growing need to have access to more real-time data, particularly regarding new HIV diagnoses. The primary obstacle is the frequent need for manual data entry of

surveillance data which slows down the completeness of the data. This program will support a position that will ensure that all manual data entry occurs promptly. *(Relevant pillar(s): Respond)*

- **Intensifying *community engagement*** activities, including community forums, education and outreach, and leadership and mentorship training. *(Relevant pillar: Treat)*
- **Establishing *alternative forms of HIV medical care***, namely drop-in clinics to create options for persons who have not been successfully retained in more conventional forms of medical care. *(Relevant pillar: Treat)*
- **Establishing *molecular epidemiology***, including a substantial community readiness and education effort, to interrupt high-transmission clusters of HIV, reduce new infections and ensure that persons living with undiagnosed HIV can be identified and linked to care and other support services. *(Relevant pillar(s): Treat, Respond)*
- A San Diego CFAR project led by Dr. Davey Smith entitled **TRANS(ending) the HIV Epidemic: Planning a Mobilized Community-delivered Response with Transgender persons at High Risk for HIV Transmission.** No CDC PS 20-2010 funding was allocated to this project. *(Relevant pillar(s): Diagnose, Treat, Prevent, Respond)*
- **CHIPTS CFAR Project: Regional Response to HIV Eradication Efforts in Southern CA Counties.** San Diego County is participating, along with Los Angeles, Orange, Riverside, and San Bernardino Counties, in a CHIPTS CFR study led by Dr. Stephen Shoptaw titled *Regional Response to HIV Eradication Efforts in Southern CA Counties.*[9] No CDC PS 20-2010 funding was allocated to this project*. (Relevant pillar(s): Diagnose, Treat, Prevent, Respond)*

Key Partners

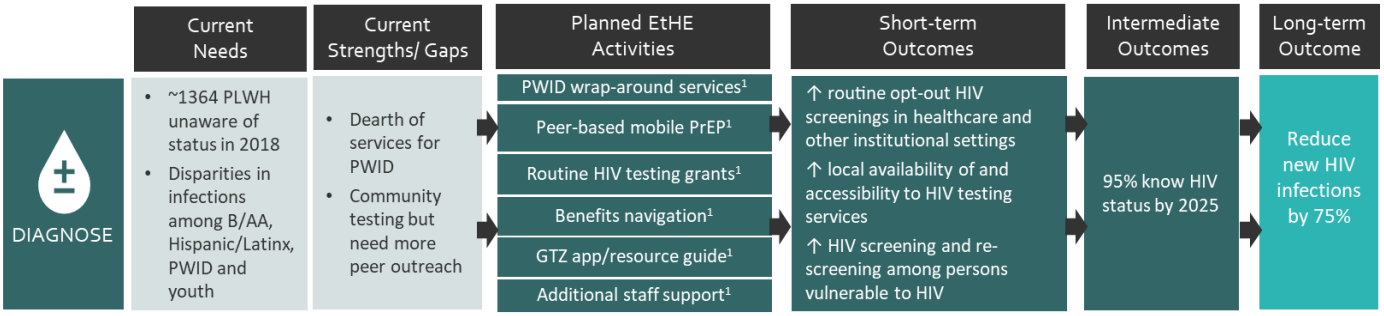
The County of San Diego will work with key partners to complete these proposed programs, including organizations serving young MSM of color, those working with PWID, and those with particular technical expertise. These include:

- **Clinic Staff and Administrators.** Staff and administrators at clinic partners that are the recipients of Routine HIV Testing Implementation Grants will allow San Diego County to increase the number of Federally Qualified Health Center Clinics and other non-profit health care systems providing routine, opt-out HIV testing.
- **Tijuana and San Diego Service Providers.** Service providers on both sides of the Mexico/U.S. border may see some of the same patients. Enabling them to share surveillance and testing information will allow us to better identify and deploy resources, as well as maintain services for individuals receiving care on both sides of the border.
- **Consumers with and those vulnerable to contracting HIV.** Current PrEP consumers, especially those of color or who are transgender, will be recruited as PrEP Champions to encourage and recruit their peers to use testing and other prevention and support services.
- **Tijuana, San Diego, and California governmental liaisons.** Work with local and state governmental liaisons on both sides of the border to facilitate the proposed projects.

- **CDPH Office of Binational Border Health.** The Office of Binational Border health facilitates communication, coordination, and collaboration among California and Mexico health officials, health professionals, and communities in order to optimize binational and border health.
- **Family Health Centers of San Diego (FHCSD) and San Diego Harm Reduction Coalition.** Family Health Centers operate the SSP in the City of San Diego, currently the only sanctioned SSP in the City of San Diego. The San Diego Harm Reduction Coalition has applied to CDPH to establish additional SSP sites. FHCSD long and successful work with PWID will be a key to engaging this population.

San Diego County's Plan to End the HIV Epidemic

Diagnose



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Wrap Around Services for Persons who Inject Drugs**
- **Peer-based Mobile PrEP**
- **Routine HIV Testing Implementation Grants**
- **Benefits Navigation**
- **Getting to Zero App and Resource Guide**
- **Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee**

Diagnose: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities	
Routine HIV Testing Implementation Grants	
• Provide competitive **start-up grants** for local community health centers and other non-profit health care **providers to implement routine HIV testing in primary care, urgent care and emergency departments**. • The funding would pay for any needed revisions to electronic health record systems, training for all staff, educational materials for clients, funding for unfunded (uninsured) tests, and funding for linkage to care for clients who are diagnosed with HIV.	• Implement programs and monitor grantees. • Support grantees to develop sustainability grants. • Conduct additional grant cycles.
Benefits Navigation	
• Hire benefits counselors. • Train benefits counselors **to increase availability of testing services,** ability to rapidly link clients to PrEP or ART, and ability to rapidly re-engage persons not engaged from care. • Help clients enroll in necessary benefits programs, including Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs, etc.	• Continue benefits navigation.
Strategy 1B. Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings	
Wrap Around Services for People Who Inject Drugs	
• Develop a plan to **provide comprehensive testing (HIV, HCV, STDs),** status-neutral health care navigation for PrEP or ART, and linkage to substance use treatment and mental health resources for persons who inject drugs. • Pilot test and evaluate intervention components. • Scale up successful efforts.	• Continue to implement and evaluate services.
Peer-based Mobile PrEP	
• Recruit and hire Black and Hispanic/Latinx MSM and transgender persons who are currently utilizing PrEP to become **PrEP champions to support outreach and education efforts** connected with mobile PrEP clinics. • Provide **PrEP-related medical evaluation, including comprehensive testing** (HIV, HCV, STDs and safety labs), ongoing PrEP medical care, linkage to Benefits Navigation, and prescriptions for PrEP via mobile clinics.	• Continue providing services and expand peer champion model.
Getting to Zero App and Resource Guide	
• Develop a **mobile application to increase knowledge** among persons living with or vulnerable to HIV in San Diego County **of availability and accessibility of HIV testing**	• Continue to publicize the app and distribute up-to-date printed guides.

Diagnose: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
services, ART and PrEP resources, and support services. • Pilot test the app. • Publicize the app. • Create and distribute printed versions of the resource guide to ensure accessibility by a large proportion of residents.	• Conduct ongoing maintenance of all resources and information to ensure that it remains up-to-date, comprehensive, and accurate.
Strategy 1A. Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities **Strategy 1B.** Develop locally-tailored HIV testing programs to reach persons in non-healthcare settings **Strategy 1C.** Increase at least yearly re-screening of persons vulnerable for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings	
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee	
• Provide additional staff support to the HIV Planning Group to augment the group's ability to effectively **plan for and evaluate HIV testing efforts** in alignment with the County of San Diego's Getting to Zero initiative and the federal Ending the HIV Epidemic initiative.	• Continue to expand staff support by funding one additional staff person each year to support planning, implementation, evaluation, research, and administrative activities.

HIV Workforce Development Needs

Positions

- **Testing and Linkage Staff.** These contracted personnel will perform comprehensive testing, status-neutral linkage to care, and linkage to mental health and substance use disorder services.
- **PrEP Champions.** These specially trained persons who are currently utilizing PrEP will support outreach and education efforts at mobile PrEP clinics, including comprehensive testing.
- **Medical Staff.** These providers will be responsible for providing gender-responsive and trauma-informed medical care at the mobile clinics.
- **Benefits Navigators.** These trained benefits counselors will help clients enroll in necessary benefits programs.
- **Mobile Application Developer.** The mobile application developer will be responsible for creating and maintaining the Getting to Zero App, to increase knowledge of availability and accessibility of HIV testing services, ART and PrEP resources, and support services among persons living with or vulnerable to HIV.
- **Health Information Specialist.** Provides administrative support, research, analysis, evaluation, and recommendations to the HIV Planning Group to augment the group's ability to effectively plan for and evaluate HIV prevention efforts.

- **Benefits Training.** Ongoing benefits training for Navigators and other staff will ensure that the information they provide is continually up-to-date despite the rapidly changing benefits landscape. This will enable clients to receive testing and other necessary services promptly and regularly.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, San Diego County will make special efforts to recruit workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase capacity to reach these priority populations.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Clinic Staff and Administrators**
- **Tijuana and San Diego Service Providers**
- **Consumers with and those vulnerable to contracting HIV**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Wrap Around Services for PWID	$1,938,734	CDC PS20-2010
Peer-based Mobile PrEP		
Routine HIV Testing Implementation Grants		
Benefits Navigation		
Getting to Zero App and Resource Guide		
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee		
TOTAL FUNDING FOR DIAGNOSE PILLAR*	$1,938,734	

*$0 exclusively for Test Pillar, and $1,938,734 for programs that cut across test and other pillars.

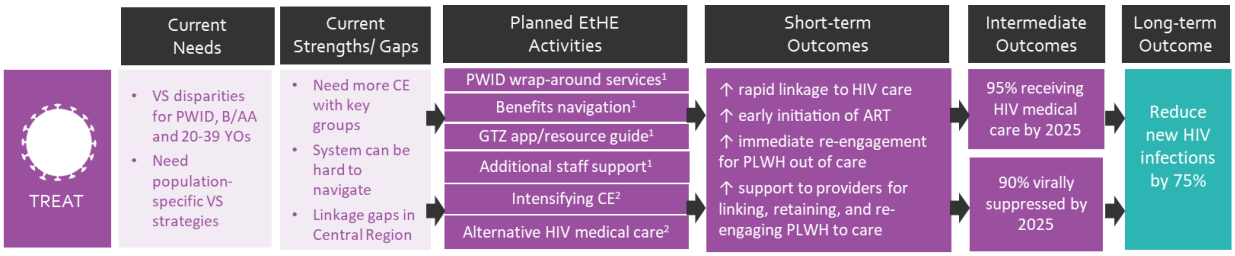
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan (EPMP).[32] Targets will be determined in coordination with CDC as the EPMP is finalized.

Diagnose: San Diego County	
Outcome Measure	**Data Source**
Percent of health care facilities that are identified as priority for routine opt-out HIV screening*	Monthly progress reports
Percent of HIV tests that are conducted in healthcare facilities identified as a priority for the EHE testing services*	Monthly progress reports, Local Evaluation Online (LEO) for positive diagnoses
Number of "champions" or key staff leading activities to routinize HIV screening at intake per project year*	Monthly progress reports
Number of non-traditional venues conducting HIV testing†	Records of HIV testing events
Percent of HIV tests that are conducted in non-traditional venues identified as a priority for the EHE testing services†	Records of HIV testing events
Number of HIV self-test kits distribution locations planned†	Records of HIV self-test kits distribution events
Number of locations where HIV testing is bundled with screening for other conditions relevant to the local population†	Records of HIV testing and medical screening events
Incorporate strategies to rapidly link persons to HIV medical care and prevention (i.e., PrEP and SSP) in all non-traditional settings†	Documentation of strategies utilized
Percent of all persons tested in non-traditional test settings that are linked to medical care within 30 days†	Linkage to care records
Percent of all persons tested in non-traditional test settings that are linked to appropriate prevention services†	Linkage records

*Routine HIV Testing Implementation Grants
†Wrap-Around Services for PWID

Treat



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Proposed Programs and Efforts

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- **Wrap Around Services for Persons who Inject Drugs**
- **Benefits Navigation**
- **Getting to Zero App and Resource Guide**
- **Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee**
- **Intensifying *community engagement***
- **Establishing *alternative forms of HIV medical care***

Treat: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV	
Wrap-Around Services for PWID	
• Develop a plan to provide comprehensive testing (HIV, HCV, STDs), status-neutral **health care navigation for** PrEP or **ART,** and linkage to substance use disorder treatment and mental health resources for persons who inject drugs. • Pilot test and evaluate intervention components. • Scale up successful efforts.	• Continue to implement and evaluate services.
Getting to Zero App and Resource Guide	
• Develop a **mobile application to increase knowledge** among persons living with or vulnerable to HIV in SDC **of availability and accessibility of** HIV testing services, **ART** and PrEP **resources,** and support services. • Pilot test the app. • Publicize the app.	• Continue to publicize the app and distribute up-to-date printed guides. • Conduct ongoing maintenance of all resources and information to ensure that it remains up-to-date, comprehensive, and accurate.

Treat: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
• Create and distribute printed versions of the resource guide to ensure accessibility by a large proportion of residents.	
Strategy 2A. Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV **Strategy 2B.** Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Program (RWHAP)	
Benefits Navigation	
• Hire benefits counselors. • Train benefits counselors to **increase** availability of testing services**, ability to rapidly link clients to** PrEP or **ART, and ability to rapidly re-engage persons disengaged from care.** • Help clients enroll in necessary benefits programs, including Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs, etc.	• Continue benefits navigation services.
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee	
• Provide additional staff support to the HIV Planning Group to augment the group's ability to effectively **plan for and evaluate linkage to care and ART initiation efforts** in alignment with the County of San Diego's Getting to Zero initiative and the federal Ending the HIV Epidemic initiative.	• Continue to expand staff support by funding one additional staff position each year to support planning, implementation, evaluation, research and administrative activities.
Intensifying community engagement	
• As COVID-19 response allows, ramp up community engagement including community forums, education and outreach through new media. • Also, implement leadership and mentorship training to priority populations, including youth.	• Continue community engagement efforts.
Establishing alternative forms of HIV medical care	
• Evaluate efficacy and feasibility of offering alternative forms of HIV medical care. • Design and pilot services.	• Conduct ongoing evaluation of planning, implementation, and operations of alternative services.

HIV Workforce Development Needs

Positions

- **Testing and Linkage Staff.** These contracted personnel will perform comprehensive testing, status-neutral linkage to care, and linkage to mental health and substance use disorder services.

- **Medical Staff.** These providers will be responsible for providing gender-responsive and trauma-informed medical care at the mobile clinics.
- **Benefits Navigators.** These trained benefits counselors will help clients enroll in necessary benefits programs to help ensure that they are able to access ART and the HIV-related medical care, as well as any other services they need.
- **Mobile Application Developer.** The mobile application developer will be responsible for creating and maintaining the Getting to Zero App to increase knowledge of availability and accessibility of HIV medical care, ART and PrEP resources, and support services among persons living with or vulnerable to HIV.
- **Health Information Specialist.** Provides administrative support, research, analysis, evaluation, and recommendations to the HIV Planning Group to augment the group's ability to effectively plan for and evaluate HIV treatment efforts.
- **Benefits Training.** Ongoing benefits training for Navigators and other staff will ensure that the information they provide is continually up-to-date despite the rapidly changing benefits landscape. This will enable clients to receive HIV medical care, ART, and other necessary services promptly and regularly.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, San Diego County will make special efforts to recruit a workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Clinic Staff and Administrators**
- **Tijuana and San Diego Service Providers**
- **Tijuana, San Diego, and California governmental liaisons**
- **CDPH Office of Binational Border Health**
- **Consumers with and those at risk of contracting HIV**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Wrap Around Services for Persons who Inject Drugs	$1,938,734	CDC PS20-2010
Benefits Navigation		

Getting to Zero App and Resource Guide		
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee		
Intensifying *community engagement*	$1,000,000	HRSA 20-078
Establishing *alternative forms of HIV medical care*		
TOTAL FUNDING FOR TREAT PILLAR*	$2,938,734	

*$0 exclusively for Treat Pillar, and $2,938,734 for programs that cut across diagnosis and other pillars.

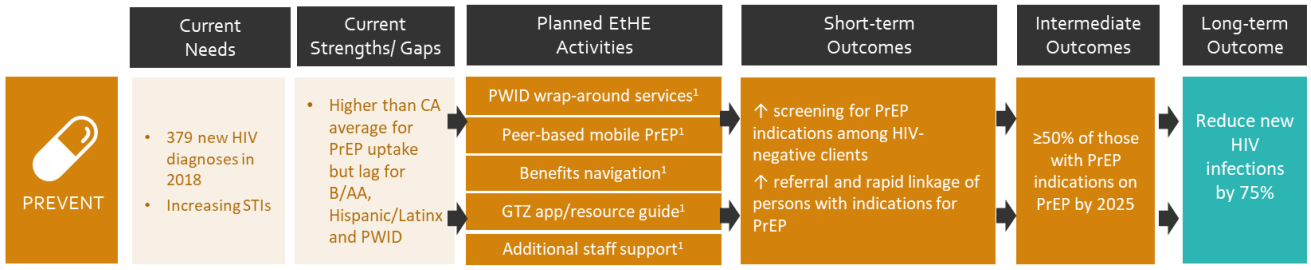
Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[32] Targets will be determined in coordination with CDC as the EPMP is finalized.

Treat: San Diego County	
Outcome Measure	**Data Source**
Percent of all persons with a new HIV diagnosis who receive a rapid assessment.†	
Percent of all persons with assessment conducted who are linked to a disease intervention specialist and/or case manager as needed.†	Linkage records.
Number of clients provided with case management and other support services.†	Case management and support services records.

†Wrap-Around Services for PWID

Prevent



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Wrap Around Services for Persons who Inject Drugs**
- **Peer-based Mobile PrEP**
- **Benefits Navigation**
- **Getting to Zero App and Resource Guide**
- **Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee**

Prevent: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP	
Peer-based Mobile PrEP	
• Recruit and hire Black and Hispanic/Latinx MSM and transgender persons who are currently utilizing PrEP to become PrEP champions to **support outreach and education efforts** connected with mobile PrEP clinics. • Provide **PrEP-related medical evaluation**, including comprehensive testing (HIV, HCV, STDs and safety labs), ongoing **PrEP medical care**, linkage to Benefits Navigation, and **prescriptions for PrEP via mobile clinics.**	• Continue providing services and expand peer champion model.
Benefits Navigation	
• Hire benefits counselors. • Train benefits counselors to **increase** availability of testing services**, ability to rapidly link clients to PrEP** or ART, and ability to rapidly re-engage persons not engaged in care. • Help clients enroll in necessary benefits programs, including Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs, etc.	• Continue benefits navigation services.

Prevent: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
Getting to Zero App and Resource Guide	
• Develop a mobile application to **increase knowledge** among persons living with or vulnerable to HIV in San Diego County **of availability and accessibility of** HIV testing services, ART and **PrEP resources,** and support services. • Pilot test the app. • Publicize the app. • Create and distribute printed versions of the resource guide, to ensure accessibility by a large proportion of residents.	• Continue to publicize the app and distribute up-to-date printed guides. • Conduct ongoing maintenance of all resources and information to ensure that it remains up-to-date, comprehensive, and accurate.
Strategy 3A. Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP use among those with indications for PrEP **Strategy 3B.** Increase availability, use, and access to and quality of comprehensive syringe services programs (SSPs)	
Wrap Around Services for Persons Who Inject Drugs	
• Develop a plan to **provide** comprehensive testing (HIV, HCV, STDs), **status-neutral health care navigation for PrEP** or ART, and linkage to substance use disorder treatment and mental health resources for persons who inject drugs. • Pilot test and evaluate intervention components. • Scale up successful efforts.	• Continue to implement and evaluate services.
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee	
• Provide additional staff support to the HIV Planning Group to augment the group's ability to effectively plan for and evaluate SSP efforts in alignment with the County of San Diego's Getting to Zero initiative and the federal Ending the HIV Epidemic initiative.	• Continue to expand staff support by funding one additional staff person each year to support planning, implementation, evaluation, research, and administrative activities.

HIV Workforce Development Needs

Positions

- **PrEP Champions.** These specially trained persons who are currently utilizing PrEP will support outreach and education efforts at mobile PrEP clinics.
- **Medical Staff.** These staff members will provide PrEP-related medical care at mobile clinics, including evaluation, ongoing PrEP medical care, and prescriptions for PrEP.
- **Benefits Navigators.** These trained benefits counselors will help clients enroll in necessary benefits programs to help ensure that they are able to access the treatment services they need.

- **Testing and Linkage Staff.** These contracted personnel will perform comprehensive testing, status-neutral linkage to care, and linkage to mental health and substance use disorder services.
- **Mobile Application Developer.** The mobile application developer will be responsible for creating and maintaining the Getting to Zero App, to increase knowledge of availability and accessibility of HIV medical care, ART and PrEP resources, and support services among persons living with or vulnerable to HIV.
- **Health Information Specialist.** Provides administrative support, research, analysis, evaluation, and recommendations to the HIV Planning Group to augment the group's ability to effectively plan for and evaluate HIV prevention efforts.
- **Benefits Training.** Ongoing benefits training for Navigators and other staff will ensure that the information they provide is continually up-to-date despite the rapidly changing benefits landscape. This will enable clients to receive HIV medical care, ART, and other necessary services promptly and regularly.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

When building capacity, San Diego County will make special efforts to recruit a workforce mirroring the priority populations demographically, linguistically, and in lived experience in order to increase our capacity to reach these priority populations.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **CDPH Office of Binational Border Health**
- **Consumers with and those vulnerable to contracting HIV**
- **Family Health Centers of San Diego**
- **San Diego Harm Reduction Coalition**
- **Tijuana and San Diego Service Providers**
- **Tijuana, San Diego, and California governmental liaisons**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Wrap Around Services for Persons who Inject Drugs	$1,938,734	CDC PS20-2010
Peer-based Mobile PrEP		
Benefits Navigation		

Getting to Zero App and Resource Guide		
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee		
TOTAL FUNDING FOR PREVENT PILLAR*	$1,938,734	

*$0 exclusively for Prevent Pillar, and $1,938,734 for programs that cut across diagnose and other pillars.

Monitoring and Evaluation

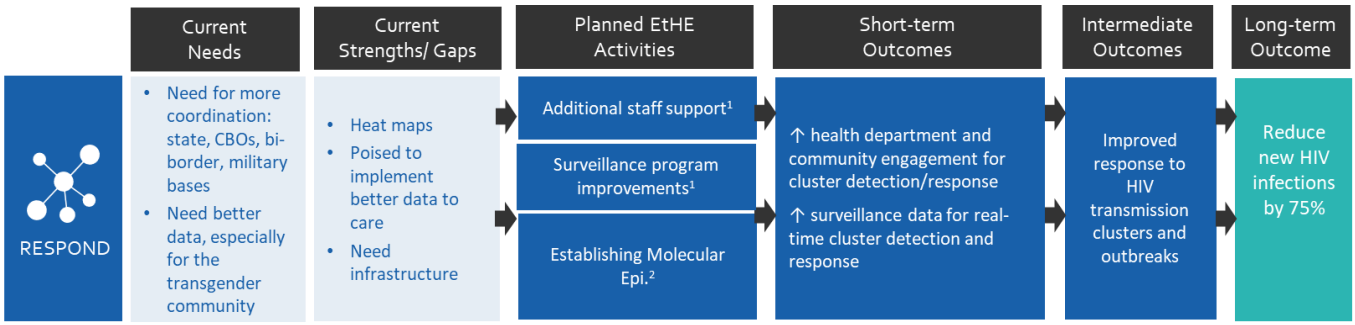
The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[32] Targets will be determined in coordination with CDC as the EPMP is finalized.

Prevent: San Diego County	
Outcome Measure	**Data Source**
Percent of persons hired as PrEP detailers*†	Hiring records
Number and percentage of clinicians prescribing PrEP within 3 months following detailing visit(s)*†	Detailing and prescribing records
Number of HIV-negative clients who are screened for PrEP*†	Patient charts: Local Evaluation Online
Number and percentage of HIV-negative clients with indications for PrEP who are linked to PrEP*†	Patient charts: Local Evaluation Online
Number of persons prescribed PrEP among those with indications for PrEP*	Patient charts: Local Evaluation Online
Number of Black African American PrEP users engaged to educate and provide support for PrEP uptake and use*	Hiring record: Local Evaluation Online
Number of Hispanic/Latino PrEP users engaged to educate and provide support for PrEP uptake and use*	Hiring records: Local Evaluation Online
Documentation of supporting client access to existing traditional PrEP care delivery systems and non-traditional PrEP care delivery systems†	Patient charts
Number of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment†	SSP records
Percent of SSPs with direct provision of or formal active referral arrangements to infectious disease prevention, detection, care, and treatment†	SSP records
Number of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment†	SSP records

Percent of SSPs with direct provision of or formal active referral arrangements to substance use disorder care and treatment†	SSP records
Number of SSPs with direct provision of or formal active referral arrangements to essential support services†	SSP records
Percent of SSPs with direct provision of or formal active referral arrangements to essential support services†	SSP records: Local Evaluation Online for referrals to PrEP and ART

*Peer-based Mobile PrEP
†Wrap-Around Services for PWID

Respond



1. CDC PS20-2010; 2. HRSA 20-078.

Proposed Programs and Efforts

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **Coordinate with CDPH**
- **Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee**
- **Surveillance Program Improvements**
- **Establishing molecular epidemiology (HRSA 20-078)**

Respond: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time HIV cluster detection and response	
Coordinate with CDPH	
• County Surveillance Staff will work with the CDPH OA Surveillance Staff to ensure ability to respond when HIV clusters are identified and investigation is needed.	• Sustain communication between surveillance staff and CDPH OA.
Surveillance Program Improvements	
• **Increase the ability** of the County of San Diego's HIV Epidemiology Surveillance Program **to detect potential HIV clusters.** • Ensure timely entry and assignment of all new HIV case reports as well as entry of lab reports not received via electronic lab reporting. • **Improve data reporting and QA activities** to create a "real-time" surveillance system capable of providing updates regarding HIV transmission. • Develop a system to **integrate STD surveillance data with HIV surveillance data** to improve the ability to identify and deploy resources to emerging hot spots in the county. • Work with the Tijuana Health Jurisdiction to develop an EHE situational analysis.	• Evaluate whether efforts are improving the ability of the HIV, STD and Hepatitis Branch and its contracted providers to respond in a timely manner, ensure linkage to ART and other resources for persons newly diagnosed or newly re-engaged, ensure linkage to PrEP for those who are HIV-negative but have ongoing vulnerability to HIV, and reduce onward transmission of HIV.

Respond: San Diego County	
Year 1 Activities	**Year 2-5 Activities**
Strategy 4A. Develop partnerships, processes, data systems, and policies to facilitate robust, real-time HIV cluster detection and response	
• Develop protocols for maintaining services for individuals receiving care on both sides of the border. • Explore possibilities for implementing **Black Box technology to deduplicate** HIV/AIDS cases between Tijuana and San Diego.	
Establish molecular epidemiology	
• With research partners, assess and develop community readiness and education efforts to interrupt high-transmission clusters of HIV, reduce new infections and ensure that persons living with undiagnosed HIV can be identified and linked to care and other support services.	• Pilot and evaluate educational materials and protocols with community constituents.
Strategy 4B. Investigate and intervene in networks with active transmission	
Coordinate with CDPH	
• County surveillance staff will provide CID with as much locating information as possible in order that CID can reach out and contact those identified as part of the cluster, as well as the partners identified in the initial interviews. If the number of people to be interviewed is higher than the capacity of the county CID staff, CDPH OA will have their partner services staff deployed to the county. If the cluster response is elevated, CDPH Emergency Response protocols will be followed.	• Continued initiation of Cluster Response activities.
Strategy 4C. Identify and address gaps in programs and services revealed by cluster detection and response	
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee	
• Provide additional staff support to the HIV Planning Group to augment the group's ability to effectively **identify and address gaps in programs and services revealed by cluster detection and response** in alignment with the County of San Diego's Getting to Zero initiative and the federal Ending the HIV Epidemic initiative.	• Continue to expand staff support by funding one additional staff position to support planning, implementation, evaluation, research and administrative activities.
Coordinate with CDPH	
• A debrief meeting with county staff and CDPH OA staff will happen after each outbreak response in order to refine and ensure the most effective response actions are initiated.	• Post-response debrief meetings will continue to be conducted.

HIV Workforce Development Needs

Positions

- **Health Information Specialist.** Provides administrative support, research, analysis, evaluation, and recommendations to the HIV Planning Group to augment the group's ability to effectively plan for and evaluate HIV prevention efforts.
- **Program Evaluator.** The program evaluator will design and deploy evaluation tools and works with internal staff and contracted providers to monitor program deliverables and outcomes. The program evaluator is also responsible for initiating quality improvement activities when necessary.
- **Mental Health Staffing to Support the Workforce.** Mitigate employee burnout by providing mental health support to all staff working in HIV programs.

Capacity-Building

HHSA will work closely with state and federal partners to respond quickly to a newly identified HIV clusters, utilizing trained county epidemiological staff and Communicable Disease Investigators. HHSA will leverage resources and expertise of the California State Office of AIDS to tailor local response efforts. HHSA will also work with research partners to establish molecular epidemiology protocols and increase community readiness to respond to clusters.

Key Partners

Proposed Programs and Partners are described in detail in the EtHE Programs and Key Partners section beginning on page 36. A list of those related to this pillar is below.

- **CDPH Office of AIDS**
- **HPG**
- **San Diego CFAR**

Funding

Program/Effort	Total Funding	Proposed Funding Source
Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee	$1,938,734	CDC PS 20-2010
Surveillance Program Improvements		
Establishing molecular epidemiology (078)	$1,000,000	HRSA 20-078
TOTAL FUNDING FOR RESPOND PILLAR*	$2,938,734	

*$0 exclusively for Respond Pillar, and $2,938,734 for programs that cut across diagnosis and other pillars.

Monitoring and Evaluation

The table below describes the outcome measures and data sources. Further detail is provided in the Evaluation and Performance Measurement Plan.[32] Targets will be determined in coordination with CDC as the EPMP is finalized.

Respond: San Diego County	
Outcome Measure	**Data Source**
HIV cluster data is reviewed and prioritized, response is guided and reviewed, procedures are modified to improve responses.	Reports of committee and community meetings, after action review meetings.
Percent of all persons with diagnosed HIV infection entered into the local surveillance system within ≤30 days of date of diagnosis.	Surveillance system.
Percent of laboratory results entered into the surveillance system ≤ 14 days after specimen collection.	Surveillance system.
A data system is developed to rapidly analyze, integrate, visualize, and share data in real time.	Data system documentation.
A flexible funding mechanism is developed to allow reallocation of resources for a response within one month.	Funding mechanism documentation.
Implementation of methods to understand the entire network, including people with diagnosed HIV, or vulnerable to HIV infection.	Methodology documentation.
Processes and mechanisms are developed to ensure appropriate prevention activities, such as testing, retesting, and PrEP referral, for people in cluster networks.	Documentation of processes and mechanisms.
Data analysis and response results for clusters of concern are reported to CDC until investigation and intervention activities are closed.	Documentation of submission.

Section V: Concurrence

The County of San Diego received concurrence from the HPG for the San Diego County EtHE plan on September 8, 2020. On November 12, 2019, the HPG received a presentation by CDPH-OA and Facente Consulting that introduced the Ending the HIV Epidemic in America, phase 1 accelerated planning year funded through CDC PS 19-1906. The HPG was asked to disseminate information about the project and to seek input from people living with and vulnerable to HIV.

The HPG was kept apprised of progress in development of the EHE plan, including receiving a copy of this draft document in December 2019. The HPG also participated and co-sponsored the community engagement activities that contributed to the final plan.

The HPG is comprised of consumers, providers, city representatives, public health staff, mental health agencies, and community-based organizations. Members of the HPG will be encouraged to participate in community engagement activities throughout the implementation of this plan and to help oversee its progress.

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Appendix 1: Resource Inventory

Exhibit 24 lists the services and programs currently available in San Diego County along with their funding sources, by pillar.

Exhibit 24: San Diego County Baseline HIV Activities with funding sources, by pillar.

Pillar	Baseline Program/Activity	Funding Sources
DIAGNOSE	• Routine opt-out HIV testing programs[i, vii] • Routine HIV screening in clinical and non-clinical settings[i, iii] • Focused testing in areas and venues with high HIV prevalence rates[i] • Establish policy regulating laboratory protocols for routine HIV testing[i] • Navigation services to support linkage to testing among PWID[i] • Integrated HIV/HCV testing with services for PWID[i]	i. CDC PS-18-1802 ii. HRSA Ryan White Part A iii. HRSA Ryan White Part B (incl MAI) iv. HRSA Ryan White Part C v. HRSA Ryan White Part D vi. HRSA Ryan White Part F vii. County GF
TREAT	• Peer navigation services through Early Intervention Services[i] • Navigation services to support linkage to care among PWID[i] • Engagement of priority populations in planning, evaluation, and refinement of HIV service and support system[i] • Data-to-care to re-engage PLWH who are out of care [ii] • Programs to reduce stigma related to HIV to support ART engagement[vii] • Educate health care systems and providers about resources to support linkage to and retention in care[vii] • Partner services for newly diagnosed individuals identified through focused or routine, opt-out testing[i] • Partner services for individuals co-infected with HIV and syphilis [vii] • Training and technical assistance for contracted organizations and staff to support partner services interventions[i, vii] • Use of HIV surveillance data to identify candidates for partner services[i] • Referral and linkage services to address co-factors (mental illness, substance abuse, education, unemployment, insurance status, unstable housing, food scarcity) [i, ii, iii, vii] • Provide continuum of care for PLWH to ensure they are linked and retained in care.[ii, iii, iv, v] • Core care and treatment services (primary care, early intervention services, medical case management, mental health and outpatient substance use services, early intervention services, oral health care, home and community-based health services)[ii,iii,iv,v] • Support services (housing, medical transportation, food bank/home-delivered meals, case management, emergency financial assistance, residential substance use services, legal services, medical transportation services, health education/risk reduction, child care services, referrals, treatment adherence counseling)[ii,iv,v,vi]	
PREVENT	• Navigation services to support linkage to PrEP/nPEP among PWID[i] • PrEP coordination at all County-funded categorical STD clinics[i, vii] • Outreach to identify medical providers interested in developing PrEP/nPEP capacity[i] • Education and technical assistance for PrEP providers[i, vi] • Integration of PrEP/nPEP education into all HIV Programs[i, vii] • PrEP/nPEP education and promotion on websites, social media platforms, in campaigns, and at County STD clinics [i, vii] • Use of STD surveillance data to identify individuals at high risk for HIV and link them to PrEP[i, vii] • Use of surveillance data to identify priority sites for PrEP/nPEP provider education and programs[i, vii] • Programs to reduce stigma related to HIV to support PrEP engagement[vii]	

	• Linkage to care protocols to identify individuals at high risk for HIV infection and link them to care within 10 working days[i, vii] • Access to nPEP through County STD Clinics for un-/under-insured individuals[vii] • Distribution of condoms at venues serving MSM, PWID, and transgender persons in communities with highest HIV prevalence[i]	
 RESPOND	• Use of HIV surveillance data to identify candidates for partner services[i] • Use of surveillance data to identify priority sites for PrEP provider education and PrEP programs[i] • Data-to-care to identify and re-engage PLWH who are out of care[ii] • Use of STD surveillance data to identify individuals at high risk for HIV and link them to PrEP[i, vii]	

Note: Additional resources for HIV services that cannot be quantified or broken down by pillar include Medi-Cal, Medicare, Veterans Administration, and 3rd party reimbursement

Appendix 2: Community Engagement Documentation

Exhibit 25 lists community engagement event dates, descriptions and key voices and partners.

Exhibit 25. Community Engagement Documentation

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
CDPH Planning Group Kick-Off Meeting[10] 10/24/2019	CDPH and the eight CA EtHE counties convened in San Diego to begin brainstorming innovative activities.	***Participants****: San Diego HPG, County of San Diego Health and Human Services Agency. All CA Phase 1 counties, CDPH.*
EtHE Presentation and Discussion[11] 11/12/2019	The San Diego HPG Steering Committee facilitated a discussion of barriers to ending the epidemic, ways to better engage people of color in treatment, and ways to increase PrEP utilization.	***Participants****: San Diego HPG, HSHB staff, public*
EtHE CHIPTS Regional Meeting[9,12] 01/24/2020	HHSA presented an overview of the county's draft EtHE plan and gave input about approaches to the regional EtHE response.	***Participants****: County health departments and Planning Council representatives from Alameda, Los Angeles, Orange Riverside, Sacramento, San Bernardino, San Francisco and San Diego. HRSA, CDC, HOPWA, OASH, PACE, CDPH, CHRP, CARG, PAETC, AETC.*
San Diego Ending the HIV Epidemic Community Summit[13] 02/29/2020	HHSA and the Summit co-sponsors presented the country's EtHE initiative and then facilitated a group discussion of barriers to ending the epidemic, methods to better engage new voices, and ways to increase the utilization of HIV and PrEP services. Nathan Fletcher, County Board of Supervisor, invited participants to sign a petition and attend the Board of Supervisors meeting on March 10, 2020 to reverse the County of San Diego policy against needle exchange.	***New Voices – Priority Populations****: Hispanic/Latinx MSM, the transgender community, PWID* ***New Voices – Providers****: research* ***Participants:*** *Board of Supervisors, people vulnerable to and living with HIV, Spanish-speakers, clinical providers, CBOs, new HIV-positives, peer advocates, pharmaceutical company representatives, San Diego HPG members.* ***Sponsors:*** *San Diego Center for AIDS Research (CFAR), San Diego HPG, County of San Diego HIV, STD and Hepatitis Branch of Public Health Services*
PrEP Listening Session[14] 02/29/2020	County of San Diego and Gilead held a listening session to discuss methods to better engage new voices, barriers to PrEP utilization, and recommendations to improve PrEP access and utilization.	***New Voices – Providers****: PrEP navigators* ***Participants****: Prevention through Active Community Engagement (PACE), San Diego HPG, clinical*

EVENT	DESCRIPTION	VOICES & PARTNERS
		providers, pharmacy providers, PrEP navigators, people vulnerable to and living with HIV. *Sponsors: Gilead*
Consumer Voices Feedback[15] **02/29/2020-05/312020**	The Getting to Zero Project and Ending the HIV Epidemic efforts collected feedback from 100+ consumers (living with and vulnerable to HIV including those who have utilized Ryan White funded services in San Diego County.	***New Voices-Priority populations:*** *B/AA MSM, Hispanic/Latinx MSM, the transgender community*

Appendix 3: Letter of Concurrence

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578
SAN DIEGO, CA 92110-3134
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WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

September 8, 2020

Marisa Ramos, Ph.D.
Chief, Office of AIDS
Center for Infectious Diseases
California Department of Public Health
MS 7700, PO Box 997426
Sacramento, CA 95899-7426

Dr. Ramos:

This letter documents that our HIV Planning Group (Part A), is in concurrence with the Ending the HIV Epidemic in America, Phase I accelerated planning report funded through CDC PS 19-1906.

In November 2019 our planning body was provided a presentation by the State Office of AIDS and Facente Consulting. Facente Consulting was contracted to assist in the development of the Ending the HIV Epidemic Plan. We were asked to disseminate information about the project and seek consumer input on what is most critical to decrease new infections as we work toward ending the epidemic.

We were provided a copy of the December, 2019 draft plan, and were part of the community engagement activities that contributed to the final plan.

The plan being submitted is in harmony with our other HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero Plans and other county documents that guide the delivery of HIV prevention and care services, and maintains a surveillance system in collaboration with the State Office of AIDS.

The selected activities will expand our reach to populations underserved to date, with novel and innovative interventions that will increase testing, provision of rapid ART, and use of PrEP, and will assist more people living with HIV in our county to achieve and sustain viral suppression.

The CDC PS 20-2010 funding to implement the plan will expand services, and will work in unison with the HRSA 20-078 and in partnership with health centers provided Ending the Epidemic funding through HRSA 20-091.

Our planning body will continue to monitor the implementation of the Ending the Epidemic Federal Initiative and its family of interventions. We will also continue to engage the community to assure ongoing, real-time feedback so that the interventions are executed optimally for the populations they are serving.

Sincerely,

Joseph Burke
Chair, HIV Planning Group

Appendix 4: Planning Council Membership Roster

San Diego HIV Planning Group **Website: http://www.sdplanning.org/** **Contact: Patrick Loose (619) 293-4709**	
Council Members	**Title/ Position**
Michael Wimple	Council Member
Luis Meza	Council Member
Mikie Lochner	Council Member
Raul Robles	Council Member
Roger Al-Chaikh	Council Member
Jose Luis Martinez-Madrigal	Council Member
Joseph Burke	Council Member
Robert Lewis	Council Member
Rhea Van Brocklin	Council Member
Regina Underwood	Council Member
Delores A. Jacobs	Council Member
Cheryl Houk	Council Member
Elizabeth A. Hernandez	Council Member
Myres Tilghman	Council Member
Yvette Laguitan	Council Member
Aaron Heier	Council Member
Jamie Woods	Council Member
Abigail West	Council Member
David J. Grelotti	Council Member
Stephen A. Spector	Council Member
Amy Applebaum	Council Member
Joe Zilvinskis	Council Member
Alberto Cortes	Council Member
Susan Martin	Council Member
Shannon Hansen	Council Member
Karla Torres	Council Member
Moira Mar-Tang	Council Member
Susan Little	Council Member
Heidi Aiem	Council Member
Reginald Jerome Carroll	Council Member

Developed by a broad coalition of government and community-based stakeholders, through funding from CDC's PS-19-1906, and with the support of Facente Consulting

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