Draft Getting to Zero Plan 2019 Update

San Diego County's Integrated Plan for

HIV Care, Prevention, Testing and Surveillance

San Diego HIV Planning Group

County of San Diego Health and Human Services

HIV, STD and Hepatitis Branch of Public Health Services

(Ryan White Treatment Extension Act Part A Recipient and Centers for Disease Control and Prevention Funds Administered by the California Department of Health, Office of AIDS)

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Table of Contents

Introduction Statement 4

Overview of HIV Planning Group and Committees 4

Epidemiological Overview 7

Needs Assessment and Assessing Needs, Gaps, Barriers 9

HIV Care Continuum 10

Financial and Human Resource Inventory 12

HIV Prevention and Care Plan 13

Collaboration, Partnership and Stakeholder Involvement 14

People Living with HIV and Community Engagement 15

Monitoring and Improvement 18

Appendices 20

Introduction Statement

This document serves as an update for San Diego County's 2017-21 *Integrated Plan for HIV Care, Prevention, Testing and Surveillance*, known as the "Getting to Zero Plan." The Getting to Zero Plan outlines objectives, strategies and activities to provide prevention, care, treatment, and support services to meet the needs of those vulnerable to and living with HIV in San Diego County. Overall, the plan directs maintenance and improvement of the system of care to adjust to the changing epidemic and unmet health care needs. There are five strategies: test, treat, prevent, engage and improve. Since its inception, the "Getting to Zero" initiative has undergone changes in an effort to offer quality services, continuous monitoring and meaningful outcomes to HIV/AIDS affected community. The Getting to Zero activities and partnerships have prompted new focuses and changes to the HIV Planning Group committee organization and needs experienced by people vulnerable to and living with HIV.

This document is designed to serve as a supplement to the 2017-21 *Getting to Zero: San Diego County's Integrated Plan for HIV Care, Prevention, Testing and Surveillance*. This document provides information on all significant changes in epidemiological data, research data, key stakeholders, target populations and strategies since the plan was completed in 2016. Please refer to the full Getting to Zero Plan for all other information.

Overview of HIV Planning Group and Committees

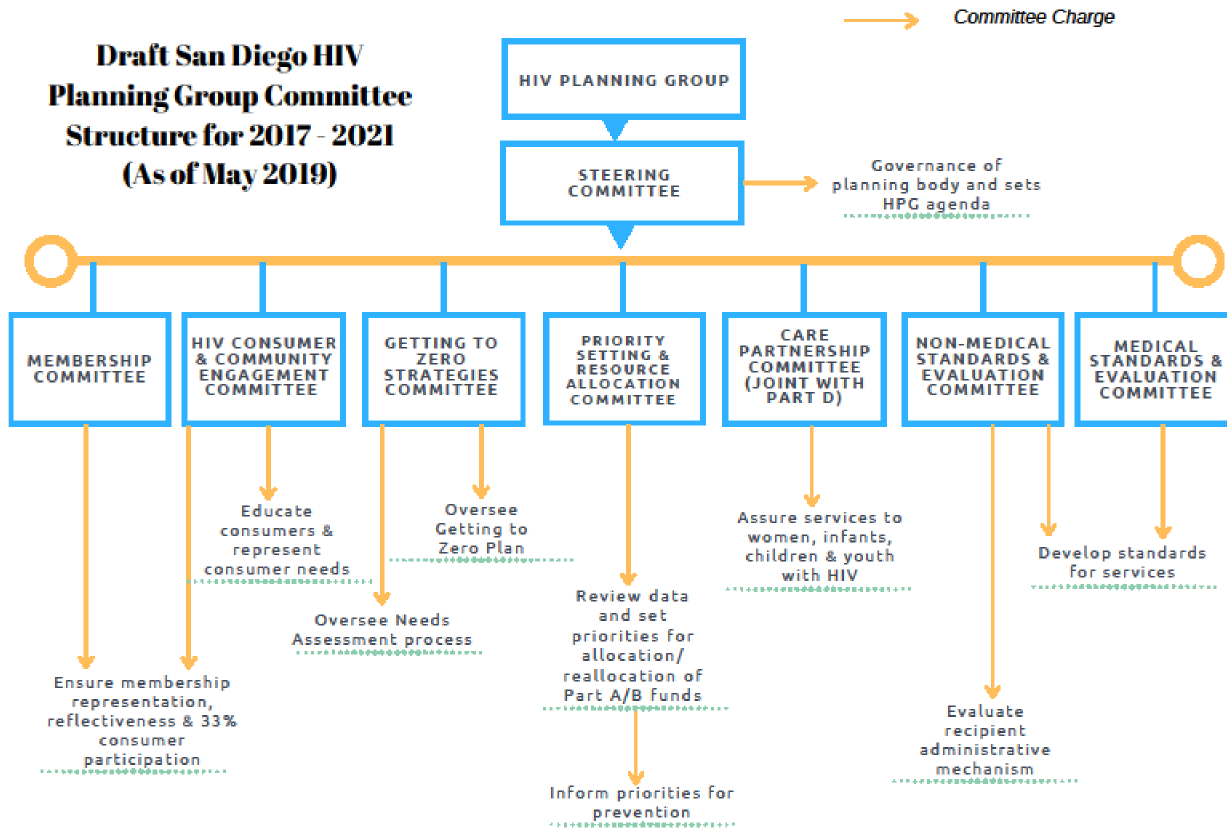
In December of 2015, the County Board of Supervisors approved the unification of the San Diego HIV Prevention Group and the San Diego HIV Health Services Planning Council to form a single entity that would plan for the delivery of HIV services for people in need in the jurisdiction and reduce the overall impact of HIV. In September 2016, the two entities unified to become the San Diego HIV Planning Group. The HIV Planning Group (HPG) serves in an advisory capacity for prevention services and early intervention services for people vulnerable to HIV, and also sets priorities and allocates funds to provide services for people living with HIV/AIDS. These services for people vulnerable to and living with HIV are assessed to see how they complement testing, surveillance, care and treatment. The HIV Planning Group directs the County of San Diego Public Health Services HIV, STD and Hepatitis Branch in what services to prioritize and the amount of funding to apply to each Ryan White service category.

A series of committees guide the activities and decisions made by the HIV Planning Group. The Needs Assessment and Community Engagement Committee and the Strategies Committee were formerly two separate committees. The two committees were restructured in May 2019. The Consumer Committee took on the functions and duties of community engagement and The Strategies Committee was renamed to the Getting to Zero Strategies Committee and took on the functions and duties related to the needs assessment. Throughout this update the committees are referred to by their previous name as this reflects the activities under their charge. The new committee structure can be found in figure 1. The following is the current list of committees and their charges. All committees are subject to change as the needs of the HIV Planning Group and those vulnerable to and living with HIV in the jurisdiction change.

- **CARE Partnership**
  - Facilitate collaboration between consumers, providers and community members that empowers consumers, shares resources, educates the community, advocates for public policy plans and services for women, children, youth and families living with and affected by HIV/AIDS.
- **Getting to Zero Strategies Committee** (*formerly Strategies Committee, and includes some of the former Needs Assessment Committee charges*)

    - Oversee the needs assessment process and 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 living well in San Diego.
  - **HIV Consumer and Community Engagement Committee** (*formerly the HIV consumer Committee;* a more detailed committee charge can be found in the Getting to Zero Plan.)
    - Educate consumers, increase consumer participation, and represent consumer needs throughout the HIV Planning Group process.
  - **Medical Standards and Evaluation Committee**
    - Ensure that HIV primary care services provided through local Ryan White-funded clinics meet or exceed established HIV clinical practice standards and Public Health Services (PHS) guidelines, assuring availability and access to state-of-the-art medical care for all eligible persons living with HIV.
  - **Membership Committee**
    - Recruit, interview, select and coordinate training for HIV Planning Group Members.
  - **Non-Medical Standards and Evaluations Committee**
    - Oversight of the process to evaluate the performance and administrative mechanism of the HIV Planning Group and Recipient.
    - Monitor program outcomes for non-medical HIV services funded through HSHB.
    - Provide feedback on various quality assurance issues.
    - Set service standards for Ryan White and prevention service delivery.
  - **Priority Setting and Resource Allocation Committee**
    - Review, analyze and consider available data and make recommendations to the HIV Planning Group based upon that data regarding service priorities, service delivery and funding allocation by service category.
  - **Steering Committee**
    - Establish the agenda for full meetings of the HIV Planning Group and address issues of HIV Planning Group governance.

Figure 1: San Diego HIV Planning Group Committee Structure



The HIV Planning Group was formed to ensure that the continuum of care is more efficient in terms of how HIV services are delivered to the community. The continuum of care includes the services given to people vulnerable to and living with HIV to reduce viral load and transmission of HIV. The continuum is assessed by monitoring awareness of status, linkage to care (prevention and HIV care) and retention to care and viral load suppression. Among the committees, the Non-Medical Standards and Evaluation and Medical Standards and Evaluation Committees develop services standards for all HIV services. The Needs Assessment and Community Engagement Committee was originally established to determine the needs of both people vulnerable to and living with HIV along the HIV care continuum. As of May 2019, these functions were taken on by the Getting to Zero Strategies Committee. These actions made the proposed Disproportionality Committee unnecessarily repetitive. Instead, all committees assess how services can better serve minority populations and address disproportionalities. For example, a literature review on viral suppression for HIV among the Latinx population was presented at the Strategies Committee in October 2018. This presentation highlighted the specific needs of the Latino/a population with regards to HIV services.

Epidemiological Overview

HRSA: Consider incorporating tables form the needs assessments that delineate the geographical regions and populations most impacted by HIV into their Integrated HIV, Surveillance, Prevention, and Care Plan.

The primary epidemiological review highlighted the areas with the highest rates of HIV diagnosis in 2016. There has not been any significant change in the makeup and diversity of people living with HIV in the San Diego area. Reviews of epidemiological data are done on a biannual basis, with data for 2018 released in 2019. Epidemiological data can be found on the County website (https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/hiv_aids_epidemiology_unit.html). The Central, Southeast and South regions continue to have the highest rates in the county therefore most interventions and resources have been concentrated on those areas since they have the greatest needs. The prevalence of HIV is highest in African Americans, Latinos and Whites, with African American individuals having a statistically significant, disproportionately higher rate of HIV diagnosis. Men who have sex with men are still the highest incidence and prevalence cases for HIV transmission. The prevalence percentages by race/ethnicity, gender and region are on Table 1, with prevalence percentages by age and transmission risk group are on Table 2.

Table 1. Regional HIV Cases by Race and Gender:

Demographic Group	HIV Cases Diagnosed 2012-2016 (%)	HIV Prevalence (%)	HIV Cases Diagnosed 2012-2016 (%)	HIV Prevalence (%)
	San Diego County		Central Region	
Males by race/ethnicity				
White	37%	50%	42%	55%
African American	12%	12%	14%	13%
Hispanic/Latino	43%	33%	37%	27%
Females by race/ethnicity				
White	31%	31%	44%	28%
African American	16%	24%	37%	43%
Hispanic/Latino	43%	39%	19%	28%
	South East Region		South Region	
Males by race/ethnicity				
White	20%	26%	10%	18%
African American	21%	24%	10%	11%
Hispanic/Latino	52%	44%	75%	67%
Females by race/ethnicity				
White	11%	13%	11%	17%
African American	15%	35%	6%	11%
Hispanic/Latino	70%	50%	74%	66%

Table 2. HIV Cases by Age and Transmission Risk Group for San Diego County

Demographic Group	HIV Cases Diagnosed 2012-2016 (%)	HIV Prevalence (%)
Age		
0-12 years	<1%	1%
13-18 years	1%	1%
19-24 years	20%	17%
25-34 years	39%	40%
35-44 years	21%	26%
45-54 years	13%	11%
55+ years	7%	4%
Transmission Risk Group		
MSM (male only)	74%	76%
IDU (Hetero M/F)	3%	4%
MSM/IDU (male only)	4%	6%
Other/unknown	9%	14%

Some barriers continue to be an issue. Although there is a high incident rate of people under 40 years of age, there has not been a significant presence of younger members involved in the HIV Planning Group or committees. Lack of representation could be an issue when it comes to dialogue being heard from younger people vulnerable to and living with HIV about their needs around HIV care. There is also a lack of affordable housing in San Diego. Approximately 70% of moderate-income households cannot afford to own a home, and 30% of moderate-income households cannot afford rent, according to the City of San Diego's first *Housing Inventory Annual Report.*

Based on the epidemiological data and outcomes data utilized to monitor the Getting to Zero Plan, progress has been made to provide accessible care to those vulnerable to and living with HIV, provide HIV care to more areas in San Diego County, target specific issues and diminish stigma. The HIV Planning Group and the committees developed a community engagement plan to assess what groups need to be reached with a goal to bring in younger members to address their needs during planning. Overall, HIV diagnoses have decreased among all age groups between 2013 and 2017. With regards to gay men, bisexual men, other men who have sex with men and transgender people living with HIV, there are local campaigns with representation of the most vulnerable populations.

There has also been an effort to address the barriers that people living with HIV face. These major barriers are low-income status, transportation support, housing support, homelessness, mental health and substance use. Low-income status disproportionately affects people vulnerable to and living with HIV living on limited income or other high costs of medical care. Partnerships with federally qualified health centers (FQHCs) as well as connecting individuals to appropriate care (Medi-Cal or Ryan White), means people vulnerable to and living with HIV can receive access to pre-exposure prophylaxis (PrEP) and medical assistance to alleviate financial burden. Connecting people living with HIV to Medi-Cal also allows more Ryan White monies to be allocated in high need areas that could not be focused on previously. Transportation services have been supported by the HIV Planning Group so that clients can access services. Furthermore, the County of San Diego Health and Human Services agency has contracted with medical services in each region so that people living with HIV can access care close to them. The HIV Planning Group supports the Partial Assistance Rental Subsidy and the Emergency Housing program to provide monetary assistance and prevent eviction. This is not a complete fix to San

Diego's housing situation, but it does provide support. A growing concern has been expressed that there are homeless people living with HIV who may not be receiving services. Mental health and substance use are also high priority issues among the HIV affected community. The HIV Planning Group has prioritized psychiatric services and outpatient and residential substance use treatment as tenth, eleventh and twelfth among all other priorities. The 2017 ranking of Ryan White service categories from the 2017 *Community Survey of HIV Impact* is below in Table 3.

Since 2014, the top five Ryan White Service Category rankings have slightly shifted. HIV/AIDS medication, HIV primary care, dental care, and case management are still the top four service categories. Medical specialist other than HIV has moved to the fifth position, instead of transportation. A 10% reduction in transportation that people living with HIV "need but can't get" was seen. The difference in services people living with HIV "need but can't get" between 2014 and 2017 shows that efforts to link people with services are effective.

Table 3: Ryan White Service Category Rankings

2017 Ranking	2014 Ranking	Service Category
#1	#1	**HIV/AIDS medication**
#2	#2	**HIV primary care**
#3	#3	**Dental care**
#4	#4	**Case management**
#5	#7	**Medical specialist other than HIV**
#6	#8	Counseling/therapy
#7	#6	Help to pay rent
#8	#5	Transportation
#9	#15	Coordinated services centers
#10	#9	Psychiatric services

Plans for the future involve reaching younger people vulnerable to and living with HIV, continuing to address the needs of the most affected people living with HIV (low-income, homeless, people of color, gay, bisexual, and other men who have sex with men, transgender individuals) and continuing to assess what needs are changing among people living with HIV. There are continuous efforts to conduct outreach events on a monthly basis to engage the greater community and get them involved with the HIV Planning Group or its committees. Local data are reviewed at the Getting to Zero Strategies Committee on a yearly basis to determine how well the Getting to Zero Plan's objectives are being met.

Needs Assessment and Assessing Needs, Gaps, Barriers

The needs assessment continues to be a multi-year process in San Diego County. The multi-year cycle involves a client-level assessment, that was last conducted in the 2017 *Community Survey of HIV Impact*, an assessment of provider capacity and capability, that was developed in 2018 and approved by the Health and Human Services Agency Director in 2019. Data collection and preliminary analysis is complete at the time of this writing and regional and population specific focus groups of people vulnerable to and living with HIV (last conducted in 2016) are in the process of being conducted.

The 2017 *Community Survey of HIV Impact*, formerly called the *Survey of People Living with HIV/AIDS* or "consumer survey," is part of the needs assessment process outlined in the Health Resources and Services Administration's Ryan White Part A Manual. The purpose is to identify the needs of people living with HIV. The local survey also assesses needs of those vulnerable to HIV. The survey also gives respondents an opportunity to prioritize identified needs. The 2017 *Community Survey of HIV*

Impact was conducted by the HIV Planning Group, the recipient of Ryan White, Centers for Disease Control and Prevention and California Department of Public Health funds, HIV, STD and Hepatitis Branch of Public Health Services, County of San Diego, and the community.

In 2017, the Needs Assessment and Community Engagement Committee of the HIV Planning Group developed the survey with consultation from Institute of Public Health (IPH), San Diego State University Research Foundation. To support integration of HIV prevention planning with HIV care and treatment planning, questions specific to those unaware of their HIV status or vulnerable to HIV were included. Work began on the survey in January 2017. The HIV Planning Group approved the survey instrument on April 26, 2017. Data collection occurred between April 27, 2017 and May 31, 2017.

The survey launched on April 27, 2017. Paper copies in both English and Spanish were distributed to HIV service providers, including HIV primary care, HIV counseling and testing and HIV prevention. Surveys were also distributed to social service, substance use treatment, mental health and homeless service providers, community organizations and businesses that serve people vulnerable to and living with HIV. Electronic versions in English and Spanish were sent out using email lists from providers and the HIV Planning Group contact list. Marketing of the electronic survey also occurred through social media platforms, primarily Facebook, the regional websites and through flyers posted and distributed throughout San Diego County.

One thousand, thirty-eight (1,038) people completed the 2017 *Community Survey of HIV Impact* with 781 (75%) identifying as people living with HIV and 257 (25%) identifying as HIV negative or unaware of their HIV status. A majority of the surveys (737) were completed electronically. Results were analyzed by Institute for Public Health, San Diego State University Research Foundation and can be found at www.sdplanning.org. Demographic data from the survey can be found in Appendix A.

Data from the *Community Survey of HIV Impact* were used to complete two key findings documents utilized by the Priority Setting and Resource Allocation Committee of the HIV Planning Group: 2017 Co-Occurring Conditions/Poverty/Insurance and the Community Survey of HIV Impact Summary of People Living with HIV (Appendix B). These documents were used in the priority setting process. The Priority Setting and Resource Allocation Committee asked for a report of people who are vulnerable to HIV and PrEP awareness and uptake. The key findings document, Community Survey of HIV Impact Summary of People Vulnerable to HIV, was presented to the Strategies Committee and Priority Setting and Resource Allocation Committee meetings in June 2019 (Appendix C).

HIV Care Continuum

HRSA: The recipient is missing a clear description on how the continuum data will be used in the planning.

The HIV Care Continuum data is used in planning including, but not limited to local continuum data, which is included in the Getting to Zero Outcomes Dashboard. These data are reviewed at the Getting to Zero Strategies Committee and utilized to assess and develop strategies to address disparities. The Getting to Zero Outcomes Dashboard was presented to the Priority Setting and Resource Allocation Committee for consideration when prioritizing services categories and recommending allocations for service categories; the dashboard was also presented to the HIV Planning Group. The Getting to Zero Outcomes Dashboard and tracking of progress support efforts to reach the goal of getting to zero new infections in San Diego County. This initiative's plan and goals are consistent with the National HIV Strategy Indicators released in 2015.

Data for the dashboard are reviewed every six months to a year to monitor how much closer the county is getting to the outcome goals. The committee utilizes available local data collected from the Enhanced HIV/AIDS Reporting System (eHARS), AIDS Regional Information and Evaluation System (ARIES), and National HIV Behavioral Surveillance (NHBS) survey to monitor objectives and track progress. The Strategies Committee monitors the indicators by comparing the ideal state to the current

state in the county. Gaps between both states are analyzed to see if the county is on course to achieve the desired state.

There have been many successes and some challenges since the Getting to Zero Plan was submitted to the Health and Human Resources Administration September 2016. The objectives, strategies and activities section of the plan was updated and vetted with the Strategies Committee of the HIV Planning Group in April, May and July of 2019 and the Consumer Committee in June 2018 (Appendix D). The language used to refer to the activities in the strategies section of the plan was updated based on current funding guidance and to be culturally responsive and trauma informed. Specifically, what was: "targeted" testing is referred to as "focused" testing, "high risk" for HIV is referred to as "vulnerable to" HIV and "risk reduction activities" are referred to as "biomedical and biobehavioral interventions". Other changes based on member input from the Getting to Zero Strategies and the Consumer and Community Engagement Committee have been incorporated into this update. The HIV Planning Group reviewed and approved the update on (date).

Current reports for these outcomes can be found at https://insight.livestories.com/s/v2/gtz-outcomes/dbbb69ec-199c-4a9a-8f8f-40b7a9bdade4/ with data from 2015 to the present. Some data may be delayed by a year. The current outcomes do not provide the full picture of HIV in San Diego County. Local data about PrEP uptake, the HIV status of homeless individuals and deaths due to HIV either does not exist or is difficult to obtain. The surveillance data does not record who has passed away, false positives without follow-up tests or people living with HIV who are getting care from certain organizations (for example, Navy Medical Center). Individuals who are trying to be linked to care or newly diagnosed with HIV may have high needs, have not accepted they have HIV, have personal beliefs that deter them from linking to care or not accessing Medi-Cal. These barriers can make it harder to link these individuals to care.

Data to Care, surveillance-based partner services and high-risk gonorrhea cases are a few initiatives that attempt to link individuals into the care continuum. Data to Care, funded by Ryan White Part B, is an initiative that attempts to link individuals who have fallen out of care back into care using surveillance data. Epidemiological and local data is used to determine people living with HIV who may have fallen out of care or who never accessed care. These people are contacted by disease investigators to confirm if they are living within the jurisdiction or in care. The medical provider an individual may have had before is contacted to confirm if the person is in care. Surveillance-based partner services uses data to locate new positives, link them to care and help inform partners vulnerable to HIV about their risk and get them tested. People living with HIV can choose to disclose this information to their partner(s) with a health advisor present or have a third-party health department staff member anonymously notify the vulnerable partner to get tested. High-risk gonorrhea surveillance entails gathering a list of men who are positive for rectal gonorrhea but negative for HIV. These individuals are contacted to take a HIV test and linked to support services. If they test negative, they are educated about and if interested linked to PrEP navigation services. If they test positive, they are linked to care services.

Getting to Zero activities include implementing PrEP prevention efforts via social media and marketing campaigns designed for gay and bisexual men, other men who have sex with men and transgender individuals. Most objectives are on target to be fulfilled by 2021.

Financial and Human Resource Inventory

HRSA: Knowledge gaps are not addressed in workforce management of managing the PLWH within the needs assessment (e.g., the primary care providers, infectious disease providers, and any other training providers may need).

The 2019 *Provider Survey of Capacity and Capability* is underway to assess the knowledge and capabilities of providers who distribute care to people vulnerable to and living with HIV. All HIV services aim to be comprehensive, accessible and culturally competent. Providers need to be aware of the available prevention options. Knowing what providers are doing well or what they may be lacking can help inform what education and training needs to be provided. Regional and population specific focus groups are being conducted to assess services needs of people vulnerable to and living. The dual focus on provider self-evaluation and consumers' experiences with Ryan White, Center for Disease Control and Prevention, State General Fund and County-funded services provides an accurate representation of whether providers are giving effective and accessible services to people vulnerable to and living with HIV. The *Provider Survey of Capacity and Capability* and focus group data are being conducted in 2019, and subsequent surveys and focus groups are expected to be done every three years.

Future assessments will dictate what trainings or improvements are needed for providers to better serve people vulnerable to and living with HIV. They will also highlight what providers have done well, including established practices or innovations that have improved services or helped retain service users. Having these key findings also informs the HIV Planning Group where data collection needs to occur, such as knowing ethnic/racial breakdowns of people living with HIV who know their serostatus.

There have been some Special Projects of National Significance (SPNS) in San Diego County that have increased the resources for people vulnerable to and living with HIV. Special Projects of National Significance are funded by Ryan White Part F to develop innovative ways to serve the emerging needs of services recipients. Local providers have participated in many Special Projects of National Significance initiatives. One recent projects increased the capacity of services at a systems level: training needs for providers, team-based care model and service integration model in an effort to create continuity of care for people living with HIV and increase capacity of medical residents to serve people living with HIV in primary care settings. Providers conducted workforce training to general primary care staff. A team provided wrap-around services to HIV patients, with a patient navigator ensuring ongoing coordination to improve retention in care. Another project is underway to utilize the coordinated services intervention to reduce the impact of unmet housing needs in people living with HIV. These projects direct resources to educating providers and housing assistance to the HIV affected community, which in turn increases the human resources available to the HIV-affected population. It also fills in the gaps and issues for provider education, reduces stigma within the health care environment and addresses housing needs.

Additional information on provider trainings was provided to the Strategies Committee by a researcher with University of California San Diego. The addition of regular updates on research being conducted and County funded activities has been added to the Getting to Zero Strategies Committee workplan.

Federally qualified health centers provide internal training conducted by HIV and PrEP-knowledgeable providers and health educators to educate other providers about HIV prevention and treatment. Internal training as well as training from the HIV, STD and Hepatitis Branch, the Getting to Zero initiative and implementing opt-out testing breaks down stigma and makes resources more readily available and accessible to the HIV affected community. People vulnerable to and living with HIV receive better care when more clinical providers are knowledgeable about prevention options and HIV services.

Overall, practitioners' care has improved. The support clinics have received through partnering with the HIV, STD and Hepatitis Branch has given them the opportunity to create specific resources for

people living with HIV. Clinics have also created processes throughout their entire organization to promote a continuum of care for people vulnerable to and living with HIV.

One challenge is that education is needed on an ongoing basis. Ideally, every health care provider would be equipped to work with people living with HIV. They would also be aware of prevention efforts and all initiatives and messaging designed to increase HIV viral suppression, like undetectable equals un-transmittable (U=U) or the presence and evidence about preventing transmission through PrEP Partners are dispensing what they have learned into the San Diego community, which then benefits the HIV community. In June 2019, the County of San Diego and all its funded prevention providers became partners of the international Prevention Access U=U campaign.

HIV Prevention and Care Plan

HRSA: The recipient does not clearly discuss the specific activities that address the gaps along the HIV care continuum. The recipient does not address if there are challenges with the barriers to implement the plan.

The Strategies Committee assesses and strategizes activities to address the gaps along the HIV care continuum. An example the committee explored is best practices to address increasing viral suppression in African American men who have sex with men who experience the lowest rates of viral suppression. The committee forwarded to the Priority Setting and Resource Allocation committees a recommendation for peer-model services in June 2018 and services were subsequently augmented.

The HIV, STD and Hepatitis Branch has led and monitored a project for HIV prevention called "Strategic HIV Prevention Project." In this project, the health department and partners participated in various levels of social media and marketing, HIV and hepatitis C virus testing, rapid linkage to care or treatment for HIV-positive persons, and PrEP engagement and retention. The efforts in this demonstration project resulted in an increase in hepatitis C virus testing, PrEP engagement and retention, PrEP education via a combination of internal education and outreach education to other organizations, and systems changes to reduce time to link newly diagnosed to ART.

The Strategic HIV Prevention Project had a number of successes for both the County and the partners on the project. A 200% increase in enrollment of PrEP between March 2017 and June 2017 through PrEP navigation was seen, and partners were able to utilize social media platforms (like Facebook or Instagram) to reach men of color who have sex with men and transgender persons. Testing events, field outreach and campaigns helped connect people to information about PrEP and how to obtain it. Overall, partners reached or surpassed their PrEP outreach goals, with 75% of those who started taking PrEP continuing to take it 90 days after they initiated PrEP. Providers created linkage to care systems, a "linkage to care" map and processes that link clients with a new HIV positive tests to rapid ART and/or their first HIV medical appointment in ideally a day or before 30 days. Over 90% of clients were linked to care, with over 90% of those clients having their first appointment within the first 30 days and receiving medication.

This project exposed some challenges. Partners found a need for culturally competent and responsible professionals, including various language proficiencies and education for clinical staff. For example, partners hired new counselors: bilingual individuals, people of color and transgender people. Clients reported to partners that stigma still existed among clinicians around PrEP. Partners expressed a need for education for clinicians outside of the program. There was also a need for trained staff to work with clients who had more needs, like transient clients, clients who may not feel ready to access care, clients who have co-factors outside of HIV affecting their health or clients who feel they may no longer be at risk and did not stay in contact with navigators.

Data from the Strategic HIV Prevention Project was utilized for the Clinical Quality Management (CQM) Committee's quality improvement project, linkage to care pilot project. The CQM Committee, part of the HIV, STD and Hepatitis Branch, helps guarantee that the County of San Diego, in conjunction

with its contracted service providers, delivers effective, efficient, and culturally responsive services to persons living with HIV in San Diego County. The CQM Committee, which is composed of representatives from the HIV, STD and Hepatitis and the Epidemiology Branches of Public Health Services as well as consumers and primary care, coordinated care, behavioral health, and HIV prevention service providers, meets monthly. Over the course of the year, the CQM Committee establishes annual quality goals, defines and adopts performance measures, establishes benchmarks, creates an annual training plan, and adopts at least one quality improvement project. To achieve these objectives, the committee regularly reviews data for the adopted performance measures, evaluates the progress of its quality improvement project, and offers training to its members in accordance to the annual training plan.

The goal for the linkage to care pilot project was to link 85% of clients to care within 30 days of diagnosis. This outcome objective replaced the previous one, which aimed to link 80% of patients to care within 90 days. The pilot project utilized a rapid linkage to care model as a change agent, which provided a mechanism for attempting to link patients to care within 24 hours of an HIV diagnosis. The pilot sites conducted a PDSA (plan, do, study, act) between January 2018 and December 2018, and successfully linked 92% (84 of 91) clients to care within 30 days of their HIV diagnosis.

Future activities include continuing to develop and improve marketing towards vulnerable populations. The HIV, STD and Hepatitis Branch and their partners hope to provide services and culturally competent care to these groups. Clinics plan to conduct and maintain in-reach and outreach to providers to educate on the importance of PrEP and HIV care services. It is also an effort to reduce stigma system wide.

Collaboration, Partnership and Stakeholder Involvement

HRSA: The recipient only includes partial information regarding the specific contributions of stakeholders and key partners.

Over the past two years, specific Getting to Zero activity recommendations from the task force included collaboration, partnership and stakeholder involvement to promote awareness of HIV, engage public and private health care systems, implement PrEP and PEP, use HIV and STD surveillance data, develop strategies to reduce disproportionalities and pursue policies all in order to help achieve getting to zero new HIV infections. The Demonstration Project, Project PrIDE and the Strategic HIV Prevention Project have been collaborative prevention projects the past three years. The Demonstration Projects included a focus on PrEP, couple's HIV testing, HCV testing and PrEP campaign. The Strategic HIV Prevention Project included PrEP, rapid ART linkage and hepatitis C virus testing and Getting to Zero campaign. The County partnered with federally qualified health centers and the LGBT Center and HIV, STD and Hepatitis Branch testing services to institute "same day PrEP and ART". This project provided medication quickly to those newly affected with HIV. The project ended June 30, 2019 and "rapid linkage" models of care are expected to continue to connect individuals with PrEP and ART in a number of days. Project PrIDE was a partnership with local providers that ended in November 2018. Project PrIDE was an effort to reach out to transgender individuals and link them to PrEP and PEP. Presentations were done by the health department and project partners for the CDC and at a national conference to share best practices. The San Diego County's success in accessing and serving the transgender community exceeded that of all the state and nationally funded projects.

Some of these collaborations have created more effective ways to interact with specific groups. With regards to Project PrIDE, it was an effort to outreach to transgender individuals about HIV prevention services. Throughout this initiative, the HIV, STD, and Hepatitis Branch and collaborators assessed the needs of transgender individuals in San Diego and what they would need to improve access to PrEP and HIV care. These collaborations created focused interventions that allowed multiple entities to work toward a single objective together and assess which activities worked best for different communities to reach the same objective.

One of the challenges is that much of this exploration involves working with multiple issues at once. Most of these populations, like the transgender community, have multiple barriers that prevent them from seeking or obtaining services, such as homelessness, substance use, unemployment or comorbid medical conditions. As a result, trial and error is a common approach in these collaborative efforts. There is proactive planning on how to engage the community and partner meetings to discuss new information around the needs of the community.

In the future, there is hope to expand the network of HIV aware professionals in the medical and general community. Federally qualified health centers have developed processes and programs that did not exist before. This new knowledge then gets dispersed through the entire community, expanding the provider network for people vulnerable to and living with HIV. Initiatives done by healthcare centers help disperse information to other clinics to improve linkage to care, disclosure and prevention efforts among people vulnerable to and living with HIV. There is also an interest in deepening relationships with local universities. There is a continued need for implementation science research (how to apply interventions in a variety of settings) and population specific interventions.

People Living with HIV and Community Engagement

HRSA: The reflectiveness of the persons involved with developing the Integrated HIV Care plan is not adequate. The recipient should include details on methods used to train PLWH and members of the planning bodies to participate in planning, analysis, evaluation, and modifications to the plan, allocations, and priorities.

Annual training on the priority setting and resource allocation process occurs prior to ranking priorities and establishing the allocations for service categories. Presentations also occur at the monthly HIV Planning Group meetings. For example, 2017, 2018 and 2019 HIV Planning Group presentations included those listed in Table 4.

Table 4: HIV Planning Group Presentations

2017	*2018*	*2018 continued*
January: · Distribution and Review of Opportunities for Involvement Document	January: · Ralph M. Brown Act · Conflict of Interest · HIV Prevention	September: · The San Diego County Eliminate Hepatitis C Initiative
February: · Needs Assessment Process Overview · Language Interpretation and Consumer Engagement	February: · Engagement in Care/HIV Epidemiology · The National HIV/AIDS Strategies Getting to Zero (GTZ) Plan Dashboard	October: · Eliminate Hepatitis C Initiative · Needs Assessment and Community Engagement Committee's Outreach Plan
May: · County of San Diego Prevention Programs Overview	April: · Conflict of Interest · The Brown Act	*2019*
June: · High Impact Prevention	May: · Changes to the HIV Planning Group Bylaws · Overview of the HIV Prevention guidance	April: · Research on the needs of gay and bisexual men in the Central region who are living with HIV and over the age of 50
July: · Health and Human Services HIV/AIDS Region IX	June: · Rates verses Percentages	May: · Ask the Experts Liver Wellness Forum
September: · Assessment of the Administrative Mechanism · Evaluation of Administrative Mechanism Survey	August: · Assessment of County of San Diego's Administration of Ryan White Funds	June: · Analyzing and using data for decision making in the priority setting and resource allocation process · AIDS Education and Training Center resources

Presentations and trainings for the HIV Planning Group offer training and information for people vulnerable to and living with HIV and group and/or committee members. The presentations review the goals and roles of the HIV Planning Group members. The trainings, Getting to Zero Summit and the needs assessment findings offer the opportunity for people vulnerable to and living with HIV to discuss what they want from these events and initiatives.

Future trainings for the HIV Planning Group and other committees are determined by consumer need, current priorities and steps in the planning process. Trainings keep HIV Planning Group members aware of their roles. They also allow consumers to understand how the HIV Planning Group can support affected communities, the progress of different initiatives and progress on the strategies in the Getting to Zero plan. HIV Consumer and Community Engagement Committee trainings specifically inform consumers about what services are available to them and what other processes or information they would like to know about as well as hoe to participate in the planning process. The HIV Planning Group chair is committed to reviewing the Ryan White Manual and recently released Primer with the committee. Trainings will continue a regular basis.

The HIV Planning Group tasked the Needs Assessment and Community Engagement Committee to develop a community engagement plan. The Community Engagement Committee presented their plan to the HIV Planning Group in October 2018 and highlighted four priority strategies: event outreach and tabling, HIV Planning Group presentations at support groups, increase recruitment of young (under 35 years old) people living with HIV and recruitment of people who are vulnerable to HIV and/or PrEP uses. The committee worked with the HIV Planning Group to request individuals to help with targeted and general tabling and outreach in San Diego. This kind of outreach has occurred at local events such as health fairs, action coalitions, HIV awareness days and local conferences. To recruit individuals under 35 years old living with HIV, outreach is being conducted at group events that focus primarily on young people, most specifically gay, bisexual and other men who have sex with men. A minimum of six support group presentations or outreach events are scheduled to take place yearly. This Getting to Zero Plan update was presented to the HIV Consumer Committee June 2019 and the HIV Planning Group to keep consumers informed about what the Getting to Zero Plan has accomplished, what is planned in the future and solicit input on strategies and activities.

In an effort to engage the community, the County launched the "Getting to Zero" campaign publicly at the Getting to Zero Summit on November 29th, 2018. There were 136 people in attendance, with representations from 20 organizations and 40 people who were people vulnerable to or living with HIV. During the summit, in addition to the campaign launch, there was with a consumer video, a panel of people living with HIV, breakout discussions and report outs on how to develop a system that works for everyone so San Diego can get to zero new infections. The Getting to Zero Summit had translation services in Spanish, and a transgender group to talk about the needs of the transgender community. The breakout groups offered reports and next steps to achieve Getting to Zero Plan goals or improvements for the next Getting to Zero Summit. The main themes from the groups included:

- Support systems, networks and services
    - Community and family support that helps build relationships and connections
    - Support groups allowing people to seek support from others going through similar circumstances, through either in-person support groups and/or on social media
- Education and knowledge
    - Education for consumers on HIV awareness, prevention and safer sex education
    - Education for providers to stay current about HIV developments and resources available for prevention and treatment through training
- Access and resources
    - Access to services and resources that are readily accessible and pertinent to each individual's unique circumstances
- Advocacy
    - Providers advocating for clients
    - Empowering clients and consumers to become their own advocates

For future Getting to Zero Summits, the HIV, STD and Hepatitis Branch will explore having testing on-site. There also needs to be more engagement of people vulnerable to and living with HIV, youth, medical field, PrEP users and/or navigators and providers not normally involved in HIV care. The recommendations from the breakout groups will be used to inform planning and services for the future summits. Future biennial summits will continue to occur to engage with the community and gather more consumers and providers from which to gain feedback. Smaller summits may be staggered between the larger summits to assess the progress between larger summits.

Monitoring and Improvement

HRSA: Define processes and Standard Operation Procedures for PLWH and their inclusion in planning processes. Detail activities and results for outreach to PLWH in the community to assess the impact of services on needs. Synthesize the epidemiologic overview and discussion found in the state's Needs Assessment for HIV and incorporate into the Integrated HIV Surveillance, Prevention, and Care Plan. Consider incorporating tables from the needs assessments that delineate the geographical regions and populations most impacted by HIV into their Integrated HIV, Surveillance, Prevention, and Care Plan.

As a public entity, the County conducts regular evaluations on all services by monitoring services, initiatives and plans. These evaluations use compiled data to monitor the progress of long and short-term goals. Monitoring is conducted in a variety of ways, with related short and long-term outcomes that are meant to be reached over time. Funders require regular reports and these are a good source of program changes and the resulting outcomes. There is current monitoring being done to ensure San Diego is on target to reach the Getting to Zero outcomes (https://insight.livestories.com/s/v2/gtz-outcomes/dbbb69ec-199c-4a9a-8f8f-40b7a9bdade4/). These outcomes are monitored and updated by the Getting to Zero Strategies Committee. The Strategies Committee monitors current strategies and assesses opportunities for improvement. There is also an AIDS Regional Information and Evaluation System monthly progress reports that assess outcomes. The AIDS Regional Information and Evaluation System contains data on people living with HIV and the services provided. It allows for coordination of client's medical care, treatment and support. Also prevention providers submit monthly progress reports, and HSHB combines narrative and aggregate report for funders.

Regular monitoring occurs on a yearly or bi-yearly basis. Monthly monitoring is compiled into a yearly snapshot to assess progress over time. Provided below is a list of current monitoring being done. This is not an exhaustive list, but instead a snapshot of regular data collection and assessment efforts:

- Data necessary to monitor Getting to Zero outcomes
    - Enhanced HIV/AIDS Reporting System Epidemiological data
    - High Impact Prevention Outcome Database
    - National HIV Behavioral Surveillance Survey
- AIDS Regional Information and Evaluation System monthly progress reports
- High Impact Prevention Outcome Database monthly progress reports
- Getting to Zero campaign data
- Getting to Zero report update(s) to the County of San Diego Board of Supervisors
- Strategies Committee reviews current strategies and assess opportunities for improvement
- Getting to Zero initiative implementation meeting
- Program reports from contracted organizations
- Data to Care updates at Strategies Committee three times a year
- Early Identification of Individuals with HIV/AIDS (EIIHA) report
- Program level assessments and plan level assessments

The Getting to Zero Strategies Committee is responsible for reviewing data for the outcomes of the objectives in the Getting to Zero Plan. During meetings, members and attendees assess the data to see if outcomes are on track. Prior to May 2019, the Needs Assessment and Community Engagement Committee formerly monitored the needs of the community. As noted, this committee merged with the newly renamed Getting to Zero Strategies and the Consumer and Community Engagement Committees. Ongoing and regular needs assessments ranks needs to ensure that the HIV Planning Group makes the necessary allocations to serve the community.

People who receive HIV services have the opportunity to participate on all committees. They can speak during public comments and are encouraged to ask questions and seek clarification. The HIV Planning Group and committees encourage consumer involvement and requests to become members. Data are also shared with consumers at all meetings.

Overall, evaluation and monitoring has been consistent, which has allowed the HIV Planning Group, committees and the HIV, STD and Hepatitis Branch to look back on data and monitor the progress towards goals and objectives. Additionally, consistent monitoring allows for adaptability so that planning aligns with Getting to Zero Plan's goals. Strategies, like Data to Care, utilize data to engage people in care.

A challenge experienced was that some initial outcomes required data collection that did not represent the outcome well. For example, the outcome was to reduce the death rate among persons diagnosed with HIV infection by at least 33% did not represent that people living with HIV were living longer lives than before, as they were able to access care and manage their HIV. As a result, this outcome was coupled with the outcome to reduce the proportion of new HIV diagnoses that progress to AIDS within one year. Some data is also difficult to compile, like people living with HIV who are homeless or on PrEP. General county or state data may be used to estimate missing data, but there is also an effort to collect data based on specific areas in San Diego County.

In the future, monitoring will continue on a regular basis. Future needs assessment data will be presented to the HIV Planning Group. Needs assessments will inform how funding is allocated. This plan will continue to be assessed by the Getting to Zero Strategies Committee to assure that the plan's objectives and goals match the outcomes.

The Getting to Zero Plan and updates will be reviewed annually. The next plan is projected to be released in 2022. This plan and subsequent updates are a collaborative effort of the San Diego HIV Planning Group and the County of San Diego HIV, STD and Hepatitis Branch of Public Health Services.

Appendices

Appendix A

HIV Impact Survey 2017														
	AIDS 2012-2016		HIV 2012-2016		AIDS Prevalence		HIV Prevalence		HIV Positive		HIV Negative/Unaware		Total	
Demographic Category	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Gender														
Female	83	12%	173	10%	742	10%	635	10%	86	11%	50	19%	136	13%
Male	612	88%	1585	90%	6693	90%	5700	90%	675	86%	191	74%	866	83%
Transgender	0	0%	0	0%	0	0%	0	0%	16	2%	14	5%	30	3%
Unknown Gender	0	0%	0	0%	0	0%	0	0%	4	1%	2	1%	6	1%
Males by Race/Ethnicity*														
White	218	36%	592	37%	3254	49%	2844	50%	355	53%	84	44%	439	51%
African Amer.	62	10%	184	12%	767	12%	662	12%	50	7%	13	7%	63	7%
Hispanic	275	45%	687	43%	2356	35%	1868	33%	204	30%	72	38%	276	32%
API/Other	57	9%	122	8%	316	5%	326	6%	66	10%	22	12%	88	10%
Total Male	612		1585		6693		5700		675		191		866	
Females by Race/Ethnity*														
White	27	33%	54	31%	220	30%	196	31%	21	24%	13	26%	34	25%
African Amer.	20	27%	28	16%	178	24%	151	24%	21	24%	6	12%	27	20%
Hispanic	28	33%	74	43%	291	39%	247	39%	35	41%	26	52%	61	45%
API/Other	8	10%	17	10%	17	7%	41	7	9	10%	5	10%	14	10%
Total Female	83		173		742		635		86		50		136	
Transgender by Race/Ethnicity*														
White									4	25%	8	57%	12	40%
African Amer.									3	19%	1	7%	4	13%
Hispanic									8	50%	4	29%	12	40%
API/Other									1	6%	1	7%	2	7%
Total Female									16		14		30	
Region of Residence														
Central	156	22%	472	27%	2364	32%	2045	32%	353	45%	104	40%	457	44%
East	137	20%	326%	19%	1460	20%	1284	20%	67	9%	19	7%	86	8%
South	153	22%	319	18%	1172	16%	940	15%	87	11%	20	8%	107	10%
North Coastal	63	9%	134	8%	571	8%	451	7%	109	14%	34	13%	143	14%
North Inland	40	6%	93	5%	353	5%	275	4%	41	5%	16	6%	57	5%
North Central	81	12%	236	13%	877	12%	815	13%	66	8%	25	10%	91	9%
South East San Diego	54	8%	167	10%	595	8%	512	8%	35	4%	14	5%	49	5%
Region Unknown	11	2%	11	1%	44	1%	13	<1%	23	3%	25	10%	48	5%
Age Group														
13-18 Years	1	<1%	22	1%	26	<1%	88	1%	5	1%	4	2%	9	1%
19-24 Years	47	7%	346	20%	419	6%	1052	17%	34	4%	22	9%	56	5%
25-34 Years	188	27%	677	39%	2369	32%	2521	40%	83	11%	85	33%	168	16%
35-44 Years	162	23%	372	21%	2852	38%	1669	26%	121	15%	49	19%	170	16%
45-54 Years	183	26%	221	13%	1304	18%	713	11%	244	31%	46	18%	290	28%
55+ Years	112	16%	116	7%	435	6%	241	4%	283	36%	48	19%	331	32%
Unknown Years	0	0%	0	0%	0	0%	0	0%	11	1%	3	1%	14	1%
Transmission Risk Group**														
MSM (inc.M-FTG,Bi Male)	507	60%	1294	74%	5286	71%	4790	76%	443	57%	122	47%	565	54%
IDU (non-MSM)	55	8%	57	3%	535	7%	256	4%	45	6%	23	9%	68	7%
MSM/IDU	35	5%	71	4%	674	9%	355	6%	142	18%	9	4%	151	15%
Other Sex Risk (non-IDU)/Unk	188	27%	336	9%	941	13%	934	14%	151	19%	103	40%	254	24%
Total	**695**		**1758**		**7436**		**6335**		**781**	**100%**	**257**	**100%**	**1038**	**100%**

Sources: *HIV Impact Surey database (entry and Survey Monkey imported)*

Footnotes:

*Mutually exclusive: Hispanic (recorded as Hispanic regardless of what other race/ethnicity selected), Black (Black or Black+anything non-Hispanic), White (White or White + Other), API/Other - all Asian Pacific Islander, Other and Unknown.

** Mutually exclusive categories, based on behaviors in the past 12 months and sexual orientation/gender. Hierarchical assignment wit MSM/IDU at top followed by MSM, IDU, Other Sex Risk, Unknown. Other sex risk = any sex for non-MSM, non-IDU individuals.

Appendix B

SURVEY OF HIV IMPACT SUMMARY OF PEOPLE LIVING WITH HIV

Total respondents: 1038 (737 completed online)
People living with HIV: 781 (75%)
HIV negative/unaware/no answer: 257 (25%)

95% **or 745 people living with HIV report having current HIV medical care**

4% or **33** people living with HIV reported no current HIV care

9% or **71** people living with HIV reported being out-of-care for at least 1 year in the past

Ryan White Service Category Ranking Specifics by people living with HIV:

62% Of those **with children** rank **Childcare** as top priority (16 of 26)

Help to Pay Rent ranked as top priority by 84% of the 195 who are **unstably housed** or **homeless**

and 32% ranked **Emergency Housing/Shelter** as top priority

289 reported **chronic mental illness**

Counseling/Therapy top priority for 89%

Psychiatric Services top priority for 51%

41% of 305 who report current or past issues with alcohol and/or other substances rank **Alcohol/Drug Recovery Services** as top priority

"Need but Can't Get"

Dental Care is still top of list but significantly better at **18%** from 24% in 2014.
Transportation is also significantly better at **10%** from 20% in 2014.

Appendix C

SURVEY OF HIV IMPACT SUMMARY OF PEOPLE UNAWARE AND VULNERABLE TO HIV

Total respondents: 1038 (737 completed online)
People living with HIV: 781 (75%)
HIV negative/unaware/no answer: 257 (25%)

81% **or 209 HIV negative/unaware people report having a healthcare provider at some point**

77% or **198** negative/unaware people reported having a current healthcare provider

16% or **40** negative/unaware people reported not having a current healthcare provider

28% or **71** negative/unaware reported they have never been offered an HIV test by their provider

13% or **33** negative/unaware reported they do not know if they have ever been offered an HIV test by their provider

34% or **88** negative/unaware reported having an HIV test within the last three months

17% or **43** negative/unaware reported having an HIV test within the last six months

19% or **50** of negative/unaware reported that they are considering PrEP

17% or **43** of negative/unaware reported that are currently taking PrEP

29% or **74** of negative/unaware reported that they decided not to take PrEP

21% or **54** of negative/unaware reported that they have never heard of PrEP

Appendix D

Section II: Integrated HIV Prevention and Care Plan 2019 Update

A. Integrated HIV Prevention and Care Plan 2019 Update

There have been many successes and some challenges since the Getting to Zero Plan was submitted to the Health and Human Resources Administration September 2016. The following section of the plan was updated and vetted with the Getting to Zero Strategies Committee of the HIV Planning Group March through July of 2019.

Overview of Objectives and Strategies

The Getting to Zero Integrated Plan is focused on eight (previously nine) core objectives. Most of these objectives were adapted from the National HIV/AIDS Strategy's indicators released in 2015; two of the objectives (3 and 9) are based on local priorities. At the time of this update, reliable and meaningful data were not available for objectives 3, 7 and 8. The Getting to Zero Strategies committee recommended that objective 5 be kept in the HIV continuum but not monitored by the committee given objective 6 more accurately reflects efforts to retain people in care to achieve and maintain viral suppression. Efforts to access data or surrogate data for objectives 3, 7 and 8 are underway. Objectives 2, 6 and 9 have been assessed by the committee to be the highest priorities to get to zero new infections in San Diego.

2019 Updated Getting to Zero Objectives **Five Measurable Objectives: 1, *2, 4,* 6, * 9 (*prioritized objectives)** **Three Measures Under Development: 3, 7, 8** **and One Removed for Update: 5**	
Objective 1:	By 2021, maintain the percentage of people living with HIV who know their serostatus at 90% or higher
Objective 2:	By 2021, reduce the number of new HIV diagnoses by 25%
Objective 3:	Local PrEP uptake objective is under development; explore available data to update the objective
Objective 4:	By 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%
Objective 5:	NHAS indicator for retention in care is part of HIV continuum but due to issues with measurement not included
Objective 6:	By 2021, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%
Objective 7:	NHAS indicator on homelessness not measurable locally; due to data limitations continue to explore available data
Objective 8:	NHAS indicator on death rates not measurable locally; due to data limitations continue to explore available data
Objective 9:	By 2021, reduce the proportion of new HIV diagnoses that progress to AIDS within one year by 50%

The preceding objectives are being achieved through the implementation of **five key strategies**: **1) test, 2) treat, 3) prevent, 4) engage, and 5) improve.** To follow are descriptions of each strategy and tables outlining the 32 activities that are being conducted for each of the strategies. Activities that are marked with an asterisk are drawn from the *County of San Diego's Getting to Zero Implementation Plan*.

In 2019, the Getting to Zero Strategies Committee provided input on the need for revisions to and addition of the following:

- Include bidirectional sharing of research and all activities in the county to measure and support getting to zero new infections.
- Address incarcerated populations and ensure medication are accessible to all detained people living with HIV.
- Include representation of all impacted populations including Caucasian heterosexual women in campaigns, advertisements and on summit panels.
- Include local planning body, the HIV Planning Group, and community in planning, implementation and monitoring of Getting to Zero objectives, strategies and activities.
- Develop strategies to decrease time to viral suppression and to address STDs.

These recommendations have been integrated into the following strategies as appropriate and three new activities have been added.

Strategy 1 Test: Identify individuals living with HIV but unaware of their status by:

1) Focusing testing for individuals and populations that are vulnerable to HIV infection;
2) Promoting adoption of routine screening for HIV in primary care (Out-patient/Ambulatory Health services) settings;
3) Linking individuals newly diagnosed with HIV to treatment and needed support services; and
4) Linking individuals who are vulnerable to HIV to pre-exposure prophylaxis (PrEP), and other needed services.

Activities for Strategy 1 Test
Test 1: Conduct focused HIV testing throughout San Diego County
Test 2: Conduct routine opt-out HIV testing in County STD clinics
Test 3: Support the continued implementation of routine HIV screening in primary care settings in local federally qualified health centers
Test 4: Conduct routine HIV screening in local detention facilities and ensure those newly diagnosed are linked to care
Test 5: Work with public and private healthcare systems and providers to increase adoption of recommendations of the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force with regard to routine HIV testing in healthcare settings*
Test 6: Utilize surveillance data to identify individuals vulnerable to HIV infection or transmission and link to testing and prevention services*

Test 7: Utilize HIV partner services, including surveillance-based partner services, to identify individuals who are unaware and/or not in care*
Test 8: Link individuals vulnerable to infection or transmission to biomedical and biobehavioral interventions

Strategy 2 Treat: Improve health outcomes for persons living with HIV by:

1) Linking all persons living with HIV to care and helping them remain in care over time; and
2) Ensuring that all persons living with HIV achieve and maintain viral suppression as rapidly as possible.
3)

Activities for Strategy 2 Treat
Treat 1: Link all individuals newly diagnosed with HIV to care within 0 – 30 days*; and ensure initiation of ART occurs as rapidly as possible and time to viral suppression is reduced systemwide
Treat 2: Provide a continuum of care for persons living with HIV to ensure they are linked to and remain in care over time
Treat 3: Implement Data to Care program to identify individuals who have been diagnosed with HIV but who are not currently receiving HIV care so that they can be re-engaged in care*
Treat 4: Educate health care systems and providers about County and community resources that support linkage to and retention in care for persons living with HIV as well as resources for persons vulnerable to infection*
Treat 5: Implement use of HIV surveillance data to identify all individuals who are newly diagnosed with HIV in San Diego County so that they can receive linkage to care and referrals to support services*

Strategy 3 Prevent: Reduce the spread of HIV by:

1) Linking individuals vulnerable to HIV infection to pre-exposure prophylaxis (PrEP), and other needed services; and
2) Linking individuals vulnerable to HIV transmission to primary care, medical case management, adherence counseling, HIV partner services, and other needed services.

Activities for Strategy 3 Prevent
Prevent 1: Focus HIV prevention activities geographically on populations most vulnerable to transmission and infection of HIV
Prevent 2: Coordinate outreach and public information activities focused on populations who are most vulnerable to HIV infection or transmission
Prevent 3: Conduct evidenced based biobehavioral interventions with populations most vulnerable to HIV infection or transmission
Prevent 4: Promote condom use and availability
Prevent 5: Expand current HIV prevention social media activities to promote HIV awareness throughout the County*
Prevent 6: Develop and implement campaign(s) to promote awareness of pre-exposure prophylaxis (PrEP) among populations vulnerable to HIV*
Prevent 7: Incorporate PrEP and PEP education into County prevention interventions and testing programs and provide navigation assistance for PrEP and PEP among populations vulnerable to HIV infection

Prevent 8:	Provide PrEP education to all HIV-negative individuals seeking services at the County's STD Clinics, and provide referrals to PrEP navigation assistance for individuals who are seeking PrEP*
Prevent 9:	Develop systems to immediately link individuals who have had a HIV exposure to PEP*
Prevent 10:	Provide access to PEP through County STD Clinics for individuals who are uninsured or underinsured*

Strategy 4 Engage: Mobilize 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.

Activities to Support Strategy 4: Engage	
Engage 1:	Develop campaigns to promote awareness, encourage testing and treatment, and educate individuals about available services*
Engage 2:	Develop an action plan outlining current disproportionalities among identified populations with recommended 10-year targets for reductions in those disproportionalities and strategies for achieving those reductions*
Engage 3:	Reduce stigma associated with HIV so that individuals at risk can seek testing and fully engage in treatment*
Engage 4:	Refine referral and linkage services to address co-factors that lead to disproportionate outcomes, such as mental illness, substance abuse, education, unemployment/ underemployment, lack of insurance, unstable housing, food scarcity,* and former or currently incarcerated
Engage 5:	Convene biennial Getting to Zero Summits focused on the local HIV service delivery system and providers* with representation from all affected populations (such as on panels)
Engage 6:	Refine programs that provide assistance in navigating the health care system, including benefits access*
Engage 7:	Institute bidirectional sharing of research and activities to measure and support getting to zero new infections
Engage 8:	Include local planning body and community in planning, implementation and monitoring of getting to zero objectives, strategies and activities.

Improve Strategy: Continually seek to improve outcomes along the HIV Care Continuum by:

1) Maintaining a performance management system capable of measuring progress in meeting the objectives;
2) Maintaining a comprehensive quality improvement program that focuses on both improving underperformance as well as identifying opportunities for improvements where performance already meets expectations; and
3) Conducting annual quality assurance reviews to measure program performance against national standards and benchmarks for quality.

Activities to Support Strategy 5: Improve
Improve 1: Maintain a performance management system capable of measuring progress in meeting the objectives of the Integrated Plan
Improve 2: Maintain a comprehensive quality improvement program
Improve 3: Conduct annual quality assurance reviews to measure program performance against national standards and benchmarks for quality
Improve 4: Disseminate information to planning body, services providers and stakeholders on progress meeting objectives, quality improvements and quality assurance reviews

2017-2021 Objectives

Please refer to the plan for tables providing detailed information about each of the objectives and how they will be achieved, including:

- The current state, or starting point, including data about several subpopulations that have been prioritized locally due to disproportionality;
- The desired state;
- The data sources that will be used to measure progress;
- How each objective is linked to the National HIV/AIDS Strategy; and
- The strategies and activities being utilized to achieve each objective (noted above).

The following populations were identified in the plan:

- African American/Black gay, bisexual and other men who have sex with men
- Latino gay, bisexual and other men who have sex with men
- Caucasian/White gay, bisexual and other men who have sex with men
- Transgender
- Women
- Youth
- People who inject drugs
- Native Americans