OAKLAND TRANSITIONAL GRANT AREA
COLLABORATIVE COMMUNITY PLANNING COUNCIL,
ALAMEDA COUNTY OFFICE OF AIDS ADMINISTRATION, AND
CONTRA COSTA COUNTY HIV/AIDS & STD PROGRAM

2017 - 2021 ALAMEDA & CONTRA COSTA COUNTY INTEGRATED HIV PREVENTION & CARE PLAN

SUBMITTED TO THE U.S. HEALTH RESOURCES & SERVICES ADMINISTRATION &
THE U.S. CENTERS FOR DISEASE CONTROL & PREVENTION
SEPTEMBER 30, 2016

ALAMEDA & CONTRA COSTA COUNTY, CALIFORNIA
2017 - 2021 INTEGRATED HIV PREVENTION AND CARE PLAN

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COLLABORATIVE COMMUNITY PLANNING COUNCIL

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Collaborative Community Planning Council
OAKLAND TRANSITIONAL GRANT AREA (TGA)
Serving Alameda and Contra Costa Counties

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September 21, 2016

Steven R. Young
Director, Division of Metropolitan HIV/AIDS Programs
Attn: HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 09W12
Rockville, MD 20857

Dear Mr. Young;

As Co-Chairs of the Oakland Transitional Grant Area HIV Collaborative Community Planning Council, we are pleased to endorse the enclosed 2017 - 2022 Alameda and Contra Costa County Integrated HIV Prevention and Care Plan and to provide assurance to HRSA and the CDC that the Planning Council played a strong leadership role in the development and producton of the Plan.

The Planning Council approved the formation by the Alameda County Office of AIDS Administration (OAA) of an Integrated Plan Working Group in December 2015 whose specific charge was to work in partnership with both the Council and the Contra Costa HIV Consortium to develop the five-year Plan. While operating under the auspices of OAA, a majority of Working Group members were members of the Planning Council who worked alongisde consumers, community-based agency representatives, and representatives of the Office of AIDS Administration and the Contra Costa County HIV/AIDS and STD Program. The Group met monthly from January through July 2016 to review the region's previous HIV prevention and care plans and to collect information and data and discuss components of the new Plan. This process was highlighted by a series of nine Community Input Groups held between March and July 2016 which included consumers, clinicians, and key local HIV planners and agency representatives. The planning process culminated in a day-long planning and decision-making meeting in Oakland on June 10, 2016. The Plan's final five-year goals, objectives, and action steps were revised and approved by the Planning Council at its meeting on August 31, 2016.

The 2017-2022 Integrated HIV Prevention and Care Plan represents an important step forward in our region's ongoing efforts to address the HIV crisis thorugh an integrated approach to prevention and care which particularly recognizes the need to eliminate all HIV-related disparities in our region. The Council will use the Plan as a living document to help guide our future course at a time of unprecedented challenge and change.

Sincerely,

Monica Cross
Planning Council Co-Chair

Liam Galbreth
Planning Council Co-Chair

SECTION I. NEEDS ASSESSMENT

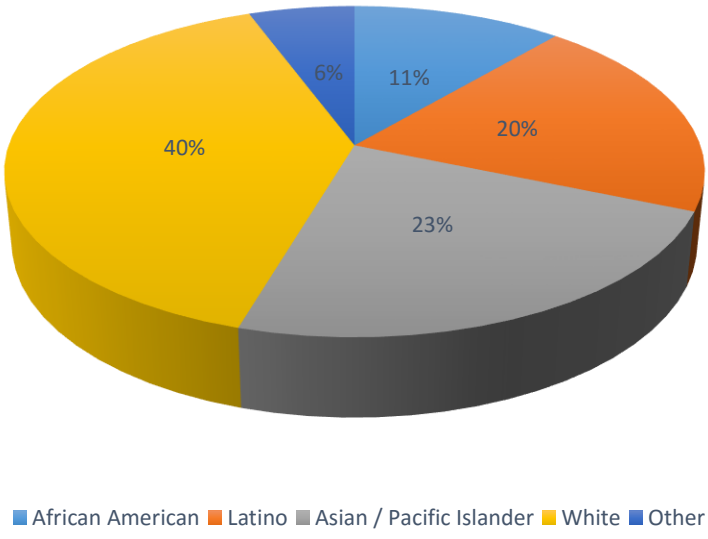
A. Epidemiologic Overview

a. Introduction to the Target Region

The two-county jurisdiction encompassed by Alameda and Contra Costa Counties - known for purposes of the Ryan White Care Act as the Oakland Transitional Grant Area (TGA) and also referred to in this Plan as the Oakland region - is an area that has been hard-hit by the HIV/AIDS epidemic, particularly in regard to its impact on ethnic minority populations. The counties are the two easternmost counties of the San Francisco Bay Area and together they share a land area of **1,458** square miles encompassing major urban and suburban centers and extensive rural areas. The counties are large, and roughly equivalent in land mass (**733** square miles for Alameda and **725** for Contra Costa), which means that the underprivileged in both counties must often travel far distances to access needed services.

The combined Alameda / Contra Costa County region is one of the most ethnically diverse in the nation. According to the 2010 Census, the region is home to **2,559,296** residents, **59%** of whom reside in Alameda County and **41%** who live in Contra Costa County. Persons of color make up fully **60.3%** of these residents, including a population that is **20.0%** Latino, **11.3%** African American, and **23.3%** Asian / Pacific Islander (see **Figure 1**). Non-Hispanic whites, by contrast, make up only **39.7%** of the overall region population. The city of **Oakland** in Alameda County - the nation's **47th** largest city - has a 2010 population of **390,724** and is even more diverse than the region as a whole, with whites making up **25.9%** of the total population and other ethnic groups comprising **74.1%** of local residents. The percentage of African Americans in Oakland (**28.0%**) is the **second** highest in California for places of 100,000 or more. More than **one third** of Oakland region residents (**37.2%**) speak a language other than English at home while more than **one-fourth** (**27.2%**) are foreign born. A total of at least **46**

Figure 1. Ethnic Distribution of Oakland Region Population, 2010



different languages and dialects are spoken here.

b. Persons Living with and at Risk for HIV

The epidemic of HIV/AIDS continues to constitute a severe and urgent health emergency for the Oakland region, one that takes a highly disproportionate toll on persons of color, women, and low-income individuals and families. With **11,799** cumulative AIDS cases diagnosed as of June 30, 2014, Alameda and Contra Costa Counties have the **17th largest** number of cumulative diagnosed AIDS cases of any US metropolitan area, and a cumulative AIDS caseload larger than that of **29** US states.[1] Alameda County alone had the **fourth highest** number of cumulative AIDS cases by county in California as of June 30, 2014, while Contra Costa ranks **tenth** in relation to other counties.[2]

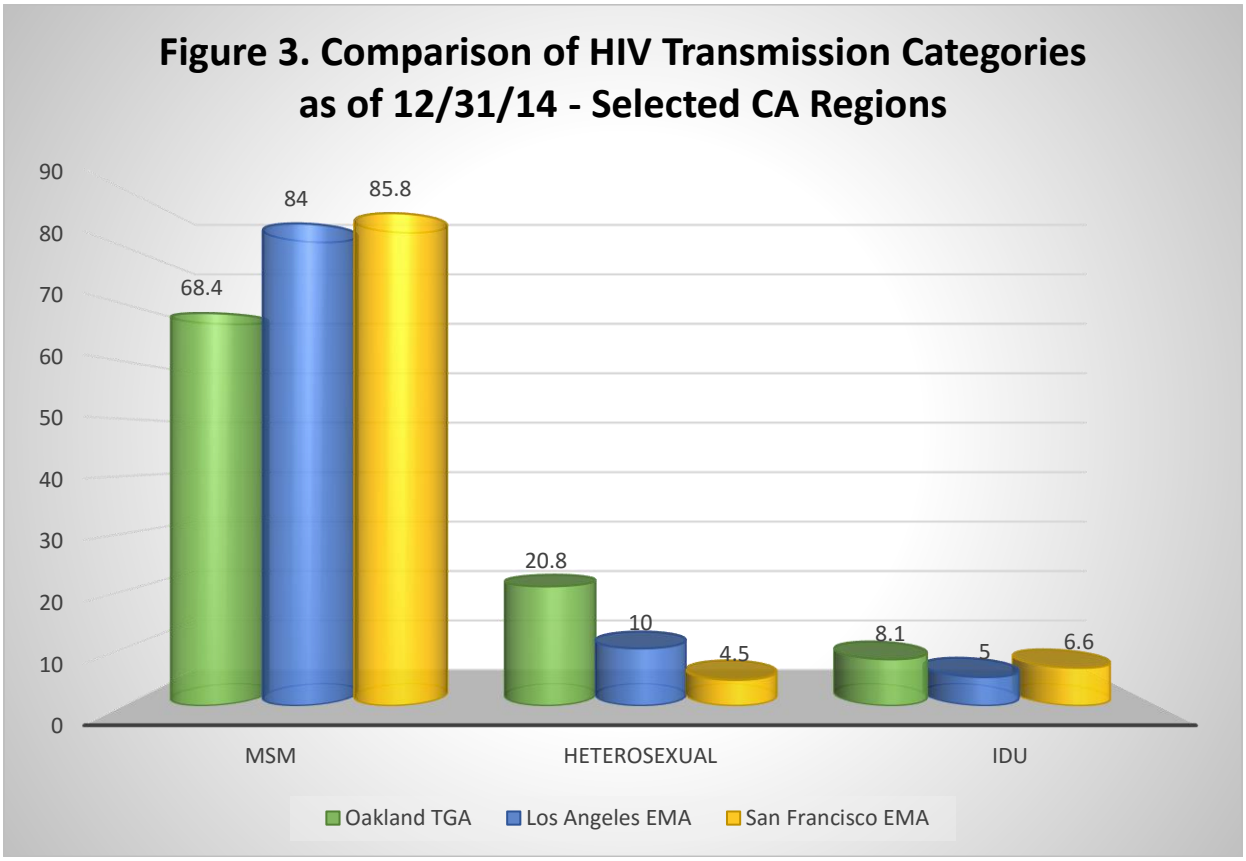
As of December 31, 2014, a total of **8,252** persons were living with HIV infection in our region, for an overall prevalence of **322.4** per 100,000 population, meaning that at least **1 in every 310** residents of the Oakland region is already living with HIV infection (see **Figure 2**).[3] Between 2002 and 2014, the total number of persons living with HIV in the region increased by **over 40%,** despite the fact that federal resources to address the epidemic have declined significantly over that period. A total of **6,121** persons living with HIV (PLWH) reside in Alameda County, representing **74.2%** of PLWH in the two counties, while **2,131** PLWH (**25.8%**) live in Contra Costa County.

Figure 2. Persons Living with HIV in Alameda & Contra Costa Counties as of December, 31, 2014

Demographic Group / Exposure Category	Combined PLWH as of 12/31/14	
Race/Ethnicity		
African American	3,115	37.7%
Latino	1,468	17.8%
Asian / Pacific Islander	470	5.7%
White (not Hispanic)	3,030	36.7%
Other / Unknown	169	2.0%
Gender		
Female	1,377	16.7%
Male	6,784	82.2%
Transgender	91	1.1%
Age		
12 Years and Younger	13	0.2%
13 - 24 Years	219	2.7%
25 - 29 Years	443	5.4%
30 - 39 Years	1,176	14.3%
40 - 49 Years	2,129	25.8%
50 - 64 Years	3,537	42.9%
65 Years and Above	735	8.9%
Transmission Categories		
MSM	5,174	62.7%
IDU	671	8.1%
MSM Who Inject Drugs	469	5.7%
Non-IDU Heterosexuals	1,718	20.8%
Other	83	1.0%
Unknown	137	1.7%
TOTAL	**8,252**	**100%**

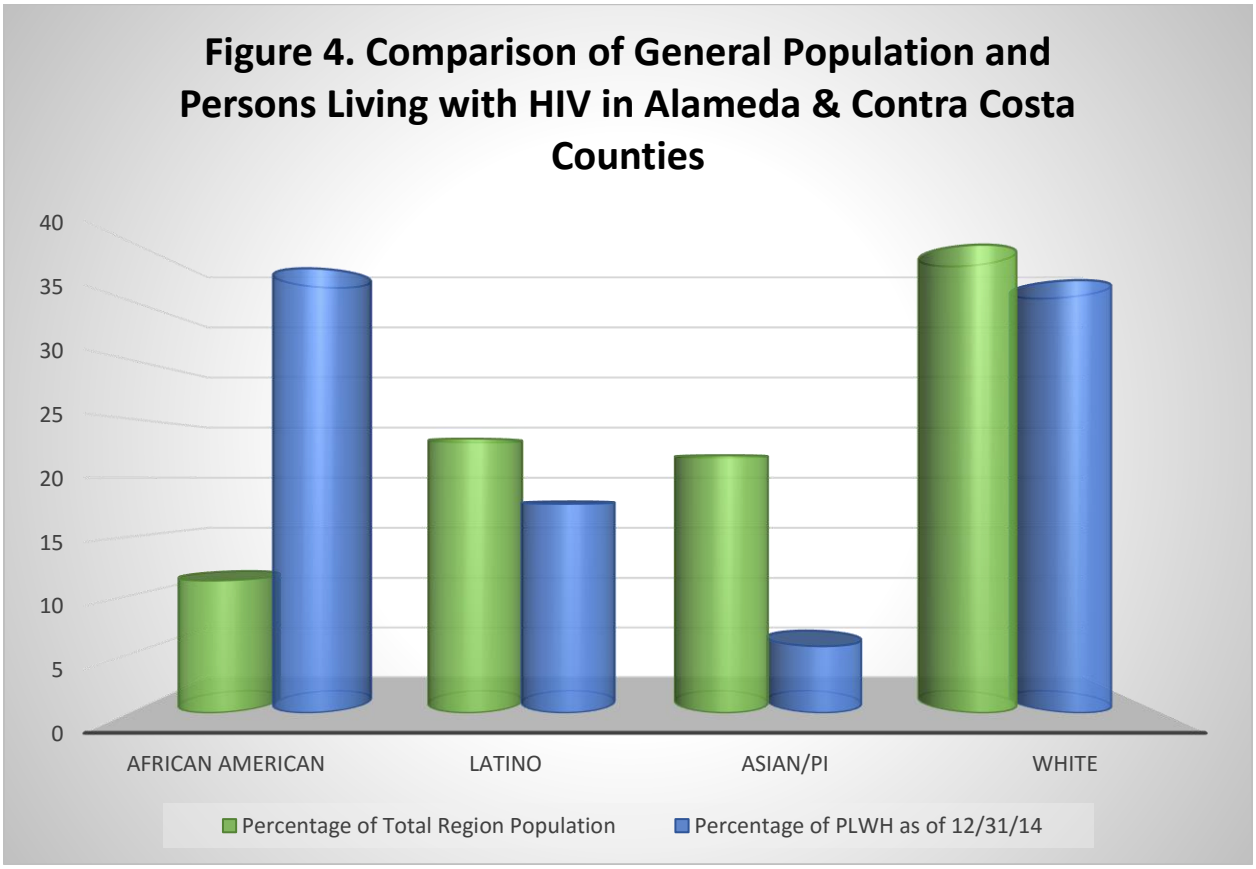
Mode of Transmission: As in the rest of California, the predominant mode of HIV transmission in the Oakland region continues to be **male-male sexual contact**. Men who have sex with men (MSM) account for slightly more than **two-thirds (68.4%)** of all persons living with HIV in the region (n=**5,643**), an increase from **63.9%** of cases five years ago. This includes **5,174** cases of HIV infection occurring through MSM contact only (**62.7%** of al PLWH) and another **476** cases occurring through both MSM and injection drug use (IDU) (**5.7%** of al PLWH). HIV infections attributed to heterosexual contact account for **20.8%** of all local cases (n=**1,718**) while **8.1%**

(**671** cases) are attributed to injecting drug use among heterosexuals. **While MSM make up the leading transmission category in the region, heterosexual and IDU cases constitute a larger share of the epidemic than in virtually any other metropolitan region in the western US**. The Oakland region is more comparable to regions in the east and south than to the west in terms of its HIV infection profile. **Figure 3** compares the composition of the local epidemic with other heavily impacted regions. Adult cases reported with no risk identified account for **1.7%** or **137** cases while **83** cases (**1.0%**) are attributable to other causes such as perinatal exposure or infection through blood or blood products.

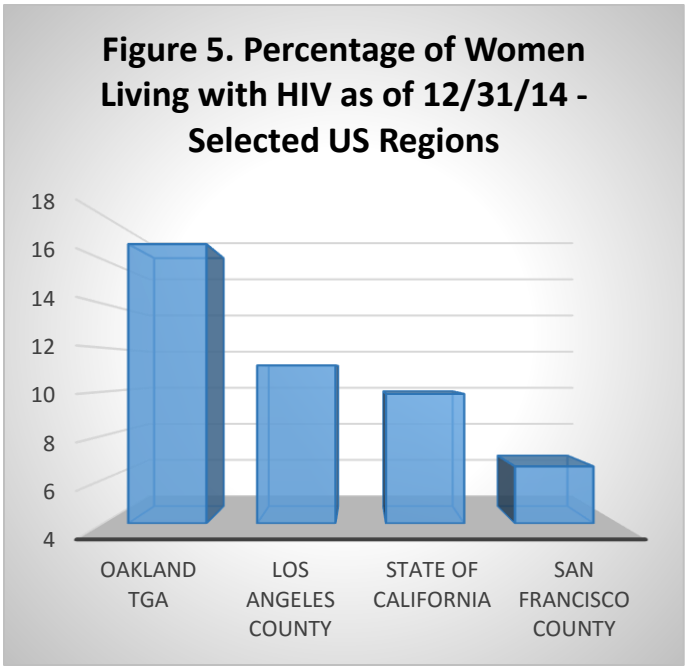


<u>Race/Ethnicity:</u> The HIV/AIDS epidemic in Alameda and Contra Costa Counties continues to have devastating consequences for African American populations. As of December 31, 2014, African Americans make up **37.7%** of all persons living with HIV in the region (n=**3,115** cases) while making up only **11.3%** of the region's total population, a startling over-representation of nearly **300%**. While roughly **1 in every 310** residents of the region is infected with HIV, **fully 1 in every 93 African American residents of the region is already infected with HIV - an infection rate higher than 1%.** The crisis of HIV among African Americans is so acute that in 1998 Alameda County took the unprecedented step of declaring a State of Emergency in relation to the African American HIV/AIDS epidemic, the first time that a local jurisdiction had taken such an action. African American cases are followed by cases among whites (**36.7%** or **3,030** cases); Latinos (**17.8%** or **1,468** cases); and Asian/Pacific Islanders (**5.7%** or **470** cases). African Americans are the only ethnic PLWH population in the two-county region that is over-represented in comparison to total

population (see **Figure 4**). The remaining **169** PLWH (**2.0%**) are persons of more than one race and persons of other races.



<u>Gender:</u> The Oakland region contains the highest percentage of diagnosed AIDS cases among women of any major metropolitan area in the western United States. As of December 31, 2014, fully **16.7%** of all persons living with HIV in our two-county region were women, as compared to percentages of **11.2%** for Los Angeles County, **9.9%** for the State of California, and **6.6%** for the San Francisco EMA (see **Figure 5**).[4] A total of **1,377** women were living with HIV in the Oakland region as of December 31, 2014. **The high prevalence of HIV and AIDS cases among women in our region has a highly disproportionate impact on African Americans.** Fully **61.3%** of all women with HIV in our region as of December 31, 2014 were African



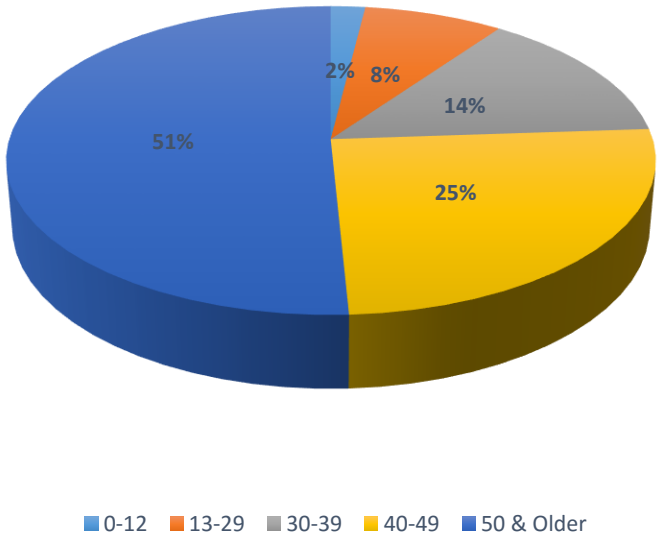
American while **13.7%** were Latina; **18.7%** were white; and **4.8%** were Asian and Pacific Islander (Asian / PI). **The disproportionate rate of HIV cases among African American women highlights the deadly magnitude of the HIV/AIDS epidemic within our region's communities of color**. In terms of transmission categories, the majority of female PLWH - **58.0%** - result from heterosexual transmission (n=**798**) while **21.2%** were infected through injection drug use (n=**292**). However, **20.2%** of women living with HIV have an HIV transmission category listed as "unknown." This may be related to unknown HIV risk among male partners.

As of December 31, 2014, nearly **one out of every five** persons living with HIV in the Oakland region was a woman, infant, child, or young person (WICY) age 24 or younger (approximately **1,570** persons living with HIV)**. The WICY population in the two-county region is by far the largest in the Western United States, creating severe challenges for both service providers and persons involved in identifying and linking these populations to care.** According to the most recent published CDC statistics through December 31, 2012 (the most recent date for which statistics could be obtained), the Oakland region WICY population was the **highest among all 14 western EMAs and TGAs,** with a WICY proportion nearly **three times higher** than that of our neighbor San Francisco EMA.

Additionally, a total of at least **91** transgender individuals - the vast majority of them transwomen - were living with HIV in the Oakland region as of December 31, 2014, representing **1.1%** of the region's total PLWH population. However, this may significantly under-represent the magnitude of the transgender epidemic in our region, both because of inaccurate reporting of gender at time of HIV testing and because of the ongoing stigma against these groups which can result in an unwillingness to seek or obtain HIV testing or care.

<u>Age Group:</u> As in many jurisdictions hard-hit by HIV, persons 50 and older with HIV now make up the majority of persons living with HIV in Alameda and Contra Costa Counties (see **Figure 6**)**.** Through December 31, 2014, fully **51.8%** of all persons living with HIV in the Oakland region were age 50 or older (n=**4,272**), including **42.9%** ages 50 - 64 (n=**3,537**) and **8.9%** age 65 and above (n=**735**). According to the most recent analysis in the region, the vast majority of PLWH 50 and older are **long term survivors**, with fully **71.1%** of PLWH age 50 and above having lived with an HIV diagnosis for **more than 10 years** including nearly **one-quarter** (**21.7%**) who have lived with HIV for **more than 20 years.** Aging populations will present challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care,

Figure 6. Age Distribution of PLWH in Oakland Region as of 12/31/14



and for meeting the long-term needs of clients with increasingly complex health problems. New models will need to be devised to provide effective services to aging populations that link and integrate HIV and geriatric specialty care and that ensure effective medical homes that successfully combine HIV and aging approaches and support services.

Meanwhile, persons between the ages of 40 and 49 made up the next largest group of PLWH in the Oakland region as of 12/31/14 (**2,129 PLWH / 25.8%**) while persons 30 - 39 made up **14.3%** (n=**1,176**). Young people between the ages of 13 and 29 made up **8.1%** of PLWH, including **2.7%** between the ages of 13 and 24 (n=**219**) and **5.4%** between the ages of 25 and 29 (n=**443**). A total of **13** children age 12 and younger were reported to be living with HIV as of the end of 2014, the vast majority of them HIV-exposed youth in treatment.

Trends in New HIV Infections: Data on new HIV infections in Alameda and Contra Costa County suggest potential shifts in HIV case rates that may in time signal larger changes in the overall local HIV epidemic. Data on new HIV infections in Alameda and Contra Costa County outlined on the following pages show differences between newly identified HIV-positive populations and the overall population of persons living with HIV across several categories. These trends are highlighted in the following figures:

- **Figure 7** shows ethnicity among men who have sex with men (MSM) with HIV, revealing substantial reductions in new HIV infections among white populations and increases in new infections among African Americans, Latinos, and Asian / Pacific Islanders, relative to the ethnic distribution among MSM already living with HIV.

- **Figure 8** shows the age distribution among MSM living with HIV and among those newly diagnosed with HIV; thirty-nine percent of new HIV infections in Alameda County between 2012 and 2014 occurred among MSM ages 0-29 and 43% of new HIV infections in Contra County between 2013 and 2014 occurred among this population.

- **Figure 9** shows ethnicity among those persons 50 and older living with HIV and among those 50 and older with new HIV infections, in both Contra Costa and Alameda Counties.

- **Figure 10** shows gender among those persons 50 and older living with HIV and among those 50 and older with new HIV infections, in both Contra Costa and Alameda Counties.

- **Figure 11** shows ethnicity among young people ages 13-24 living with HIV and among those with new HIV infections.

Figure 7. Ethnicity of MSM with HIV and Newly Diagnosed MSM with HIV in Alameda & Contra Costa County

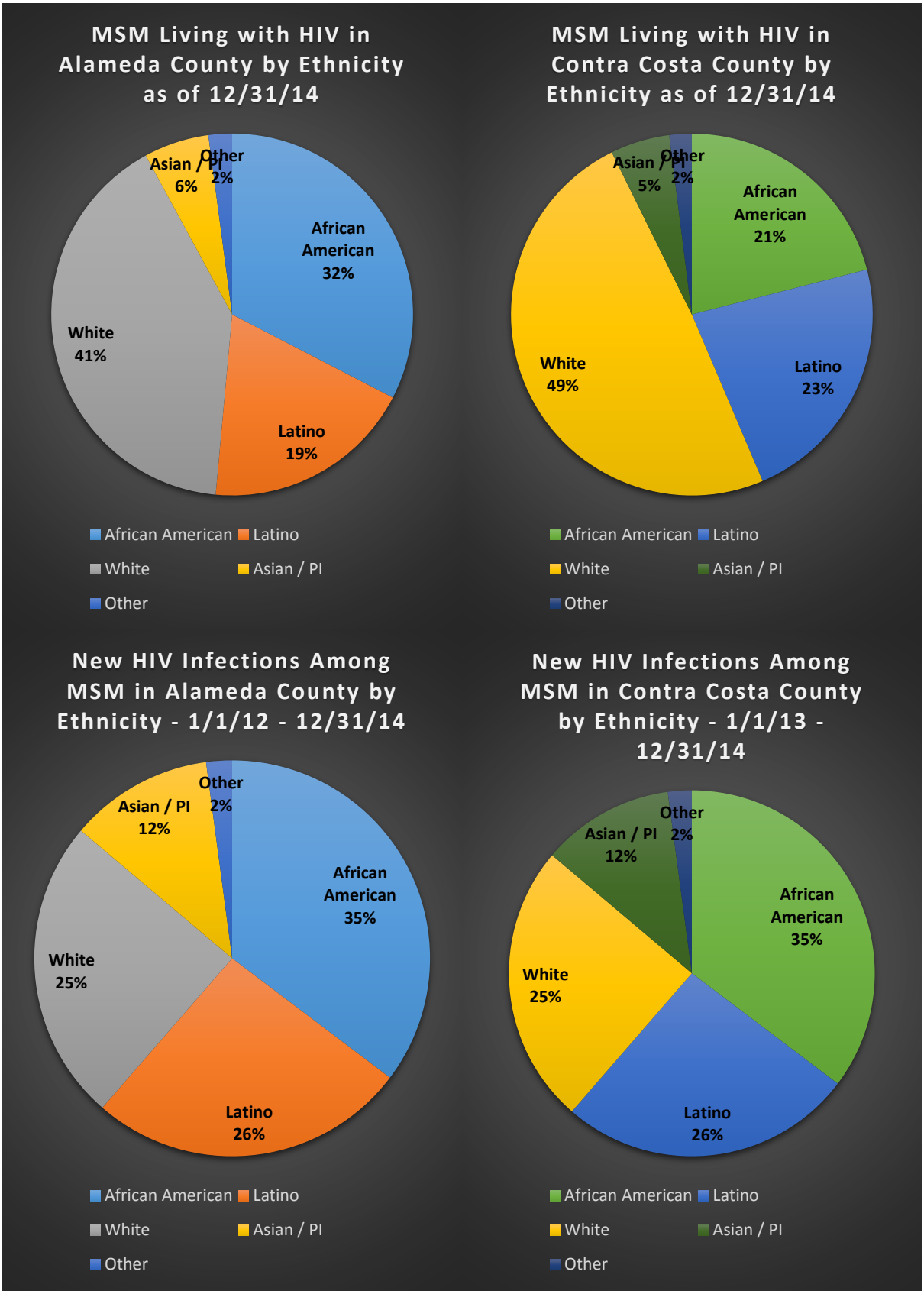


Figure 8. Age of MSM with HIV and Newly Diagnosed MSM with HIV in Alameda & Contra Costa County

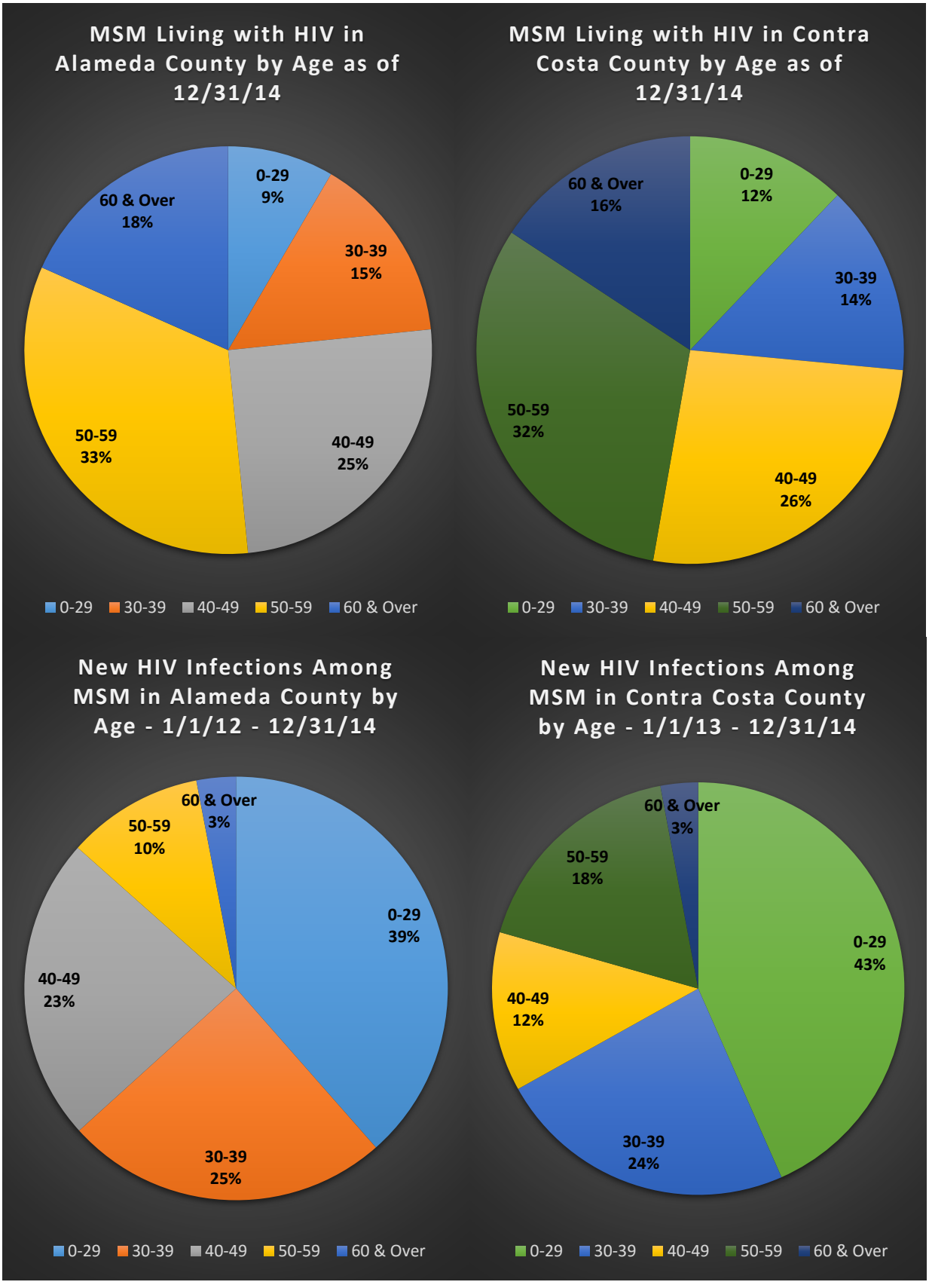


Figure 9. Ethnicity of Persons 50 & Older with HIV and Newly Diagnosed Persons 50 & Older with HIV in Alameda & Contra Costa County

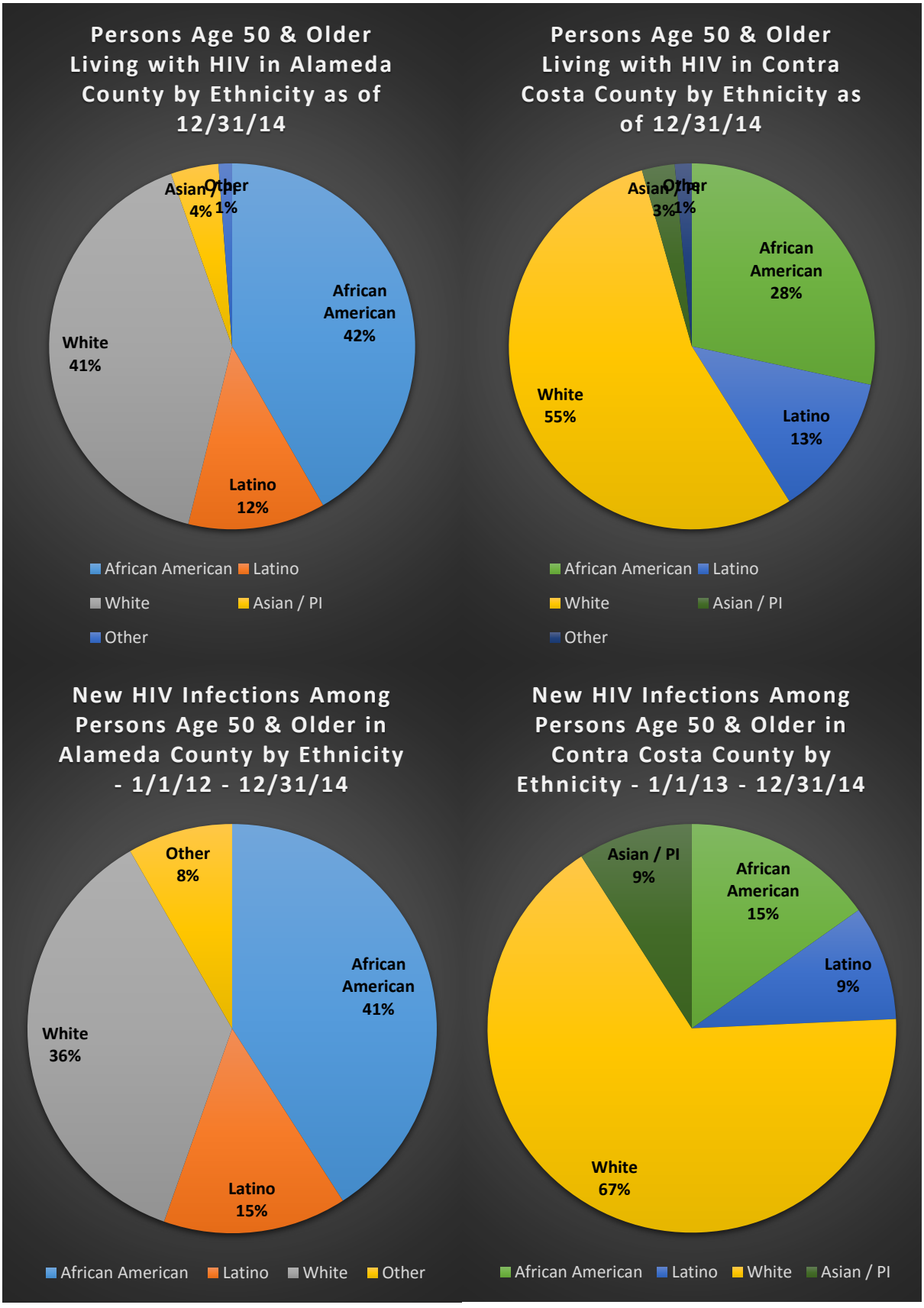


Figure 10. Gender of Persons 50 & Older with HIV and Newly Diagnosed Persons 50 & Older with HIV in Alameda & Contra Costa County

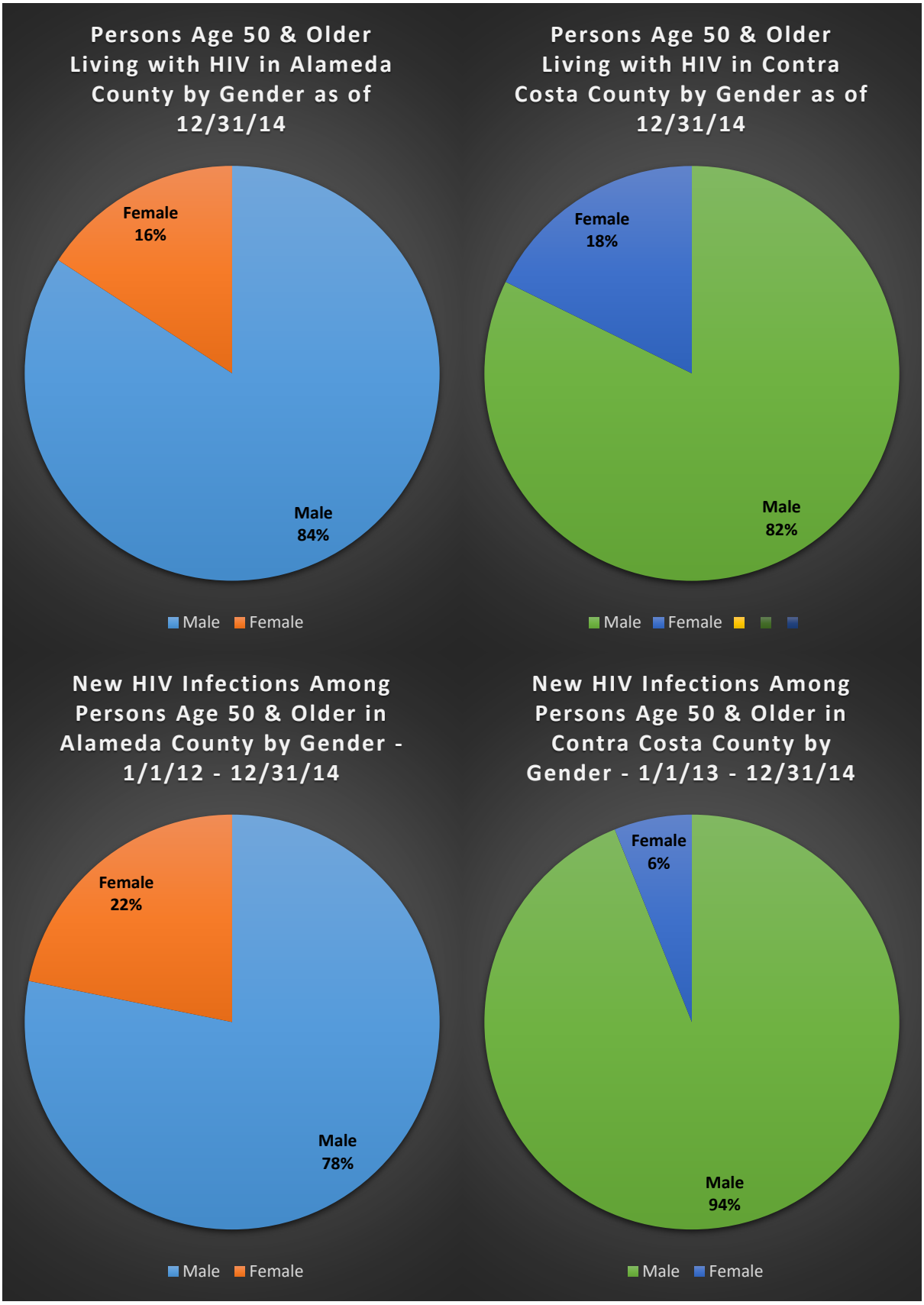
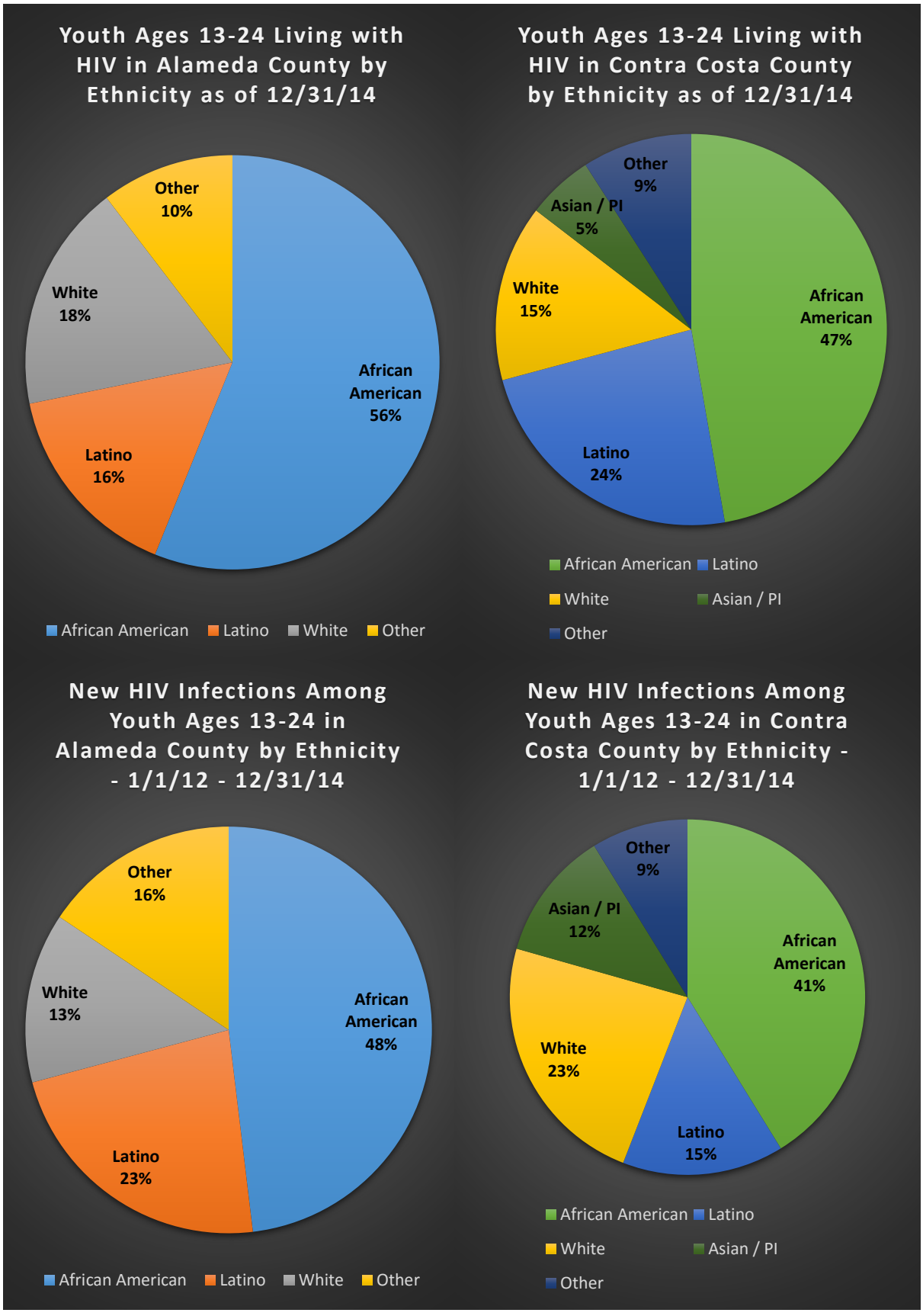


Figure 11. Comparison of Ethnicity of Youth Ages 13-24 with HIV and Newly Diagnosed Youth Ages 13-24 with HIV in Alameda & Contra Costa County



Late HIV Diagnosis: Late HIV diagnosis - defined as newly diagnosed persons with HIV receiving a diagnosis of AIDS either **at the same time** as their HIV diagnosis or **within 12 months** of their HIV diagnosis - has been a persistent problem in the Oakland region. High rates of late HIV diagnosis suggest that people are not being tested for HIV early in their infection, and are in turn not accessing treatment early enough to prevent progression to AIDS. In Contra Costa County, late diagnoses account for **27.2%** of all newly identified HIV infections in 2013 and 2014. **However, in Alameda County, late diagnoses make up 40.5% of all newly identified HIV infections from January 1, 2011 through December 31, 2013.** The late HIV infection rates in Alameda County show little variation by race and ethnicity, although whites have the lowest rate of late diagnosis at **37.4%** (see **Figure 12**). Men in Alameda County have substantially higher rates of late diagnosis than women in the County (**42.0%** vs. **31.2%**) (see **Figure 13**). Across age groups, persons 50 and older show the highest proportion of late HIV diagnosis (**52.7%**), followed by persons 40-49 (**43.8%**) and young people ages 13-19 (**42.9%**) (see **Figure 14**). Late HIV diagnosis is a marker for how far our region still has to go in prompting high-risk persons and groups to receive HIV testing earlier and more consistently, and forms the basis of several of our Action Plan objectives, including objectives to significantly expand HIV testing utilization by men who have sex with men and transgender persons and to eliminate HIV disparities throughout our region.

Figure 12. Late HIV Diagnosis by Ethnicity Among All New HIV Diagnoses, Alameda County, 2011-2013

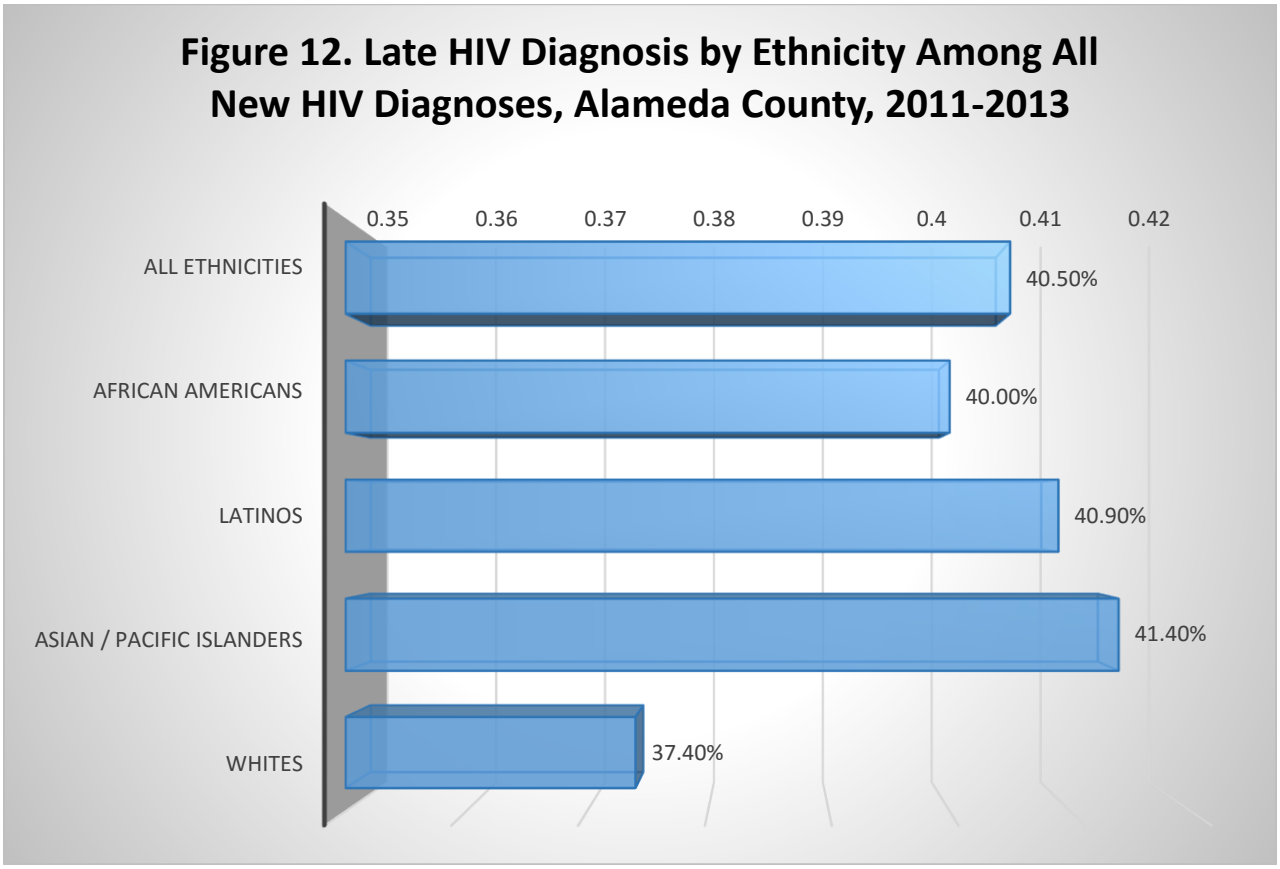


Figure 13. Late HIV Diagnosis by Gender Among All New HIV Diagnoses, Alameda County, 2011-2013

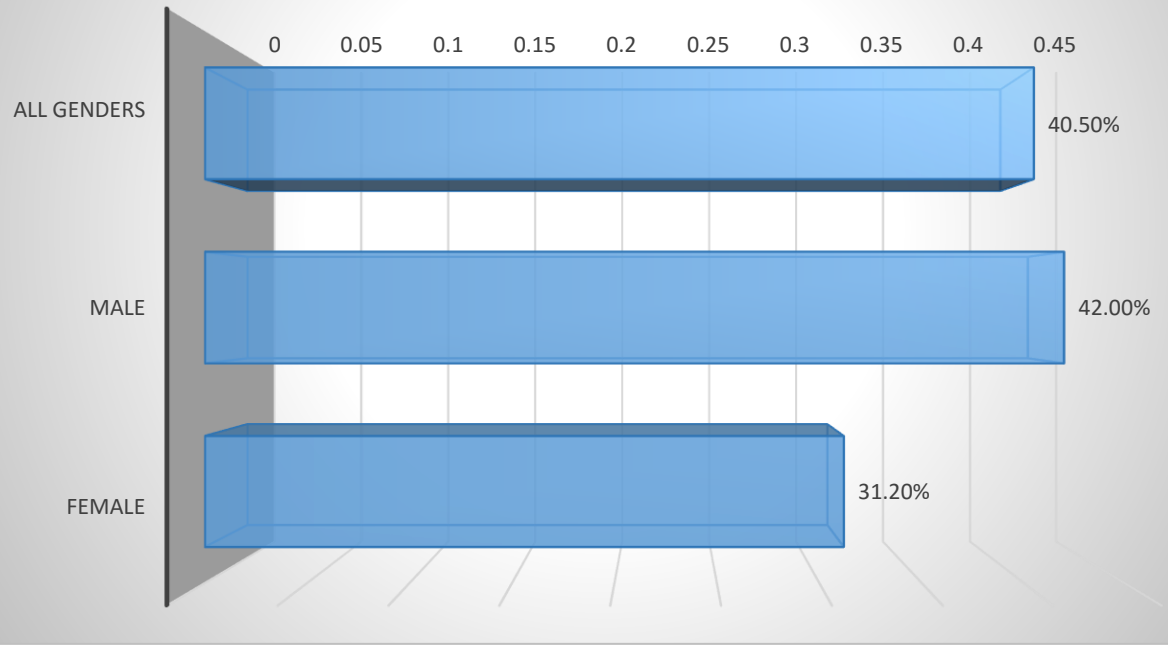
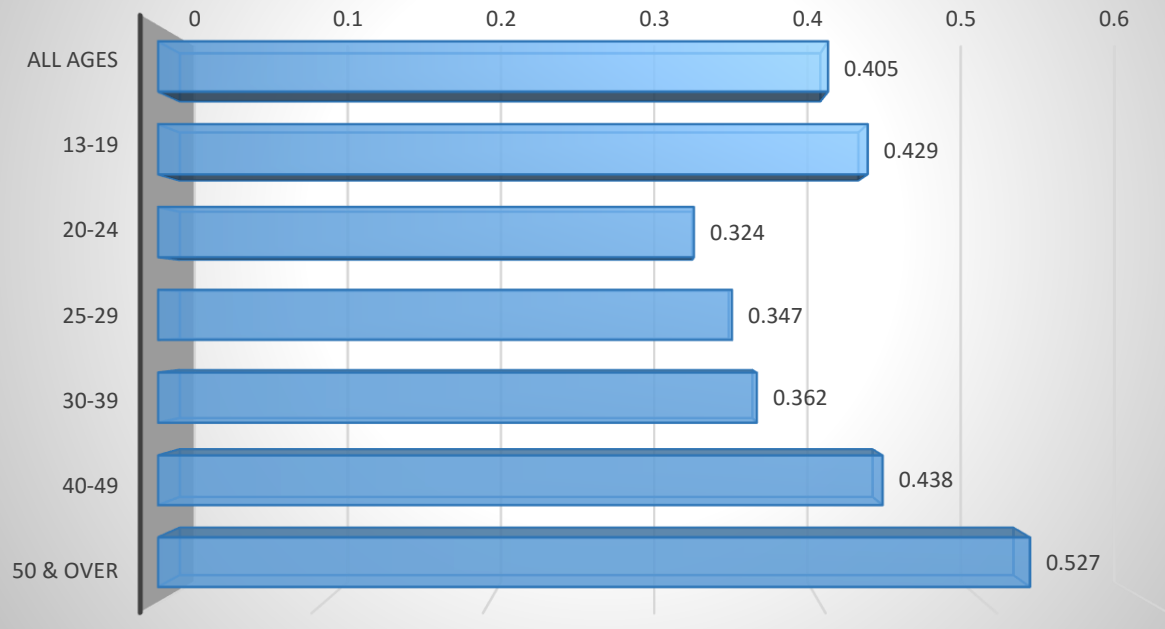


Figure 14. Late HIV Diagnosis by Age Among All New HIV Diagnoses, Alameda County, 2011-2013



Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP): A substantial body of research now supports the efficacy of PrEP, oral antiretroviral therapy (ART) medications taken by persons at risk for HIV, in order to prevent new HIV infections. Approval of Truvada for use as PrEP by the US Food and Drug Administration in 2012 opened the door to broader PrEP utilization and insurance coverage. PEP, an intervention in which ART medications are taken immediately following a high-risk encounter and continued for 28 days to prevent HIV infection, has been available for longer but remains underutilized. Both PrEP and PEP are currently administered to high-risk HIV negative individuals throughout the Oakland region. Most people are covered for both PrEP and PEP through insurance or pharmaceutical company access programs, but there are exceptions and steep co-pays may apply in some cases.

While PrEP utilization has grown rapidly, there are still significant disparities in the degree to which it is both publicized and utilized by specific high-risk populations. Many of the consumers interviewed as part of our own information-gathering process had little or no knowledge of PrEP or PEP, and believed it was not being publicized among groups such as women, transgender persons, MSM of color, and Spanish-speaking populations. Many providers fear that PrEP will replace behavior change counseling and prevention support interventions, which remain popular but difficult to scale-up, with no guarantee that individuals will use PrEP consistently or for extending lengths of time. There is also resistance to PrEP within African American and other communities that have been historically mistreated by the medical establishment, and which view the "magic pill" approach to HIV prevention with justifiable suspicion.

A further issue related to both PrEP and PEP use for HIV prevention is the difficulty in tracking their use, since there is no mechanism or legal requirement for reporting these interventions to local health jurisdictions outside of specific and limited funding program mandates. This makes it more difficult to identify disparities and to better target PrEP and PEP resources. A recent report by Gilead Sciences (June 2016) found that more than **40,000** persons in the US had so far filled Truvada subscriptions for PrEP, an increase of **52%** between late 2013 and late 2015.[5] Data on race and ethnicity was available for **42%** of these individuals, and among these, the study found that **72%** of PrEP prescriptions had been to white persons while **12%** of PrEP prescriptions had been to Latinos; **10%** to African Americans; and only **4%** to Asians. Moreover, the proportion of African Americans who started PrEP actually **dropped** from **12%** of prescriptions in 2012 to **10%** in 2015.[6] Another study conducted by the CDC found massive gaps between persons who are at high risk for HIV infection and eligible for PrEP and those who are actually receiving it. The CDC estimated that **24.7%** of MSM ages 18-59 (between 212,000 and 772,000 persons); **18.5%** of persons 18 and older who inject drugs (between 45,000 and 185,000 persons) and **0.4%** of heterosexually active adults (between 404,000 and 846,000 persons) had substantial risks for HIV infection indicating PrEP use, yet only **40,000** persons in the US were so far enrolled on the treatment.[7]

RAPID Early Intervention Model: The San Francisco General Hospital HIV/AIDS Division's Ward 86 HIV Clinic has pioneered the so-called **Rapid Antiretroviral Program Initiative for New Diagnoses (RAPID)** program, a comprehensive plan designed to overcome the financial and social barriers to linkage to care.[8] RAPID was created to provide **same-day linkage to care** for all newly diagnosed HIV patients who are initiating care at the Ward 86 clinic, with a focus on initiating **immediate ART** in these individuals. Five day "treatment packs" are dispensed for

new clients entering the clinic on the **same day** they have received an HIV diagnosis, a full set of labs are drawn and the patient meets with a social worker to ensure coverage for the continuation of the ART medications. The model has drawn national attention as an approach to beginning treatment for persons with very early HIV infection even **before** a confirmatory HIV test result is received, in order to reduce viral load. Early HIV infection likely contributes disproportionately to ongoing HIV spread and very early antiretroviral therapy may improve subsequent clinical outcomes. In Alameda County, there is currently limited access to RAPID treatment, despite the possible benefits to individual and community health. However, the Ryan White-funded HIV ACCESS program in Alameda County - a consortium of local FQHCs providing HIV specialty care to diverse populations - has already developed a protocol for RAPID treatment administration, and will be sharing the results of this pilot program with the Planning Council. The Council will work with HIV ACCESS to disseminate findings of the program and to promote similar programs in our region should it prove successful.

c. Burden of HIV in the Service Area

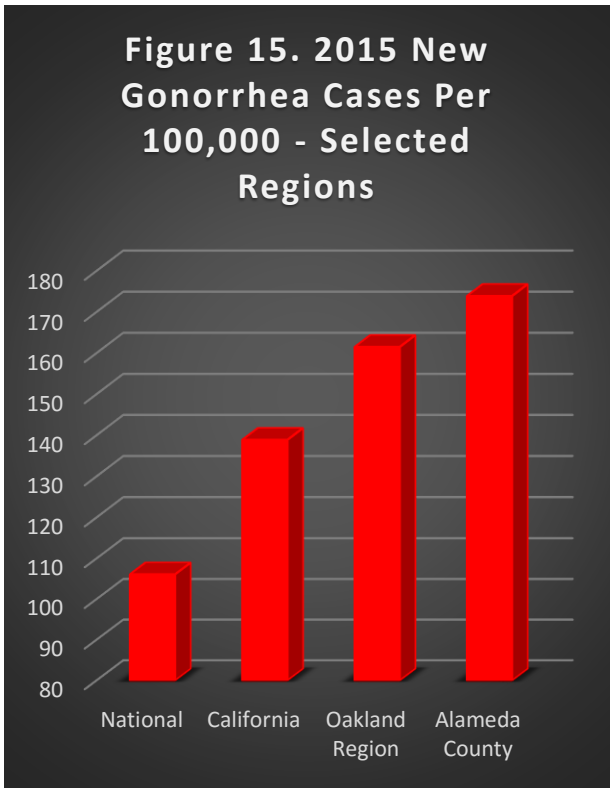
National HIV Behavioral Surveillance (NHBS) Data: As described in greater detail in Section I.E. below, the National HIV Behavioral Surveillance system tracks risk behaviors, HIV prevalence, and HIV incidence among populations at high risk for HIV infection in in a number of highly impacted US jurisdictions. NHBS data collection uses a survey instrument that collects information on demographics, social experience, sexual behavior, alcohol and substance use, drug treatment, HIV testing, health, and prevention activity. HIV testing is conducted in conjunction with the survey using validated HIV testing kits and standardized laboratory methods for confirmation of HIV-positive cases.

One of the key populations among which the NHBS collects data is **men who have sex with men.** MSM survey participants represent the broadest possible range of ages, ethnicities, and sociodemographic and behavioral characteristics, and provide a valuable sample for information on key HIV-related topics in the two-county region. In 2014, the NHBS focused in part on the use of **pre-exposure prophylaxis (PrEP)** among HIV-negative MSM. The NHBS survey found that PrEP use was higher than anticipated among HIV-negative MSM, reported by only **10%** of this group of survey respondents. Despite a relatively small sample size (**27** total persons using PrEP), the findings also confirmed the fact that at least in 2014, PrEP utilization was largely taking place among MSM who were white, college educated, and privately insured. White MSM made up **88.9%** of all persons on PrEP in the study, the same percentage as persons with private insurance. Persons with college or post-graduate degrees made up **70.1%** of all PrEP-using MSM identified through the survey, and **two-thirds** of respondents had personal incomes greater than $50,000 per year. These findings speak to the need emphasized in the Action Plan for greater publicizing of PrEP among ethnic minority and lower-income MSM communities in the Oakland region.

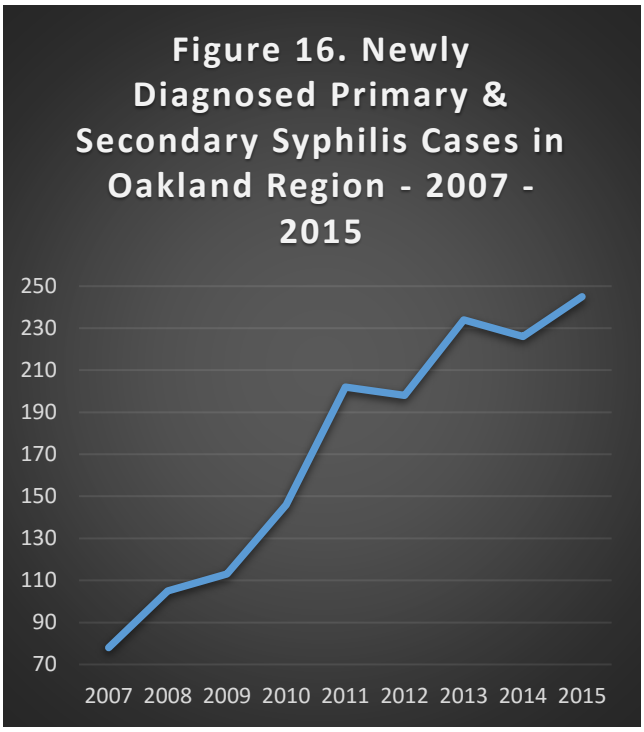
In terms of **persons who inject drugs (PWID)**, the NHBS conducts a sample **every three years** using the **respondents driven sampling (RDS)** methodology, in which persons participating in the survey in turn refer other social network members to the survey. PWID complete behavioral survey questions and then are tested for HIV. In 2012, the last year in which the PWID sample was conducted, over **two-thirds** of participants were male and slightly

less than **one-third** were female, with a small number of self-identified transgender participants. Whites made up **40%** of the sample; African Americans made up **30%** of the sample, and Latinos comprised **10%** of the sample. While the majority of participants identified as heterosexual, a significant populations identified as bisexual (**22%**) and homosexual (**8%**). **In terms of health coverage, NHBS data indicated a promising trend, with the proportion of persons who inject drugs reporting no health coverage declining from 62.1% in 2005 to 18.2% in 2012.** Self-reported HIV-positive status also declined from **12.0%** in 2005 to **6.8%** in 2012, while HIV rates based on lab tests were relatively stable at **13.6%** in 2009 and **11.6%** in 2012. Although over a third of PWID reported zero unprotected intercourse acts in the past six months, almost **half** reported having 6 or more unprotected sex acts in the same period. The most commonly used drug reported among PWID n 2012 was heroin, at **61.4%**, and methamphetamine, at **27.5**%. A large proportion of persons who inject drugs also reported using marijuana (**60%**) and downers (**25%**) in each of the survey waves. Also on a positive note, an increasing proportion of PWID reported accessing **clean needles** from pharmacies, with the proportion nearly doubling from **18.4%** in 2005 to **34.6%** in 2012.

Sexually Transmitted Infections (STIs): The Oakland region continues to experience a severe epidemic of sexually transmitted infections (STIs) which complicate the provision of care to persons with HIV and serve as ominous markers for the future of the HIV epidemic in our region. In terms of **gonorrhea,** for example, a total of **4,134** new cases were identified in the Oakland region in calendar year 2015 for a region-wide incidence rate of **161.5** cases per 100,000. This rate is higher than both the 2015 California rate of **138.9** cases per 100,000 and the national rate of **106.1** cases per 100,000 (see **Figure 15**).[9] Alameda County's 2015 gonorrhea incidence of **173.9** cases per 100,000 is the **9th highest incidence rate** of any of California's 58 counties and has increased by **75%** over the last four years alone, from a rate of **98.5** per 100,000 in 2012. Many of the region's new gonorrhea cases are occurring among **young women aged 15 – 24,** who accounted for **803** cases in 2015 or **19.4%** of all gonorrhea cases diagnosed in the two-county region. However, over the period 2011-2015, the number of gonorrhea infections among young men ages 15-24 **nearly doubled**, growing from **499** total cases to **817** cases in only four short years.



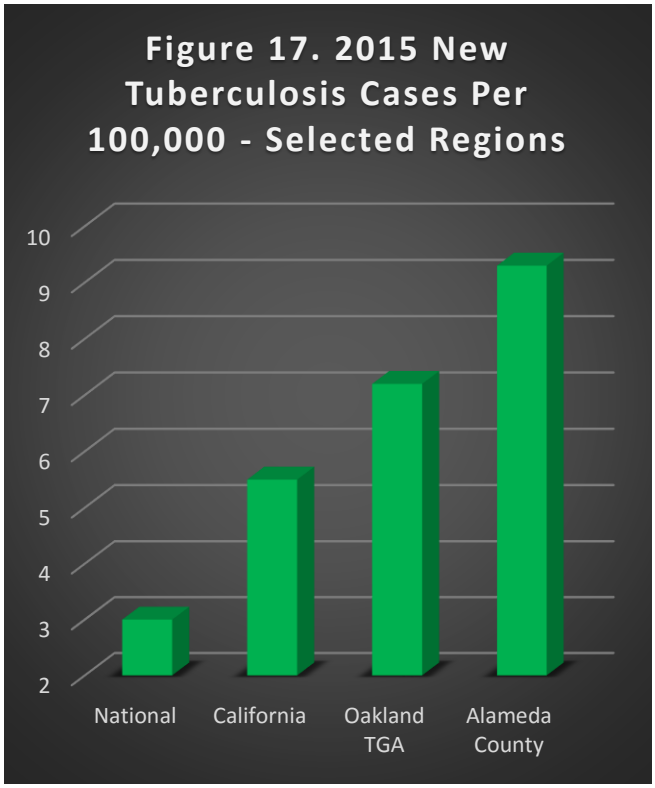
The Oakland region is also facing a serious epidemic of **Chlamydia,** with a total of **12,798** new Chlamydia cases reported during calendar year 2015 for a region-wide incidence rate of **500.1** per 100,000.[10] The 12,798 chlamydia cases diagnosed in 2015 represent a **40.0% increase** from the **9,148** cases diagnosed in 2006, and represent a significant threat to our region



particularly in terms of their indication of sexual risk for young women. **Nearly 2 in every 5** new Chlamydia cases diagnosed in the Oakland region in 2015 occurred among **young women between the ages of 14 and 24** (**39.7% /** n=**5,076**), including **2,967** cases in Alameda County for a stunning countywide rate of **2,997.2** per 100,000.

Syphilis also remains a serious problem in the Oakland region. In calendar year 2015, a total of **245** new primary and secondary syphilis cases were diagnosed in the region, for an overall region-wide incidence of **9.6** cases per 100,000, lower than the California incidence of **12.5** per 100,000 but significantly higher than the 2013 national incidence rate of **6.3** per 100,000.[11] The 2015 syphilis caseload represents a **23.7% increase** over the 198 new syphilis cases diagnosed in the Oakland region in 2012 and a **214% increase** over the **78** cases diagnosed in 2007 (see **Figure 16**). The local growth of syphilis cases has become a significant concern for both county health departments, which have launched intensive public education and prevention campaigns relating to the epidemic.

Tuberculosis: A total of **184** new cases of active tuberculosis were diagnosed in Oakland region in 2015, an increase of **18.0%** over the **156** cases diagnosed in 2014, reflecting a region-wide rate of **7.2** cases per 100,000. This rate is significantly higher than both the statewide rate of **5.5** cases and the national rate of **3.0** cases per 100,000 (see **Figure 17**).[12] In Alameda County the TB rate is significantly higher, at **9.3** cases per 100,000, meaning that Alameda County has the **4th highest tuberculosis rate among all of California's 58 counties.** Service data indicates that at least **27** Ryan White clients served in the last fiscal year were co-infected with TB and HIV. The treatment for TB is both costly and lengthy. HIV-positive patients with active TB need an initial chest x-ray, prophylactic treatment, and must be followed daily until the disease is controlled. Treatment for cases **of multidrug-resistant tuberculosis** are



particularly expensive, with one nationwide study indicating that the cost of treating multidrug-resistant TB - including indirect costs to families - averaged **$89,594** per person for those who survived, and as much as **$717,555** for patients who died.[13]

Hepatitis C: The growing local epidemic of **hepatitis C** also remains a significant concern. Because it is a blood-borne infection, hepatitis C is closely tied to injection drug use and is a frequent co-factor for persons living with HIV/AIDS, complicating care and often leading to severe long-term health consequences. In 2011 alone - the last date for which statistics are available - a total of **2,219** cases of hepatitis C were identified in the Oakland region, for a region-wide incidence of **86.7** per 100,000.[14] Co-infection with hepatitis C can make persons living with HIV unable to tolerate new treatments, and is the leading cause of death from chronic liver disease in America.[15] While significant advances have been made in hepatitis C treatment over the past two years, these treatments are extremely costly, and it is still unclear as to what extent insurers will be willing to shoulder the burden of treatment for low-income persons living with hepatitis C. At the present time, a 12-week course of Salvadi treatment costs **$84,000**, while a 12-week course of Harvoni treatment is **$94,500**. One study estimated a total of **$10.7 billion** in direct medical care costs related to HCV in the US for the years 2010 to 2019, along with a combined loss of **1.83 million years of life** in those younger than 65, at a societal cost of **$54.2 billion.**[16] The HIV care system is rapidly becoming the default medical provider for many persons with hepatitis C – a trend which, as persons with HCV age, will place enormous cost burdens on the system.

Poverty and Homelessness: Both Alameda and Contra Costa County face severe challenges related to poverty and a shortage of affordable housing, issues that have particularly damaging impacts on persons living with HIV. According to the National Low Income Housing Coalition, Alameda and Contra Costa County both rank among the **five 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 (see **Figure 18**).[17] At the same time, the four counties that surround the Oakland region are all in the **top six** most expensive counties in the US, creating a desperate housing squeeze for low-income persons. Because of the high costs of housing, low vacancy rental unit rates in the two counties (only **2.7%** in Alameda County and **3.3%** in Contra Costa 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 found **4,040** individuals living in streets or shelters on the

Figure 18.
Top 10 Least Affordable Counties in the U.S. in Terms of Housing Costs, 2016

County	Hourly Wage Needed to Rent a Two-Bedroom Apartment at HUD Fair Market Rents
San Francisco County, CA	$ 44.02
Marin County, CA	$ 44.02
San Mateo County, CA	$ 44.02
Alameda County, CA	$ 40.44
Contra Costa County, CA	$ 40.44
Santa Clara County, CA	$ 38.35
Honolulu County, HI	$ 38.17
Orange County, CA	$ 32.15
Pitkin County, CO	$ 31.96

night of the count, while Contra Costa County's most recent count found **3,715** homeless individuals on the night of count, resulting in estimates of at least **15,000** individuals in the two counties find themselves homeless at some point during the year.[18] In Alameda County, African Americans made up **54.0%** of all sheltered and unsheltered homeless persons, despite making up only **11.8%** of the county's population.[19] The National Alliance to End Homelessness estimates that **3.4%** of homeless people are HIV-positive. Although this estimate varies widely by geographic region, the homeless population has a median HIV prevalence rate at least **three times higher** than the general population.[20] The chart on the following page outlines key indicators of poverty and homelessness in the two-county region, including the fact that a **majority** of individuals in both counties - regardless of income - pay **more than 30%** of their monthly income on rent and that more than **one-quarter** pay **more than 50%** of their monthly income on rent (see **Figure 19**).

The high rates of homelessness and poverty experienced by persons living with HIV in comparison to the general population place PLWH at a much greater risk for negative health outcomes than the general public as a whole. Utilization databases indicate that **18.9%** of Ryan White clients in the region had a period of homelessness or unstable housing during the most recent 12-month reporting period, while **13.9%** of respondents to the most recent Oakland region Needs Assessment reported that they had been homeless in the last five years and **14.3%** stated that they had lived in a homeless shelter at some point during that time. Oakland Ryan White clients are far less likely to attend to basic healthcare needs, and often present at emergency rooms with advanced ailments such as abscesses, blood poisoning, and AIDS diagnosis in late stages of HIV infection.

Figure 19. Selected Socioeconomic Characteristics of the Oakland Region[21]

County	Point in Time Homeless Estimate	Homeless Rate	Federal Poverty Rate	Households Paying 30% or More of Income in Rent	Households Paying 50% or More of Income in Rent	Unemployment Rate	Vacancy Rate for Rental Units
Alameda	4,040	0.25%	12.5%	50.1%	26.2%	5.4%	2.7%
Contra Costa	3,715	0.34%	10.5%	52.9%	26.9%	5.6%	3.3%

Formerly Incarcerated Individuals: While absolute numbers of incarcerated persons with HIV are difficult to ascertain, a blinded HIV seroprevalence survey of inmates entering California Department of Corrections reception centers found that **2.5%** of entrants were HIV positive with rates highest among African American women (**2.8%**) and African American men (**2.3%**).[22] By applying this **2.5%** to the total of **65,000** inmates released to Alameda and Contra Costa counties over the last 3 years,[23] we estimate that a minimum of **1,625** HIV infected inmates are released to the two counties in the Oakland region each year. Most of these prisoners return to the low income neighborhoods in either Oakland in Alameda County or Richmond and San

Pablo in Contra Costa County. As is the case with the local Ryan White client population generally, HIV positive prisoners reentering our region from state, federal and local incarceration facilities deal with a wide variety of health problems in addition to HIV. A California Department of Health Services study reveals that the prevalence of hepatitis C in California prisons is **34%** and hepatitis B is **28%.** Estimates of prisoners with serious mental illness are as high as **20%**. Alcohol and other drug abuse rates are estimated to be as high as **85%.** California's **70%** recidivism rate is also nearly twice the national average. A high rate of recidivism means that many parolees reenter prison several times, which can subject HIV-positive individuals to treatment delays or interruption if the individual refuses medication in prison to avoid revealing that he is HIV positive.

Mental Illness: According to local HIV providers, about **one third** of all Ryan White clients in the Oakland region present with mental health issues each year. The most commonly reported mental health problem in the 2010 Needs Assessment was **depression**, with a near-majority of respondents (**47.8%**) reporting having been diagnosed with depression, and **42.2%** having been diagnosed with anxiety disorder. Another **16.5%** had been diagnosed with post-traumatic stress syndrome while **12.7%** suffered from bipolar disorders. Transgender women and women of color reported being diagnosed and treated more frequently than other groups with **66%** of transgender women and **48%** of women of color reporting diagnosis and treatment for depression. An additional **8.5%** of Needs Assessment respondents reported being diagnosed with bipolar disease, with women of color (**16%**) and IDU (**9.5%**) diagnosed more than other groups.

Substance Use: Local providers report that at least **25%** of our region's Ryan White clients present with substance abuse issues each year, and that nearly **17%** of these are injection drug users. Tri City Health Center, a community based medical care provider in south Alameda County, has reported that **57%** of clients who identified as MSM stated that they engage in substance use and/or experience depression, anxiety or mental illness while **41%** of Latino clients reported these same problems. There were a total of **1,140** IDU PLWH cases in the Oakland region as of December 31, 2014, including MSM who inject drugs, representing **13.8%** of all PLWH in the region. A collaborative study involving the University of California AIDS Research Program, the Grantee, and Tri-City Health Center found a notable diversity in the ethnic background of methamphetamine using HIV positive MSM in Alameda County. Investigators conducted ethnographic mapping, field observations and qualitative interviews, and found that after learning about their positive status many MSM engaged in a period of accelerated meth use and suffered deteriorating health.[24]

Rapidly Aging HIV Service Population: As in many jurisdictions hard-hit by HIV, **persons 50 and older with HIV** have now become the largest population being treated by the local HIV service system, making up **more than half** of all persons living with HIV and AIDS (**51.8%**). Aging populations will present challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care, and for meeting the long-term needs of clients with increasingly complex needs. New models will need to be devised to provide effective services to aging populations that link and integrate HIV and geriatric specialty care and that ensure effective medical homes that effectively combine HIV and aging approaches and support services.

Impact of Intimate Partner Violence: **Intimate partner violence (IPV)**, also referred to as domestic violence, is a major public health issue in the United States. According to the 2010 National Intimate Partner and Sexual Violence Survey (NIPSVS), approximately **1 in 3** women and **1 in 4** men in the United States have experienced physical violence, rape, and/or stalking by an intimate partner in their lifetime.[25] IPV is closely related to HIV infection, with one national study among 14,000 women finding that at least **12%** of HIV infections were attributed to intimate partner violence within this population.[26] Other studies have shown that HIV-positive MSM may be at least as likely to be survivors of IPV as HIV-positive women[27] and that HIV-positive MSM are more likely than HIV-negative MSM to report both physical and psychological abuse by a partner in the past 5 years.[28] In 2013, the Oakland TGA Collaborative Community Planning Council commissioned a targeted needs assessment in part designed to explore the impact of intimate partner violence on both HIV infection and on access to and utilization of HIV care in the region. Findings in regard to the IPV included the following:

- Of consumers who completed detailed surveys, fully **25%** reported having been survivors of intimate partner violence;
- Contrary to traditional views, **38%** of consumers who identified themselves as IPV survivors were **men** and **62%** were **women**;
- **Twenty percent** of whites, **27%** of African Americans, and **28%** of Latinos who responded to the survey reported being survivors of IPV
- Among persons who were IPV survivors and PLWH, more than **half** said they thought their experience with IPV affected whether they became HIV-positive or had an impact on their health as a PLWH; and
- Among agency providers who participated in the study, **72%** said that domestic violence is an important issue among their agency's clients.

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B. HIV Care Continuum

a. HIV Care Continuum Overview

The tables on the following pages show the most recent HIV continuum of care data for both Alameda and Contra Costa Counties, California. While the two counties are moving toward a reliable merged continuum chart, some specific data barriers make a presentation of separate continuum tables more accurate for purposes of this Plan.

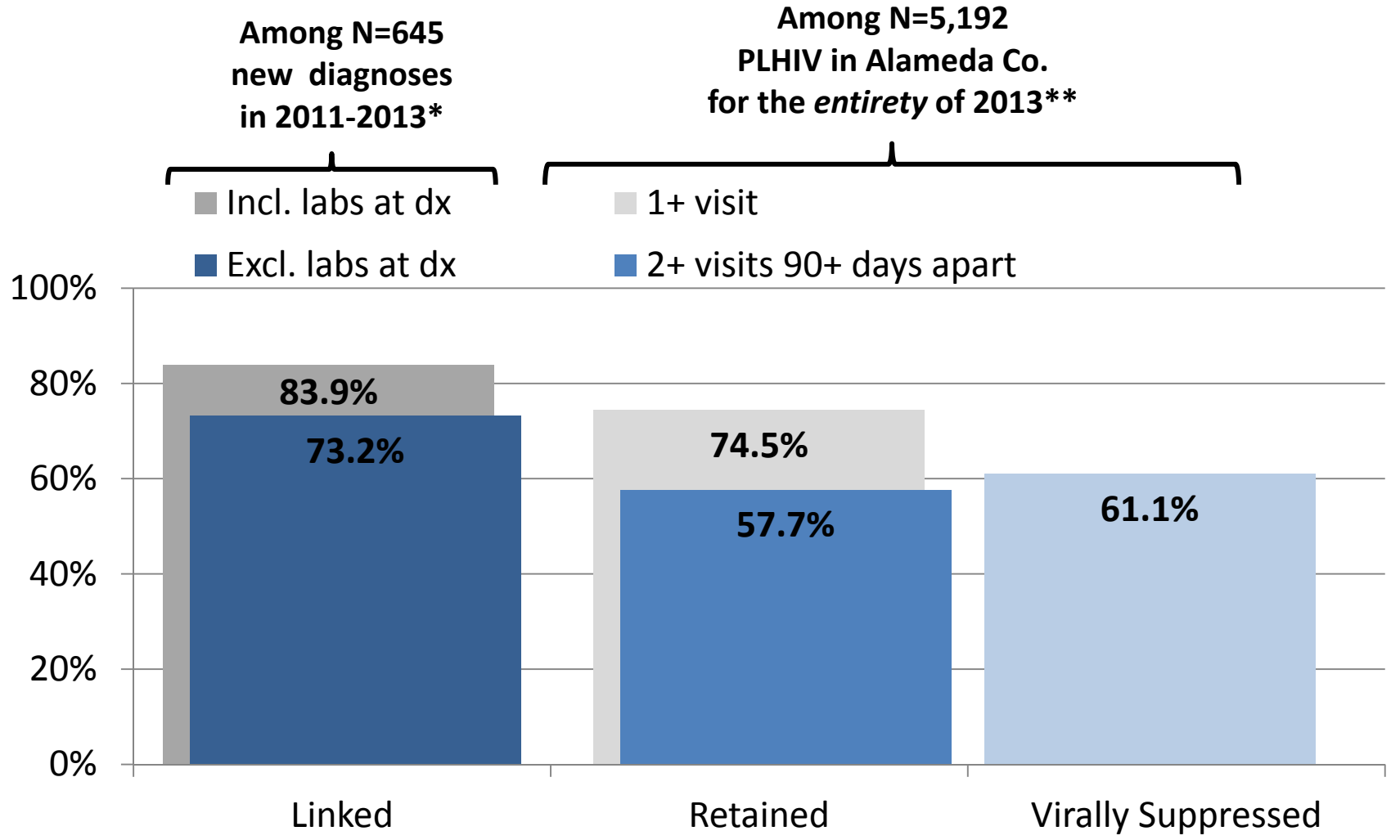
In Alameda County, a total of **645** new HIV diagnosis occurred between January 1, 2011 and December 31, 2013. The County's continuum chart provides two alternate methods of assessing whether an individual has been effectively linked to care within 90 days of diagnosis. The first method counts **all** CD4 and viral load tests ordered among new patients, including tests ordered at the time of diagnosis. Using this standard, a total of **83.9%** of Alameda County residents were effectively linked to care within 90 days. However, this may not always be a truly accurate measure of linkage to care, since some tests are automatically ordered before the patient receives a confirmatory HIV test, without the patient actually returning to receive confirmatory results or following up in care. An alternative standard is to **exclude** laboratory tests at diagnosis, to include only those individuals who actually followed up with a subsequent medical appointment. Using this standard, a total of **73.2%** of newly diagnosed patients from 2011 through 2013 were linked to HIV care.

Meanwhile, among the total of **5,192** persons living with diagnosed HIV in Alameda County in 2013, **57.7%** were retained in care using a standard of at least **two** medical visits in a calendar year taking place at least 90 days apart, while **74.5%** were retained in care using a standard of at least **one** medical visit in a calendar year. The standard of one visit per year is gaining greater usage since many patients who are stable, long-term survivors with undetectable viral loads are no longer required to return to their provider for more than annual visits. Finally, **61.1%** of all persons with HIV in the County in 2013 were confirmed as virally suppressed, defined as having a viral load of less than 200 copies per milliliter (<200 copies/ml).

In Contra Costa County, **258** new HIV diagnoses were made between January 1, 2012 and December 31, 2014, and of these **83%** were linked to care within 90 days of diagnosis as measured by any confirmed HIV lab test. While **8.2%** of newly diagnosed persons did not receive a lab test, just under **70%** received a lab test within 30 days of HIV identification and **22%** received a lab test within 31 and 90 days of identification. Among the **2,074** PLWH living in the county in calendar year 2014, **78%** were retained in care using the standard of at least **one** lab test in a given 12-month period. Fully **70%** of all PLWH living in the county were found to be virally suppressed as measured by their latest viral load test during calendar year 2014.

The continuum findings for the two counties of the Oakland region demonstrate better outcomes along each stage of the HIV care continuum than for either California as a whole or the entire US. Between 2011 and 2014 alone, the percentage of PLWH who were virally suppressed in Contra Costa County rose from **50.2%** to **69.7%** - an increase of nearly 20%. **Figure 20** compares the most recently available continuum data for our two counties and the state and US. While we have much work to do, it is important to acknowledge the progress we have made in achieving better outcomes along each stage of the HIV continuum.

The Continuum of HIV Care in Alameda County

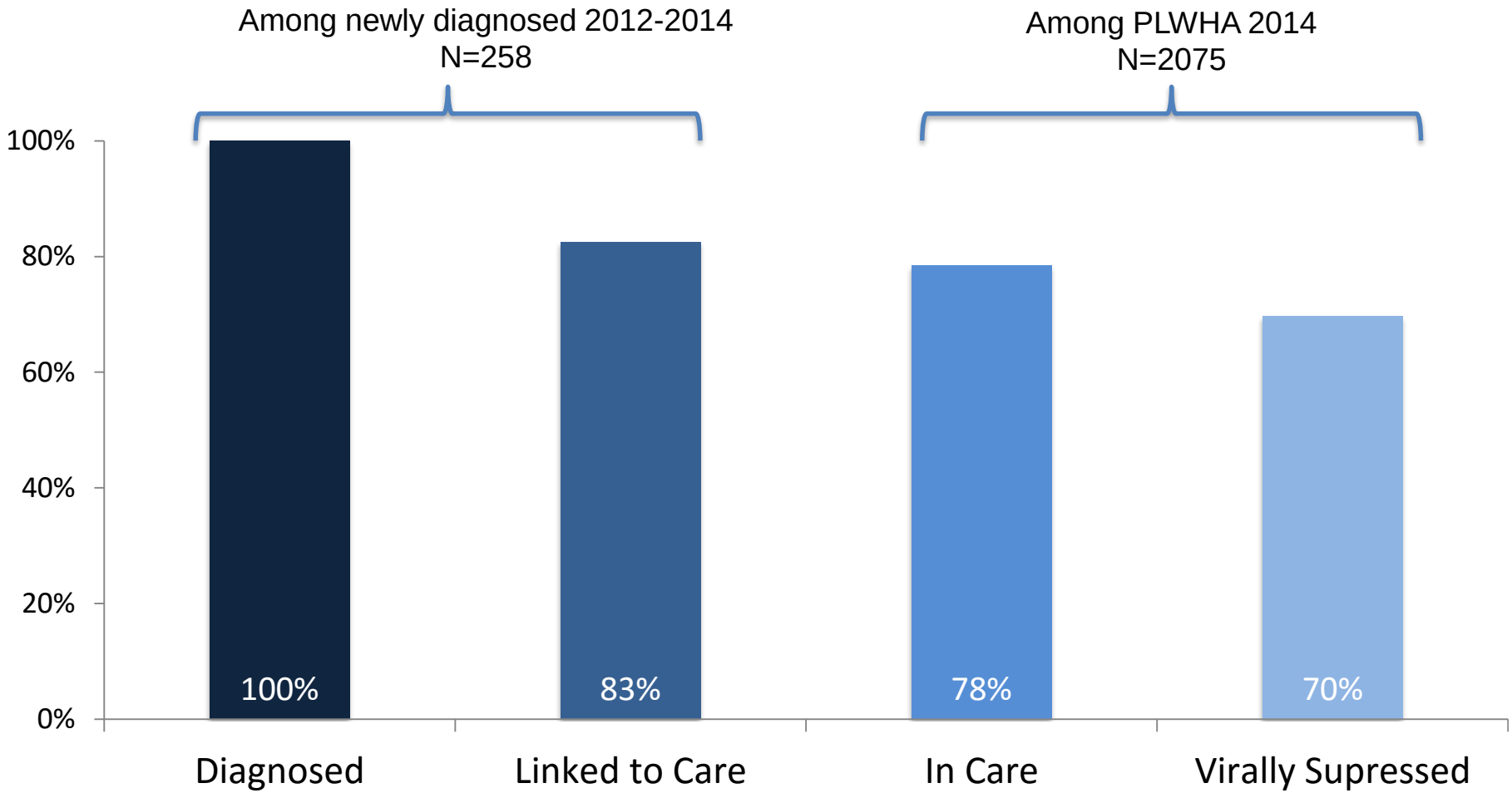


*Of 660 total diagnoses, 15 died within 90 days and are excluded from analysis

**Of 5,441 PLHIV at year-end 2012, 60 are known to have died and an additional 189 to have moved out of Alameda County in 2013

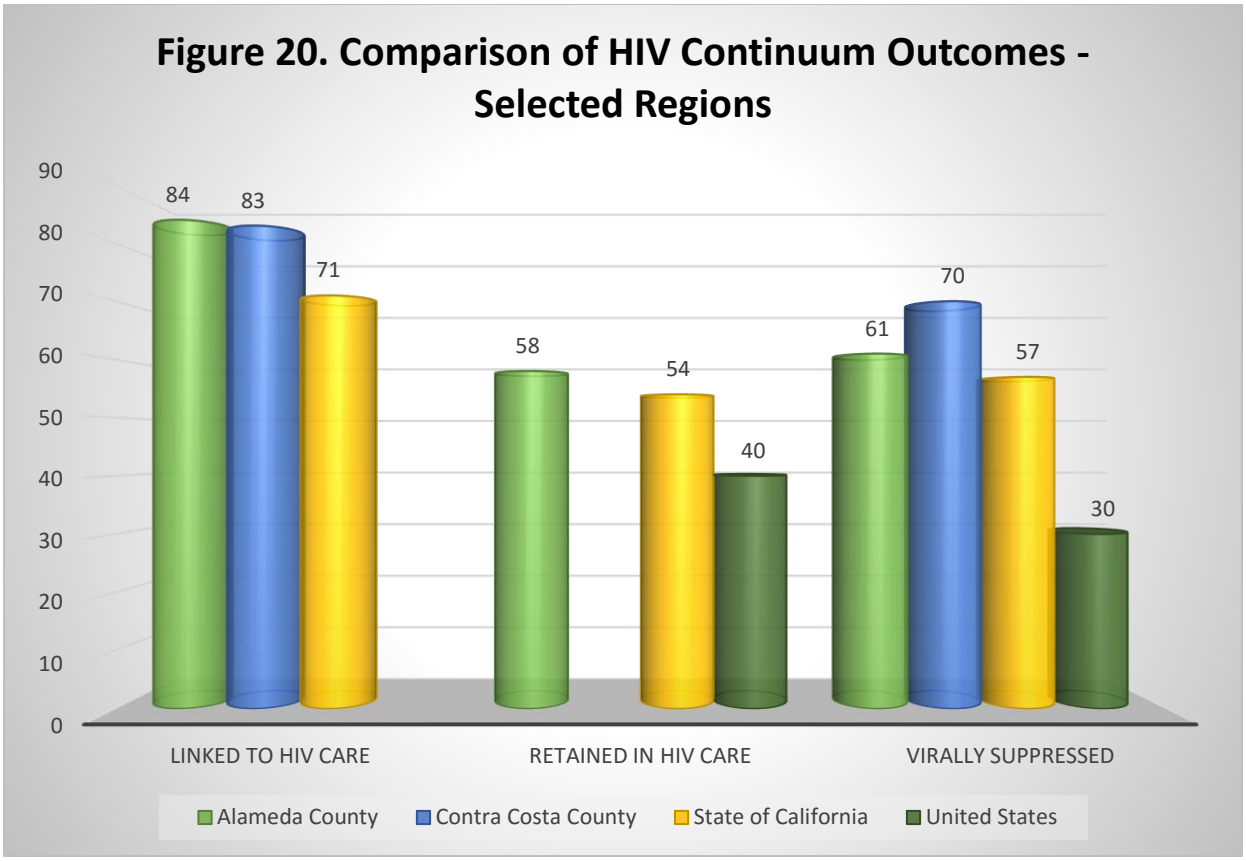
1) Linkage defined as having a reported CD4 or VL ordered within 90 days or less of diagnosis; 2) Retention calculated using labs ordered in 2013; 3) Viral suppression defined as most recent VL in 2013 < 200 copies/mL

Continuum of HIV Care in Contra Costa



1) Diagnosed is people living in Contra Costa in 2014 who were diagnosed by a confirmed lab test in 2012-2014.
2) Linked to care is defined as a lab test within 90 days of diagnoses for the newly diagnosed living in Contra Costa.
3) In Care is defined as PLWHA who received a lab test during the calendar year of 2014, who were diagnosed before 2014. 4) Viral Suppression is a viral load test <200 copies/ml after 2013

Prepared by Contra Costa Public Health, Epidemiology, Planning & Evaluation. August 2015



Notes: 1) US data on linkage to care are not currently available; and 2) data on HIV retention in Contra Costa County are based on 1 lab result per year, as opposed to the minimum 2 lab results per year as shown in the percentages above, and so are not directly comparable.

b. Disparities in Regard to the HIV Care Continuum

While the continuum of care findings for the Oakland region are in many ways positive, some disparities remain in regard to attainment of outcomes among specific gender, age, and ethnic groups, although in most cases these disparities are not dramatic. For example, in terms of retention in HIV care in Alameda County, defined as at least two medical visits in a calendar year at least 90 days apart, Asian / Pacific Islander populations show the highest rate of retention, at **63.6%**, while Latinos have the lowest rate of retention, at **55.2%** (see **Figure 21**). Across age groups, persons between the ages of 30 and 36 show the lowest rates of retention (**48.5%**) while young people ages 13 to 19 show by far the highest levels of retention, at **74.1%**, followed by persons 60 and older at **62.9%** (see **Figure 22**). In terms of viral suppression, **Figure 23** below compares rates of viral suppression by ethnicity in both Alameda and Contra Costa Counties for the most recent continuum periods. The tables show lower viral suppression levels for specific ethnic minority populations, with the lowest levels among African Americans and Latinos in Alameda County and among African Americans and Asian / Pacific Islanders in Contra Costa County.

Figure 21. Retention in HIV Care in Alameda County by Race / Ethnicity, 2013

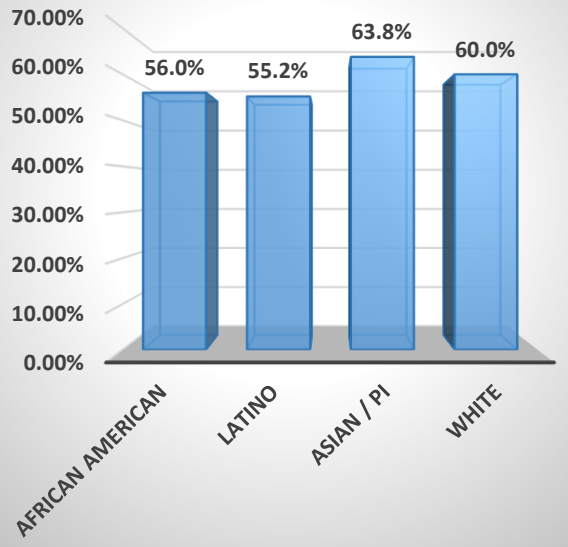


Figure 22. Retention in HIV Care in Alameda County by Age Range, 2013

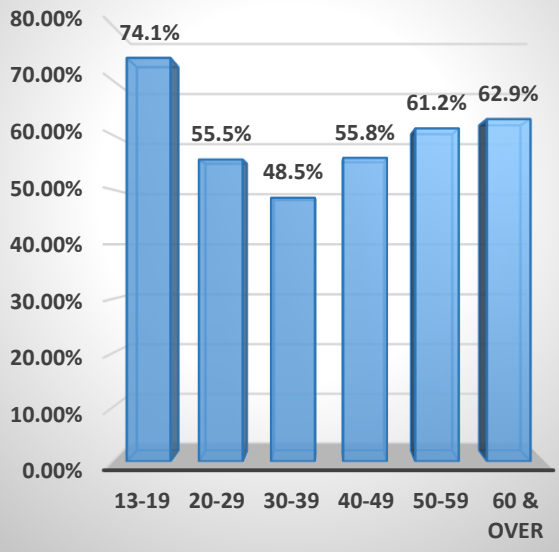
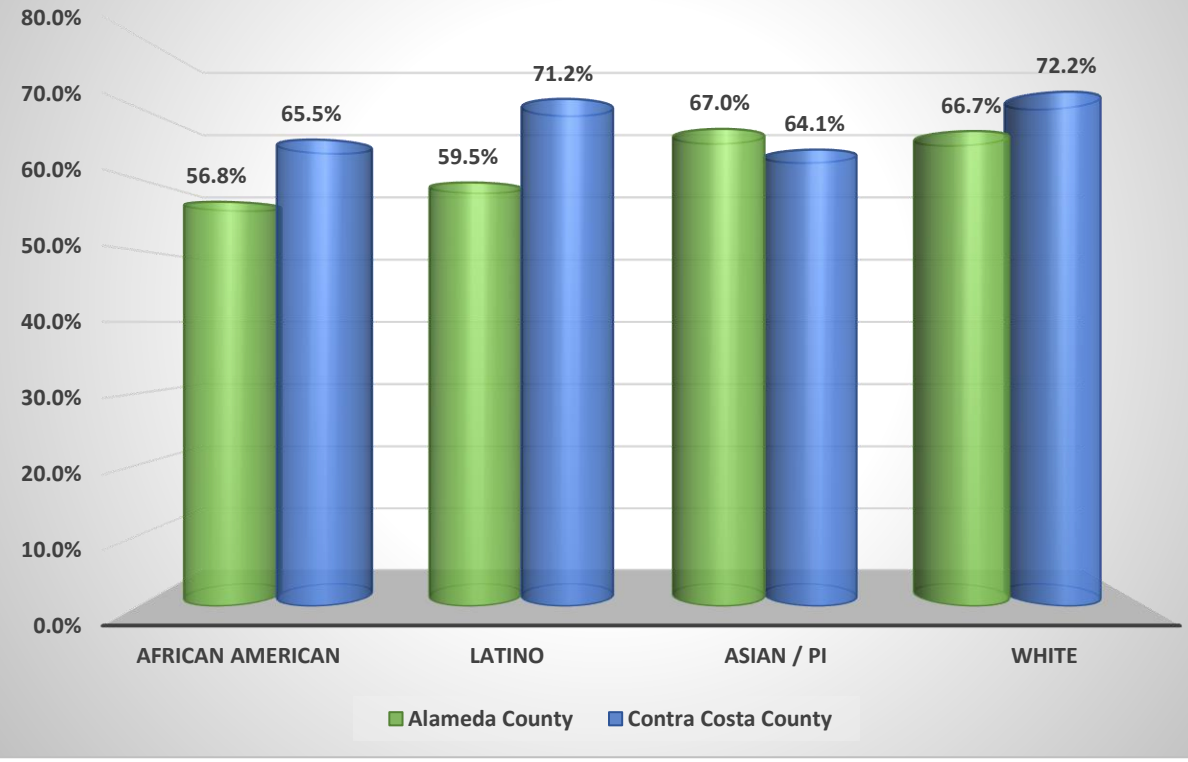


Figure 23. Viral Suppression Rates in Alameda County (2013) and Contra Costa County (2014) by Ethnicity



c. Utilization of the HIV Care Continuum

The continuum of care framework embodies a critical approach to HIV prevention and service planning and priority-setting which has begun to have an important impact at the level of both the Oakland Planning Council and the two counties that make up the Oakland region. The continuum provides indications as to where our system is falling short in meeting its goals as well as information on the specific disparities that exist across each stage of the cascade. The chart also gives us a sense of the progress we are making in linking and retaining persons with HIV in care, and achieving viral suppression across all categories. The chart reinforces an already understood need for providers to better manage, enter, track, and coordinate data, and to begin to build expanded bridges of information-sharing between public and private providers. More importantly, the continuum provides a basis for a **merged vision of prevention in care** in which prevention and care coexist on a continuum that we hope will in the future also include PrEP use. The Oakland region will continue to incorporate consideration of the continuum of care chart in all key planning meetings and in discussions that consider ways to better improve systems and infrastructure and to better engage, support, and retain clients as they move through the continuum.

C. Financial and Human Resources Inventory

a.1. Financial Overview

Figure 24 on the following page summarizes public funding for HIV prevention, care, and support services in the Oakland region for the most recent 12-month funding period. The chart incorporates all major sources of federal HIV funding in the region, while describing specific HIV care and prevention categories for which funding is allocated. Additional funding for HIV in the region is received through the State of California, the two counties that make up the local region, and private funding from foundations, corporations, and individual donors.

Figure 24. Chart of Alameda and Contra Costa County Public HIV Resources

Funding Source	FY 2016 Budget	**Core Medical-related Services**	Outpatient/Ambulatory Medical Care	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-	Home Health Care	Home & Community-based Health	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services –	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive	Substance Abuse Services –	Treatment Adherence Counseling	**HIV Testing & Prevention**	HIV Testing	PrEP & PEP Services	Other HIV Prevention
Part A	**$ 4,062,180**		X	X	X			X	X	X	X	X			X	X	X	X	X	X	X	X		X							
Part B	**$ 794,504**		X						X		X																				
Part C	**$ 1,075,688**		X		X					X													X								
Part D	**$ 948,290**		X						X		X									X			X	X	X		X				
CDC	**$ 1,290,670**																	X									X		X	X	X
SAMHSA	**$ 4,455,609**								X		X	X		X				X					X	X	X	X	X		X		
HOPWA	**$ 10,233,661**																		X												
MEDICAID	**$ 31,856,773**		X	X	X		X		X		X	X																			

a.2. Resource Inventory

The charts that begins on the following page provides a comprehensive listing of agencies in Alameda and Contra Costa County that provide direct outreach, prevention, care, and support services for persons infected with HIV, at risk for HIV, and affected by HIV. Together, these agencies make up a high-quality continuum of care that is designed to provide the most effective and sensitive levels of treatment, support, and prevention services, while offering a high degree of cost-effectiveness and coordination. The charts are broken into three distinct components:

- **Figure 25. Ryan White Part A & B Funded Agencies:** This chart lists all recipients of Ryan White Part A and/or B funding in the Oakland region, and lists the specific key services agencies are funded to provide during the current FY 2016 Ryan White fiscal year. The chart also indicates whether agencies also receive Part C, Part D, HOPWA, and/or HIV prevention funds through the State of California.

- **Figure 26. County-Funded HIV Prevention Providers:** The second chart lists all recipients of County HIV prevention funding in the two-county region. The chart also lists all HIV prevention activities that are supported by this funding. Some of the agencies listed in Figure 26 are also care providers who are included in Figure 25.

- **Figure 27. Additional HIV Care and Prevention Service Agencies:** The third chart lists all key HIV prevention and service agencies in the two-county region who do not receive either Part A/B or HIV prevention funding. Many of these agencies play key partnership roles within the overall system of HIV care and prevention in the Oakland region.

2016 ALAMEDA & CONTRA COSTA COUNTY HIV CARE AND SERVICE INVENTORY

FIGURE 25. RYAN WHITE PART A & B FUNDED AGENCIES

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded														
		Core Services							Support Services					Part C	Part D	HOPWA	HIV PREV.
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
AIDS Healthcare Foundation / Magic Johnson Clinic 400 30 Street, Suite 300 Oakland, CA 94609	**Alameda County** HIV primary care and medical case management services; substance abuse, psycho-social support and ADAP services	X	X			X							X				
AIDS Project of the East Bay (APEB) 1320 Webster Street Oakland, CA 94612	**Alameda County** HIV primary care and medical case management services; emergency food, utility and housing assistance; psycho-social support and ADAP services	X	X						X	X			X			X	X
Alameda County Medical Center HIV Services – Fairmont Campus 15400 Foothill Blvd San Leandro, CA 94578	**Alameda County** Comprehensive inpatient and outpatient HIV/AIDS services; medical nutrition therapy and ADAP services	X	X	X									X	X	X		
Alameda County Medical Center Adult Immunology Clinic – Highland Campus 1411 E. 31st Street Oakland, CA 94602	**Alameda County** Comprehensive inpatient and outpatient HIV/AIDS services; mental health, substance abuse, oral health and ADAP services	X	X	X	X	X							X	X	X		X

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
Alameda Health Consortium HIV Dental Care Program 101 Callan Avenue, Suite 300 San Leandro, California 94577	**Alameda County** Oral health services				X									X			
Allen Temple Health & Social Services Ministry 8501 International Boulevard Oakland, California 94621	**Alameda County** Congregate Meal Program									X			X Medical Transport				
Ark of Refuge, Inc. / Yvette A. Flunder Foundation, Inc. 8501 International Boulevard Oakland, California 94621	**Alameda County** Medical case management and housing services		X						X							X	
Bay Area Legal Aid Services 1025 Macdonald Avenue Richmond, CA 94801	**Contra Costa County** **Non-criminal legal services including eviction prevention and disability claims**												X Legal				
Cabulence Comfort 2301 Camino Ramon, San Ramon	**Contra Costa County** **Van Transportation Services**												X Van Services				
California Prostitutes Education Project (Cal-PEP) 2811 Adeline Street Oakland, CA 94608	**Alameda County** Medical transportation services												X				X

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
Catholic Charities of the East Bay HIV AIDS Services 433 Jefferson Street Oakland, CA 94607	**Alameda County** Medical case management		X														
Children's Hospital - Oakland Pediatric HIV/AIDS Program 747 52nd Street Oakland, CA 94609	**Alameda County** HIV primary care, medical case management, mental health, psycho-social support services and emergency financial assistance	X	X	X									X	X	X		
Community Care Services 3317 Elm Street, # 202 Oakland, CA 94609	**Alameda County** Home health care						X										
Contra Costa Health Services HIV/AIDS Program 597 Center Avenue, Suite 200 Martinez, CA 94553	**Contra Costa County** Comprehensive HIV health services, ADAP enrollment services, medical case management, reimbursement for dental services, outreach, EIS	X	X		X		X	X		X	X	X	X Medical Transport	X		X	X
Contra Costa Health Services West County Health Clinic 13601 San Pablo Ave. San Pablo, CA 94806	**Contra Costa County** Comprehensive HIV health services and Medical Case Management		X									X		X			

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
Contra Costa Health Services Pittsburg Health Center – Positive Health Clinic 2311 Loveridge Rd. Pittsburg, CA 94565	**Contra Costa County** Comprehensive HIV health services and Medical Case Management	X	X									X					
Costa Contra Health Services – Martinez Health Center - Positive Health Clinic 2500 Alhambra Ave. Martinez, CA 94553	**Contra Costa County** Comprehensive HIV health services and Medical Case Management	X	X									X		X			
Contra Costa Interfaith Housing 3164 Putnam Blvd., Suite C Walnut Creek, CA 94597	**Contra Costa County** Housing and rental assistance															X	
East Bay AIDS Center (EBAC) Alta Bates Summit Medical Center 3100 Summit Street Oakland, CA 94609	**Alameda County** HIV primary care, medical case management, mental health and outreach services; emergency housing assistance and psycho-social support and ADAP services	X	X	X					X				X	X	X		X
East Bay Community Law Center 2921 Adeline Street Berkeley, CA 94703	**Alameda County** Legal services and emergency financial assistance												X				

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
East Bay Community Recovery Project 2551 San Pablo Avenue Oakland, CA 94612	**Alameda County** Mental health and substance abuse services					**X**											
East Oakland Community Project 7515 International Blvd. Oakland, CA 94621	**Alameda County** Emergency/short-term housing assistance; medical case management and substance abuse services					**X**			**X**							**X**	
Family Support Services of the Bay Area 401 Grand Avenue, Suite 200 Oakland, CA 94610	**Alameda County** Child care services												**X**				
Food Bank of Contra Costa and Solano County Extra Helpings Program	**Contra Costa County** Food bank services			X **Medical Nutrition Services**						**X**				**x**			
La Clinica de la Raza 1515 Fruitvale Ave. Oakland, CA 94601	**Alameda County** HIV primary care and medical case management services, vision, oral health and psycho-social support and ADAP services		**X**	**X**	**X**				**X**	**X**			**X**	**X**			**X**

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
LifeLong Medical Care 2001 Dwight Way Berkeley, CA 94704 and 10700 MacArthur Blvd. (Foothill Square) Oakland, CA 94605	**Alameda County** HIV primary care and medical case management, oral health, medical nutrition therapy and ADAP services	X	X		X								X	X			
Lifelong Brookside Health Community Health Center 2023 Vale Road San Pablo, CA 94806	**Contra Costa County Medical Case Management Services**		X														
Lion Bridge 1010 Wayne Avenue, # 240 Silver Springs, MD 20910	**Alameda County** Linguistic Services												X				
Neighborhood House of North Richmond 820 23rd Street Richmond, CA 94801	**Contra Costa County** Outreach Support												X	X			
Nightingale/ RSCR California, Inc 101 Callan Avenue, Suite 405 S San Leandro, CA 94577	**Contra Costa County** Home health care services						X										
Pacific Center for Human Growth 2712 Telegraph Avenue Berkeley, CA 94705	**Alameda County** Mental health services			X													

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
Project Open Hand 1921 San Pablo Ave. Oakland, CA 94610	**Alameda County** Food services									X							
Providence House 540 23rd Street, Oakland, CA 94612	**Alameda County** Mental health services			X													
Rainbow Community Center 3024 Willow Pass Road Concord, CA 94519	**Contra Costa County** LGBTQ counseling services, food pantry services					X				X		X	X				X
Resources for Community Development 2220 Oxford Street, Berkeley CA, 94704	**Alameda County** Medical case management		X													X	
Tri -City Health Center (TCHC) HIV / Hepatitis Services 39184 State Street Fremont, CA 94538	**Alameda County** HIV primary care and medical case management services; oral health, early intervention, emergency assistance, mental health, medical nutrition therapy, medical transportation and psycho-social support and ADAP services	X	X	X				X	X	X			X	X		X	X

Agency Information	County or Counties Served & Services Provided	Ryan White Part A / B Service Categories Funded												Part C	Part D	HOPWA	HIV PREV.
		Core Services							Support Services								
		Primary Medical Care	Medical CM	Mental Health Care	Oral Health Care	Substance Abuse	Home & Comm. Based Care	EIS	Housing	Food	Outreach	TX Adherence	Other				
Women Organized to Respond to Life-threatening Disease (WORLD) 449 15th Street, Suite 303 Oakland, CA 94612	**Alameda County** Mental health, outreach and psycho-social support services; emergency financial assistance			X							X		X		X		
YWCA of Contra Costa and Sacramento Counties 1320 Arnold Drive, Suite 170 Martinez, CA 94553	**Contra Costa County** Mental health and substance abuse treatment services			X		X						X	X				

FIGURE 26. COUNTY-FUNDED HIV PREVENTION PROVIDERS

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
AIDS Project of the East Bay (APEB) 1320 Webster Street Oakland, CA 94612	X	X	X		X	X	X	X					X	X
Alameda County Medical Center HIV Services – Fairmont Campus 15400 Foothill Blvd San Leandro, CA 94578														
Alameda County Medical Center Adult Immunology Clinic – Highland Campus 1411 E. 31st Street Oakland, CA 94602		X	X		X	X	X	X					X	X
Alameda County Office of AIDS Administration (OAA) 1000 Broadway, #310 Oakland, CA 94607					X			X				X	X	X

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
California Prostitutes Education Project (Cal-PEP) 2811 Adeline Street Oakland, CA 94608 Also provides after hours and weekend HIV rapid testing services in Contra Costa County in Antioch, Bay Point, Pittsburg, and Richmond.	X	X	X	X	X		X	X				X	X	X
Contra Costa Health Services AIDS Program 597 Center Avenue, Suite 200 Martinez, CA 94553	X	X	X	X	X	X	X	X			X		X	X
East Bay AIDS Center (EBAC) Alta Bates Summit Medical Center 3100 Summit Street Oakland, CA 94609	X	X	X	X	X	X	X	X	X	X		X	X	X

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
HIV Education and Prevention Project of Alameda County (HEPPAC) 5323 Foothill Blvd. Oakland, CA 94601 Also provides syringe exchange services in Contra Costa County in Bay Point, Pittsburg, and Antioch.	X	X	X	X	X			X				X	X	X
La Clinica de la Raza 1515 Fruitvale Ave. Oakland, CA 94601	X	X	X	X	X	X	X	X				X		X
LifeLong Medical Care 2001 Dwight Way Berkeley, CA 94704 and 10700 MacArthur Blvd. (Foothill Square) Oakland, CA 94605	X	X	X	X	X	X		X	X					
Rainbow Community Center 3024 Willow Pass Road Concord, CA 94519	X						X				X		X	X

Agency Name and Contact Information	Prevention Services Provided													
	HIV Testing Outreach	HIV Testing	STD Testing	Hep C Testing	HIV Service Linkage	HIV Treatment Adherence Services	Prevention Counseling for Positives	HIV Care Re-Linkage	Pre-Exposure Prophylaxis	Post-Exposure Prophylaxis	Primary Prevention for HIV-Negative	HIV Social Marketing	Condom Distribution	OAA Grantee
Tri -City Health Center (TCHC) HIV / Hepatitis Services 39184 State Street Fremont, CA 94538	X	X	X	X	X	X	X	X				X	X	X
Women Organized to Respond to Life-threatening Disease (WORLD) 449 15th Street, Suite 303 Oakland, CA 94612	X	X	X		X	X	X	X				X	X	X

FIGURE 27. ADDITIONAL HIV CARE AND PREVENTION SERVICE AGENCIES

Agency Information	County or Counties Served & Services Provided
AIDS Healthcare Foundation / Magic Johnson Clinic 400 30 Street, Suite 300 Oakland, CA 94609	**Alameda County** HIV primary care and support services; HIV testing
AIDS Housing & Information Project (AHIP) / Eden Information & Referral 570 B street Hayward, CA 94541	**Alameda County** Information & Referral Services
Asian Health Services 818 Webster Street Oakland, CA 94607	**Alameda County** HIV primary care and oral health services; prevention, testing and ADAP services
Berkeley Free Clinic 2339 Durant Avenue Berkeley, CA 94704	**Alameda County** Prevention & testing services
Berkeley Needle Exchange Emergency Distribution (NEED) Berkeley, CA	**Alameda County** Syringe Exchange Services
City of Berkeley Public Health Clinic 830 University Avenue Berkeley, CA 94710	**Alameda County** Prevention & testing services
Community Health for Asian Americans (CHAA) 255 International Boulevard Oakland, CA 94608	**Alameda County** Prevention with Positives
Corizon (Correctional Health Care Services) Santa Rita Jail Facility 5325 Broder Blvd. Dublin, CA 94568	**Alameda County** Prevention & testing services
East Bay AIDS Education & Training Center 614 Grand Avenue, # 400 Oakland, CA 94510	**Alameda and Contra Costa Counties** HIV Healthcare Service Providers Training
Harm Reduction Coalition 1440 Broadway, # 510 Oakland, CA 94612	**Alameda County** HIV Provider Training
Kaiser Medical Center – Fremont 39400 Paseo Padre Parkway Fremont, CA 94538	**Alameda County** HIV primary care, medical case management and testing services

Agency Information	County or Counties Served & Services Provided
Kaiser Medical Center – HIV Services 27400 Hesperian Blvd. Hayward, CA 94545	**Alameda County** HIV primary care, medical case management, testing and ADAP services
Kaiser Medical Center – HIV Services 280 W. MacArthur Blvd. Oakland, CA 94611	**Alameda County** HIV primary care, medical case management, testing and ADAP services
Kaiser Medical Center – HIV Services 4501 Sand Creek Rd. Antioch, CA 94531	**Contra Costa County** HIV primary care, medical case management, testing and ADAP services
Kaiser Medical Center – HIV Services 200 Muir Rd. Martinez, CA 94553	**Contra Costa County** HIV primary care, medical case management, testing and ADAP services
Kaiser Medical Center – HIV Services 901 Nevin Ave. Richmond, CA 94801	**Contra Costa County** HIV primary care, medical case management, testing and ADAP services
Kaiser Medical Center – HIV Services 1425 S. Main Street Walnut Creek, CA 94596	**Contra Costa County** HIV primary care, medical case management, testing and ADAP services
Native American Health Center 2950 International Blvd. Oakland, CA 94601	**Alameda County** Oral Health services
Planned Parenthood – Mar Monte Main Office: 1691 The Alameda San Jose, CA 95126	**Alameda County** Prevention & testing services
U.S. Department of Veterans **Infectious Disease Clinic** 2221 Martin Luther King Jr. Way Oakland, CA 94612	**Alameda & Contra Costa County Counties** HIV primary care, medical case management and testing services
Volunteers of America Bay Area 3022 International Blvd., # 310 Oakland, CA 94601	**Alameda County** Testing services
Planned Parenthood Various Locations: Antioch, Walnut Creek, El Cerrito, Richmond, San Pablo, San Ramon, Hilltop, Concord	**Contra Costa County** HIV and STD Testing, PrEP, referral to HIV care
Kaiser Medical Center **HIV Care Services** Various locations: Martinez, Antioch, Walnut Creek, Richmond, San Pablo, Pittsburg	**Contra Costa County** HIV primary care, testing, PrEP

b. HIV Workforce Capacity

HIV prevention and care programs in the Oakland region are delivered through a diverse range of highly skilled personnel, including administrators, clinicians, direct service staff, and support personnel working on both a full- and part-time basis. Staff are employed at HIV-specific public and private agencies, and within agencies and programs that incorporate HIV services as part of a larger matrix of health and/or support services (see Resource Inventory above.) Staff qualifications and expertise are geared to meeting the specific needs of each agency's particular populations in an effective, respectful, and culturally competent manner, with a high priority placed on staff who embody the ethnic, cultural, linguistic, and sociodemographic characteristics of the clients they serve. Agencies utilize **team-based approaches** to care wherever possible, ensuring that clients have access to a multi-disciplinary range of providers in both a one-stop and multi-agency format. Multidisciplinary client service teams are particularly critical in the case of populations facing complex life challenges or living with disabilities. Peers and persons living with HIV are also employed wherever possible in providing outreach, testing and care linkage, and retention support for persons at risk for and living with HIV, while consumer advisory and support groups play a key role in ensuring the client-centeredness and accessibility of services throughout the system.

At the level of client prevention and outreach, key positions include HIV prevention specialists, outreach coordinators, testers, and linkage professionals, with prevention support services provided by a wide range of staff including case managers, counselors, support group facilitators, substance use and mental health professionals, and basic service providers. Clinical services for persons living with HIV or utilizing PrEP and PEP are delivered by highly trained staff (in many cases, licensed clinicians), including physicians, dentists, nurses, nurse practitioners, medical assistants, social workers, nurse case managers, medical case managers, specialty medical care providers, and dental hygienists. Supportive services to help persons living with or at high risk for HIV to access and remain in care include linkage workers, peer support specialists, psychosocial case managers, retention navigators, benefits counselors, behaviorists and mental health and substance treatment staff, retention specialists, and providers of basic services such as food, transportation, housing assistance, and employment and job training support. Project administrators, managers, and coordinators working at a range of levels provide project oversight, coordination, planning, and staff supervision and training while project evaluation and monitoring staff assess the ongoing impact of programs and services while monitoring programmatic quality and ensuring continuous quality improvement. Consumers and clients play a key role in ensuring program quality both by serving as direct paid or volunteer staff and by participating in consumer advisory boards, annual and semi-annual client satisfaction surveys, prevention and care related needs assessments, and local and regional planning and advisory bodies.

c. Coordination of Funding Streams

Because of its long history of HIV prevention and care provision and the long-term collaborative relationships that have evolved in our region over time, public and private entities

and planning bodies in our region continually communicate and work together to plan effective program, maximize resources, and ensure non-duplication of services. This includes close collaboration among the Oakland TGA Collaborative Community Planning Council and its committees, and the Contra Costa County HIV Consortium and ongoing coordination with both the Ryan White Part C HIV ACCESS network and the Part D-funded Family Care Network systems. Additionally, the region continues to work to broaden its planning and information-sharing partnerships with private medical providers in the TGA, including major HIV care entities such as Kaiser Permanente Northern California. Regional collaborative planning has a particular focus on expanding the quality, speed, and accessibility of information technology systems through which agencies throughout the region can better and more rapidly access information on client-level data within the parameters of HIPPA regulations, with an emphasis on obtaining information on individuals who may have shifted care to another agency without notifying the primary care provider.

A significant milestone was achieved several years ago with the formation of the **East Bay Linkage Advisory Group**, an important countywide collaboration formed through the joint sponsorship of the East Bay AIDS Education and Training Center (AETC) and the Alameda County Public Health Department Office of AIDS Administration. Dr. Sophy Wong, who currently serves as Medical Director for the East Bay AETC, and Dr. Nicholas Moss, Director of the HIV/STD Section for the Alameda County Public Health Department, serve as co-chairs for this critical new planning and coordinating body. The East Bay Linkage Advisory Group meets **quarterly** and is currently comprised of nearly **60** HIV outreach and linkage specialists and planners based at more than **20** separate public and private agencies. Additional committees and ad hoc groups meet on a **monthly** basis to explore barriers and develop effective responses to specific linkage issues in the Oakland TGA. In 2014, for example, the group formed a task force to begin looking at ways to improve retention of the clients who have been recently re-linked to care. The Linkage Advisory Group is an active and committed group of individuals whose common purpose is to work together to improve the quality, impact, and efficiency of HIV outreach and linkage services in our region.

d) Resource and Service Gaps

Because of the long history of HIV in the Oakland region, a broad and diverse network of prevention and care programs and agencies are in place to address all facets of the epidemic, including general HIV outreach and education, comprehensive HIV testing and service linkage, PrEP and PEP services, HIV care and treatment, and psychosocial and support programs that support long-term risk reduction and retention in and adherence to HIV care and treatment. These services are augmented by data collection, analysis, and reporting systems that help target resources and programs to areas and populations at highest risk for HIV infection while spotting trends in new infections and in emerging activity gaps. Additional resources are continually needed, however. Key resources that could help dramatically improve our ability to identify, test, link to care, and retain populations in care include: a) expanded data resources to better track HIV continuum indicators and to map high-risk neighborhoods and target high-risk populations and groups; b) expanded resources for social marketing and stigma reduction campaigns that help normalize HIV, HIV testing, and the behaviors that can transmit HIV; c)

expanded funding for community-based testing outreach; d) increased resources that create greater employment opportunities for persons living with HIV in outreach, linkage, and retention areas; e) expanded support for a larger number of HIV prevention and care service locations, particularly in high-risk neighborhoods; and f) expanded support to generate broader, multidisciplinary responses to the HIV epidemic.

D. Assessing Needs, Gaps, and Barriers

a. Process to Identify HIV Prevention and Care Needs

The 2017-2022 Integrated HIV Prevention and Care Plan for Alameda and Contra Costa Counties TGA) was developed through a collaborative planning process involving the Oakland TGA Collaborative Community Planning Council, dedicated local consumers, the Alameda County Public Health Department Office of AIDS Administration (OAA), and the Contra Costa County Health Services HIV/AIDS Program. As a merged Planning Council that has jointly overseen prevention and care planning and allocations for nearly a decade, the Council is in an ideal position to consider and develop a merged planning document. The planning process spanned a total of **nine months**, from November 2016 through August 2016, and incorporated a broad range of activities and key milestones.

The planning process began with initial strategy discussions concerning the best way to prepare the Plan. In the past, the two-county region has prepared its HIV Care Plan using a Working Group made up exclusively of Planning Council members and representatives of the region's two health departments. The region previously has prepared separate HIV Prevention Plans for the two counties, with responsibility for development of the Prevention Plan for Alameda County falling to the Prevention Subcommittee of the Oakland Planning Council and in Contra Costa County to the HIV/AIDS Program working in concert with the Contra Costa HIV Consortium, the region's local HIV prevention and care planning body.

For the current Integrated Plan, spanning the broadest possible range of HIV activities and categories, a consensus emerged that forming an **integrated planning group** encompassing not only council members and government representatives from but also representatives of HIV and non-HIV-specific agencies and programs would be most appropriate for the complex plan development process. For this reason, the Alameda County Office of AIDS Administration proposed and received approval from the Planning Council to create an **independent Integrated Plan Working Group** in December 2015, whose specific charge was to work in partnership with both the Council and the Contra Costa HIV Consortium to develop the five-year Plan. Operating under the auspices of OAA, the Working Group included a majority of members who were also members of the Planning Council and who worked alongisde consumers, community-based agency representatives, and representatives of the Office of AIDS Administration and the Contra Costa County HIV/AIDS and STD Program. The Working Group was augmented by additional participants from the Alameda County Office of AIDS Administration and from additional community experts working in both the public and private sector who provided input on key Plan-related issues, as shown in the lists on the following page.

2017-2021 Alameda & Contra Costa County Integrated HIV Plan Working Group Members

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Cynthia Carey-Grant, Women Organized to Respond to Life-Threatening Diseases (WORLD)
Holvis Delgadillo, Corizon (Santa Rita Jail health services)
Carla Goad, Contra Costa HIV/AIDS Program
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Obiel Leyva, Contra Costa HIV/AIDS Program
Lois Lindsey, HIV ACCESS Network
Loris Mattox, HIV Education and Prevention Project of Alameda County (HEPPAC)
Donna McNichol, Planned Parenthood Mar Monte
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Additional Planning Participants & Input Group Facilitators

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Ifeoma Udoh, Project CRUSH, EBAC
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Additional Alameda County AIDS Office Participants

Pamela Casey-Lewis
Richard Lechtenberg

Nicholas Moss, MD
Neena Murgai, PhD, MPH
Phoenix Smith
Shelley Stinson
Matthew Wong

The Integrated Plan Working Group met **monthly** from January through July 2016 to review the region's previous HIV prevention and care plans and to collect information and data and discuss components of the new Plan. The group collected updated epidemiological, service, and prevention data from a wide range of sources, and obtained updated versions of the HIV care continuums for the two coutnies. The Group also reviewed the previous care and prevention plans produced in the region and assessed progress toward plan goals and objectives. The Working Group's information-gathering process was highlighted by a series of **nine Community Input Groups** held between March and July 2016 which included consumers, clinicians, and key local HIV planners and agency representatives. The input group process is described in greater detail in **Section II.B** below. The Working Group also sponsored a separate meeting sepcifically to discuss **HIV data and reporting issues** across the two counties on **May 23, 2016.** The meeting included over **20** data staff and specialists from both public and private agencies in the two counties, and which was co-facilitated by Neena Murgai, Director of the Alameda County HIV Edpiemiology and Surveillance Unit, and by Sophy Wong, MD, Medical Director of both the Bay Area and North Coast AIDS Education and Training Center (AETC) and the Alameda County Part C HIV ACCESS network.

The planning process culminated in a **day-long planning and decision-making meeting** in Oakland on June 10, 2016. During this meeting, the group reviewed an extensive list of potential recommendations and action steps for improving the HIV prevention and care system in the Oakland region, along with additional recommendations and concepts that had emerged through the ongoing Working Group process. The group reviewed and prioritized this entire list, and then made additional prioritization decisions at its final meeting on July 8, 2016. The final prioritized concepts approved by the Working Group are included in the Plan's Goals, Objectives, and Activities section (Section II.A) as potential activities to be prioritized by the Planning Council. The Plan's final five-year goals, objectives, and action steps were reviewed in advanced by the Oakland TGA Colalborative Community Planning Council and unanimously approved at the Council meeting on August 31, 2016.

The 2017 – 2021 Integrated HIV Plan offers a wide-ranging roadmap to help guide the work of the Oakland region over the next five years. The Plan is designed to function as a **living document** - one that can be changed or completely rewritten by at any time in order to better address emerging needs and shifting priorities. The Plan seeks to provide a rudder in a time of change – one that gives both the Planning Council and the region as a whole the greatest possible leverage to continue its critical work of ensuring equitable access to the highest quality services for **all** persons living with HIV in the Oakland TGA.

b. HIV Prevention and Care Needs of Persons at Risk for and Living with HIV

The Oakland TGA Collaborative Community Planning Council continually reviews trends in HIV service delivery as well as case report and treatment outcome data to identify populations that may be facing special or growing needs within the region. This information is supplemented by regular needs assessments. By 2012, for example, it had become clear that the expanding HIV epidemic among **young MSM of color** and the ongoing care needs of **women of color** living with HIV in the Oakland TGA required additional and special focus. **African Americans** make up the majority of young PLWHA, comprising **51.2%** of this population, as compared **40.1%** among PLWHA in the TGA as a whole. **Latino and Asian / Pacific Islander** youth are also over-represented in comparison to general PLWHA populations, with Latinos making up **26.0%** of youth PLWHA but only **17.9%** of PLWHA overall and Asian / Pacific Islanders making up **6.8%** of youth PLWHA but only **4.4%** of PLWHA. **MSM transmission** - including MSM / IDU transmission - accounts for **70.9%** of new HIV cases among the youth PLWHA population. Young MSM of color, who are already stigmatized as a result of race and sexual preference, are frequently reluctant to seek care in a timely manner because of the fear of stigma. Additionally, **26%** of youth respondents to a prior Needs Assessment reported being diagnosed and treated for substance abuse within the 12-month period preceding the survey. A large percentage reported using a variety of substances including alcohol, meth, and ecstasy.

In addition to the burden borne by youth, the Oakland TGA contains what is the largest proportion of **women** living with HIV and AIDS (**18.2%**) of any EMA or TGA in the western United States. These cases are disproportionately found among women of color, particularly **African American women**. African American women make up **62.7%** of all female PLWHA in the TGA. By contrast, Latina women account for **13.1%** of PLWHA; Asian / Pacific Islander women account for **3.5%** of PLWHA; and white women represent **18.5%**. The dominant mode of HIV transmission in women is through **heterosexual contact,** which accounts for at least **60.8%** of all female PLWHA cases as of December 31, 2014. **Injection drug use** also plays a critical role, resulting in **21.1%** of all female HIV cases. Risk factors of the remaining cases are unreported. Many providers also report that a large percentage of their female clients are **domestic violence victims**. Due to the threat of violence and out of a general fear of the stigma associated with an HIV diagnosis, many women avoid treatment. Additionally, their HIV infection may in part be due to an inability to suggest or enforce safer sexual behaviors with their male partners. Women also often fail to prioritize their HIV care because of competing survival needs. Heading up single-parent households means that many HIV-infected women struggle with barriers related to **childcare** and **transportation** in accessing regular HIV medical care and services.

In response to this growing problem, the Council made the decision in 2014 to devote **all** of the region's Part A MAI resources specifically to increasing outreach, testing, care linkage, treatment, and treatment adherence support to young MSM of color ages 13 to 24 and to women of color, both with a focus on African American populations. Although implementation of MAI programs in the TGA after this shift has been a success, the specific needs of young MSM of color and women persist.

c. Service Gaps Identified for Persons at Risk for and Living with HIV

The chart below compares the population of PLWHA enrolled in the Oakland TGA Ryan White system of care for calendar year 2015 with the TGA's combined PLWHA population as of 12/31/15 (see **Figure 28**)

Figure 28. Demographic Comparison of Ryan White Data with HIV/AIDS Surveillance Data

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Part A Services - Jan. 1 - Dec. 31, 2014		Combined PLWH Population as of 12/31/14		Population Variances
Race/Ethnicity					
African American	1,371	44.2%	3,115	37.7%	+ 6.5%
Latino / Hispanic	657	21.2%	1,468	17.8%	+ 3.4%
Asian / Pacific Islander	113	3.6%	470	5.7%	- 2.1%
White (not Hispanic)	747	24.1%	3,030	36.7%	- 12.6%
Other / Multiethnic / Unknown	214	6.9%	169	2.0%	+ 4.9%
	3,102	**100%**	**8,252**	**100%**	
Gender					
Female	1567	27.1%	1,377	16.7%	+ 10.4%
Male	4057	70.1%	6,784	82.2%	- 12.1%
Transgender	162	2.8%	91	1.1%	+ 1.7%
	3,102	**100%**	**8,252**	**100%**	
Age					
12 Years and Younger	27	0.8%	13	0.2%	+ 0.6%
13 - 24 Years	90	2.9%	219	2.7%	+ 0.2%
25 - 29 Years	301	9.7%	443	5.4%	+ 4.3%
30 - 39 Years	673	21.7%	1,176	14.3%	+ 7.4%
40 - 49 Years	748	24.1%	2,129	25.8%	- 1.7%
50 - 64 Years	1,066	34.4%	3,537	42.9%	- 8.5%
65 Years and Above	197	6.4%	735	8.9%	- 2.5%
	3,102	**100%**	**8,252**	**99%**	
Transmission Categories					
MSM	1,577	50.8%	5,174	62.7%	- 11.9%
Injection Drug Users	196	6.3%	671	8.1%	- 1.8%
MSM Who Inject Drugs	103	3.3%	469	5.7%	- 2.4%
Heterosexuals	398	12.8%	1,718	20.8%	+ 8.0%
Other	144	4.6%	83	1.0%	+ 3.6%
Unknown	684	22.2%	137	1.7`%	+ 20.2%
TOTAL	**3,102**	**100%**	**8,252**	**TOTAL**	**3,102**

The chart above indicates the success of the local Part A program in bringing higher percentages of marginalized, impoverished, and traditionally underserved clients into care. In terms of ethnicity, for example, the comparison indicates that **African Americans** (**+6.5%**) and **Latinos** (**+3.4%**) are overrepresented in the local Ryan White system of care, while non-Hispanic whites (**-12.6%**) are significantly underrepresented, a fact that reflects the lower rates of income and private insurance among communities of color in our region. In terms of gender, **women** (**+10.4%**) and **transgender persons** (**+1.7%**) are overrepresented in the Part A system of care while **men** (**-12.1%**) are underrepresented, again attesting to the higher prevalence of disadvantaged and impoverished women and transgender persons with HIV in our region. By age group, persons between the ages of **25 and 29** (**+4.3%**) and **30 and 39** (**+7.4%**) are overrepresented among Ryan White program clients because of the rising HIV case rates among younger MSM of color as well as increased testing outreach that has enabled us to successfully identify many new HIV-positive members of this population. The underrepresentation of members of primary transmission categories in Part A services is not due to a lack of service access, but to a high proportion of cases that report an unknown etiology for HIV infection. This is believed to be attributable both to gaps in reporting by local agencies and to an unwillingness for persons with HIV to disclose transmission-related behaviors in light of the persistent stigma that is still attached to HIV infection in many Oakland TGA communities.

The Oakland TGA Collaborative Community Planning Council (CCPC) works in close collaboration with both the Alameda and Contra Costa County Health Department to ensure that all potential Ryan White funding streams in our region are fully maximized and that funds are never used to support duplicative and overlapping services. During its FY 2016 prioritization and allocation process, the Planning Council reviewed income and utilization data related to all Ryan White sources of income, and carefully considered service gaps and client needs data to ensure that Part A funds were used to support only the most critical and underfunded services for low-income persons living with HIV/AIDS in our region. The Planning Council continually incorporated consideration of Part B funding while taking into account the dramatic cuts in funding throughout the State of California which devastated the State beginning in July 2009.

The Planning Council receives annual service category summaries that include a detailed listing of all non-Ryan White funding streams for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, city and county funds, CDC, HOPWA and SAMHSA grants, and state mental health funds. The Grantee also works to ensure that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

d. Barriers to HIV Prevention and Care

A key local strategy for ensuring input by consumers and community members involves the **needs assessment process** in which the Council engages to solicit and obtain direct input on specific needs, barriers, and issues faced by persons living with HIV/AIDS throughout the TGA. For the past 3 years, the Oakland TGA Collaborative Community Planning Council has used the needs assessment program to focus on **specific emerging sub-areas** that have been identified as areas of special importance. In **2013**, Facente Consulting conducted an information-gathering

process focused on four specific areas: a) accessibility of HIV services; b) services to heterosexual African American men; c) services to active injection drug users; and d) services to victims of intimate partner violence (IPV). [1] The assessment collected both quantitative and qualitative data from a wide range of sources throughout the Oakland TGA, including:

- **3** regional stakeholder meetings;
- **6** agency-focused group meetings or one-on-one interviews;
- **6** client / consumer focus groups, including groups centered around Latinos, women, youth, persons who inject drugs, HIV-positive men of color, and African American men;
- **52** provider surveys received from **38** separate TGA agencies; and
- **97** consumer surveys collected from **14** agencies and in the context of several community events.

Among the key recommendations contained in the 2103 needs assessment which were influential in regard to Planning Council decision-making for the FY 2016 prioritization and allocation process were the following:

- Prioritize mobile services whenever feasible, especially in regions where clients are located physically far from services and/or are particularly disadvantaged with regard to transportation options – particularly in unincorporated areas. Also investigate the possibility of having pop-up or satellite clinics on rotating days in these areas that would provide nearby access to HIV specialty clinicians and other wrap-around services.
- Prioritize comprehensive, rather than single-specialty, services at agencies whenever possible, to minimize the amount of travel required for consumers with multiple needs. Also encourage service providers to locate their agencies in the same or very nearby locations, to allow for a more “mall-style” one-stop service opportunity.
- Identify some simple but useful data points to collect system-wide about HIV-positive heterosexual men, and require them to be collected from as many service providers as possible throughout the TGA. Prioritize inclusion of these and any other data about heterosexual men in epidemiological reports or presentations about HIV within the TGA.
- Develop a plan to improve services in the TGA for injection drug users, including provider awareness and sensitivity. This would include an integrated approach to awareness, prevention, and intervention that includes harm reduction approaches (such as a combination of free condoms, HIV and HCV testing, and provision of clean needles and works). It also includes a commitment to investigating “wet” housing support (housing that does not require abstinence from alcohol or drugs to be eligible), as this is impossible for many injection drug users who nonetheless have significant housing support needs.
- Raise visibility about how to identify inter-personal violence (IPV) for one-self or others, promote IPV resources, and reduce shame and stigma about IPV through a social marketing and/or social media campaign within the Oakland TGA. Do this in partnership with IPV service agencies such as the Alameda County Family Justice Center or STAND! For Families Free of Violence to maximize resources, increase collaborations and improve cohesiveness of services.

- Encourage widespread IPV screening during intake at all HIV-related agencies throughout the TGA. If possible, develop a centralized, standard procedure and make this template available to all agencies in the TGA for use if desired. Include training for intake staff at all agencies about how to properly screen for IPV.
- Ensure the existence and appropriateness of IPV services for men – both survivors and perpetrators. Prioritize the establishment of these services where needed, and promote the existence of these services to agencies throughout the TGA so that agency staff will be better able to support their male clients.

An additional focused needs assessment was conducted in **2015** – also by Facente Consulting – which focused on a different set of key areas: a) impact of health care reform on health care access, services, and cost for people living with HIV and AIDS (PLWHA) in the TGA; b) incidence of hepatitis C among PLWHA in the TGA, current HIV/HCV treatment status, and prognosis, and c) barriers and challenges to hepatitis C treatment by PLWHA, with proposed strategies for mitigation.[2] The assessment collected data through:

- **11** agency-focused group meetings or one-on-one interviews;
- **4** client / consumer focus groups, including groups centered around Latino men; Latino women; persons who inject drugs, and women; and
- **121** consumer surveys collected from **11** agencies.

Key recommendations of the 2015 needs assessment included the following:

- Work to increase information and awareness regarding HCV treatment options for PLWHA and their providers in the Oakland TGA;
- Support increased staffing in medical clinics to manage the bureaucratic process for treatment approval for patients;
- Train HIV specialty providers on HCV treatment protocols and access strategies;
- Increase options for substance use treatment, particularly those that are integrated with other services in a "one-stop shop" model; and
- Continue to advocate for increased financial support and improved treatment access for PLWHA in California.

[1] Facente Consulting, *Oakland Transitional Grant Area 2013 HIV/AIDS Needs Assessment*, Richmond, CA, September 2013.
[2] Facente Consulting, *Oakland Transitional Grant Area 2015 HIV/AIDS Needs Assessment*, Richmond, CA, August 2015.

E. Data: Access, Sources, and Systems

a. Main Data Sources to Assess Needs in the Region

RSR Data: Alameda and Contra Costa County participate in the statewide, HIV-specific **AIDS Regional Information and Evaluation System (ARIES).** ARIES is a custom, web-based, centralized HIV/AIDS client data management system that provides a single point of entry for clients; allows for coordination of client services among providers; meets HRSA and State care and treatment reporting requirements; and provides comprehensive data for program monitoring and scientific evaluations. ARIES enhances services for clients with HIV by helping providers automate, plan, manage, and report client- and service-level data. ARIES incorporates **four** integrated applications that work in conjunction with one another:

- The ARIES **Client Application** is the main application through which staff enters client data and search, edit, and generate reports from records.
- The ARIES **Report Export Application** allows users to define custom reports. Users can also export ARIES data in a variety of formats including XML for inclusion in other applications.
- The ARIES **Import Application** allows users to bring data into ARIES from other sources. ARIES Import accepts XML files, checks them for validity, and then inserts or updates the database with the newly imported data.
- The ARIES **Administration Application** allows users to monitor and control ARIES activity as well as customize ARIES edit screens.

ARIES employs multiple layers of security to protect access to data. Each user has a unique login and password to access ARIES. In addition, each computer must have a separate digital security certificate installed for every user who accesses the system. The ARIES web servers and databases are also protected by firewalls to prevent unauthorized access.

Qualitative Data: The Oakland region relies on a wide range of qualitative approaches to assess ongoing needs, barriers, conditions, and emerging issues in our region. The Oakland TGA Collaborative Community Planning Council commissions and conducts ongoing needs assessments as part of its work to prioritize and allocate HIV prevention and care resources. These assessments may be broad-based, covering the full range of needs of local high risk or HIV-infected populations, or topic-specific, exploring needs and preferences related to an emerging issue such as effects of domestic partner violence or utilization of pre-exposure prophylaxis (PrEP). Council-generated needs assessments complement ongoing solicitations for public input in regard to HIV prevention and care needs, barriers, and priorities, including town hall meetings; community forums; surveys and questionnaires; and public and consumer input at all Planning Council meetings, including the meetings of Council committees. This input is in addition to the ongoing planning and assessment work of the Contra Costa HIV Consortium, which reviews both HIV prevention and care data and needs in the county and produces ongoing allocations recommendations in regard to both HIV prevention and care. Invaluable experiential data is also provided by persons living with HIV who are members of both the Planning Council and the Contra Costa Consortium. Qualitative input processes at the Council

level are augmented by a range of additional data that feed into the Council's ongoing deliberations regarding HIV prevention and care services. These include reports and presentations by experts in a broad range of fields on emerging HIV prevention and care strategies and findings; circulation to the Council of key new HIV-related reports, articles, and studies; and presentation of findings of broad-based client satisfaction surveys and needs assessments conducted by local agencies and programs.

HIV Surveillance Data: As defined by the US Centers for Disease Control and Prevention (CDC), the term 'surveillance' refers to the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event. HIV surveillance entities collect, analyze, and disseminate information about new and existing cases of HIV infection with the ultimate goal of combining information on HIV infection, disease progression, and behaviors and characteristics of people at high risk for HIV on a regional, statewide, or national level. **HIV prevalence data** provides information on all persons or designated sub-groups of persons living with diagnosed HIV infection in a given region as of the end of a given time period, including persons who have ever been classified as having an AIDS diagnosis. **New HIV diagnosis data** reflects persons newly diagnosed with HIV infection in a specific region or sub-population within a given period of time (such as a calendar year). **Mortality data** refers to data on the deaths of overall populations or sub-groups of persons with diagnosed HIV infection in a given region which can either be directly ascribed to HIV-related symptoms or which occurs regardless of cause of death. This latter approach is becoming increasingly common as the population of persons living with HIV continues to age, and as the attribution of a specific cause of death becomes more complex and ambiguous in the face of a multitude of health conditions.

All local health departments collect and report data on new HIV infections in their region following State legislative standards and using State-mandated electronic reporting systems and procedures. This data is in turn aggregated and de-duplicated at the state level to eliminate previously identified cases, then further aggregated at the national level to eliminate cases previously identified in a different state or territory. All 50 states, the District of Columbia, and US territories collect comparable confidential, names-based case reports of persons living with diagnosed HIV infection, based on established case definitions. Medical providers, laboratories, and other organizations providing HIV testing services are required, by law, to report persons diagnosed with HIV to the state or local health department. Meanwhile, the State of California requires automatic reporting of all CD+ T-cell tests to track retention in care and regional viral load levels.

In California and the rest of the United States, HIV infections and AIDS diagnoses are reported through a combination of **passive and active surveillance**. Passive surveillance is conducted through State-required reporting of HIV and AIDS cases by health care providers and reporting of HIV-positive test results from laboratories to Local Health Departments (LHDs). Active surveillance is accomplished through routine visits by LHD staff to hospitals, physician offices, laboratories, counseling and testing clinics, and outpatient clinics to ensure completeness, timeliness, and accuracy of reported data. In California and other states, HIV/AIDS surveillance has historically relied heavily upon local health department staff who perform: a) active case surveillance; b) on-site chart reviews; and c) case report completion. To improve timeliness and completeness of reporting and ensure prompt identification and

response to emerging problems in the field, the California Office of AIDS (OA) supports a **decentralized reporting system** where HIV and AIDS case reports are identified through passive and active surveillance efforts coordinated by California's 61 LHDs. HIV/AIDS surveillance case data, reported to local jurisdictions by health care providers and laboratories, is then sent to OA's HIV/AIDS Surveillance Section. The Surveillance Section then submits electronic HIV/AIDS case reports, without personal identifiers, to CDC while providing aggregated data to local health jurisdictions.

Medical Monitoring Project: The Medical Monitoring Project (MMP) is an ongoing CDC-funded national HIV/AIDS supplemental surveillance project. Multi-stage probability proportional-to-size sampling is used to recruit HIV-infected adults receiving care to participate in MMP surveillance. Information about care utilization, clinical outcomes, resource needs, and HIV risk behaviors is collected through patient interviews and medical chart review. Data collected through the MMP is intended to provide an enhanced picture of the experience of being a person living with HIV, including information on how many people living with HIV are receiving medical care; how easy or complex it is to access medical care, prevention, and support services; what the met and unmet needs of persons living with HIV are; and how HIV treatment is affecting persons living with HIV. Ongoing MMP data and findings are continually shared with the Oakland Planning Council and incorporated into prevention and care planning in both county health departments.

National HIV Behavioral Surveillance (NHBS): First initiated by the CDC in 2003, the NHBS system tracks risk behaviors, HIV prevalence, and HIV incidence among populations at high risk for HIV infection in **22** high prevalence areas. The NHBS uses state of the art sampling methods to reach members of high risk populations for standardized behavioral surveys and HIV testing. The NHBS samples **three** populations at highest risk for HIV in alternate cycles: men who have sex with men (MSM), people who inject drugs (PWID), and heterosexuals living in high risk areas. The NHBS survey instrument collects demographic, social experience, sexual behavior, alcohol and substance use, drug treatment, HIV testing, prevention activity, and health data. HIV testing is conducted using validated HIV testing kits and standardized laboratory methods for confirmation of HIV-positive cases. NHBS findings cited in this plan summarize data from the first **nine years** of the NHBS and comprise **three data collection cycles** for each high-risk population.

b. Facilitating or Inhibiting Data Policies

The key existing data challenge in our region involves the complementary need to: a) produce more reliable cross-county data related to stages along the continuum of HIV care; and b) move towards an enhanced "data-to-care" orientation in which surveillance is broadly and practically used to directly impact the quality of patient care in our region. This mirrors a priority at both the state and national level, and relates to the strong potential for data to lead to **direct patient impacts** in terms of both linkage to and retention in care. In a data-to-care framework, for example, surveillance units monitoring new diagnoses and VL/CD4 labs might use these registry reports to work directly with linkage/retention teams to help support individuals both in getting into and remaining in care. Surveillance data could also be used to help care sites provide enhanced support for people who are not virally suppressed.

In addition to the basic metrics on which our region will focus in working toward the enhanced outcomes described in Objectives 2.1., 2.2, and 2.4 below are the following additional metrics on which our region will focus throughout the five-year Plan period. These metrics are collectively aimed at moving towards a system in which surveillance can more broadly be applied to supporting linkage and retention:

- Reporting **linkage to care** rates using laboratory data on a **quarterly** rather than annual basis, to support clinics in prioritizing linkage populations;

- Reporting **HIV retention** rates using laboratory data on a **quarterly** rather than annual basis;

- Tracking **anti-retroviral therapy (ART) prescription rates** among Ryan White-funded clinics in the two-county region, as a way to move toward more accurate monitoring of ART levels;

- Reporting **viral load suppression** rates on a **quarterly** instead of annual basis; and

- Aiming for collection of HIV testing data not only in terms of publicly funded tests and late testers, but **lifetime HIV testing rates, partner HIV testing rates; and social network HIV testing rates.**

c. Missing or Unavailable Data

The advent of **pre-exposure prophylaxis (PrEP)** has transformed the HIV prevention landscape and has the potential to significantly reduce new HIV infections. However, while much progress has been made, there remains little actual data on how PrEP is being used, such as adherence and disparities in access across different sub-populations and regions. While some data can be pieced together to reveal a somewhat fragmented picture of the impact of PrEP on risk behaviors, there is, as yet, no comprehensive source of data currently available. The Oakland region continues to develop new strategies for tracking PrEP use and adherence in our region, and for potentially incorporating this data into the HIV Care Continuum and ongoing HIV data reports. Among the specific PrEP data goals our region has identified and is currently pursuing are the following:

- Adding PrEP utilization to the standard case reporting form for new HIV-positive individuals;

- Utilizing laboratory data to help track PrEP utilization, including piloting a system to identify Truvada-only prescriptions as a reliable marker for PrEP use;

- Generating PrEP eligibility estimates through data such as the number of persons diagnosed with a sexually transmitted infection or identified as an injection drug user within the last 12 months or by demographic NHBS-type health risk surveys;

- Producing PrEP uptake estimates through approaches such as dividing the number of unique individuals who filled a Truvada-only prescription (numerator) by the number of people at risk as identified in the bullet immediately above; and

- Incorporating PrEP counseling for the HIV-negative partners of persons living with HIV as a standard part of ongoing patient assessment, and documenting the percentage of PLWH in care who have prevention counseling documented in medical charts.

SECTION II. INTEGRATED HIV PREVENTION AND CARE PLAN

A. Integrated HIV Prevention and Care Action Plan

a. Underlying Principles of HIV Prevention and Care in the Oakland Region

The text box below contains key underlying principles to guide the provision of effective HIV prevention and care services in Alameda and Contra Costa County over the five-year course of the new Integrated HIV Plans. These principles continually emerged during consideration by the Working Group of suggestions and ideas offered by consumers and providers in the course of our information-gathering activities, and represented approaches that crossed all service boundaries and populations. The populations below must underlie **all** prevention and care services provided in our two counties, and serve as benchmarks to help ensure the quality and effectiveness of our approaches to meeting the needs of our diverse client populations.

HIV Prevention and Care Principles of the Oakland Region

- Providing **culturally and linguistically competent HIV prevention and care services** is at the core of any effective approach to eliminating HIV-related disparities. This includes hiring and supporting staff that reflect the ethnic, linguistic, gender, sexual, age, and cultural backgrounds of the clients they serve, and providing frequent training in cultural competency and cultural humility models.

- HIV prevention and care systems and services must be **trauma-informed**, incorporating both an understanding and effective services to address the impacts of widespread violence, trauma, hate, and institutionalized discrimination faced by HIV-impacted communities such as women, men who have sex with men, transgender persons, and substance users.

- HIV systems must affirm, support, and celebrate **sexual health** and **healthy sexuality** as critical approaches to supporting the health of persons living with and at risk for HIV and as key components of all HIV prevention and service activities.

- Persons at risk for HIV and persons living with HIV must be **directly incorporated** in the planning and implementation of HIV outreach, prevention, care, and support programs, particularly prevention and care programs geared to specific sub-populations.

- HIV prevention and care services must be provided in a **variety of languages** by persons who are both linguistically and culturally competent to provide those services.

- A **social justice perspective** must be incorporated into HIV-related programs and policies wherever possible, and the HIV system should utilize involvement in social justice activities as an HIV prevention and care enhancement strategy.

- The HIV prevention and care system must continually foster the **empowerment of persons living with and at risk for HIV** to increase their capacity to lead self-sufficient, dignified, productive, and satisfying lives and to support them in advocating effectively for their needs. This includes creating opportunities for persons at risk for and living with HIV to meet and support one another and to be involved in HIV outreach, prevention, care, and support programs as part-time or full-time peer staff wherever possible.

- Access to **safe, decent, and affordable housing** is indispensable in reducing HIV infection and supporting the health and wellness of persons living with HIV. Housing is an integral component of healthcare, and must be viewed as a right to which all individuals are entitled. HIV prevention and care systems must incorporate effective housing support services and linkages to housing resources at all levels of service, and the region as a whole must continually advocate for expanded safe housing opportunities for all persons at risk for or living with HIV.

ALAMEDA & CONTRA COSTA COUNTY 2017-2021 INTEGRATED HIV PREVENTION & CARE PLAN

GOALS, OBJECTIVES, AND ACTIVITIES

National HIV/AIDS Strategy Goal # 1:
Reduce New HIV Infections

- **Objective # 1.1 By December 31, 2021, reduce the number of new annual HIV diagnoses in the Oakland region by at least 25%.**

  Strategies:

  - **1.1.1** By December 31, 2017, through a collaboration involving the Oakland Planning Council, the Contra Costa Consortium, and the two County entities, develop an **End of AIDS Action Plan** for the Oakland region that outlines steps to implement a collaborative, multidisciplinary campaign to end HIV in the two-county region, including ending new HIV infections, ending HIV-related deaths, and ending HIV-related stigma.

  - **1.1.2** Continually collect and report data on new HIV diagnoses in the Oakland region, including breakdowns by ethnicity, gender, transmission category, and age.

  - **1.1.3** Conduct ongoing needs assessments to identify emerging issues related to HIV infection and access to HIV education, testing, and other resources.

  - **1.1.4** Deliver targeted, sustained, and evidence-based HIV prevention interventions appropriate to high-risk populations.

  - **1.1.5** Support the development of expanded, tailored HIV-related stigma reduction campaigns in English and Spanish that are aimed at specific, high-risk sub-populations and are developed in collaboration with consumers; that address stigma related to HIV, homophobia, and HIV risk behaviors; that incorporate cutting-edge social media approaches; and that contain sex-positive messages.

  - **1.1.6** Utilize targeted social marketing, media, mobilization and condom distribution programs in English and Spanish to raise and sustain awareness of HIV risk.

  - **1.1.7** Ensure widespread, accessible, and well-publicized syringe distribution and syringe exchange services.

- **1.1.8** Assess, implement, and/or support new or expanded initiatives to reduce new HIV infections in the Oakland region such as the following:

    - Develop and test an enhanced "cocktail counseling" interview model which consists of one part PrEP/ PEP education and referral, one part HIV and STD testing, and one part Partner Services, targeted specifically to high-risk groups and populations, with the goals of increasing HIV status disclosure; reducing transmission and exposure risk; strengthening intimate, monogamous relationships; and increasing sexual health management.

    - Explore the creation of a supervised drug consumption facility designed to reduce HIV and hepatitis C infection among persons who use injection drugs.

    - Support expanded opportunities for peers and persons living with HIV to develop and participate in HIV prevention activities in the Oakland region.

    - Develop HIV outreach, education, and access programs that acknowledge the challenges and taboos some communities face in discussing HIV or HIV risk behaviors or accessing care in HIV-identified facilities, particularly among Latina and African American women.

- **1.1.8** Continually improve the quality of HIV prevention efforts by monitoring and evaluating the effectiveness of HIV prevention programs on an ongoing basis, and by utilizing collaborative relationships and approaches to increase the value and impact of HIV prevention efforts.

- **<u>Objective # 1.2</u> By December 31, 2021, increase the percentage of men who have sex with men (MSM) and transgender persons receiving publicly funded HIV testing in the Oakland region by at least 20%, including African American and Latino MSM.**

  <u>Strategies:</u>

    - **1.2.1** Continually collect and report data on publicly funded HIV testing in the Oakland region by demographic categories and expand data linkages to non-publicly funded HIV testing sites.

    - **1.2.2** Ensure widespread, accessible, culturally competent, and continually expanding HIV testing services, including routine, opt-out testing in health care and treatment settings and targeted HIV testing to high-risk populations.

    - **1.2.3** Support publicizing HIV testing resources in the Oakland region through targeted social marketing, media, mobilization and condom distribution programs in

English and Spanish that raise and sustain awareness of the ongoing importance of frequent HIV testing.

- **1.2.4** Assess, implement, and/or support new or expanded initiatives to reduce new HIV infections in the Oakland region such as the following:

  - Support expanded social network-based HIV testing programs in which persons living with or at risk for HIV involve members of their social, sexual, and/or drug-using networks in regular HIV testing.

  - Expand linkages between sexually transmitted infection (STI) testing and HIV testing by promoting HIV testing or conducting opt-out HIV testing for persons who test positive for one or more STIs and by providing PrEP and PEP education, linkage, and/or treatment for STI-positive individuals.

  - Explore the development and implementation of an innovative, community-based sexual wellness clinic serving the diverse populations of the Oakland region, with specific cultural competencies around a spectrum of LGBTQ and ethnic / racial identities.

  - Explore the effectiveness of home-based HIV testing as an approach to expanding testing participation, potentially in conjunction with home-based STI testing.

- **Objective # 1.3 By December 31, 2021, increase the total number of persons on pre-exposure prophylaxis (PrEP) in the Oakland region by at least 100%, based on PrEP reporting data continually enhanced over the life of the Plan.**

  Strategies:

  - **1.3.1** Continually expand the capacity of the Oakland region to collect and report accurate data on PrEP utilization, with the goal of establishing a preliminary baseline estimate of PrEP utilization by December 31, 2017 and incorporating PrEP utilization into the regional Continuum of Care chart by December 31, 2021.

  - **1.3.2** Support the development and expansion of tailored efforts to publicize PrEP and PEP resources in the Oakland region.

  - **1.3.3** Assess, implement, and/or support new or expanded initiatives to expand PrEP and PEP use in the Oakland region such as the following:

- Create more accessible, appropriate, flexible, and neighborhood-based spaces to provide PrEP and PEP assessment, linkage, and treatment, including mobile programs, night and weekend programs, and programs that provide drop-in, on-demand services for PEP.

- Collaborate with the Bay Area and North Coast AIDS Education and Training Center (AETC) to develop a comprehensive pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) education and training program for medical and social service providers outside of the traditional HIV service system based on existing PrEP / PEP education models.

- Incorporate PrEP and PEP counseling in all relevant health and social service settings that serve individuals at high risk for HIV, including jails and prisons, community health clinics, private physician's offices, obstetrics and gynecology offices, hospitals and emergency rooms, domestic violence agencies, and homeless shelters.

- Create PrEP Navigator positions which function in the same way as HIV care linkage and retention navigators, and represent the full range of cultures and languages in the Oakland region, potentially using peers in this role.

- Develop and distribute a wallet card in targeted locations that lists on-demand PEP locations and resources in the Oakland region for use by individuals after a risky HIV-related encounter.

- Explore the development of a PrEP and PEP-specific web application to help individuals locate PrEP, PEP, and other HIV prevention and service sites based on their desired service region or current location.

- Implement an outreach and education program to inform clients of their ability to exclude information on PrEP, PEP, and other HIV medications from their health insurance records, particularly to encourage young people to become involved in prevention and care.

- **<u>Objective # 1.4</u> By December 31, 2021, reduce the percentage of late testers among all new annual HIV diagnoses in the Oakland region by at least 50%, with late testing defined as receiving an AIDS diagnosis within 12 months of initial HIV diagnosis.**

  <u>Strategies:</u>

- **1.4.1** Continually collect and report data on late HIV testing in the Oakland region by demographic categories

- **1.4.2** Support the ongoing development of accessible, appropriate, flexible, and neighborhood-based HIV testing services, including mobile and community-based testing, social network-based testing, and testing during night and weekend hours

- **1.4.3** Support the expansion of opt-out HIV testing programs in both public and private healthcare and social service settings.

- **1.4.4** Provide culturally competent partner services (PS) which inform the sexual and drug-using partners of persons with HIV of their potential infection risk and provide them with HIV testing options**.**

- **1.4.5** Continually track and integrate emerging HIV testing technologies, and work to incorporate advanced testing approaches in community settings.

National HIV/AIDS Strategy Goal # 2:
Increase Access to Care and Improve Health Outcomes for People Living with HIV

- **Objective # 2.1 By December 31, 2021, increase the percentage of persons in the Oakland region who are linked to HIV medical care within 1 month of receiving an HIV diagnosis to at least 90%.**

  Strategies:

  - **2.1.1** Continually collect and report data on HIV care linkage in the Oakland region by demographic categories and continually expand the capacity of the system to reliably collect and report linkage data.

  - **2.1.2** Quickly and efficiently link newly identified persons with HIV, including persons leaving incarceration settings, to all needed health and psychosocial services, including evidence-based linkage intervention and follow-up support to ensure care engagement**.**

  - **2.1.3** Assess, implement, and/or support new or expanded initiatives to improve HIV care linkage in the Oakland region such as the following:

    - Continue to pilot the Rapid ART Program for HIV Diagnosis (RAPID) model in Alameda County FQHCs in which a short-term supply of HIV medications is

immediately given to individuals newly identified as HIV-positive before a confirmatory test is received to treat potential acute HIV infection, and expand the service to other public and private sites in both counties if the model proves effective.

HIV Care Retention and Adherence Objectives

- **Objective # 2.2.A By December 31, 2021, increase the percentage of persons in the Oakland region who are retained in HIV medical care - based on at least 1 medical visit per year - to at least 90%.**

- **Objective # 2.2.B By December 31, 2021, increase the percentage of persons in the Oakland region who are virally suppressed - defined as having less than 200 copies/ml at most recent viral load test - to at least 80%.**

Strategies:

- **2.2.1** Continually collect and report data on HIV care retention and viral suppression in the Oakland region by demographic categories and continually expand the capacity of the system to reliably collect retention and viral suppression data.

- **2.2.2** Conduct ongoing needs assessment, data gathering, and community input activities to obtain information on local and regional service gaps, trends, and needs, including information on service utilization, emerging client issues, and evolving funding for HIV services**.**

- **2.2.3** Conduct an annual prioritization and allocations process that identifies and prioritizes care needs and gaps for low income and severely impacted persons with HIV and allocates funding to maximize the impact of Ryan White resources in the Oakland region.

- **2.2.4** Ensure that persons living with HIV are central to the planning and allocation of services and resources in the Oakland region.

- **2.2.5** Continually identify and locate previously diagnosed persons with HIV who are not in care, including persons leaving incarceration settings, and effectively re-link them to all needed health and psychosocial services, including using evidence-based strategies and providing follow-up support to ensure long-term care engagement.

- **2.2.6** Assess, implement, and/or support new or expanded initiatives to improve HIV care retention in the Oakland region such as the following:

- Through Ryan White contracts, increase the availability of drop-in, weekend, and evening hours to facilitate client access to care, including specialized, one-stop clients for highly impacted sub-populations.

- Increase the availability of HIV medical and psychosocial services directly within supportive housing facilities, shelters, and other settings that house persons with HIV facing complex barriers to accessing care.

- Ensure access to key essential supportive services that help retain low-income individuals in care, including transportation, food, housing, and child care services.

- Explore a program for persons with HIV who wish to return to work to partially subsidize HIV medications and care between the period when Medi-Cal and other low-income benefits end and employer-based insurance begins.

- Develop and implement a collaborative, countywide program of comprehensive post-release services for incarcerated persons with HIV that includes immediate treatment linkage, benefits support, housing and employment services, and mental health and substance use services.

- Create and implement a plan to expand the availability of mobile medical, mental health, and harm reduction services for low-income persons with HIV.

- Work with providers to develop effective models to: a) assess client risk of either falling out of care or not remaining adherent to HIV medication regimens and b) provide pro-active, staff and peer-based retention and adherence support.

- Research, develop, test, and/or replicate new models of care for persons 50 and older with HIV in HIV clinics, including models that utilize geriatric consultation, advanced aging screening tools, and multidisciplinary care teams for acutely impacted individuals.

- Develop new collaborations with existing aging service agencies and programs in the Oakland region to expand access to supportive services for persons with HIV ages 50 and older; address loneliness and social isolation; and improve HIV knowledge and service capacity at aging agencies.

- Explore the development of a comprehensive day treatment center program for older persons with HIV who are affected by dementia and other disabilities, including food, socialization, recreation, medical care, and rehabilitation services.

- Explore the creation of a program of directly observed therapy for persons with HIV who need support in taking daily medications, such as persons with severe and persistent mental illness or severely disabled persons, potentially in the context of a day treatment center.

- Develop a new system in which persons who have been stably living with HIV for at least 5 years are able to negotiate agreements with case managers to schedule their own appointments and manage their own care with case manager support.

- **<u>Objective # 2.3</u> By December 31, 2021, increase the percentage of Ryan White clients in the Oakland region who are stably housed to at least 90%.**

  <u>Strategies:</u>

  - **2.3.1** Continually collect and report data on the housing status of persons with HIV receiving Ryan White services in the Oakland region by demographic categories.

  - **2.3.2** Ensure the availability of effective housing assessment, referral, linkage, and advocacy services by HIV prevention and care agencies and providers and expand systems to track and monitor these activities.

  - **2.3.3** Participate in and support collaborative efforts to expand housing opportunities and reduce or prevent evictions for persons at risk for and living with HIV in the Oakland region.

- **<u>Objective # 2.4</u> Through December 31, 2021, continually enhance the quality of HIV data tracking, reporting, and sharing in the Oakland region both to effectively track HIV regional linkage and retention outcomes and to directly link and retain persons with HIV in care, as measured through the following activities:**

  - **2.4.1** By June 30, 2017, form a new HIV Data Enhancement Working Group convened jointly by the Alameda and Contra Costa County HIV/AIDS offices for the purpose of enhancing HIV prevention and care-related data-to-care tracking, reporting, and analysis across the Oakland region.

  - **2.4.2** Between January 1, 2107 and December 31, 2018, support the Contra Costa County HIV/AIDS Program in seeking direct access to client-level HIV data through the State of California HIV database, including client laboratory data.

  - **2.4.3** By December 31, 2019, incorporate conditional reporting on PrEP utilization as a component of the HIV Care Continuum chart for both Alameda and Contra Costa Counties.

- **2.4.4** By December 31, 2021, produce a single unified HIV Care Continuum chart for the Oakland region, encompassing both Alameda and Contra Costa Counties.

- **2.4.5** Between January 1, 2017 and December 31, 2021, continually enhance and expand the quality and utilization of client laboratory data to monitor HIV linkage and retention rates in the Oakland region while continually using data to better link and retain persons with HIV in essential services and treatment.

National HIV/AIDS Strategy Goal # 3:
Reduce HIV-Related Health Disparities and Health Inequities

- **Objective # 3.1 By December 31, 2021, eliminate disparities across all HIV Care Continuum categories in the Oakland region, including HIV testing, new diagnoses, linkage to care, retention in care, and viral suppression.**

For the 2017-2021 Integrated HIV Prevention and Care Plan, the Oakland region is committing to a unified effort to eliminate **all** disparities in relation to HIV prevention, testing, and care access and support, including disparities related to ethnicity, sexuality, gender identity, age, HIV risk behaviors, substance use behaviors, socioeconomic and income status, housing status, US residency status, and personal disabilities. In regard the HIV Care Continuum, the region particularly commits to eliminate disparities related to the four documented demographic categories of ethnicity, gender, age, and HIV transmission categories. These activities are strongly supported by the key principles outlined above.

Strategies:

- **3.1.1** Continually collect and report data on HIV-related disparities across all categories of HIV prevention and care, including education, outreach, testing, PrEP and PEP access and utilization, linkage to care, retention in care, viral load suppression, medication and treatment access, cultural competency of services, and housing status.

- **3.1.2** Conduct ongoing needs assessment, data gathering, and community input activities to obtain information on local and regional service gaps, trends, and needs related to disparities in prevention in care, including information on HIV testing, PrEP and PEP utilization, HIV treatment utilization, and access and utilization of core and supportive services**.**

- **3.1.3** Conduct an annual prioritization and allocations process that is focused in part on eliminating HIV disparities for low income and severely impacted persons with

HIV and that allocates funding to maximize the impact of Ryan White resources in the Oakland region.

- **3.1.4** Develop, promote, and participate in collaborative efforts to address HIV-related disparities in the Oakland region, including partnerships with local HIV planning groups, coalitions, and consumer bodies and potentially in the context of a regional Getting to Zero initiative**.**

- **3.1.5** Assess, implement, and/or support new or expanded initiatives to improve HIV care linkage in the Oakland region such as the following:

    - Monitor and expand the availability of staff at HIV prevention and care agencies who reflect the full spectrum of populations they serve and who are respectful to and understanding of the needs and problems of key HIV-impacted subpopulations.

    - Work with Ryan White providers to incorporate hormone therapy into HIV medical care as an incentive for transgender people to access HIV services.

    - Advocate for expanded law enforcement education and the change of law enforcement practices that specifically discriminate against transgender persons and create barriers to HIV health maintenance and risk reduction.

    - Expand access and linkage to high-quality job training and employment services for low-income persons at risk for and living with HIV, particularly for transgender women and persons involved in sex work, and increase mentorship and support opportunities that foster new PLWH leaders who can provide enhanced client-centered prevention and care services and serve in leadership positions in the HIV prevention and care community.

    - Greatly expand the availability of outreach, education, support, access, and treatment services for Latino populations in the Oakland region, including bilingual / bicultural services in English and Spanish.

    - Ensure the continuation and expansion of culturally competent, trauma-informed prevention and care services directed toward high-risk and HIV-infected women in the Oakland region, particularly African American and Latina women.

    - Support the creation and expansion of multi-service resources and locations for LGBT individuals in the Oakland region, with a focus on MSM of color and transgender persons of color.

- Support the delivery of compassionate, respectful, and inclusive HIV prevention messages and programs in churches and religious settings, including in ethnic minority communities.

- Develop and provide HIV stigma reduction training for all relevant agencies and providers, including information on delivering non-stigmatized testing, linkage, PrEP/PEP and HIV treatment information and services to specific sub-populations.

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Contributions of Stakeholders and Key Partners

As noted in Section I.D above, the Alameda County Office of AIDS Administration formed an **independent Integrated Plan Working Group** in December 2015 whose specific charge was to work in partnership with the Oakland TGA Collaborartive Community Planning Council, the Contra Costa HIV Consortium, and the Contra Costa County HIV/AIDS Program to develop the new five-year Plan. The Working Group included a diverse range of Planning Council members, consumers, community-based agency representatives, and representatives of local County government. **The Working Group had a specific commitment to incorporating the broadest range of perspectives and input from key stakeholders and partners who would play a part in implementing the new five-year plan.** The Working Group met monthly from January through July 2016 to review the region's previous HIV prevention and care plans and to collect information and data and discuss components of the new Plan. The group also collected updated epidemiological, service, and prevention data from a wide range of sources, and reviewed the previous care and prevention plans produced in our region.

The Working Group's information-gathering process was highlighted by a series of **nine Community Input Groups** held between March and July 2016 which included consumers, clinicians, and key local HIV planners and agency representatives (see **Figure 29**). The input group process was designed to include consumers from each of the hardest-hit populatons in the region in terms of HIV infection, as well as the input of agency representative, providers, and planning specialists. The first input, group conducted on March 17, 2016, sought input on the Integrated Plan from members of the **East Bay HIV Linkage Advisory Group**, a multidiscilinary group described above whose membership includes virtually all direct client linkage and retention personnel in the two-county region. **Two** input groups specifically included **African American consumers** - one in Alameda County and one in Contra Costa County. Additional consumer groups - described in greater detail in Section II.C below - were held that involed **Spanish-speaking consumers, transgender women, women of color, HIV-infected and high-risk HIV-negative youth of color,** and a group conducted in Contra Costa County involving **persons 50 and older with HIV**.

As noted in Section I.D, a **special data input group** was held on May 23, 2016 involving key HIV data and epidemiology specialists and planners from throughout the two-county region. Co-sponsored by the Alameda County HIV Edpiemiology and Surveillance Unit and the Bay Area and North Coast AIDS Education and Training Center (AETC), the meeting focused specifically on: a) how to improve local data collection and reporting to increase the accuracy and timeliness of HIV care continuum data; b) how to improve data collection capactiy in regard to utilization of pre-exposure prophylaxis; and c) how to move toward more integrated data collection and reporting processes among the two counties, including the possible creation of a merged two-county HIV care continuum. Specific data targets developed through this meeting are listed in **Sections 1.E.b and 1.E.c** above, whlie data collection and reporting objectives and activities are included in **Obective # 2.4** of our action plan.

Figure 29. Chart of Integrated HIV Plan Input Group Sessions

GROUP TOPIC / COMPOSITION	PARTNER / SPONSOR	LOCATION	DATE	TIME
East Bay HIV Linkage Advisory Group	Sophy Wong, Bay Area / North Coast AETC	California Endowment, 1111 Broadway, Oakland 94607	Thursday, March 17	12:30 PM – 4:30 PM
African American Input Group # 1 - Alameda County	Office of AIDS Administration / Phoenix Smith	1000 Broadway, 3rd Floor, Oakland, 94607	Monday, May 2	11:30 AM – 1:00 PM
Project CRUSH Community Advisory Board (Young MSM of Color)	Brian Ragas / East Bay AIDS Center	Bay Street Mall Community Room, 5616 Bay Street, Emeryville, 94608	Tuesday, May 17	6:30 PM – 8:30 PM
Cross-County HIV Data Meeting	Sophy Wong, Bay Area / North Coast AETC & Monica Gandhi, Alameda Office of AIDS	1000 Broadway, 3rd Floor, Oakland, 94607	Monday, May 23	2:00 PM – 4:00 PM

GROUP TOPIC / COMPOSITION	PARTNER / SPONSOR	LOCATION	DATE	TIME
50 & Older HIV-Positives Input Group	Marcos Apolonio / Rainbow Community Center	2118 Willow Pass Rd, Suite 500, Concord, 94520	Monday, May 23	6:30 PM – 8:00 PM
Latino / Spanish Language HIV-Positives Input Group	Yvonne Escarsega / Alameda Health System	Highland Hospital, Classroom B, 1411 E. 31st Street, Oakland 94602	Monday, June 6	12:00 PM – 1:30 PM
Transgender Women Input Group	Anand Kalra / Transgender Law Center	Public Health Institute, 405 14th Street, Oakland 94607	Tuesday, June 7	5:00 PM – 6:30 PM
Women of Color Input Group	Nikia Harris / WORLD & Loren Jones	389 39th Street, Oakland	Thursday, June 9	12:00 PM – 1:30 PM
African American Input Group # 2 - Contra Costa County	Betty Gee / Neighborhood House of North Richmond	830 23rd Street, Richmond, 94806	June 18, 2016	12:00 – 2:00 PM

b. Stakeholders and Partners Not Involved in Planning Process

Through its extensive ties to the community, the diversity of its membership, and the nine input sessions conducted as part of the Work Plan's activities, representatives of virtually all key regional stakeholder groups were involved in the integrated planning process. If there was an identifiable gap in our input process, it involves the lack of direct representation by **private and other public medical providers and HMOs** who provide a significant proportion of HIV care in our region and with whom a greater degree of interaction and coordination is continually being sought. Chief among these is the **Kaiser Permanente** system, which cares for hundreds of persons with HIV in both counties but is not a direct Ryan White or CDC subgrantee. Additional HIV care services are provided by the **Veterans Administration (VA)** system and by local private physicians who maintain practices that include significant proportions of persons living with HIV. While both counties have made significant progress in working with private providers, they were not present as ongoing Working Group members in our process. This remains a priority area on which our region will continue to work over the course of the five-year Plan implementation process.

c. Letter of Concurrence

Please see Letter of Concurrence from the Oakland TGA Collaborative Community Planning Council at the beginning of this document.

C. People Living with HIV (PLWH) and Community Engagement

a / b. Reflectiveness of Plan Development Participants and Inclusion of Persons Living with HIV (PLWH)

As noted in Section II.B above, **seven of the ten** input groups held in conjunction with the integrated planning process were specifically conducted among groups of consumers heavily impacted by HIV in our region. **Two** of these input groups involved male and female **African American consumers**. The first group, sponsored by the Alameda County Office of AIDS Administration, included many consumers who had direct roles within local agenices, and who had a wide-ranging perspective on local HIV prevention and care needs and issues in the African American community. The second African American group was held at Neighborhood House of North Richmond, a grassroots organization in a highly underserved region of Contra Costa County. While the first group offered a perspective on the needs of the African American community from the viewpoint of long-time leaders, the Contra Costa group focused signfiicantly more on the needs low-income populations face in accessing HIV care and meeting the necessities of life on a daily basis.

A group involving **Spanish-speaking consumers** was held at Highland Hospital, Alameda County's largest public hospital, whose HIV clinic has sponsored a weekly Spanish-speaking support group for more than a decade. Through facilitators speaking in Spanish, the group's participants offered significant insights into the degree of marginalization they experience in seeking services and striving to obtain information and benefits, including the inadequate amount of Spanish-language staff available in many agencies. A **transgender women's group** sponspored by Transgender Law Center and held in Alameda County provided even more devastating insights into the extent to which these populations daily experience discmination, violence, and economic disempowerment, with most of the group's members being either homeless or in shelter facilities and with none able to access adequate employment. A **women of color group** consisting of HIV-positive African American and Latino women was held at Women Organized to Respond to Life-Threatening Disease in Oakland, and provided many inspiring stories of resiliency and strength in the face of marginalization and discrimination.

Key input from **HIV-infected and high-risk HIV-negative young people of color** was obtained through a meeting with the Project CRUSH Advisory Board based at East Bay AIDS Center (EBAC) in Oakland. Project CRUSH (Connecting Resources for Urban Sexual Health) is an innovative and ambitious program funded in part by the California HIV/AIDS Research Program that is recruiting and bringing into medical care 400 of the very highest risk HIV-negative young MSM of color between the ages of 13 and 29 living in Oakland and Alameda Counties. Project CRUSH provides its youth clients with comprehensive medical, behavioral, psychosocial, and risk reduction services along with access to free daily PrEP treatment for any young people who wish to receive it, through a five-year funding commitment from Gilead Sciences. The Project CRUSH CAB is comprised entirely of consumer members and meets quarterly to provide input into the project's outreach, testing, and support services, giving particularly important input into the use of **social media** to promote the CRUSH program throughout high-risk youth communities.

Finally, an input group involving **men 50 and older living with HIV** was held in the context of a weekly men's support group at Rainbow Community Center in Concord, in central Contra Costa County. The support group has been meeting for several years, and had invaluable perspective on the issues of both new and long-term survivors in accessing and obtaining services and in navigating an ever-changing system in which individuals often must serve as their own best advocates in locating and obtaining services and benefits.

c / d. Community and Consumer Engagement Methodologies to Ensure Responsiveness and Solve Problems

It is important to note that the consumer input process was **not** designed to serve as a formal or informal needs assessment, but as a way to obtain **new ideas and concepts for improving the system of HIV prevention and care in our region.** Both Alameda and Contra Costa County conduct regular client needs assessments to identify specific gaps and barriers in prevention and care, and also conduct and review findings of local Town Hall meetings, focus groups, and client satisfaction surveys. The questions asked in each input group specifically focused on key topics and emerging issues in the epidemic about which the Working Group wished to obtain direct input from consumers. For example, for our input group involving **young HIV-positive youth of color**, the following were the key questions guiding the session:

- What are some emerging or growing HIV risk behaviors you are seeing among young MSM? Is there an awareness of the importance of HIV risk reduction among young MSM?

- How familiar are young MSM with both PEP and PrEP? What sub-populations should be targeted for PEP and PrEP education and what are some good ways to get the word out to them? What are some of the major objections that young MSM might have to the use of PEP and PrEP?

- Are young MSM aware of the importance of HIV testing? Do they know how to access testing if they want it? Do you think HIV is a major concern for young MSM? What new programs or approaches could be used to increase awareness of the importance of HIV and HIV prevention among young MSM?

- Are young MSM aware of the importance of STD testing? Do they know how to access STD testing if needed?

- What are some ways to potentially use social media to spread the work about HIV risk and PrEP / PEP?

- Would social network programs that include incentives for referring high risk friends be effective for both PrEP and HIV testing referral?

And for our input group involving **women of color with HIV**, the following list of questions was used:

- How aware are women of HIV risk in Alameda County? Is there less awareness that HIV is a major issue than there used to be? Are there some population of women who are unaware of or in denial regarding their risk? How could we increase HIV awareness among women?

- Do women know it's important to get tested for HIV? Do they know how to find testing? Is HIV testing liked to STD testing? How could we increase awareness of both the importance of testing and how to access it?

- Are you aware of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)? Are there any fears or suspicions around PrEP for women? Are their specific women's populations that would be appropriate for PrEP and/or PEP? How could we get the word out to high-risk women regarding PrEP and PEP?

- What are some of the key issues facing women with HIV in care? What barriers or issues make it hard for you to remain in care or adherent to medications? How could we address these problems? Would peer based or social support programs specifically for women help you remain in care?

- How good are local HIV services for women age 50 and older? Do HIV clinics do a good job of addressing aging issues? How could HIV services be improved so that clinics could do a better job of caring for older women with HIV?

Suggestions and concepts obtained at the two input groups were recorded by consulting group facilitators and compiled into lists that were presented to the Integrated Plan Working Group, categorized by the input group at which the set of ideas was generated. The Working Group then reviewed and prioritized these concepts at a full-day planning meeting, and made later decisions at to which concepts to include as potential Plan activities at its final meeting in July 2016. This process provided a unique strategy for directly incorporating the input of persons living with HIV, along with high-risk persons, clinicians, and providers, in the actual substance of the 2017-2021 Plan document.

SECTION III. MONITORING AND IMPROVEMENT

A. Plan Monitoring Process

Implementation, monitoring, and evaluation of the 2017 - 2021 Integrated HIV Prevention and Care Plan will be the shared responsibility of the Oakland TGA Collaborative Community Planning Council, the Contra Costa HIV Consortium, and the Alameda and Contra Costa County AIDS Offices with leadership for Plan monitoring coming from the Oakland Planning Council. At the time of this writing, there are **three** major options for Plan monitoring and evaluation. **First,** the Plan may be monitored by the Planning Council's **Executive Committee**, the main steering body for the Council whose members include all Planning Council Co-Chairs as well as the Chairs of all Standing Committees. This was the process by which the region's 2006 - 2009 and 2012 - 2014 Comprehensive Plans were monitored. **Second**, the Plan may be monitored by a designated subcommittee, ad hoc committee, or Work Group that includes broad representation by consumers and representatives of the local HIV care system and that would be given specific responsibility for overseeing and monitoring the Plan. This was the strategy for monitoring the 2009 - 2012 Comprehensive Plan as well as previous Alameda County HIV Prevention Plans, which have been monitored by the Council's Prevention Committee. **Third**, the responsibility for monitoring specific Plan components could be divided among different Standing Committees based on the specific roles and responsibilities of each Committee, with reports provided on a regular basis to both the Executive Committee and the Planning Council as a whole.

Regardless of the specific body that is to monitor the Plan, a key element of Plan implementation is expected to involve an **annual Plan review and priority-setting process** conducted early in the year in which Planning Council representatives meet with key representatives of the Alameda and Costa Contra AIDS Programs and with additional local planners to **prioritize activities for the upcoming year.** Because the Plan is structured to include a wide range of potential activities, this process will focus in part on selecting prioritized activities for focused implementation and monitoring during the upcoming year. Selection of these priorities will be based on a combination of emerging data and information, prioritization of issues by local consumers, and local opportunities which create a favorable climate for implementing specific initiatives. **Two** specific action steps already prioritize specific new activities for the Council in 2017. **Action Step 1.1.1** calls for development of an **End of AIDS Action Plan** for the Oakland region by December 31, 2017. **Action Step 2.4.1** calls for the formation of a new HIV Data Enhancement Working Group convened jointly by the Alameda and Contra Costa County HIV/AIDS offices for the purpose of enhancing HIV prevention and care-related tracking, reporting, and analysis across the Oakland region.

All prioritized activities for the coming year will be incorporated into a **systematized action step grid** developed early each year. The grid will include proposed action steps contained in the Plan and will feature clear incremental deadlines that identify persons or groups responsible for each action step. The designated monitoring entity or entities will track progress toward Plan objectives and action steps; discuss key decisions or barriers related to attainment of these objectives and action steps; and propose changes or modifications to the

action plan to the Grantee and the Planning Council to address new and emerging issues or to address barriers to the attainment of specific action steps. Monitoring entities will also provide reports to the Planning Council as a whole on a regular basis.

The process of monitoring and evaluating the 2017 - 2021 Integrated Plan will include the potential for the Planning Council to edit, change, or revise the Plan to respond to emerging challenges and to better meet the needs of low-income persons living with HIV in the Oakland region. This includes the possibility of adding new action steps or changing the order of action steps presented in the Plan or revising existing objectives or adding new objectives and corresponding action steps. It also includes the possibility of producing a completely new revised Plan if needed or required by changing needs and circumstances. Incorporating a greater degree of flexibility than in past Plans is particularly important at a time of unprecedented change in both the Ryan White and general health care systems.

The process of monitoring and evaluating the 2017-2021 Comprehensive HIV Plan will be fully coordinated with our region's **Quality Management (QM) Program**, designed to ensure the provision of high quality, culturally sensitive core and support services to people living with HIV/AIDS in Alameda and Contra Costa Counties. The goals of the QM program closely mirror those of the current Comprehensive Plan, including:

- Returning to care those aware of their status but not in care and enrolling out of care clients in care;
- Increasing awareness of quality improvement (QI) principles and knowledge among contracted service providers;
- Improving the effectiveness of the Council's decision-making process for establishing priorities and making allocations;
- Improving access to and retention in substance abuse and mental health treatment services; and
- Ensuring conformity to PHS treatment guidelines and HRSA expectations and ensuring that services planning and delivery is informed by the Integrated Plan.

B. Monitoring Quantitative Plan Objectives

The Oakland region will continually monitor progress toward the quantitative objectives contained in the Integrated Plan. The action step grid to be developed in early 2017 will include clear timelines, action steps, and assigned responsibilities for tracking and reporting progress toward SMART objectives, targets that will developed in collaboration with the HIV prevention and care units of the two local health departments, as well as the HIV epidemiological units of both departments. The grid is expected to include a requirement for at least **annual** reporting to the Planning Council on progress made toward SMART objectives, including objectives specific to the HIV Care Continuum and the goal of eliminating disparities in the Oakland region. In some cases, the Planning Council may request more frequent updates on urgent, complex, or time sensitive objectives.

In keeping with the view of the Integrated Plan as a living document, additional quantitative objectives may be added to the Plan over time to reflect emerging knowledge,

issues, or tracking technologies. SMART timelines or targets also be modified at any time to reflect rapid progress in a given area or to more realistically respond to unanticipated barriers or challenges. For example, as enhanced data collection systems and processes continue to evolve for tracking PrEP utilization, including the production of more reliable baseline data, PrEP objectives in the Plan may be modified upward or downward to reflect more realistic or ambitious targets for PrEP expansion. All modifications to SMART objectives will be developed through a collaborative process involving the Planning Council and local public agencies, and will be fully discussed and approved by the Council prior to being included in the Integrated Plan.

C. Using Findings to Track Impacts Along the HIV Care Continuum

Tracking and continually enhancing outcomes along the HIV care continuum is a key outcome of the 2017-2021 Plan period. The Plan includes specific, quantifiable objectives for enhanced continuum outcomes, while describing steps to enhance the quality of continuum-related data in both counties. During the annual Plan review and priority-setting process conducted early in each calendar year, the planning group will review current data along each stage of the continuum for both counties, and potentially set **incremental goals** for continuum improvement over the upcoming 12-month period. The group will also discuss specific ways in which each continuum outcome can be **better tracked** both to result in more accurate data and to ensure that data is utilized to better reinforce identification, linkage, and retention of persons living with HIV. Creating specific benchmarks and action steps for making progress toward each quantitative objective will be a key component of the annual priority-setting, implementation. and monitoring process.