

ii. Project Narrative

INTRODUCTION

San Diego County comprises over 4,200 square miles, with urban, suburban and rural communities. With a population of almost 3.4 million, it is the second most populous county in California and the fifth most populous county in the United States. There are 18 incorporated cities within the County, as well over 30 unincorporated communities, 10 military installations, and 18 federally recognized Indian reservations. San Diego County is home to more than 100,000 active-duty military personnel and over 240,000 veterans, which is the highest concentration of the military in the United States. San Diego County further forms one of the largest conurbations in the world with Tijuana, Baja California, Mexico, with a combined regional population of over five million. Because of the international border, San Diego County has three land ports of entry with more than 50 million northbound crossings from Baja California into the County each year, making it one of the busiest land border crossing in the world.

HIV continues to be a major health concern in San Diego County. As of December 31, 2020, there were 14,061 people in the County living with diagnosed HIV and an additional 1,392 persons estimated to be living with undiagnosed HIV infection. In 2020, there were 302 residents who were newly diagnosed with HIV, representing just under one new diagnosis, on average, every day.

Ryan White Part A serves as a vital funding source for our local continuum of HIV care, ensuring that all persons living with HIV have access to high quality care and treatment without regard to their ability to pay. In San Diego County, there are no waiting lists for core medical services, and other than temporary housing support, there are no waiting lists for any other service category. The local Ryan White system has fully integrated changes created by the Affordable Care Act, and the reduction in need for medical care funded by Ryan White has allowed the HIV Planning Group (San Diego County's planning council) to seek and receive a core medical services waiver for the past six years. As a result, the HIV Planning Group has focused on allocating Ryan White Part A funding to address the barriers to care experienced by persons living with HIV in San Diego County, including development of strategies to increase health outcomes among populations that are less likely to experience viral suppression (African Americans, persons who inject drugs, persons between 20 and 40 years of age, and persons residing in the Central region of the County).

In the *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019*¹, comparative data presents some of the challenges and successes of San Diego County. One of the most significant challenges faced by San Diego County is the intersection of poverty and the cost of living, as San Diego County continues to be one of the least affordable places to live in the United States. The average cost of rent is close to \$1,900 per month², which is almost twice the federal poverty level for 2020, \$1,073 per month. Of all the Ryan White-funded counties in California, San Diego County has the highest proportion of persons who are living at or below

¹ Health Resources and Services Administration. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019*. <http://hab.hrsa.gov/data/data-reports>. Published December 2020.

² Molinar, Phillip. April 3, 2018. "San Diego average rent up to \$1,887, breaking record. Will it last?." *San Diego Union-Tribune*. Accessed from <https://www.sandiegouniontribune.com/business/real-estate/sd-fi-rent-vacancy-20180403-story.html> on September 27, 2019.

100% of the federal poverty level (80.6%, HRSA), the third lowest proportion who are stably housed (78.1%, HRSA), with 8.7% of clients identified as unstably housed. Despite these challenges, San Diego County Ryan White clients achieved 92.1% viral suppression among clients with reported viral load tests. The results seen in the 2019 RSR data are the result of the continued partnership among several important stakeholders, including persons living with or vulnerable to HIV, organizations serving these communities, the HIV Planning Group, and the County of San Diego. An outcome of this partnership was the creation of the Getting to Zero initiative, which seeks to end the HIV epidemic locally. It was unanimously adopted on March 1, 2016, by the County of San Diego Board of Supervisors.

Getting to Zero in San Diego County

San Diego County's Getting to Zero initiative is composed of five overlapping strategies. The first three of these strategies map directly to the first three pillars of the federal Ending the HIV Epidemic initiative:

- **Test (Diagnose):** Identify individuals living with HIV but unaware of their status as well as persons who are HIV-negative but vulnerable to HIV infection by:
 - 1) Conducting focused HIV testing for individuals and populations that are vulnerable to HIV infection;
 - 2) Supporting federally qualified health centers in conducting routine HIV testing by paying for the cost of uncompensated testing for the uninsured as well as providing staff and funding to support linkage to ART for those diagnosed with HIV;
 - 3) Working with private health care systems to promote adoption of routine screening for HIV in primary care settings;
 - 4) Rapidly linking individuals newly diagnosed with HIV to treatment and needed support services; and
 - 5) Rapidly linking individuals who are HIV-negative but vulnerable to HIV infection to PrEP and other needed services.

- **Treat:** Improve health outcomes for persons living with HIV by:
 - 1) Linking all persons living with HIV to care and helping them remain in care over time; and
 - 2) Ensuring that all persons living with HIV achieve viral suppression.

- **Prevent:** Reduce HIV transmission by:
 - 1) Linking individuals vulnerable to HIV infection to risk reduction activities, PrEP, and other needed services; and
 - 2) Linking individuals at risk for transmission to primary care, risk reduction activities, medical case management, adherence counseling, HIV Partner Services, and other needed services.

- **Engage:** Mobilize community efforts to achieve collective impact by:
 - 1) Partnering with communities disproportionately impacted by HIV;

- 2) Developing and deploying media campaigns to promote awareness, encourage testing and treatment, and promote use of PrEP;
 - 3) Reducing stigma;
 - 4) Developing action plans for reducing disproportionalities; and
 - 5) Refining referral and linkage systems to address co-factors that lead to disproportionate outcomes.
- **Improve:** Continually seek to improve outcomes along the HIV Care Continuum by:
 - 1) Maintaining a performance management system capable of measuring progress in meeting operational, program and outcome objectives;
 - 2) Maintaining a comprehensive quality improvement program that focuses on both improving underperformance as well as identifying opportunities for improvements where performance already meets expectations; and
 - 3) Conducting annual quality assurance reviews to measure program performance using national standards and benchmarks for quality.

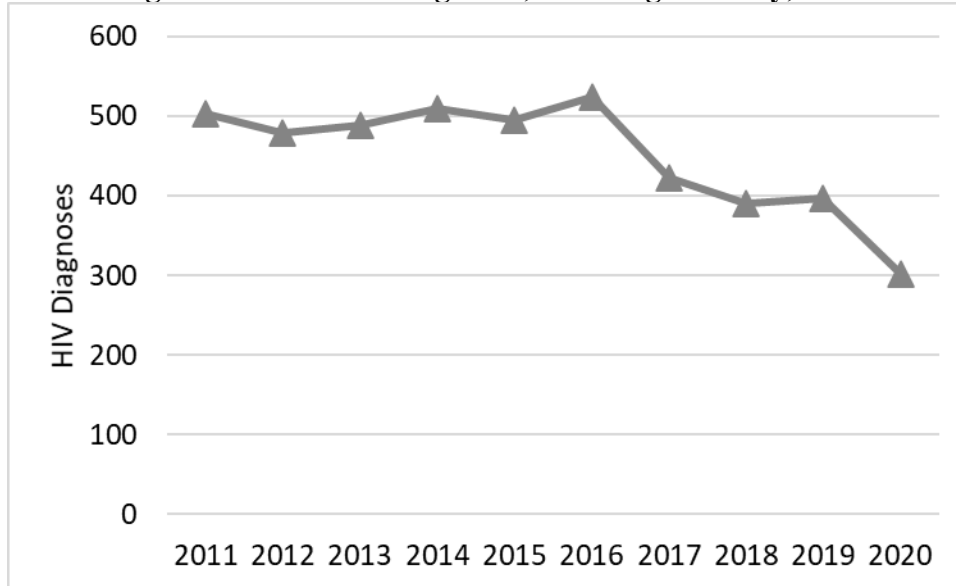
The Getting to Zero initiative became the basis for the comprehensive plan for addressing HIV in San Diego County for the period of 2017 through 2021. Titled *Getting to Zero: San Diego County's Plan for HIV Care, Prevention, Testing and Surveillance*, the plan was developed in collaboration with the County of San Diego's HIV Health Services Planning Council and the HIV Prevention Group, which merged into the single HIV Planning Group in September 2016. This plan closely follows the requirements of the Integrated HIV Prevention and Care Plan Guidance released by HRSA and CDC in June 2015.

The Getting to Zero initiative also supports the *Live Well San Diego* vision adopted by the County of San Diego's Board of Supervisors. *Live Well San Diego* is a comprehensive, innovative regional vision that combines the efforts of partners inside and outside County government to help all residents be healthy, safe, and thriving. It is comprised of three core components: 1) Building Better Health focuses on improving the health of residents and supporting healthy choices; 2) Living Safely seeks to ensure residents are protected from crime and abuse, neighborhoods are safe, and communities are resilient to disasters and emergencies; and 3) Thriving focuses on promoting a region in which residents can enjoy the highest quality of life.

Since inception in 2016, the County's Getting to Zero initiative has shown real gains in ending the HIV epidemic. As shown in Figure 1, from 2016 to 2020, the County of San Diego saw a 40% decrease in new HIV diagnoses. While the significant decrease in 2020 is undoubtedly related to significant disruptions in HIV testing caused by the COVID-19 pandemic, San Diego County had already seen a 27% decrease in new HIV diagnoses as of 2019. Moreover, the County has seen sustained increases in the proportion of persons living with diagnosed HIV who were virally suppressed (from 31% in 2011 to 61% in 2019). We have also seen decreases in the number of deaths among persons with diagnosed HIV (from 136 in 2011 to 78 in 2019).

The Ending the HIV Epidemic in the U.S. initiative directly aligns with the goals of our local Getting to Zero initiative. San Diego County is one of the 57 priority areas identified in the initiative and is part of the California Consortium made up of six California counties including Alameda, Sacramento, San Bernadino, Orange, and Riverside.

Figure 1: New HIV Diagnoses, San Diego County, 2011 - 2020



Partnerships with Consumers and Providers During the COVID-19 Pandemic

The County of San Diego’s long-standing partnerships with consumers and provider organizations have supported making rapid modifications and adaptations to ensure the HIV service delivery system functions optimally, given the challenges created by the COVID-19 pandemic. On March 19, 2020, California Governor Gavin Newsom issued a stay-at-home order to reduce the spread of COVID-19. This order created numerous system challenges, as many organizations, including the County of San Diego, quickly implemented remote working strategies. Some of the required adaptations were operational in nature, such as ensuring the providers of outpatient/ambulatory health services could bill for telehealth as well as in-person services, or establishing policy to permit electronic signatures on most documents that had previously required wet signatures. Much more of the focus, however, has been on ensuring that clients can maintain positive health outcomes amid the unforeseen challenges and barriers created by the pandemic and the public health response to it. In April 2020, the County of San Diego instituted weekly on-line meetings among all of its Ryan White funded providers to identify and eliminate or mitigate all system challenges and barriers faced by clients, and this meeting continues to this day, although the frequency has been reduced to twice per month.

Recipient staff members make lists of all issues identified at each meeting, and then work collaboratively with providers, the HIV Planning Group, and, most importantly, persons living with or vulnerable to HIV to solve. For example, one of the issues identified early on by consumers and providers was housing stability and a concern for persons unstably or temporarily housed. As a result, the Recipient recommended, and the HIV Planning Group adopted, funding re-allocations to Housing Services, creating more funding for eviction prevention, short-term hotel stays, and rental subsidy. Another example was the need to provide additional support to clients living with HIV who had other co-morbidities placing them at greater risk for negative health outcomes from COVID-19 infection (i.e., diabetes and chronic respiratory conditions). The Recipient recommended and the HIV Planning Group adopted new measures including a temporary extension of ride-sharing services, as opposed to public transportation, to support

accessing nutritional support services, as well as a temporary extension of home-delivered meals to ensure adequate nutrition for clients who do not feel safe leaving their homes.

NEEDS ASSESSMENT

A. Demonstrated Need 1) Epidemiologic Overview a) Summary of the HIV epidemic in the County of San Diego

Description of geographic region. San Diego County, one of 58 counties in the state of California, is home to over 3.3 million people.³ The area encompasses about 4,200 square miles of land, 70 miles of coastline and is larger in area than Rhode Island and Delaware combined. San Diego County is the second most populous county in California and the fifth most populous county in the United States. It is composed of urban, suburban and rural areas. The county also borders Baja California, Mexico, and the combined San Diego/Tijuana region contains approximately five million residents.⁴ As stated earlier, there are 50 million border crossings each year from Tijuana into San Diego (Baja California does not track the number of Southbound crossings), making it one of the busiest land border crossing in the world. Table 1 shows some socio-demographic characteristics of San Diego County residents.

Table 1: Socio-Demographic Characteristics of San Diego County Residents

Socio-Demographic Characteristics	#	% of total
Race/Ethnicity*		
White, not Hispanic	1,510,756	45.6
African American, not Hispanic	156,084	4.7
Hispanic	1,117,517	33.7
Asian/Pacific Islander, not Hispanic	398,404	12
American Indian/Alaskan Native, not Hispanic	12,474	0.4
Multi-Race, not Hispanic	114,278	3.4
Other, not Hispanic	6,560	0.2
Total	3,316,073	100
Gender*		
Male	1,669,515	50.3
Female	1,646,558	49.7
Total	3,316,073	100
Age (Years)*		
≤14 years	605,353	18.3
15 - 19 years	207,980	6.3
20 - 44 years	1,243,308	37.5
45+ years	1,259,432	38
Total	3,316,073	100

³ SANDAG. San Diego County 2020 Demographic and Socioeconomic Estimates. https://datasurfer.sandag.org/download/sandag_estimate_2020_region_san-diego.pdf. Retrieved 09/22/2021.

⁴ Earth Observatory. San Diego – Tijuana Region. <https://earthobservatory.nasa.gov/images/81053/san-diego-tijuana-region>. Retrieved August 6, 2019.

Language Spoken at Home (5 years and over) †		
Speak English Only	1,938,538	62.4
Speak a Non-English Language at Home and Speak English “Very Well”	741,558	23.9
Speak Spanish and English less than "very well"	268,664	8.6
Speak Asian and Pacific Islander Language and English less than "very well"	106,157	3.4
Speak Other Language and English less than "very well"	51,476	1.7
Total	3,106,393	100
Educational Attainment (25 years and over) †		
Less than high school	282,031	12.6
High school graduate (includes equivalency)	409,613	18.2
Some college (no degree) or Associates degree	683,145	30.4
Bachelor’s degree or higher	871,782	38.8
Total	2,246,571	100
Economic**		
All People Below the Federal Poverty Level	374,787	11.6
All Families Below the Federal Poverty Level	59,259	7.8
Median household income‡	\$78,980	--
Health Insurance Coverage for Civilian Noninstitutionalized Population‡		
With health insurance coverage	2,964,290	92.2
No health insurance coverage	252,036	7.8
Total	3,216,326	100

Percentages may not total 100 due to rounding

* U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates Detailed Tables, Table B03002, B01001.

†U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates Data Profiles, Table DP02 Selected Social Characteristics in the United States.

**U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates Detailed Tables, Tables B17024, B17010.

‡ U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates Data Profiles, Table DP03 Selected Economic Characteristics in the United States.

As seen in Table 1, the County has a diverse population, including 34% Hispanic/Latino (referenced throughout this document as Hispanic), 12% Asian/Pacific Islander, 5% Black/African American (referenced throughout this document as African American) and 3% multi-racial residents. Additionally, 24% of San Diego County residents speak a language other than English at home and 9% speak English less than “very well.”

Table 1 also shows economic characteristics. Twelve percent of County residents live below the federal poverty line, and the median household income is \$78,980. Among County residents, 10% have no health insurance. While it may appear that County residents are economically comparable to other regions of the state and country, the Center on Policy Initiatives reported that based on the cost of living without public or private assistance in the County, 33% of working-age families live in economic insecurity.⁵

⁵ <https://www.ppic.org/blog/californians-outlook-is-bleak-as-low-income-families-struggle/> Retrieved 9/22/2021.

HIV Epidemic in San Diego County. In San Diego County 2,026 residents were diagnosed with HIV between 2016 and 2020, and a total of 14,061 persons living with HIV disease resided in the county as of December 31, 2020.

The HIV epidemic is geographically most concentrated in the City of San Diego, which is the largest incorporated city in the region with a population of 1.4 million. Eleven of the 15 zip codes with the highest five-year rates of HIV diagnosis during 2016-2020 are in the City of San Diego. Of county residents diagnosed with HIV during this period, 53% were residing in one of these 11 zip codes. Nonetheless, persons living with HIV reside in most cities, communities and areas of the county.

To enhance service planning and delivery, the County of San Diego's Health and Human Services Agency (HHSA) divides the county into six regions: North Coastal, North Inland, North Central, Central, South and East as shown in Figure 2. For HIV planning purposes, the HIV Planning Group has identified one additional region: Southeastern San Diego as shown in Figure 3. This region has concentrated communities of poverty and a large percentage of people of color living with diagnosed HIV.

Figure 3 illustrates the concentration of HIV diagnoses in the Central and South regions over the past five years. The Central and South regions also have a greater representation of people of color than the other regions.⁶ African Americans represent 5% of the county population while comprising 10% of the Central region. Similarly, while Hispanics comprise 34% of the county population, they make up about 61% of the South region and 43% of the Central region. In addition, Central and South contain a slightly younger demographic, with a smaller percentage of residents 65 years and older than the county overall.

A cluster of four zip codes in the Central region have some of the highest five-year rates of HIV diagnosis in the county, ranging from 222 (zip code 92101) to 434 (zip code 92103) per 100,000 population. The zip code 92103 contains the neighborhood of Hillcrest, which is the center of San Diego County's large lesbian, gay, bisexual and transgender (LGBT) community, and this zip code continues to have the highest rate of HIV in San Diego County. Zip code 92103 differs from other Central region zip codes by having a higher percentage of non-Hispanic Whites (60%) and higher median income (\$73,893).

b) Socio-demographic characteristics of persons newly-diagnosed, people with HIV and persons at higher risk for HIV in the County of San Diego.

i. Demographic data

Table 2 (also included as Attachment 3) provides demographic characteristics of San Diego County residents diagnosed with HIV in 2016-2020 (incident cases) and persons living with HIV disease (prevalent cases) in San Diego County in 2020. The number of newly diagnosed HIV cases in San Diego County has declined significantly during the past five years. In 2016, there were 502 newly identified cases; in 2020, there were 302, a decrease of 40%. Nonetheless, HIV continues to show a disproportionate impact on certain communities. As the data below show, San Diego County sees a disproportionate share of HIV cases among individuals assigned male at birth, Hispanic and African American residents, and men who have sex with men. Treatment outcomes (i.e., viral suppression) are poorer for African Americans and for persons who inject drugs.

Individuals assigned male birth sex comprise 87% of incident and 89% of prevalent cases; this has been consistent in San Diego County since the 1990s. Transgender women

⁶ SANDAG, 2020 San Diego County population estimates. Received 9/22/2021.

represent only 1% of incident and prevalent cases, while transgender men represent less than 1%. These figures likely underestimate the proportion of transgender women and men due to inconsistent data collection.

Non-Hispanic Whites make up 42% of prevalent cases, while the percent of incident non-Hispanic Whites is 30%. As Non-Hispanic Whites make up 46% of the population, they are under-represented in in both prevalent and incident cases. On the other hand, Hispanics comprise 38% of prevalent cases and 48% of incident cases, demonstrating significant disproportionality, given that they represent 34% of the population. African Americans, who make up less than 5% of the population, nonetheless account for 12% of incident cases and almost 13% of prevalent cases, which, like Hispanics, demonstrates significant disproportionality. Asian/Pacific Islanders comprise 3% of prevalent cases and 5% of incident cases, and they comprise just over 11% of the population.

Figure 2: San Diego County Health and Human Service Agency Regions

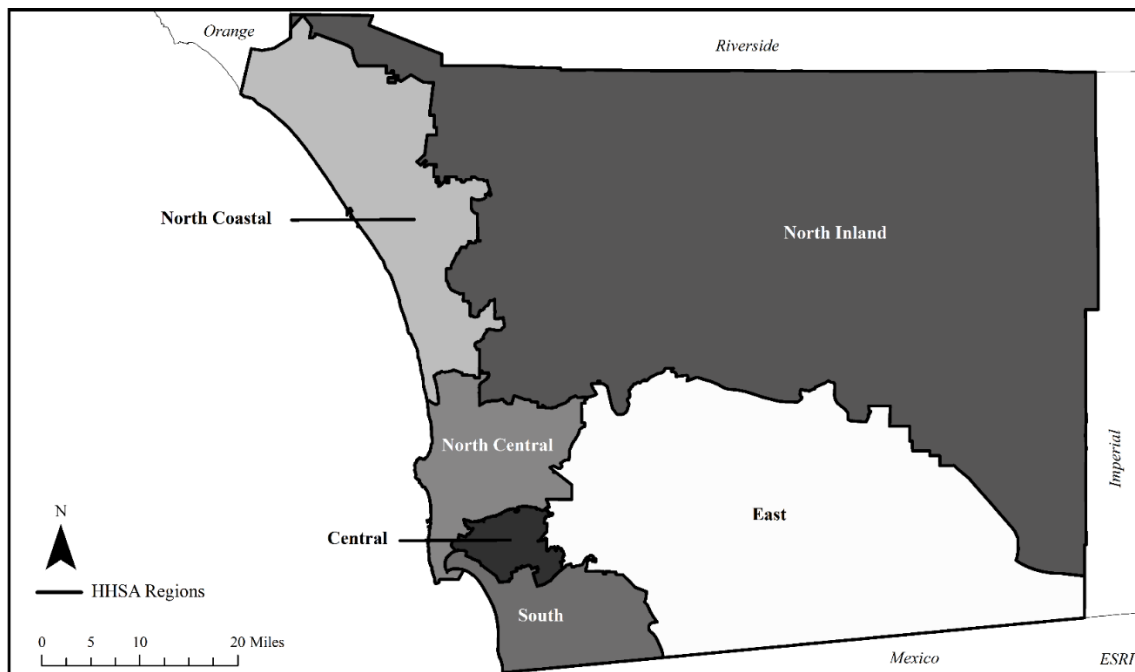
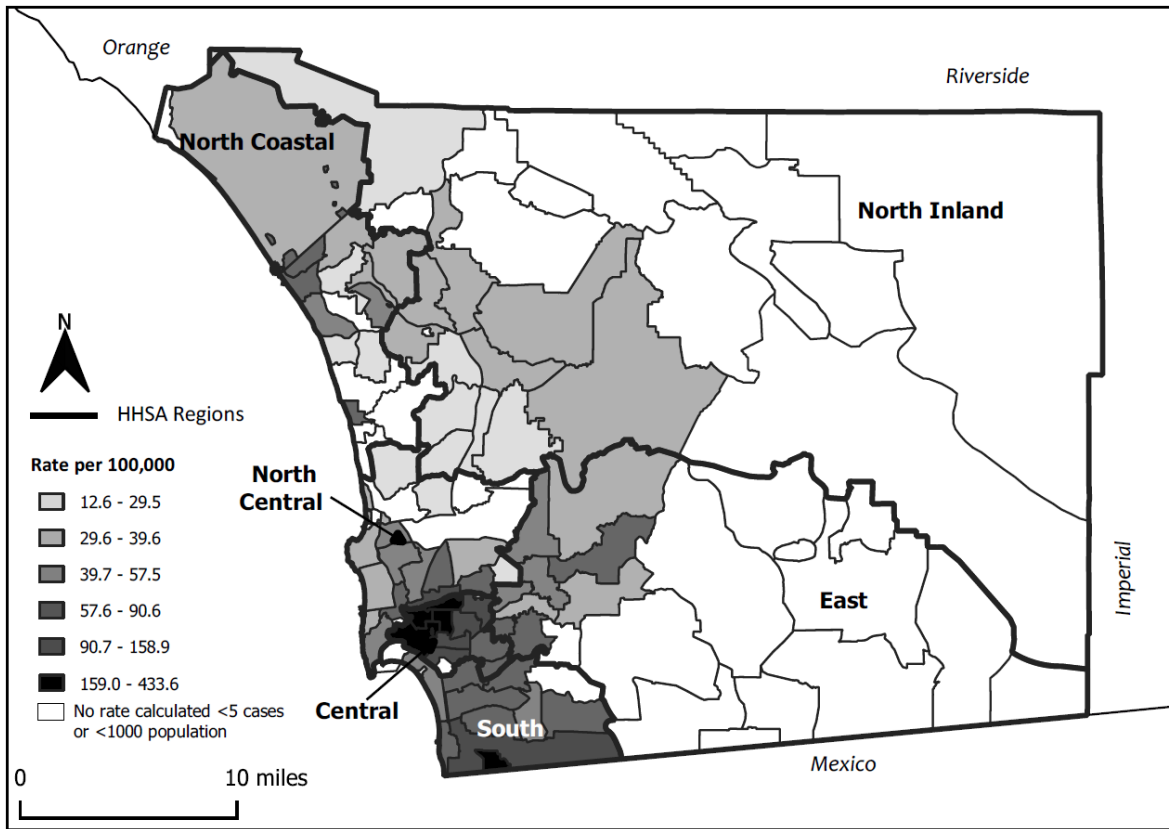


Figure 3: San Diego County, 2016-2020, Five-Year Rate of HIV Diagnoses per 100,000*



*No rates calculated for zip codes with fewer than five cases or population less than 1,000

Over half of prevalent cases are 50 years of age and older (57%), and the age group with the highest percentage of incident cases is 20-29 years of age (36%). Male-to-male sexual contact (MSM) is the most frequent transmission category for both prevalent and incident cases. The second highest transmission category for both prevalent and incident cases is heterosexual contact at 13% and 11%, respectively. Thirteen percent of prevalent cases and 9% of incident cases were among persons whose transmission category was injection drug use or MSM and injection drug use.

Table 2: Newly Diagnosed and Persons Living with HIV Disease by Demographic Group and Exposure Category in San Diego County

Demographic Group/ Exposure Category	NEWLY DIAGNOSED WITH HIV DISEASE, 2016-2020		PERSONS LIVING WITH HIV DISEASE, AS OF 12/31/2020	
	#	% of Total	#	% of Total
Race/Ethnicity				
White, not Hispanic	614	30.3	5,962	42.4
African American, not Hispanic	246	12.1	1,794	12.8
Hispanic/Latino ¹	963	47.5	5,457	38.8
Asian/Pacific Islander, not Hispanic	103	5.1	460	3.3
American Indian/Alaska Native, not Hispanic	5	0.2	40	0.3
Multiple races, not Hispanic	53	2.6	348	2.5

Unknown	42	2.1	0	0.0
Gender				
Male	1,757	86.7	12,425	88.4
Female	247	12.2	1,446	10.3
Transgender women	22	1.1	187	1.3
Transgender men	0	0.0	3	<0.01
Age²				
<13 years	5	0.2	15	0.1
13-19 years	54	2.7	20	0.1
20-29 years	726	35.8	825	5.9
30-39 years	562	27.7	2,351	16.7
40-49 years	331	16.3	2,839	20.2
50-59 years	240	11.8	4,540	32.3
60+ years	108	5.3	3,471	24.7
Transmission Category				
Men who have sex with men	1,265	62.4	10,096	71.8
Injection drug use	105	5.2	794	5.6
Men who have sex with men and inject drugs	78	3.8	978	7.0
Heterosexual contact ³	225	11.1	1,796	12.8
Perinatal exposure	5	0.2	89	0.6
No identified risk/Other ⁴	348	17.2	308	2.2
Total	2,026	100.0	14,061	100.0

Percentages may not total 100 due to rounding

¹Hispanics/Latinos can be of any race.

²Age at diagnosis for recently diagnosed and age as of 2020 for persons living with HIV disease.

³Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

⁴Other for Persons Living with HIV Disease includes blood/tissue exposure.

ii. Socioeconomic data

Table 3 shows the 15 zip codes with the highest five-year rates of HIV diagnosis per 100,000 from 2016-2020, ordered from the highest to lowest rate. Detailed socioeconomic data are not available for each reported case. Instead, socioeconomic data at the zip code level are presented. There is wide variation in the socio-economic status of cases. The median household income varies across these zip codes from \$40,310 to \$78,720, and the percentage of population below the federal poverty level is between 9% and 27%. The neighborhood of Hillcrest (zip code 92103) has a higher median salary and lower percentage of population below the federal poverty line than the county overall.

Table 3: Socioeconomic Characteristics of Zip Codes with the Highest Recent (2016-2020) Rate of HIV Diagnosis per 100,000

Zip Code	5-Year Rate of HIV Diagnosis per 100,000 During 2016-2020 ¹	Income ²		Educational Attainment ³		Health Insurance ²	Language ³
		Median Household Income	Percent of Population Below Federal Poverty Level	Percent High School Graduate or Higher	Percent Bachelor's Degree or Higher	Percent Uninsured, Civilian non-institutionalized	Percent Speak English less than "very well"
92103	358.1	\$78,720	8.7%	96.4%	63.8%	4.1%	6.2%
92173	294.2	\$46,549	21.3%	59.6%	9.3%	12.7%	44.4%
92104	204.8	\$67,668	11.0%	89.6%	49.3%	11.2%	11.7%

Zip Code	5-Year Rate of HIV Diagnosis per 100,000 During 2016-2020 ¹	Income ²		Educational Attainment ³		Health Insurance ²	Language ³
		Median Household Income	Percent of Population Below Federal Poverty Level	Percent High School Graduate or Higher	Percent Bachelor's Degree or Higher	Percent Uninsured, Civilian non-institutionalized	Percent Speak English less than "very well"
92101	190.5	\$71,925	16.4%	93.4%	53.3%	6.6%	7.1%
92116	189.4	\$74,559	10.6%	93.1%	53.0%	8.9%	5.9%
92102	156.1	\$51,744	21.4%	72.7%	23.3%	16.1%	25.1%
92113	137.5	\$40,310	26.4%	61.8%	8.6%	17.9%	28.7%
92105	129.5	\$43,282	26.9%	64.8%	15.5%	16.7%	32.7%
92115	115.8	\$51,636	25.8%	81.8%	32.6%	9.3%	15.8%
92154	99.7	\$66,498	12.0%	75.0%	16.8%	9.6%	26.4%
91945	87.2	\$64,027	12.3%	79.3%	18.6%	9.2%	13.0%
92110	83.8	\$73,651	13.3%	95.1%	46.7%	6.1%	5.0%
92114	82.6	\$66,015	13.2%	78.3%	18.2%	11.3%	20.6%
92108	80.2	\$75,296	13.1%	97.2%	57.7%	6.7%	9.9%
91950	78.0	\$46,708	18.2%	74.8%	13.9%	12.7%	25.8%

¹These five-year rates were based on the zip code of residence at diagnosis between 2016 and 2020, and population data from SANDAG for the midpoint, 2018 (received August 2020). Rates were only calculated for zip codes with more than five HIV cases and with more than 1,000 residents.

²U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table DP03, Selected Economic Characteristics.

³U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table DP02, Selected Social Characteristics.

c) Relative Rates of increase in HIV cases within new and emerging populations

i. Identification of emerging populations, unique challenges, and estimated costs.

To assess changes in new HIV diagnoses among different populations, Table 4 presents a comparison of cases from 2016-2017 and 2019-2020. No race/ethnicity group had a statistically significant increase between the two time points. There are decreases in the number of HIV diagnoses among all race/ethnicity groups except for other/unknown. As in previous years, African Americans continue to have a disproportionately high rate of HIV diagnosis compared to other race/ethnicity groups.

Table 4: Race/Ethnicity of Individuals Diagnosed with HIV in 2016 and 2017 vs. 2019 and 2020

Year Diagnosed	Race/Ethnicity							Total
	White	Black/African American	Hispanic/Latino	Asian/PI	Native American/Alaskan	Multi-Race	Other/Unknown	
2016-17								
n (row %)	300 (31.7%)	107 (11.3%)	450 (47.6%)	58 (6.1%)	3 (0.3%)	26 (2.7%)	2 (0.2%)	946 (100.0%)
Rate (95% CI)	19.7 (17.5, 21.9)	68.2 (55.3, 81.1)	41.0 (37.2, 44.7)	14.8 (11.0, 18.6)	--	23.8 (14.6, 32.9)	--	28.5 (26.7, 30.3)
2019-2020								
n (row %)	182 (26.4%)	91 (13.2%)	342 (49.6%)	21 (3.0%)	2 (0.3%)	15 (2.2%)	36 (5.2%)	689 (100.0%)

Year Diagnosed	Race/Ethnicity							Total
	White	Black/ African American	Hispanic/ Latino	Asian/PI	Native American/ Alaskan	Multi- Race	Other/ Unknown	
Rate (95% CI)	12.1 (10.3, 13.8)	54.0 (42.9, 65.1)	31.3 (28.0, 34.6)	4.8 (2.7, 6.8)	--	13.6 (6.7, 20.4)	--	20.6 (19.0, 22.1)
Change Over Years								
Raw Percentage Change	-5.3%	+1.2%	2.0%	-3.1%	--	-0.5%	--	--
Percentage Change Within Race/Ethni city	-39.3%	-15.0%	-24.0%	-64.0%	--	-42.3%	--	-21.2%

Two-year rates (per 100,000) based on race/ethnicity of individuals diagnosed with HIV disease and population data from SANDAG received in February 2019. Population estimates used were 2016 (for 2016 and 2017 diagnoses) and 2019 (for 2019 and 2020 diagnoses). Rates and percentage changes were only calculated for groups with more than five cases.

Many unique challenges face the different populations, especially African Americans and Hispanics. Described in greater detail in the EIIHA and subpopulation sections, consideration of the differences among populations is important in how we identify, treat and prevent HIV. For example, there is no geographic area or neighborhood for African American MSM; there isn't even a gay-identified bar for African Americans. For Hispanics, there are unique challenges regarding familial relationships and late testing. For each of these populations, stigma remains a significant challenge.

While substantial progress has been made in reducing the number of newly diagnosed cases of HIV infection, the number of persons living with diagnosed HIV in San Diego has nonetheless increased. Using an average cost per client served by the Ryan White Part A program in the last fiscal year (\$2,700), an estimated additional \$248,400 is required annually to address the needs of African Americans newly diagnosed with HIV during 2017-2018, while an estimated additional \$947,700 is needed to address the needs of Hispanics diagnosed with HIV during the same period.

Figure 5 presents the rates per 100,000 for age groups at HIV diagnosis from 2016 through 2020. The 20-29 years and 30-39 years age groups have higher rates of HIV diagnosis compared to other age groups. Of individuals recently diagnosed, 63% were 20-39 years of age at diagnosis. That is higher than the 30% of the county population who were 20-39 years of age in 2020. Nonetheless, HIV diagnosis rates declined among all age groups from 2016-2020.

Figure 5: HIV Diagnosis Rate by Age Group, San Diego County, 2016-2020

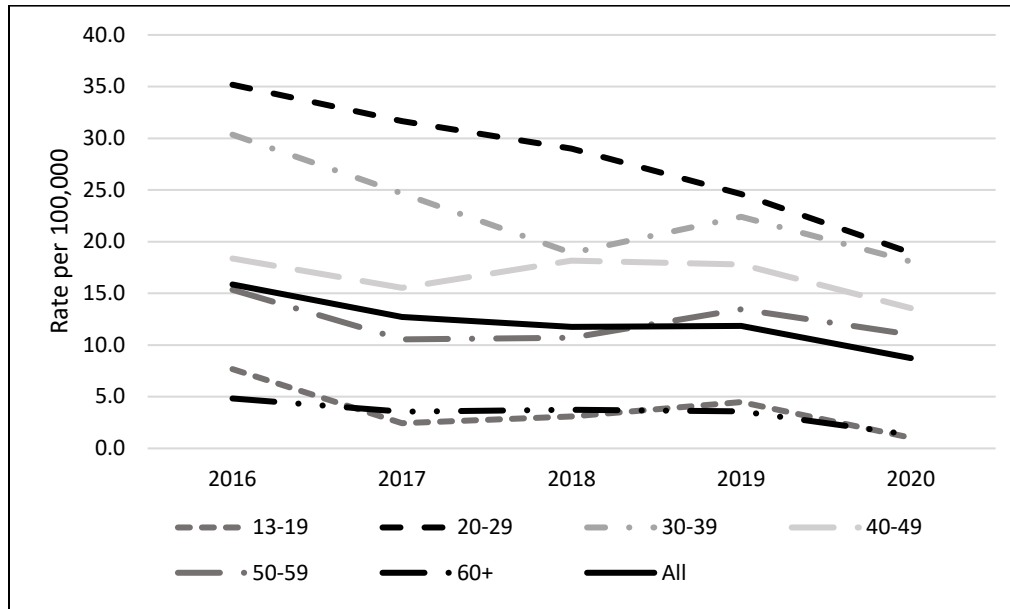


Table 5 presents the percentages and two-year rates per 100,000 for age groups at time of HIV diagnosis. There were no statistically significant increases in the rate between the two time points. Decreases in HIV diagnosis rates were seen in half of groups during the specified time period. Consistent with recent previous years, the 20-29 years and 30-39 years age groups have higher rates of HIV diagnoses compared to other age groups.

Table 5: Age Group of Individuals Diagnosed with HIV in 2016 and 2017 vs. 2019 and 2020

Year Diagnosed	Age Group at HIV Diagnosis							Total
	<13 years	13-19 years	20-29 years	30-39 years	40-49 years	50-59 Years	60+ years	
2016-2017								
N (row%)	4 (0.4%)	29 (3.1%)	362 (38.3%)	260 (27.5%)	136 (14.4%)	104 (11.0%)	51 (5.4%)	946 (100.0%)
Rate (95% CI)	—	8.0 (5.1, 10.9)	67.4 (60.5, 74.4)	54.3 (47.7, 60.9)	34.0 (28.3, 39.8)	26.1 (21.1, 31.1)	8.2 (6.0, 10.5)	28.6 (26.8, 30.4)
2019-2020								
N (row%)	1 (0.1%)	16 (2.3%)	213 (30.9%)	209 (30.3%)	123 (17.9%)	94 (13.6%)	33 (4.8%)	786 (100.0%)
Rate (95% CI)	—	4.3 (-0.2, 6.5)	42.6 (36.9, 48.3)	41.1 (35.5, 46.6)	31.3 (25.7, 36.8)	24.3 (19.4, 29.2)	4.9 (3.3, 6.6)	20.6 (19.1, 22.2)
Change Over Years								

Year Diagnosed	Age Group at HIV Diagnosis							Total
	<13 years	13-19 years	20-29 years	30-39 years	40-49 years	50-59 Years	60+ years	
Raw Percentage Change over Years	—	-0.8%	-7.4%	2.8%	3.5%	2.6%	-0.6	—
Percentage Change Within Age Group	—	-34.8%	-23.9%	9.2%	19.6%	19.1%	-12.5	—

Two-year rates (per 100,000) based on age group of individuals diagnosed with HIV and population data from SANDAG received in August 2021. Population estimates used were 2016 (for 2016 and 2017 diagnoses) and 2019 (for 2019 and 2020 diagnoses). Rates and percentage changes were only calculated for groups with more than five cases.

Although small in case count, youth ages 13-19 show a decrease of 34.8% in the proportion of newly diagnosed cases. Services that focus on youth in San Diego include outpatient ambulatory health services, medical and non-medical case management, and transportation. The age group of 50 years and older are becoming a greater focus of need and attention. As people living with HIV are aging, we have more people in this age group than in the past. We are also seeing needs that are compounded by co-morbidities, income, and housing. Many late testers fall into the older age groups. At a recent HIV Planning Group meeting, a member discussed having lived alone for his entire adult life. Now that he is a senior and needing assistance with rent, he shared that he only qualifies for housing assistance if he gets a roommate, something he doesn't want to have to consider at this point in his life.

ii. Increasing need for HIV-related services based on the relative increase of HIV cases.

Despite the successes achieved thus far in the County of San Diego's Getting to Zero initiative, the number of persons living with diagnosed HIV in the County increases each year, although those increases are getting smaller. In 2020, there were 302 new HIV diagnoses, and there were 72 reported deaths among persons with diagnosed HIV. The relative increase in the number of persons living with diagnosed HIV infection will increase the need for HIV-related services, particularly the safety net services provided by Ryan White.

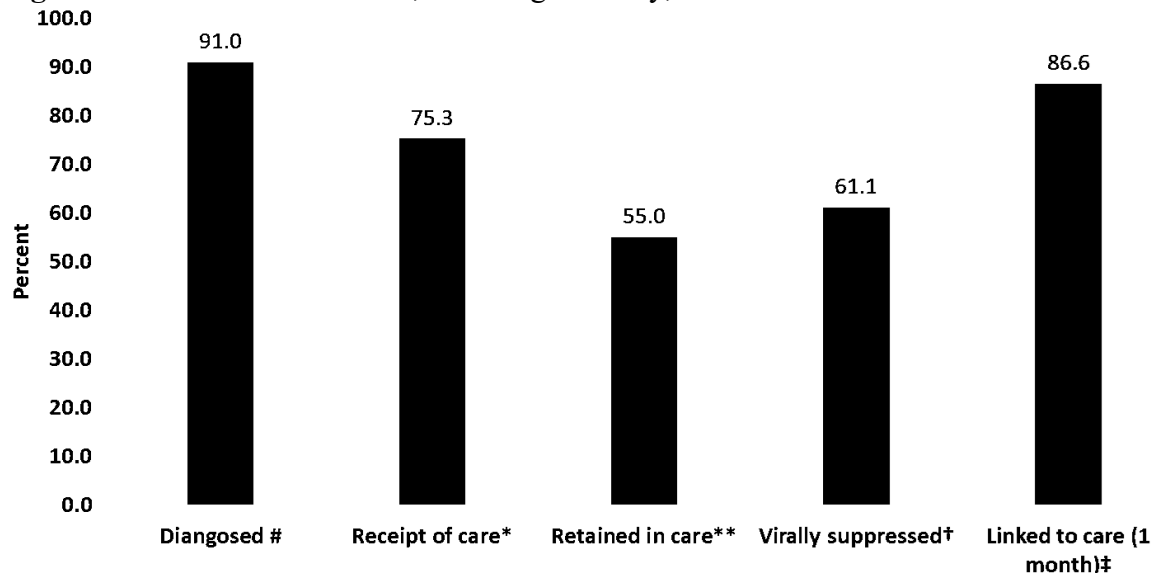
In the previous grant period, Ryan White Part A funding supported service utilization by 3,726 clients which is approximately 26% of total HIV prevalence. With a total program expenditure of \$8,998,573, the average cost per client enrolled in Ryan White Part A was approximately \$2,700. If about 26% of clients newly diagnosed with HIV in 2018 (91 of 366) were to enter services provided by Ryan White Part A, the additional expense in the current year would likely increase by almost \$246,000.

In this year's application, we are seeking an increase of 5% in funding to support the additional costs of serving persons who were recently diagnosed with HIV, the additional costs of those recently returning to care after being out of care for more than one year, and, in particular, the additional costs created by the intersection of the County of San Diego's affordable housing crisis with the lingering effects of the COVID-19 pandemic.

2) HIV Care Continuum

Figure 6 depicts the HIV care continuum in San Diego County for all people living with HIV during calendar year 2020.

Figure 6: HIV Care Continuum, San Diego County, 2020



#: Diagnosed pertains to those in 2019, the percent of all HIV infected regardless of diagnosed or not.
 *Having ≥1 care visit, as measured by a documented CD4 or viral load in 2019 among those diagnosed by the end of the previous year.
 **Having ≥ 2 care visits, as measured by documented CD4 and/or viral load in 2019 at least 3 months apart among those diagnosed by the end of the previous year.
 †Viral load of <200/ml in the most recent test in 2019 among those diagnosed and living by the end of 2019.
 ‡Linked to care within one month of diagnosis date as evidenced by a documented test result for a CD4 count or viral load among those diagnosed in 2019.

A discussion of the HIV Care Continuum and how it is used in planning can be found later in this document under the Work Plan.

3) Unmet Need

a) San Diego County’s 2022 Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program Notice of Funding Opportunity grant submission includes both the *Required* and *Enhanced* analysis (Attachment 4) for the updated Unmet Need Framework. Required analysis utilized data from the Enhanced HIV/AIDS Reporting System (eHARS) Quarter 1 data for 2021. *Enhanced* analysis utilized the AIDS Regional Information and Evaluation System (ARIES) data for 2020. While ARIES provides valuable data for clients who receive services funded by Ryan White grant allocated funds, the data likely does not represent all HIV-related services a client may receive. The two databases, eHARS and ARIES, were not linked for the subsequent analysis. San Diego County’s Unmet Need estimation was performed using the new Unmet Need Methodology for Ryan White HIV/AIDS Program (RWHAP) for 2020.

b) San Diego County opted to report *Enhanced* analysis for the current grant application, as access to Ryan White HIV/AIDS Program (RWHAP) data was available and accessible. *Required* analyses show 61 (20%) of all new diagnoses (302) in 2020 were classified as late diagnoses. Of those with diagnosed HIV infection, 31% have unmet need and were not in care in 2020 while 18.5% were not virally suppressed in 2020. With 3,657 clients represented in the

Enhanced analysis, 21% have unmet need and of those in care, 15% were not virally suppressed in 2020.

After reviewing recent, local epidemiological data, San Diego County identified three priority populations of focus: African American MSM, Hispanic MSM, and persons who inject drugs (including persons who inject drugs and identify as MSM). Priority populations were the same for the *Required* and *Enhanced* analysis.

Priority Population Required Analysis – Attachment 4:

Of the three chosen priority populations in San Diego County, Hispanic MSM had the highest percentage of new diagnoses at 24% while also having the highest percentage of late diagnoses at 13%. On the other end of the spectrum, of all MSM, African American MSM represent 14% of new infections in 2020 and 5% of late diagnoses, compared to the other MSM priority populations. These findings have been consistent with trends seen in prior years, in which we see Hispanic MSM being most likely to be late testers.

Hispanic MSM are disproportionately affected across all three unmet need categories, compared to the other selected priority populations (across categories). Of the 4,431 with unmet needs, 1,303 (30.0%) were Hispanic MSM. Hispanic MSM also reported the highest percentage of in care but not virally suppressed across categories at 23% and 13% of all late diagnoses were Hispanic MSM. Described in more detail in the Subpopulations section of this application, there are many reasons Hispanics are thought to present late to testing or in care but not virally suppressed. Regarding late testing, many Hispanic men fear HIV testing and/or accessing medical care due to distrust of the medical system, and concerns about immigration status among those who do not possess legal documentation of residency, loss of employment, and loss of family support. Many Hispanic men don't access services until they are sick, which delays early diagnosis of HIV. Being in care but not virally suppressed may occur for various reasons including stigma, mental health and substance use issues, and competing priorities such as family and income.

While African American MSM show low percentages of new diagnoses and late diagnoses compared to other chosen MSM priority populations, within categories this group had the highest percentage of both unmet need and in care but not virally suppressed, at 35% and 27%, respectively. African Americans have shown trends in not being virally suppressed. As further described in the subpopulation section, reasons for this include stigma, family dynamics, cultural beliefs, racism, discrimination and trauma. African Americans are less likely to prioritize their sexual health or HIV risk, and are distrustful of the service delivery system. This is compounded by poverty, leading to lack of adequate health care and understandable prioritization of food housing needs.

Within categories, persons who inject drugs reported the highest percentage of late diagnoses at 23%. Persons who inject drugs are most likely to experience homelessness or lack of stable housing, have unresolved mental health issues in addition to substance use issues, and experience lack of sensitive and trained professional and structural barriers as impediments to seeking healthcare, including HIV testing.

Priority Population Enhanced Analysis – Attachment 4:

When comparing within categories, persons who inject drugs had the highest percentage of unmet need at 27%. Persons who inject drugs have poorer health outcomes and lower viral suppression overall. As described in further detail in the subpopulation section of this

application, 2017 needs assessment data showed that over 23% reported being out of care for one year or more, and 64% of those respondents said it was due to drugs or alcohol, 36% said it was due to homelessness and 34% reported it was due to untreated mental illness.

Hispanic/Hispanic MSM reported the lowest unmet need at 12% while also indicating the highest percentage of in care but not virally suppressed at 16% and this was also seen when looking across categories. Hispanic MSM constitute 45% of all RWHAP clients who are in care and not virally suppressed. As described above, unmet need and not achieving viral suppression is largely due to mistrust of the medical system as it relates to their residency and employment. As such, many don't access services until they are sick.

Final analysis of both the Required and Enhanced data highlights the disproportionate effects on San Diego County's Hispanic MSM for HIV care outcome measures. When compared to the other priority populations' outcomes in each of the unmet need framework's measures, Hispanic MSM consistently show higher unmet needs in both local surveillance and RWHAP data.

4) Co-occurring Conditions

See Attachment 5 for a description of the conditions co-occurring with HIV in San Diego County.

5) Complexities of Providing Care

a) i. *Impact of reduction of formula funding and response*

In FY 2021, the San Diego EMA experienced an overall reduction to its Part A award of \$78,319. This included a reduction to the formula award of \$77,534, an increase to the supplemental award of \$30,187, and a decrease to the MAI award of \$30,972 from the previous fiscal term. To address these changes, funding was decreased in Part A administration, Health Education and Risk Reduction, Outpatient Ambulatory Health Services, and MAI administration. The decreases to Part A and MAI administration were absorbed through County general funds. The decrease to Outpatient Ambulatory Health Services did not negatively impact the delivery of services, the number of services provide, or the capacity to provide services to clients in the region. Health Education and Risk Reduction was a new category for FY 2021, and new services had not yet been procured. Although any funding decrease impacts the overall service delivery system, FY20 presented numerous challenges due to COVID-19 that were addressed systematically to minimize the impacts.

ii. *Cost containment measures implemented*

In FY 2021, no new cost containment measures were implemented. While there was a reduction to formula funding, there was no impact on service delivery or number of clients served.

b) Provide an overall description of health care coverage options available to all people with HIV in the jurisdiction.

i. *Explain how coverage options in the jurisdiction negatively or positively influence access to direct health care services and health outcomes.*

Several health care coverage options exist for people living with HIV in San Diego County. Medi-Cal (California's Medicaid program) is deployed through private health care payer systems, much like health maintenance organizations. Known as Medi-Cal Managed Plans, there are seven different plans in San Diego County, providing persons living with HIV choices in how and where they receive their care. Among the plans, persons living with HIV have access to

the largest providers of HIV care and treatment services in San Diego County, including access to federally qualified health centers as well as other public (University of California San Diego Medical System) and private (Kaiser Permanente, Sharp, Scripps) systems. All providers that accept Ryan White also accept Medi-Cal Managed Plans. Eligibility for Medi-Cal includes an income at or below 138% of the federal poverty level as well as documentation of either U.S. citizenship or legal residency for more than five years. A companion program, known as Emergency Medi-Cal, is available for individuals who meet the income requirements but not the citizenship/residency requirements and covers costs associated with hospitalization only. There are no out-of-pocket expenses related to HIV care provided through Medi-Cal. Recently, the California legislature has dedicated general purpose revenue to support all persons who are under the age 26 in Medi-Cal, regardless of their immigration status. In May 2022, all persons who are 50 years or older with incomes under 138% FPL will also be eligible for Medi-Cal, regardless of their immigration status.

Many individuals who do not qualify for coverage through Medi-Cal are eligible to purchase insurance through Covered California. There are currently six insurance plans available in San Diego County, all of which provide access to HIV care. Eligibility for insurance through Covered California includes an income above 138% of the federal poverty level as well as documentation of U.S. citizenship or legal residency for more than five years.

For individuals enrolled in Covered California, or those who are dual-enrollees in Medicare and Medi-Cal, the California Department of Public Health offers additional programs to increase the affordability of insurance, including premium payment assistance and coverage for out-of-pocket expenses, including co-pays, deductibles and co-insurances.

The County of San Diego has invested heavily in Affordable Care Act programs and created a new division, Self-Sufficiency Services, to assist residents of San Diego County in selecting and enrolling in health care coverage options. Individuals can receive in-person enrollment assistance by visiting one of the six Family Resource Centers throughout the County or through one of the many enrollment workers deployed throughout other County facilities. Enrollment assistance is also supported through contracts with non-profit organizations.

Individuals who do not meet the citizenship/residency requirements for either Medi-Cal or Covered California can enroll in Ryan White services. When combined with the AIDS Drug Assistance Program (ADAP) offered through the California Department of Public Health, **all** persons living with HIV in San Diego County have access to HIV medical care without regard to their ability to pay for it. There are no waiting lists.

As a result of the wide availability of health care coverage through options other than Ryan White, the San Diego County HIV Planning Group has been able to allocate funding to care completion, ensuring that services that are necessary to link and retain people in care are more available. These services include Early Intervention Services, Medical and Non-Medical Case Management, Referral for Health Care and Other Services, Mental Health Services, outpatient Substance Use Treatment services and Temporary and Emergency Housing services. During the past 20 months of the COVID-19 pandemic, savings in Outpatient Ambulatory Health Services have been re-allocated to Temporary and Emergency Housing Services, Transportation, Nutrition Assistance, and Emergency Financial Assistance to support virtual program participation, including equipment and limited Internet access.

c) Describe any relevant factor limiting access to health care including geographic variation, adequacy of health insurance coverage, language barriers, or other major social determinants of health.

Many factors exist that limit access to healthcare, including the size of San Diego County, transportation, housing costs, the cost of living in the region, unaddressed mental health concerns and substance use disorder. As described earlier, San Diego is a large geographic region. It is the second largest county in California and the fifth largest by population in the United States, encompassing 4,261 square miles and having an estimated population of 3.3 million residents. HIV services are widely available in the Central region of San Diego. While there are also HIV services in each of the regional planning areas in San Diego, because of the vast geography the county, there are large portions of the County that are sparsely populated and far from services. To mitigate this concern, we have deployed HIV Service Centers in each region of the County, but given the sheer size of the East and North Inland regions, we recognize that travel can be a substantial barrier for our rural residents. There are extensive mass transportation systems in San Diego; however, rural areas of the County are not served by them, creating transportation barriers for persons living with diagnosed HIV in rural areas. Even for areas that are served by mass transportation, commuting times for core medical and support service appointments can take over an hour each way due to the large land areas covered by the suburban areas of the County. To help mitigate these challenges, the local Ryan White program provides access to ride sharing services for clients who require more than an hour to access care and other needed services using mass transportation. During COVID-19, challenges related to transportation grew as many people living with HIV were concerned about utilizing public transportation. To address those concerns, providers were authorized to utilize ride sharing for local transportation needs for clients who were not comfortable using public transportation.

Affordable housing is another significant barrier in San Diego, as it is for most of coastal California. The lack of affordable housing exacerbates the overall cost of living, which remains 44% higher than the national average.⁷ The waiting lists for Section 8 vouchers in the City and County of San Diego are currently over 12 years. The waiting list for HOPWA tenant-based rental assistance currently also has a waiting list that is over 12 years. Local Ryan White Part A funding provides temporary housing assistance in the form of short-term rental subsidies, and the amount that the County of San Diego HIV Planning Group has allocated to this program has more than quadrupled during the past six years along with the number of clients who access the service. For FY 2015 the HIV Planning Group allocated \$152,896 to the service versus \$715,507 in FY 2020. During that time the number of clients who utilized the service rose from 41 to 141. The HIV Planning Group has also allocated funding to emergency housing, which consists of short-term hotel stays to prevent homelessness as well as eviction prevention for persons living with HIV who have fallen behind in their rent. Allocations in this category were significantly increased during FY 2020 due to impacts of COVID-19. In FY 2020, \$1,291,275 was expended in short-term housing.

The lack of affordable housing in the county has contributed to a rise in homelessness in the region. An annual point-in-time survey is conducted by the Regional Task Force on the Homeless to assess the number of homeless persons residing in the county. This survey combines observational and, when feasible, direct surveys of homeless persons. In the most

⁷ Cost of Living in San Diego, California. <https://www.payscale.com/cost-of-living-calculator/California-San-Diego>. Retrieved August 23, 2021.

recent survey in 2020 of over 7,500 sheltered and unsheltered homeless individuals, 25 persons (1.4%) reported living with HIV. This number is likely to be an underrepresentation of the total number of people living with HIV who are homeless. The demographics of HIV positive respondents are shown in Table 6 for 2019 and 2020. The survey was not conducted in 2021 due to COVID-19.

Table 6: Homeless Persons Living with HIV Disease

Demographic Group/Exposure Category	PERSONS LIVING WITH HIV DISEASE			
	2019 # (n=73)	2019 %	2020 # (n=25)	2020 %
Gender				
Male	56	76.7	22	88%
Female	13	17.8	2	8%
Transgender	4	5.5	1	4%
Race/Ethnicity				
White	44	60.3	18	72%
African American/African American	18	24.7	5	20%
Hispanic/Latino	20	26.4	4	16%
Multiple races	11	15.1	2	8%
Current Age				
18-24	4	5.5	1	4%
25-34	4	5.5	1	4%
35-44	15	20.5	7	28%
45-55	25	34.2	8	32%
>55	25	34.2	8	32%
Other				
Veterans	9	12.3	3	12%

According to 2019 RSR data⁸, 8.7% of Ryan White clients in San Diego County are unstably housed and 80.6% of clients are living at or below 100% of the federal poverty level. In addition to the lack of adequate housing and poverty, untreated mental health conditions as well as substance use remain significant factors that prevent people living with HIV from making HIV care and treatment a priority in their lives. Stigma also remains a barrier, especially for people of color. Many people living with HIV continue to struggle with HIV as a result of behavior stigmatized by family, community and religious institutions. This can impact whether a person living with HIV accesses healthcare. Many service providers work closely with religious institutions and communities of color to incorporate HIV into a full continuum of health-related services.

Persons living with HIV who do not possess legal documentation to live and work in the United States experience a significant barrier to accessing care because of concerns that seeking services will result in deportation, loss of employment or other legal problems. Changes in 2019 to the Public Charge Ground for Inadmissibility exacerbated these concerns among immigrant communities in San Diego County, and we saw a nearly 20% reduction in the number of persons who rely upon Ryan White to receive HIV medical care. Even though that rule change has been rescinded, many individuals who lack legal residency documentation may be unaware that they are eligible to receive services or that services even exist to help them. Distrust of the medical

⁸ Health Resources and Services Administration. *Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019*. <http://hab.hrsa.gov/data/data-reports>. Published December 2020.

system also comes into play for fear that information collected in medical settings may be shared with other government agencies.

Two additional local studies help to create additional context for complexities of providing care in San Diego County. The first is the HRSA-funded Getting to Zero Community Engagement project, and the second is the Environmental Scan of Persons Who Inject Drugs in San Diego County. The Getting to Zero Community Engagement project began in January 2020, just prior to the COVID-19 pandemic's arrival in California. The focus of this project was to engage San Diego County's Hispanic, Black and Transgender communities and develop action plans to close significant disparities related to late HIV testing (Hispanic), lower rates of viral suppression (Black), and lack of presence in planning and resource allocation (Transgender). Originally conceived to include small and large community forums, the project was re-engineered to focus more on key informant interviews with some virtual meetings.

During initial interviews, many respondents discussed challenges in accessing health care during COVID-19, including not having the requisite computer equipment to make telehealth work, or not being able to afford broadband internet connections, or, at a more basic level, not knowing how to use telehealth technology, and/or having a safe and private place in which to fully participate. Respondents also discussed the desire to see more peer navigation and peer facilitation, emphasizing how important it is for clients to see themselves reflected by the workforce of the HIV service delivery system. Respondents also expressed appreciation for the County's recent shift to coordinated HIV service centers, through which clients can access multiple services at the same location, and they asked for the service offerings to be expanded further to include a whole person/whole health approach, which was particularly important for transgender respondents. Finally, most respondents touched on in some way the need to address medical system mistrust and the need for a more culturally competent and diverse workforce that is skilled at trauma-informed care and delivering consistently respectful treatment.

After initial data collection, a task force was convened to create three-year action plans for closing identified disparities and addressing the concerns and needs expressed by participants. The action plan, which was adopted by the HIV Planning Group in July 2021, includes the following 11 recommendations:

1. Acknowledge and address health system mistrust
2. Improve HIV Planning Group communications and outreach strategies
3. Address digital disparities
4. Provide increased mental health and substance use treatment opportunities
5. Provide more rapid access to basic support services
6. Expand peer services
7. Address stigma and provide increased social support
8. Increase whole-person and whole-health strategies
9. Expand community engagement and simplify consumer reimbursement process
10. Refine documentation to decrease duplication, repetition and decrease need for in-person signature
11. Create brief on-line trainings about HPG

These recommendations have been incorporated into the work plans for both HIV Planning Group and to the Recipient.

In addition to the community engagement project, an environmental assessment of persons who inject drugs was conducted in 2019. Conducted through street intercept surveys, focus groups, and key informant interviews, these data help the County of San Diego better understand the needs of persons who inject drugs and how the HIV service delivery system can better meet them. A brief summary of these findings include:

- Injection drug use, of both opioids and other substances, is a serious and growing problem in San Diego affecting a broad age range of people and is exacerbated by its proximity to the international border.
- People who inject drugs are at increased risk of mortality and of many health and social problems and certain populations are particularly vulnerable.
- Fentanyl, methamphetamine use, and the unintended consequences of some legislation have complicated serving this population.
- More services for people who inject drugs are urgently needed.
- People who inject drugs experience extensive barriers to care.
- Services for people who inject drugs are not always well coordinated.
- Better education is needed for both professionals and the community about people and services for people who inject drugs.
- People who inject drugs need more education about their health risks.
- Promising practices exist in San Diego and other communities for serving people who inject drugs.

Based in part by the findings of the environmental assessment of persons who inject drugs, the County of San Diego Board of Supervisors has directed the Health and Human Services Agency to develop syringe service programs in areas of the County with greatest need and to ensure that a harm reduction framework is incorporated into program design. For HIV services, this welcome change in policy and direction will be implemented through Ending the HIV Epidemic funding received from the CDC.

B. Early Identification of Individuals with HIV/AIDS (EIIHA)

1) Description of planned EMA EIIHA activities

The County of San Diego's plan for the Early Identification of Individuals with HIV/AIDS (EIIHA) for the next three years period is fully aligned with its comprehensive plan, Getting to Zero, described in the Introduction. The Getting to Zero plan contains five overarching strategies:

- **Test** focuses on identifying all persons living with undiagnosed HIV infection and linking them to care, as well as identifying persons vulnerable to HIV infection and linking them to PrEP and other HIV prevention interventions;
- **Treat** focuses on improving and maintaining health outcomes for persons living with HIV by ensuring successful retention in medical treatment;
- **Prevent** focuses on reducing HIV transmission through focused activities with populations most vulnerable to HIV transmission and acquisition;
- **Engage** seeks to mobilize community efforts to achieve the Getting to Zero vision; and
- **Improve** seeks to improve outcomes along the HIV care continuum through performance management, quality improvement and quality assurance activities.

In conjunction with community and clinical partners, the County of San Diego has built a strong foundation of HIV testing, treatment and prevention services. Through countywide partnerships and strategic allocation of federal, state and local funds, the County of San Diego has made significant progress on early identification, new diagnoses, viral suppression, and mortality.

Despite these successes, there are still groups that are disproportionately affected by HIV in the County of San Diego. These groups include African American gay, bisexual and other men who have sex with men (MSM), Hispanic MSM, transgender communities, and people who inject drugs. Racism, discrimination, trauma, stigma, and the historical impact of marginalization and inequity that create barriers to accessing services are common among all these groups. In order to address these barriers, meet EHE goals, and align with the County's Early Identification of Individuals with HIV/AIDS (EIIHA) plan, the County of San Diego has identified the following action areas as critical to end the HIV epidemic in the County:

1. Continue to identify persons living with undiagnosed HIV through testing, inform them of their status, and link them to care.
2. Increase the number of individuals engaged in care from 60.4% to 95% by 2025⁹.
3. Continue to utilize data to care program to re-engage persons living with diagnosed HIV who are not currently enrolled in care.
4. Provide additional assistance in navigating the benefits system for African American, Hispanic, youth, persons who inject drugs, and Central region residents.
5. Expand the capacity of STD programs to support Getting to Zero and Ending the HIV Epidemic.
6. Ensure the availability of culturally responsive and culturally congruent services, particularly among communities with high levels of medical mistrust and/or low levels of familiarity with and facility in accessing those services.
7. Increase the number of PrEP users, particularly among those groups most vulnerable to HIV infection.

Building on these action areas, the County of San Diego is deploying additional funding for Ending the HIV Epidemic from HRSA and the CDC to implement innovative activities. These activities will entail close partnership with new and existing partners and are designed to more effectively reach and provide services to underserved populations in San Diego County. In addition, community engagement efforts will be used throughout the EHE project period to bolster the County's HIV workforce by building economic opportunities for those most impacted by HIV and creating a pipeline of critical workers to help reach EHE goals. As one of the Phase I jurisdictions, EHE funding creates an opportunity for disruptive innovations to reach clients who have not been well served by the existing system of care to and to realize the early identification of HIV infections.

It is important to note that COVID-19 has challenged the County's EIIHA efforts. Many in-person services, including field-based outreach, were suspended in alignment with public health orders to protect the health and well-being of staff and clients. Nonetheless, the County

⁹ California Department of Public Health, Office of AIDS. California Consortium Ending the HIV Epidemic (EtHE) Plan Summaries - San Diego County (2021): https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/EtHE_Summary_SanDiego_ADA.pdf

continues to work closely with funded providers to promote testing and rapid linkage to PrEP and ART. There has been an increasing emphasis on online outreach efforts, discussed more fully below. Some providers have transitioned to appointment-based HIV testing, and several other providers have expanded to include self- HIV testing, through which clients can receive a rapid HIV test via the mail or personal delivery to their place of residence along with the direct support of local agency staff in taking the test, understanding the results, and linking to appropriate care.

a) EIIHA Primary Activities

Primary activities in our EIIHA plan include outreach, HIV testing, HIV partner services, and rapid linkage to HIV primary care and related support services for individuals who are newly identified as HIV-positive. Additionally, rapid linkage to pre-exposure prophylaxis (PrEP), non-occupational post-exposure prophylaxis (nPEP) and other prevention programs is widely available for those who are HIV-negative but vulnerable to HIV infection.

EIIHA activities are funded by several sources:

- Ryan White Parts A and B: These sources fund in-person and venue-based outreach, referral and linkage, early intervention services (including HIV testing under Part B), HIV outpatient/ambulatory health services, and other core medical and support services.
- CDC Integrated HIV Surveillance and Prevention Programs for Health Departments (PS18-1802): This funding source supports in-person and online outreach, focused HIV testing, routine HIV testing, HIV partner services, and linkage to anti-retroviral therapy and PrEP.
- CDC HIV Prevention Funds: These funds are awarded directly to local federally qualified health centers to conduct outreach, HIV testing, HIV partner services, linkage to HIV care and PrEP, and health education and risk reduction education.
- HRSA Ending the HIV Epidemic Funds (HRSA 20-078): The funds support community engagement activities, leadership training and development, low barrier medical care, and community informed molecular epidemiology.
- CDC Ending the HIV Epidemic Funds (CDC 20-2010): These funds support a community readiness assessment for harm reduction in San Diego County, wrap around services for persons who inject drugs, comprehensive HIV prevention services for transgender persons, mobile peer-based PrEP services, a mobile phone application for HIV resources and corresponding printed resource guide, benefits navigation, and implementation grants for routine opt-out HIV testing.

Outreach: Outreach activities include in-person, venue-based and online approaches to identify individuals vulnerable to HIV infection and to link them to HIV testing programs. They also include efforts to identify individuals living with HIV who are not receiving care so that they can be offered assistance in obtaining care. Online outreach takes place in a number of virtual venues, including mobile phone and web-based applications (Grindr, Scruff, Facebook, Instagram, Snapchat, etc.) as well as websites funded by the County in the Central, North and South regions to ensure that residents of those regions have access to information and referrals that are most relevant to their geographic location.

HIV Testing: HIV testing is widely available in San Diego County using two different approaches. *Focused* testing is deployed in areas known through epidemiology to have high rates of transmission and acquisition. These testing services focus on reaching persons vulnerable to HIV acquisition and offering testing in locations and venues that are easily accessible. *Routine, opt-out testing (ROOT)* is deployed in health care settings, such primary care clinics, where all clients are tested without assessment of their risk.

HIV testing conducted by County of San Diego staff occurs primarily in the County's four categorical STD clinics, located in areas of San Diego County with the highest STD incidence. Combined, these four clinics provide almost 10,000 patient visits per year and provide access to persons who are vulnerable to HIV infection. All individuals seen at the County's STD clinics and not previously known to be HIV-positive are tested for HIV using blood-based antibody/antigen testing. Clients can decline the test if they prefer to not get tested. Furthermore, individuals can request standalone HIV testing if they are not seeking any additional STD-related services. Blood-based antibody/antigen testing is encouraged but rapid HIV tests are available for people who refuse a blood draw. The County operates an HIV mobile testing unit to conduct HIV and syphilis testing in various community settings throughout the County; however, mobile testing services remain suspended due to the pandemic for health and safety considerations of staff and clients.

The County of San Diego also contracts with federally qualified health centers (FQHCs) to conduct focused HIV testing in communities and venues where individuals who are vulnerable to HIV infection can be accessed. Focused testing is conducted in conjunction with Ryan White-funded early intervention services located in the Central and South regions. Focused testing provided by contractors was significantly impacted by the pandemic as many of the testing events occur at large community events or in non-clinical, community settings and events themselves were cancelled and access to community settings was limited or suspended entirely to due COVID-19 restrictions. In order to address the decreased access to in-person testing, contractors piloted HIV self-testing whereby test kits were provided to clients for self-administration. The CDC also funds two federally qualified health centers to conduct focused testing in San Diego County.

The County of San Diego funds ROOT with two federally qualified health centers providing services in North Coastal/North Inland, Southeastern Communities and East. The goal of this effort is to assist these federally qualified health centers in sustaining routine HIV screening in primary care settings. The contracts pay for the costs of HIV tests when no other payer source is identified and pays staff salaries to conduct linkage to HIV primary medical care and HIV partner services for newly identified HIV-positive persons. While the volume of routine tests conducted decreased in the fall and winter of 2020/2021 due to fewer in-person primary healthcare visits, testing numbers later increased with reopening of medical clinics for in-person care.

The County of San Diego has also deployed routine HIV testing in six of its seven local detention facilities. All persons who are incarcerated in these facilities who request a sick call are tested for HIV as a routine part of their care unless they are previously known to be HIV-positive. Inmates can also decline the test if they choose. Standalone HIV testing is also available upon request to any person who is incarcerated.

In 2018, University of California San Diego (UCSD) Medical System implemented routine testing in two of its emergency departments, one of which is a teaching hospital setting that sees large numbers of indigent and underinsured patients. As a part of their testing program,

UCSD hired a linkage to care staff person to assist with results disclosure and navigate individuals newly identified with HIV to primary medical care.

To encourage adoption of routine HIV testing in health care systems, the County of San Diego will begin one- to two-year implementation grants to local health care systems to implement routine HIV testing. These grants will support the costs of planning, training existing staff regarding revised protocols, informing patients of the upcoming change, and provide direct staff support for linkage to ART for individuals who are newly diagnosed with HIV. These grants will be funded out of new EHE funding received from the CDC.

Linkage to ART: For individuals who are newly diagnosed with HIV, the primary goal is to assure linkage to HIV primary care and initiation of anti-retroviral therapy (ART) as soon as possible and ideally within 0 to 7 days after the confirmatory disclosure session. Despite the impact of COVID-19, most individuals continued to be linked to HIV primary care with 7- 10 days. For clients who are insured, the test counselor facilitates access to HIV care through their provider network. For those who are uninsured, the test counselor links the client to Medi-Cal screening and enrollment assistance if they meet income and residency criteria. The test counselor also refers them to a Ryan White provider for enrollment into Ryan White to ensure care can commence rapidly and is not delayed due to the Medi-Cal eligibility determination process, which can sometimes take up to 60 days. Ryan White medical providers also enroll clients in other benefit programs, such as the AIDS Drug Assistance Program and the Office of AIDS HIV Insurance Premium Payment programs (OA-HIPP).

When disclosing an HIV diagnosis to an individual, test counselors assess the individual's support system, including the presence of a partner or spouse, family members, and friends who can provide emotional support. If crisis counseling is needed, the test counselor provides linkage to those services. Test counselors also assess other needs that are critical for successfully linking newly diagnosed individuals to care. This includes housing, transportation, mental health and substance use disorder services, and make facilitated referrals to case management services that will support linkage and retention to needed resources. During the confirmatory disclosure session, test counselors schedule the first HIV primary care medical appointment and offer transportation to the visit, if needed.

To assure that clients successfully link to HIV primary care, test counselors obtain releases of medical information to confirm attendance at the first medical appointment. For clients who decline to sign the release, linkage to care is assessed using HIV surveillance data. Communicable Disease Investigators are deployed whenever clients do not return for positive test results on preliminary or confirmatory tests. For preliminary results, staff seek to inform patients of their preliminary result and have them return so that confirmatory testing can be performed or perform venipuncture in the field for confirmatory testing. For confirmatory results, staff seek to inform the patient of the result, ensure linkage to care and conduct HIV partner services.

Linkage to PrEP and other Prevention Services: For all focused HIV testing programs provided or contracted by the County, individuals testing negative who report behaviors that make them vulnerable to HIV acquisition receive counseling about the benefits of PrEP. Those interested in pursuing PrEP are given a warm hand-off to a PrEP navigator or coordinator who conducts a PrEP orientation session with the client. Ideally, this orientation session occurs right after the testing session but can be scheduled for a later time depending upon the needs of the client. PrEP coordination services are funded by the County in most high-volume HIV testing locations, including the County's main STD Clinic and in federally qualified health centers in the

North, Central and South regions of the County. PrEP coordinators not only get referrals from testing but often from outreach, in-reach, medical providers, and other community members and service providers. PrEP coordinators follow up with clients to ensure they access a medical provider, obtain and fill a prescription, and begin and continue to take PrEP as appropriate. Occasionally, there are instances where early identification of new positives occurs when clients who do not know their status access testing to obtain PrEP. These clients are linked to ART and other core medical and support services.

Rapid Anti-Retroviral Therapy (ART): Linkage to HIV primary medical care and anti-retroviral therapy are critical in preventing HIV-related medical complications in people living with HIV as well as decreasing onward transmission. In fiscal year 2015-2016, only 63% of individuals newly diagnosed with HIV in testing programs funded by the County of San Diego were linked to care within 30 days. This performance was well below the National HIV/AIDS Strategy 2020 target of 85%. As a result, the Ryan White Clinical Quality Management (CQM) committee began a quality improvement project with funded providers to increase performance to meet the 2020 goal. As a result of this focused CQM effort, linkage to care for individuals newly diagnosed with HIV increased to 87% in 2018, was 86% in 2019 and 89% in 2020. The CQM committee continues to work with providers and persons vulnerable to or living with HIV to seek incremental improvements, with the goal of ensuring that 95% of persons newly diagnosed with HIV link to HIV primary care within 30 days of their diagnosis.

Rapid PrEP: Along with rapid ART, the County is seeking to transform the service delivery system to ensure rapid PrEP as well. Several contracted providers already have the capacity to rapidly initiate PrEP, including the ability to provide same-day prescriptions. The County is developing a rapid PrEP program through the County's main STD Clinic in the winter of 2021, and then it will be rolled out to the three satellite STD Clinics in 2022.

PEP: The County of San Diego provides non-occupational post-exposure prophylaxis (nPEP) in its main STD Clinic for clients who are uninsured or underinsured. Any client who reports a high-risk exposure to HIV within the previous 72 hours can come to the STD Clinic and receive full diagnostic testing and support in accessing medications through existing patient assistance programs. As clients complete nPEP, they are encouraged to transition to PrEP to reduce their risk for HIV acquisition going forward.

HIV Partner Services: The County of San Diego's HIV Partner Services program focuses on eliciting names and contact information of sex and needle-sharing partners of persons newly diagnosed with HIV and other persons known to be HIV-positive but not in care or virally suppressed. Once identified, County staff attempt to locate these partners to inform them of exposure to HIV and link them to HIV testing and other services. Partners who test HIV negative are referred to a PrEP navigator and other HIV prevention services as appropriate. For partners newly identified as HIV-positive, linkage to care, treatment and support services are provided. For partners previously known to be HIV-positive, confirmation is made that the partner is receiving HIV primary medical care and, if not, linkage to care is facilitated. All County funded HIV services providers provide disclosure assistance services.

HIV/STD Integration: Like many metropolitan areas in the U.S., San Diego County has seen a precipitous increase in STD incidence. Cases of infectious syphilis nearly doubled (from 595 to 1,154 cases) from 2013 to 2019, and cases of gonorrhea increased by 223% (from 2,865 to 6,395 cases) over the same period. Despite the COVID-19 pandemic, San Diego continued to see elevated rates of STDs in 2020 with 1,117 cases of infectious syphilis and 6,061 cases of

gonorrhea. Incidence in both diseases has disproportionately impacted men who have sex with men, the group that is most vulnerable to HIV infection.

In recognition of these increases, the County has integrated HIV disclosure assistance and PrEP navigation into STD field investigations. Currently, all individuals diagnosed with primary or secondary syphilis and select early latent cases are actively investigated by the STD Field Services team. Investigations include confirmation of adequate treatment, patient interview (including elicitation of sexual partners), and determination of HIV status. For individuals who are HIV-positive, staff verify that clients are currently receiving HIV-related medical services, and those who are not receive support in linkage to care. For individuals who are HIV negative or untested, staff work with medical providers to facilitate HIV testing. When providers do not perform HIV testing, staff reach out to the patients to link them to HIV testing. Individuals who test positive are linked to care; individuals who test negative are referred to PrEP navigation to access PrEP and other HIV prevention services. For partners elicited from infectious syphilis cases co-infected with HIV, staff inform partners not only of their exposure to syphilis but also to HIV so appropriate testing and treatment options can be provided.

Community Engagement: This project will engage women and youth/young adults of all ethnicities who are vulnerable to or living with HIV infection in community engagement opportunities. The goal is to identify early and reduce late HIV diagnosis and improve retention in care and viral suppression. Outreach and education opportunities will be provided to persons living with HIV regarding the EHE initiative to include how they can become more involved to represent their community. The needs of those living with HIV will be assessed, opportunities for workforce training will be developed and a community advisory committee will be convened to foster and support continued community engagement.

Community-Informed Molecular Epidemiology: The purpose of this program is to interrupt high-transmission clusters of HIV, reduce new infections and ensure that persons living with undiagnosed HIV can be identified and linked to care and other support services. This effort will involve analysis of HIV gene sequence data to identify growing clusters of HIV infection. Once identified, the County will deploy disease investigation staff to identify persons living with undiagnosed HIV as well as persons living with diagnosed HIV but not virally suppressed. Because of the numerous concerns that persons living with HIV have expressed about the use of molecular epidemiology, this effort will be led by a community advisory board comprised primarily of persons living with HIV. The County of San Diego and its partner in this effort, UCSD, will conduct extensive outreach and community education efforts to inform San Diego residents living with HIV about how HIV gene sequence data will be used and how their privacy will be protected. Through this program the County will implement recency testing for all persons newly diagnosed with HIV. The recency testing will help the County distinguish between recent infections (occurring in the last six months) from infections that occurred more than six months ago. Doing so will allow the County to prioritize recent infections for investigation and HIV partner services.

Wrap Around Services for Persons who Inject Drugs. This group of activities will fill critical gaps in services by providing comprehensive testing (HIV, HCV, STDs), status-neutral health care navigation (for PrEP or ART), linkage to substance use treatment and mental health resources, and linkage to housing assistance. In San Diego County, persons who inject drugs do not achieve viral suppression at rates seen by other groups; early diagnosis and linkage to substance use disorder treatment and mental health resources will help with early identification and increase viral suppression in this population.

Peer-based Mobile PrEP. This activity will entail employing African American and Hispanic MSM and transgender women and men to become PrEP champions for outreach efforts of mobile PrEP clinics that offer testing, linkages and care. The mobile clinics will provide PrEP-related medical evaluation, including comprehensive testing (HIV, HCV, STDs and safety labs), ongoing PrEP medical care, linkage to benefits navigation, and prescriptions for PrEP. Stigma related to sexual activity remains a significant barrier to PrEP. Developing and deploying PrEP champions from the populations of interest can help to mitigate stigma as a barrier and will support identification of persons living with undiagnosed HIV.

Routine HIV Testing Implementation Grants. Startup grants will be awarded to local community health centers and other non-profit health care providers to implement routine HIV testing in primary care, urgent care and emergency departments, thus extending the reach of routine testing programs described earlier. Routine HIV testing in primary care and other settings is necessary to reach persons living with undiagnosed HIV. By providing funding to support the expansion of routine testing, the County will be able to increase the number of providers conducting routine testing and increase early identification in populations that may not be aware of their HIV status.

b) Major collaborations

Collaborative efforts to implement EIIHA are extensive as noted by the partnerships that have supported rapid ART and PrEP linkage. EIIHA implementation has resulted in the integration of planning along the HIV care continuum, including testing, linkage coordination, and care and treatment.

Close coordination will continue internally between the testing program, STD Clinic and the Public Health Lab (PHL). The PHL processes the HIV tests for patients seen in the County's STD Clinics. The standard HIV screening test offered is an antibody/antigen assay that detects HIV as early as 14 days after infection. Both screening and confirmatory tests are run in the lab, which is in the same building as the main STD Clinic. Additional collaborative efforts include other departments within Public Health Services, including the Tuberculosis Control and Refugee Health Branch, which conducts HIV testing with patients in the County's categorical tuberculosis clinics, and the HIV Epidemiology and Surveillance Program, which oversees local HIV surveillance. Finally, collaborative efforts have extended to the County's Sheriff's Medical Unit to ensure that routine HIV testing is available to all persons who are incarcerated in County detention facilities. Individuals who are newly diagnosed with HIV are linked to HIV primary care during incarceration.

Due to the central importance of outreach and testing to the EIIHA plan, the County has periodically convened outreach and testing coordination meetings and coordinated activities virtually. Participants include providers funded by the County as well as other sources, including the CDC, research programs and a representative of the National HIV Behavioral Surveillance project. In the past providers developed inventories of outreach and testing activities conducted in San Diego County. As in past years, again in 2021 providers of outreach and testing services collaborated on a countywide series of social media promotions of National HIV Testing Day, which was extended to a full week of promotion of all regular and special testing events occurring in the county. Due to the COVID pandemic, in-person events were limited but an inventory of all testing locations and hours as well as the availability of self-testing were promoted on the County's and providers' websites and social media platforms.

c) Anticipated Outcomes of EIIHA Strategy

Anticipated outcomes for the County of San Diego's EIIHA strategy for the period of March 1, 2022 through February 28, 2025, include the following:

- Identify 1,400 persons living with previously undiagnosed HIV infection, and inform at least 95% of them of their status (1,330 persons).
- Provide referrals to HIV primary care services for 100% of persons newly diagnosed with HIV and informed of their status (1,330 persons).
- Link 95% of persons newly diagnosed with HIV and informed of their status to HIV primary care services and anti-retroviral therapy, with a verified medical visit (1,264 persons).
- Ensure 90% of persons newly diagnosed with HIV and informed of their status achieve viral suppression (1,197 persons).

2) Planned efforts to remove legal barriers, including state laws and regulations that increase HIV stigma and discrimination and can pose complex barriers for people with or at risk for HIV, preventing them from seeking prevention tools, learning their HIV status, and accessing medical care, treatment and supportive services. Include program/policy efforts to expand implementation of routine HIV testing.

Prior to 2017, California law imposed several criminal penalties for persons living with HIV. These included a potential felony conviction for not disclosing one's HIV status prior to engaging in anal or vaginal sex without a condom. Penalties for engaging in sex work with a prior conviction and an HIV diagnosis were increased, including an additional three years of incarceration. HIV was the only infectious disease that carried these enhanced penalties. Recognizing that these laws further stigmatized persons living with HIV, the California legislature voted to repeal these enhanced penalties.

In California there are no legal barriers to routine testing in medical settings. California law eliminated the requirement for a separate, written consent for HIV testing. Medical providers are required to inform patients that an HIV test is planned, provide information about the HIV test, inform patients that numerous treatment options exist if they test positive for HIV, counsel patients that a person testing negative for HIV should continue to test routinely, advise patients of their right to decline the HIV test and if patients decline the HIV test document that fact in their medical record. These requirements do not apply when a person independently requests an HIV test from a provider.

Beginning in 2011, the County of San Diego began working with several federally qualified health centers to implement routine, opt-out HIV testing in primary care settings. Currently, the County of San Diego is deploying funding from the CDC Ending the HIV Initiative to support non-profit medical providers, including federally qualified health centers, to increase the number of federally qualified health centers, emergency departments, urgent care centers and other primary care settings to implement routine, opt-out HIV testing.

C. Subpopulations of Focus

Subpopulation of Focus for Plan for FY 2022

1. Identify three subpopulations with disparities in health outcomes in your jurisdiction (e.g., subpopulations with disparities in viral suppression, receipt of care, retention in care, late diagnosis, HIV incidence, etc.). Describe the specific needs for each subpopulation.

Based upon local epidemiology, unmet need estimates, needs assessment data, results of the Getting to Zero Community Engagement Project, findings of the Environmental Assessment of People who Inject Drugs and other local and State compiled data, the County of San Diego has prioritized three subpopulations of focus: persons who inject drugs, including MSM, Hispanic MSM and African American MSM. For each of these populations, subpopulation analyses and qualitative data support and direct activities that will lead to the early identification of individuals in these populations.

A review of available epidemiological data through 2020 indicates that among those newly diagnosed with HIV disease in 2016-2020, 88% were males, 62% were MSM (not mutually exclusive), and just under 9% acquired HIV through injection drug use, with or without sexual contact with other men. While 10% of newly diagnosed MSM cases were among African American men, this group constitutes only 5% of the male population in the county, demonstrating the disproportionate burden of HIV in this community. Likewise, Hispanics make up 34% of the male population yet comprise 49% of newly diagnosed MSM.

Further analysis of these populations, displayed in Table 7, indicates 42% of newly diagnosed MSM cases were among persons aged 20-29, and 28% were among persons aged 30-39 years. Among those who were 20-29 years at diagnosis, 50% were Hispanic and 13% were African American. Population data indicates ongoing disparities among Hispanic and African Americans: 37% of males aged 20-29 years were Hispanic and 6% were African American. Among those who were 30-39 at diagnosis, 50% were Hispanic and 9% were African American. Population data again indicates ongoing disparities: 33% of males aged 30-39 years were Hispanic, 47% were White and 5% were African American. In both the 20-29 years and 30-39 years at diagnosis age groups, Hispanic and African Americans have a disproportionate burden of HIV.

Table 7: Newly Diagnosed MSM, 2016-2020 by Race/ethnicity and Age Group

Age Group at Diagnosis		Race								Total
		Hispanic/ Hispanic	Am-Indian/ Alaska Native	Asian	African American	Native Hawai'ian/ Other PI	White	Multiple races	Unknown/ Missing	
13-19	N	24	*	*	*	*	8	*	*	41
	%	58.5%					19.5%			3.1%
20-29	N	301	*	27	78	*	138	18	5	575
	%	52.3%		4.7%	13.6%		24.0%	3.1%	0.9%	42.8%
30-39	N	199	*	27	33	*	109	8	*	381
	%	52.2%		7.1%	8.7%		28.6%	2.1%		28.4%
40-49	N	88	*	8	13	*	73	8	*	193
	%	45.6%		4.1%	6.7%		37.8%	4.1%		14.4%
50-59	N	35	*	5	10	*	59	*	*	114
	%	30.7%		4.4%	8.8%		51.8%			8.5%
60+	N	10	*	*	*	*	26	*	*	39
	%	25.6%					66.7%			2.9%
ALL	N	657	5	71	141	5	413	37	14	1,343
	%	48.9%	0.4%	5.3%	10.5%	0.4%	30.8%	2.8%	1.0%	100.0%

*No information is provided for cells with fewer than 5 incidents.

2. Data from the unmet need framework informs the process for identifying the subpopulations of focus.

Data from the unmet need framework substantiate the that three subpopulations of focus have unmet need greater than the total unmet need (Total unmet need 30.9%, PWID 33.1%, Hispanic MSM 34.2% and African American MSM 35.2%). In addition to data from the unmet need framework, many other data sources were utilized to determine the subpopulation and needs of these subpopulations of focus. These data sources include findings from the National HIV Behavioral Surveillance Survey (2015 and 2018), findings from the Environmental Scan of Persons Who Inject Drugs in San Diego County, and findings from the Getting to Zero Community Engagement project.

3. As applicable, identify activities for each required EIIHA Component (identification of individuals unaware of HIV status; informing newly diagnosed individuals of HIV status; referral to care of newly diagnosed individuals; and linkage to care of newly diagnosed individuals- and describe how the activities align with the needs of the identified subpopulations of focus for the jurisdiction.

All Persons Who Inject Drugs

The number of new HIV cases attributable to injection drug use has declined since the beginning of the epidemic in San Diego County. Prevalent cases attributable to injection drug use and injection drug use among men who have sex with men are 13.3%, whereas incident cases during the period of 2015 to 2020 are 9.5%. Persons who inject drugs are included as a population of focus due to substantial ongoing risk for HIV transmission and acquisition. Local epidemiological data indicate that among persons living with HIV, persons who likely acquired HIV through injection drug use are less likely to achieve viral suppression (87% vs. 92% for all groups) and that difference is statistically significant. Poor health outcomes among these populations creates HIV and HCV transmission risk, and thus improving health outcomes among these populations creates opportunities to further accelerate the end of the HIV epidemic in San Diego County.

The Community Survey of HIV Impact in 2017 revealed that 66% of persons living with diagnosed HIV who report current or former injection use (n=187) report sexual activity during the prior 12 months, with substantial risk for HIV transmission. Over 58% of this group of respondents indicated multiple sexual partners, 44% reported never or only sometimes disclosing their HIV status to sexual partners, and 54% reported sometimes or never using condoms with sexual partners to whom they have not disclosed their HIV status. HIV transmission risk is also increased through use of shared needles, and 28% of survey respondents indicated they sometimes or always share needles when injecting drugs. One-third of respondents reported having injected drugs during the prior 12 months. Persons who inject drugs face substantial barriers to accessing and retaining care. Of HIV-positive respondents to the survey, over 23% of respondents reported being out of care for more than one year after their initial diagnosis with HIV. Moreover, of respondents who had reported being out of care at any point during the past five years, 64% identified use of drugs and alcohol as a contributing factor, followed by homelessness (36%) and untreated mental illness (34%). Less than half (44%) of respondents who reported prior injection drug use reported being in recovery.

The National HIV Behavioral Surveillance (NHBS) is conducted in San Diego on a three-year cycle. The three-year cycle rotates through three population: men who have sex with men, persons who inject drugs and heterosexuals. Data from the NHBS survey conducted in 2015 (n=609) and 2018 (n=234) with people who inject drugs provides additional context. Over half of the respondents reported injecting more than once a day (54.3% in 2015 and 61.7% in 2018). Only about a quarter reported always using new sterile syringes (30.3% in 2015 and 23.7% in 2018). Two out of five respondents reported using needles someone else already used (44.4% in 2015 and 43.6% in 2018). About a half of the respondents gave used needles to someone else to use (49.6% in 2015 and 50.4% in 2018). And, over a half of the respondents reported sharing injection equipment (64.1% in 2015 and 56.2% in 2018). With regard to testing for HIV, only about two out of five respondents reported they had tested for HIV in past year (43.1% in 2015 and 37.8% in 2018). And, one in five reported they had tested for STDs (25.1% in 2015 and 20.7% in 2018). Less than 15% reported having had an HIV-prevention related intervention in the past 12 months (14.8% in 2015 and 14.5% in 2018).

Additional context is provided by an Environmental Assessment of Persons Who Inject Drugs, funded by the County in 2018 and 2019 and designed to better understand the comprehensive HIV treatment and prevention needs of persons who inject drugs. Findings of the assessment support other local findings and also identified the urgent need to provide services specifically tailored to the needs of persons who inject drugs, including the need to improve coordination of care.

The unmet need framework surveillance data indicates late diagnoses at 22.7% (5), and unmet need 33.1% (587) for persons who inject drugs, which is higher than the total for all cases of 20.2% and 30.9% respectively. And for the Ryan White Program, 27.4% (268) of person who inject drugs had unmet need and 11% (78) were in care and not virally suppressed, which is higher than the total for unmet need of 20.8%.

Addressing the needs of persons who inject drugs creates opportunities to further strengthen the local HIV system of care to promote better inclusion and better health outcomes among our residents who are current or former users of injection drugs. Local research indicates that the primary service gaps and barriers include the lack of sensitive and trained professionals, as well as structural barriers, including an overall lack of a coordinated, systemic response outside of interdiction and incarceration. Street intercept survey respondents noted stigma as their most pressing concern (wanting to be “treated like a human being”), followed by a need for clean injection sites, ready access to counseling and treatment services, housing assistance, and support for re-entering society.

Specific activities to be utilized with persons who inject drugs include:

- Deploy a service contract to provide comprehensive HIV prevention services for persons who inject drugs, funded by an EHE grant from the CDC, that includes integrated HIV/HCV/STD testing, health education and risk reduction, linkage to responsive and welcoming health care, linkage to substance use disorder treatment and mental health services, linkage to housing and nutrition services, and linkage to other services that support persons who inject drugs in sustaining more stable living and reduce risk of HIV and HCV transmission and acquisition.
- Deploy system-wide competency training regarding working with persons who inject drugs, including harm reduction principles to eliminate unwelcoming and incompetent service environments as a barrier to accessing care.
- Assess the coordination of needs of persons who inject drugs within the existing HIV service delivery system to identify opportunities for streamlining enrollment and access.
- Develop critical pathways to address the mental health and substance use disorder treatment needs of persons who inject drugs and ensure that services are readily and easily accessible.
- Partner with organizations and providers within San Diego County that are trusted by persons who inject drugs to promote availability of services and encourage testing and linkage to care.
- Adopt and/or develop marketing materials that are specific to persons who inject drugs.
- Conduct outreach focused on persons who inject drugs to provide information about available services, including rapid linkage to ART, PrEP, and, when available and appropriate, substance use treatment and mental health services.
- Continue to offer consistent messages such as normalizing routine HIV testing and the importance of disclosure of HIV status to sex partners.
- Support routine, opt-out HIV testing in healthcare settings serving this population, including the County’s categorial STD clinics and detention facilities.
- Create a monthly dashboard to provide an overview of activities specific to persons who inject drugs and provide that dashboard to the HIV Planning Group.
- Implement actionable activities from Getting to Zero Community Engagement project, Ending the HIV Epidemic Plan, and the Environmental Assessment of People Who Inject

Drugs to improve planning and services delivery to those who inject drugs including all MSM who inject drugs.

Hispanic MSM

Hispanic MSM represent the largest number of recent HIV cases in San Diego County and the second largest number of persons living with HIV. Additionally, Hispanic MSM comprise 48% of the unaware estimate for 2020 (up from 44% for 2016), yet they only comprise 35% of the San Diego County population. This population has the greatest number of cases diagnosed concurrently with HIV and AIDS. Hispanic also constitute the largest number of cases that progress from HIV to AIDS in less than one year. Moreover, 2019 and preliminary 2020 epidemiological data regarding syphilis indicate that White and Hispanic MSM share the highest number of primary and secondary syphilis cases among all reported cases, indicating sexual activity that could lead to HIV transmission and infection.

The most recent Needs Assessment was conducted in 2020¹⁰ and due to COVID there were limitations including the number of respondents. And while the number of respondents were low (226) the sample was representative of the local epidemiology, and the results were consistent with past data collected to assess needs of those vulnerable to and living with HIV. According to focus group participants, stigma affects all groups of people vulnerable to and living with HIV; however, there are additional challenges for Hispanic HIV positive men. Family dynamics and cultural beliefs often result in additional challenges around being open about an HIV diagnosis.

The Community Survey of HIV Impact in 2017¹¹ revealed 82% of HIV-positive and 76% of HIV-negative Hispanic MSM respondents reported having multiple partners. Forty-four percent of the HIV-positive respondents and 57% of the HIV-negative respondents reported sometimes or never using condoms with HIV-negative partners. Regarding condom use with HIV-positive partners, 52% of the HIV positive respondents versus 28% of HIV negative partners reported sometimes or never using condoms. In addition, among the HIV-negative Hispanic MSM and Hispanic MSM who inject drugs, 37% reported *not* testing for HIV within the past six months. The risk reported combined with not getting tested results in a delay in the early identification of Hispanic MSM who are HIV-positive.

Working with Hispanic MSM presents some distinct challenges. First, men in this population may fear accessing HIV testing and/or medical care services. Hispanic MSM who are immigrants fear that HIV-positive test results could jeopardize their ability to reside in the U.S. Some of these immigrants might be living in the U.S. without legal status and have concerns that seeking services could result in deportation, loss of employment or other legal problems. These problems have been exacerbated by previous public charge regulations that were removed in 2019. Hispanic MSM may be unaware of available services or that they may be eligible to receive them without regard to legal residency. Data from the needs assessment and community engagement project indicate there is distrust of medical systems and fear that information collected in medical settings will be shared with other government agencies.

Stigma related to HIV and homosexuality is common in many traditional families, communities and religious institutions. These men report concerns about loss of familial support or basic needs such as housing or employment if members of the community become aware of their risk for HIV or their sexual behavior. They may be less likely to access services in agencies

¹⁰ County of San Diego Health and Human Services Agency. (2020). *Community Survey of HIV Impact*.

¹¹ County of San Diego Health and Human Services Agency. (2017). *Community Survey of HIV Impact*.

that are LGBT-centered, opting for services that are more family-centered. As a result, they do not access medical services until they are sick, delaying early diagnosis of HIV.

Finally, Hispanic MSM are affected by language and/or cultural barriers. They may be monolingual Spanish-speaking or prefer to receive health information in Spanish. Ensuring bilingual and culturally responsive personnel can be a challenge in providing services, as recruitment of bilingual and culturally proficient staff is a challenge faced by the entire service delivery system in San Diego County. These men may have concerns regarding confidentiality and may be less likely to disclose risk information to service providers, thus interfering with accurate assessment of risk and willingness to participate in disclosure assistance services. As a result, they may not receive services that address their needs.

The unmet need framework surveillance data indicated unmet need at 34.2% (1,303) for Hispanics, which is higher than the total for all cases of 30.9% (4,341). And for Ryan White Program 16.1% (190) were in care and not virally suppressed for Hispanic MSM, which is higher than the total 14.6% (423).

Despite the challenges described above, there are significant opportunities to further strengthen efforts to address the sexual health needs of Hispanic MSM. The County maintains close working relationships with FQHCs and community-based organizations that specialize in working with Hispanic gay, bisexual and other men who have sex with men living with or vulnerable to HIV. These organizations include the Hispanic Services Center located at the San Diego LGBT Community Center and Coordinated Assistance, Services and Advocacy (CASA) located at San Ysidro Health. These agencies serve as community gatekeepers and subject matter experts when developing interventions and activities focusing on Hispanic gay, bisexual and other men who have sex with men.

Specific activities that will be utilized with Hispanic MSM to identify those unaware, inform them of their diagnosis, refer and link them to care include:

- Assure that all services can be delivered in either English or Spanish, as needed.
- Provide focused HIV testing, outreach (in person, venue-based and online via social media), HIV partner services, and PrEP navigation.
- Reduce barriers related to fear and distrust of health care systems and government agencies by collaborating with established culturally embedded organizations and providers who are already trusted by the population.
- Provide written materials and in-person services in Spanish; assess literacy levels and provide information visually and orally, as necessary.
- Conduct focused outreach activities in key points of access, such as primary care settings, community events, and health fairs, where information about HIV can be included with other important health information so that it is more accessible.
- Collaborate with the San Diego Office of Border Health to coordinate bi-national health needs and responses.
- Collaborate with community groups and organizations to create family friendly environments to reduce the stigma related to HIV and same-sex sexual behavior.
- Utilize HIV mobile testing units to provide easy access to HIV testing in various locations that can easily be accessed by Hispanic MSM.
- Provide information on sexual risk and HIV services to private medical providers, in venues where these men congregate, and via the Internet using social media and websites.

- Support routine, opt-out HIV testing in healthcare settings serving this population including the County's categorial STD clinics and detention facilities.
- Provide training to develop the cultural proficiency of providers serving this population.
- Fund multi-disciplinary team approaches, which combine medical case management, mental health, and substance use disorder treatment with outreach activities to better address multiple unmet needs.
- Create a monthly dashboard to provide an overview of EIIHA activities specific to Hispanic MSM and provide that dashboard to the HIV Planning Group.

African American MSM

African Americans comprise 13% of the unaware estimate for 2020 and 5% of the San Diego County population. Further, African American men comprise 10% of primary syphilis cases, and gay, bisexual and other men who have sex with men represent 8% of those same cases despite their lower representation in the population. Primary syphilis indicates a recently required syphilis infection and could be indicative of increased vulnerability to HIV transmission and acquisition.

According to participants attending focus group conducted as part of the 2020 needs assessment, stigma affects all groups of people vulnerable to and living with HIV; however, there are additional challenges for African American HIV positive men. Family dynamics and cultural beliefs often result in additional challenges around being open about an HIV diagnosis.

The previous survey conducted in 2017 included both HIV positive and HIV negative or unaware respondents. Of African American respondents, 74% of HIV-positive and 60% of HIV-negative reported having multiple sexual partners. Forty-five percent of the HIV-positive respondents and 80% of the HIV-negative respondents reported sometimes or never using condoms with HIV-negative partners. Regarding condom use with HIV positive partners, 44% of the positive and 40% of the negative respondents reported sometimes or never using condoms. In addition, among the HIV-negative African American MSM and African American MSM who used injection drugs in the past 12 months, half of the respondents reported not testing for HIV within the past six months. This high vulnerability reported combined with not getting tested may result in a delay in the early identification of this specific population. Reaching these individuals vulnerable to HIV infection to identify them earlier is a goal of the activities employed to address this subpopulation of focus.

There are several challenges in working with African American MSM. Racism, discrimination and trauma create barriers for accessing services, and the stigma that is associated with same-sex sexual behavior in many segments of African American communities creates further impediments to acknowledge risk. Moreover, a history of disenfranchisement, marginalization and health inequity lead to low self-efficacy and low levels of health literacy that can impede the ability of these men to seek or receive accurate health information and services. Data from the local needs assessment and community engagement project indicate that many African American MSM do not pursue testing, primarily because they do not prioritize sexual health or HIV risk. They are often distrustful of the service delivery system, or they worry that getting tested might be perceived as an admission of engaging in stigmatized behavior. Program materials addressing HIV risk may not be accessed by African American MSM out of fear that doing so might be perceived as an admission of engaging in stigmatized behavior. The additional co-factor of poverty means many of these men lack adequate health coverage and prioritize more immediate needs, such as food and housing, over health needs. Other long-standing, unaddressed

physical health, mental health and substance use needs often exist that prevent these men from prioritizing HIV risk or HIV testing.

The unmet need framework surveillance data indicated unmet need at 35.2% (332) for African American, which is higher than the total for all cases of 30.9% (4,341); for in care but not virally suppressed 26.6% (162) compared to the total for all cases of 18.5% (1,801); and for Ryan White Program participants, 15.3% (31) of African American MSM were in care and not virally suppressed, which is higher than the total 14.6% (423).

Despite the challenges described above, there are significant opportunities to further strengthen efforts to address the sexual health needs of African American gay, bisexual and other men who have sex with men. There are many long-standing organizations such as the San Diego African American Nurses Association and the Faith-Based Action Coalition that seek to build HIV awareness and promote HIV testing within the African American and faith communities.

Ongoing, specific activities that have and will continue to be utilized with African American gay, bisexual and other men who have sex with men to identify those unaware, inform them of their diagnosis, refer and link them to care beyond the activities described in the EIIHA section include:

- Provide focused HIV testing, outreach (in person, venue-based and online via social media), HIV partner services, and PrEP navigation. While outreach and most in person events were suspended due to COVID-19, drive through HIV testing and home testing are now available.
- Collaborate with established, culturally embedded organizations and providers trusted by the populations of interest to reduce barriers related to distrust of health care systems.
- Conduct focused outreach activities in key points of access, such as primary care settings, community events, and health fairs, where information about HIV can be included with other important health information so that it is more accessible. Sexual health information has been provided at recent COVID-19 vaccine events.
- Collaborate with community groups and faith communities to reduce the stigma related to HIV and same-sex sexual behavior.
- Utilize mobile testing units to provide HIV testing in various locations that can easily be accessed by this population.
- Provide information on sexual risk and HIV services to private medical providers, in venues where these men congregate, and via social media and websites.
- Support routine, opt-out HIV testing in healthcare settings serving this population including the County's categorial STD clinics and detention facilities.
- Provide training to develop the cultural proficiency of providers serving this population.
- Fund multi-disciplinary team approaches, which combine medical case management, mental health, and substance use disorder treatment with outreach activities to better address multiple unmet needs.
- Create a monthly dashboard to provide an overview of activities specific to African American MSM and provide that dashboard to the HIV Planning Group.

A. Planning Responsibilities

1) Letter of Assurance from Planning Council Chair(s) or Letter of Concurrence from Planning Body

See Attachment 6 for a letter of assurance signed by the Chair of the San Diego HIV Planning Group.

2) Resource Inventory

a) Coordination of Services and Funding Streams Table

See Attachment 7 for an inventory of local HIV resources and includes information on funding sources for HIV prevention, care, and treatment services in San Diego County.

WORK PLAN

A. HIV Care Continuum Table and Narrative

1) FY 2022 HIV Care Continuum Table

See Attachment 8 for the HIV Care Continuum Table for San Diego County.

2) HIV Care Continuum Narrative

a) Any changes in your HIV care continuum from CY2017 to CY2019, the impact those changes had on your program, and how you responded or addressed those identified changes.

Table 08: HIV Care Continuum, San Diego County, 2017-2019

Year	Linkage to Care 30 days	Retained in Care	Receipt of Care	Viral Suppression
2017	78%	54%	*	61%
2018	87%	53%	72%	63%
2019	87%	55%	75%	61%

* Data analysis and reporting on "Receipt of Care" began in 2018.

Overall, San Diego has experienced some improvements in the HIV care continuum from 2017 to 2019. Percentages for linked to care, retained in care, and receipt of care showed favorable increases in the three-year period with a slight dip in viral suppression in 2019. Data for linkage to care in 30 days showed a favorable increase from 78% in 2017 to 87% in 2018 and held steady in 2019. Retention in care was steady between 2017 to 2019, fluctuating between 53%-55%. We now have two years of measuring receipt of care and saw a favorable increase from 72% in 2018 to 75% in 2019. Viral suppression started and ended at 61%, with a slight increase in 2018 demonstrating 63%.

The HIV Care Continuum is used for planning, establishing goals in service contracts, and for monitoring the local epidemic. It is a valuable resource that has been used to support the ongoing deployment of rapid linkage to care and Data to Care for persons living with HIV who have never linked or have fallen out of HIV care. Outcome objectives in contracts for Ryan White services that started in March 2018 require 90% of clients who are not virally suppressed at the time of enrollment to achieve viral suppression within 180 days of intake and 90% of clients who are virally suppressed at commencement of services shall remain virally suppressed throughout enrollment.

The County of San Diego and the HIV Planning Group recognize that identifying individuals unaware of their HIV infection and informing them is a crucial step in reducing the number of new infections. The County and the HIV Planning Group have adopted systematic approaches to address the identification of people living with HIV, including 1) outreach and

testing services focused on areas and communities that are disproportionately impacted by HIV; 2) routine HIV testing in primary care settings in San Diego County’s federally qualified health centers and detention facilities; 3) advocacy for implementation of routine HIV testing in private health care systems; and 4) broad use of HIV partner services for both newly diagnosed individuals as well as previously diagnosed individuals who are receiving services funded by the HIV, STD and Hepatitis Branch. From this list of activities, Ryan White Part A funding is only used for outreach. Funding for the remaining activities is derived from the California Department of Public Health.

The HIV Care Continuum for San Diego indicates that 87% of newly diagnosed individuals are linked to care within 30 days of diagnosis, which exceeds linkage rates for both California (77%) and the United States (76%) and represents a 9% increase over the 2017 data. Locally, linkage to care is incorporated into HIV test disclosure activities. The primary approach to ensuring linkage to care is to obtain a release of information from clients during HIV disclosure sessions so that staff can follow up with medical providers to confirm successful linkage to care. For patients not successfully linked, Communicable Disease Investigators follow up to provide additional referrals for primary care as well as any additional services such as mental health, substance use disorder treatment, medical case management, and any other services that might support the patient in obtaining care.

The methodology used to measure if someone is in HIV care in San Diego has changed. Previously, we utilized retention in care, defined as two CD4 or viral load tests within a 12-month period, with the two tests being at least three months apart. San Diego now utilizes the measure for receipt of care, defined as one CD4 or viral load test within a 12-month period. The HIV Care Continuum for San Diego in 2019 indicated that 75% were in receipt of care.

Staff members from the HIV Epidemiology Surveillance Program provide regular reports, updates and presentations to the HIV Planning Group and its subcommittees. When new continuums are developed, comparisons are made to previous versions of the continuum to evaluate any changes. In the Ryan White 2019-2020 fiscal year, viral suppression for Ryan White clients was 92%.

B. Funding for Core and Support Services

1) Service Category Plan

a) Service Category Plan Table

See Attachment 9 for the Service Category Plan Table that illustrates how all RWHAP Part A and MAI core medical and support services are funded in San Diego County for FY 2021 and FY 2022.

b) MAI Service Category Plan Narrative

i. All services listed in the MAI service category plan table address the needs of San Diego County’s MAI populations and aim to prevent new HIV infections, improve health outcomes, and decrease health disparities and inequities. The services listed in the MAI Service Category Plan represent a set of culturally tailored approaches designed to address the specific needs of these populations. All of the listed services are located in community settings and take into account the underlying cultural, social, and contextual factors related to MAI populations.

ii. Over the last several years, new HIV cases and HIV-related deaths in the County of San Diego have decreased steadily. Despite these successes, there are groups that are disproportionately affected by HIV. These groups include African American MSM, and MSM. Findings from

community engagement efforts offer some insight into the barriers and challenges that are impacting the EMA's ability to further reduce new HIV infections. For example, among African American MSM, racism, discrimination, trauma, stigma, and the historical impact of marginalization and inequity have created barriers to accessing services and have negatively impacted retention in care and viral suppression. Among Hispanic MSM, stigma, distrust in the medical system, immigration status, and cultural and linguistic barriers have impacted access to HIV testing and care which has led to high rates of late and simultaneous diagnoses when compared to other racial and ethnic groups across San Diego County.

The COVID-19 pandemic has also exacerbated the long-standing cultural, social, economic, and systemic issues that contribute to poorer health outcomes for African American and Hispanic populations across the EMA. This long-standing systemic health and social inequities have put African American and Hispanic groups at increased risk of contracting and dying from COVID-19 compared to White population groups. As of August 18, 2021, African Americans and Hispanics made up 57% of all known cases of COVID-19 in the County of San Diego (4.1% and 52.6%, respectively).

African Americans and Hispanics comprise the two largest racial and ethnic minority groups most impacted by HIV in the EMA. As shown in Attachment 3, African Americans make up 12.8% of prevalent HIV cases and 12.1% of new cases despite accounting for only 4.7% of the total population in the EMA. Hispanics account for 38.8% of prevalent cases and 47.5% of new cases while making up 33.7% of the total EMA population. While HIV impacts other racial and ethnic minority groups in the jurisdiction, these groups do not experience health disparities to the same extent as African Americans and Hispanics. For this reason, services have focused primarily on meeting the needs of these identified populations.

Considering these notable disparities in HIV incidence, prevalence and care, the San Diego HIV Planning Group approved the allocation of funding to two subcategories of services that are provided through coordinated service centers. The first category is Multi-Disciplinary Teams for dually and multiply diagnosed individuals of racial and ethnic minority populations living with HIV. The second category is Emergency Housing. The primary focus of these categories is to identify people living with HIV, determine their needs and link them to care through facilitated referrals and appointments. These activities differ from other Ryan White Part A services in that they utilize approaches that address various co-occurring conditions to meet the needs of all EMA racial and ethnic minority populations.

San Diego County has experienced an ongoing and increasing housing crisis. This crisis combined with growing unemployment resulting from efforts to slow the COVID-19 pandemic has led to increased risks for eviction and homelessness among MAI population groups, which directly impacts a person's ability to remain in care. To address this, the HIV Planning Group added allocations for Emergency Housing Assistance to services offered through MAI funding. The action was made to specifically address the disparities experienced by African Americans and Hispanics in obtaining and retaining affordable housing in the EMA. Gaining and maintaining stable housing will ultimately help improve viral suppression and other HIV-related health outcomes on the HIV care continuum for identified MAI subpopulations.

Similarly, and to enhance case management efforts for care coordination of dually and multiply diagnosed clients, the HIV Planning Group continued Multi-Disciplinary Teams as the primary service component offered through MAI funding. The multi-disciplinary team activities assess the needs of clients and link them to the appropriate services. Multi-disciplinary team activities include mental health, outpatient substance use treatment, outreach, and medical and

non-medical case management. Mental health and substance use disproportionately impact identified subpopulations of focus often because of historical trauma and structural inequalities.

Of note, MAI providers in the EMA are also providers of Part A-funded Outpatient/Ambulatory Health Services (OAHS), Oral Health Care, Medical Case Management, and Non-medical Case Management, operating out of “one-stop shopping” coordinated services centers. This helps to improve the HIV health outcomes among racial and ethnic minority populations within the jurisdiction by creating strong linkages between Part A OAHS and other Ryan White Program services. For the 330 clients served through Part A MAI during the last full grant period, March 2020 through February 2021, 93% achieved viral suppression.

c) Unmet Need

i. Identify specific interventions that are focused on improving the outcomes for individuals with unmet need. ii. If applicable, describe how activities related to re-engaging individuals with unmet need into intersects with plan or strategies in your jurisdiction, such as EHE, GTZ and/or 90/90/90 efforts.

Intervention	Area of Impact	Local intersection with EHE, GTZ, 90/90/90
Routine opt-out testing implementation grants (Diagnose)	<ul style="list-style-type: none"> Late diagnosis 	<ul style="list-style-type: none"> Ending the HIV Epidemic (CDC 20-2010) Getting to Zero
Wrap around services for persons who inject drugs (Diagnose, Treat, Prevent)	<ul style="list-style-type: none"> Late diagnosis Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Ending the HIV Epidemic (CDC 20-2010) Getting to Zero
Comprehensive services for transgender (Diagnose, Treat, Prevent)	<ul style="list-style-type: none"> Late diagnosis Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Ending the HIV Epidemic (CDC 20-2010) Getting to Zero
Getting to Zero mobile application and resource guide (Diagnose, Treat, Prevent)	<ul style="list-style-type: none"> Late diagnosis Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Ending the HIV Epidemic (CDC 20-2010) Getting to Zero
Low Barrier Medical Care (Treat)	<ul style="list-style-type: none"> Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Ending the HIV Epidemic (HRSA 20-078) Getting to Zero
Benefits Navigation (Treat, Prevent)	<ul style="list-style-type: none"> Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Ending the HIV Epidemic (CDC 20-2010)
Community Engagement (Diagnose, Treat, Prevent)	<ul style="list-style-type: none"> Late diagnosis Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Ending the HIV Epidemic (HRSA 20-078) Getting to Zero
Data to Care (Treat)	<ul style="list-style-type: none"> Unmet Need In care, not virally suppressed 	<ul style="list-style-type: none"> Getting to Zero
Surveillance Based Partner Services (Diagnose, Treat, Prevent)	<ul style="list-style-type: none"> Late diagnosis Unmet need In care, not virally suppressed 	<ul style="list-style-type: none"> Getting to Zero
Focused and routine opt-out testing (Diagnose)	<ul style="list-style-type: none"> Late diagnosis 	<ul style="list-style-type: none"> Ending the HIV Epidemic (CDC 20-2010) Getting to Zero

d) Core Medical Services Waiver

The EMA submitted an application for the Core Medical Services Waiver for FY 2022 on October 1, 2021.

RESOLUTION OF CHALLENGES

Table 09 lists major challenges, barriers, proposed resolutions, and intended outcomes for the EMA.

Challenge: COVID-19 necessitated changing the HIV service delivery system and assessment of what changes are lasting.		
PROPOSED RESOLUTION	INTENDED OUTCOMES	CURRENT STATUS
<ul style="list-style-type: none"> • In 2020, quick action was needed to ensure that persons living with HIV had access to HIV care and other core and support services. • Quick action needed to reallocate funds to service categories most impacted by COVID-19. • Assessment of which changes implemented at the beginning of COVID-19 are worthy of continuing, such as telehealth appointments and expanded emergency housing and emergency financial assistance. 	<ul style="list-style-type: none"> • Increased flexibility in providing services during COVID-19 to ensure people living with HIV remain in HIV care. • Increased access to housing for people living with HIV who were experiencing housing instability. • Increased funding for emergency financial assistance. • Increased flexibility for recertification of eligibility. 	<ul style="list-style-type: none"> • Short-term hotel stays increased from a maximum of two weeks to six weeks. • Annual limit on Emergency Financial disbursements increased from \$500 to \$1,000 annually. • Recertifications could be conducted up to 90 days past the point they are due. • Mid-year recertifications could be done through self-attestation through email or by phone. • Telehealth appointments continue as an alternative to reduce the number of in-person encounters.
Challenge: Housing costs. Affordable housing continues to be a significant barrier in San Diego County and many people living with HIV are low-income and prioritize housing needs over medical needs or expenses.		
PROPOSED RESOLUTION	INTENDED OUTCOMES	CURRENT STATUS
<ul style="list-style-type: none"> • Support for Partial Assistance Rental Subsidy (PARS) including funding, amount of coverage, and ability to provide services to more people 	<ul style="list-style-type: none"> • Increased proportion of persons living with HIV are linked to and retained in care. • Increased proportion of persons living with HIV who are virally suppressed. 	<ul style="list-style-type: none"> • Increased utilization of services. • Fluctuating wait list for rental assistance. • Demand is so high that the HIV Planning Group considering shortening the length of time of subsidy to allow more people to be served.
Challenge: Identifying people living with HIV who never linked to care or who have fallen out of care.		
PROPOSED RESOLUTION	INTENDED OUTCOMES	CURRENT STATUS

<ul style="list-style-type: none"> • Continue Data to Care program which uses surveillance data to identify persons living with diagnosed HIV who are not receiving care. • Use surveillance data to determine who has had a diagnosis but no CD4 or viral load tests, or who has not had a CD4 or viral load test in over a year. • Deploy staff to reach out to the people who are not in care and link or re-link them to care, addressing any barriers that may have prevented them from previously accessing care. 	<ul style="list-style-type: none"> • Increased proportion of persons living with HIV are linked to and retained in care. • Increased proportion of persons living with HIV who are virally suppressed. 	<ul style="list-style-type: none"> • During COVID-19, many people living with HIV relinked to care as their concerns about health in general increased. • In 2020, 125 people were reached through Data to Care. • Implementation of Data to Care has also demonstrated that many people identified as out of care are: 1) HIV negative, 2) in care (but labs weren't reported), 3) no longer residing in San Diego, or 4) have decided not to receive care.
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EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM) Program

As a health department accredited by the Public Health Accreditation Board (PHAB), performance management and quality improvement are core components of all activities conducted by Public Health Services, a division of the County of San Diego's Health and Human Services Agency. The HIV, STD, and Hepatitis Branch (HSHB), an organizational unit within Public Health Services, sets annual goals, monitors progress in achieving those goals, and conducts quality improvement activities related to those goals. Because Ryan White funding represents a significant portion of the HIV funding received by the County of San Diego, CQM activities conducted by HSHB meet all requirements of the legislation.

CQM activities are implemented through an internal team as well as the CQM Committee, which is composed of HSHB staff members, service providers, and consumers of HIV services. Leadership for CQM activities is provided by the following staff:

- **Branch Chief:** This position directs the activities of HSHB and directly supervises the Assistant Medical Services Administrator and the Principal Administrative Analyst. The Chief meets with direct reports weekly and monitors the progress of the CQM plan monthly. The Chief also serves on the CQM committee and threads CQM activities through the Public Health Services Performance Improvement Management Committee. The Chief is responsible for developing and implementing systems in support of CQM activities.
- **Assistant Medical Services Administrator (AMSA):** This position oversees all HIV services, including HIV prevention, HIV testing, and HIV care and treatment, including Ryan White-funded services. The AMSA is responsible for the operations of CQM activities, including routine monitoring of performance data, ensuring achievement of CQM work plan objectives, and supervising staff who monitor data and develop reports.
- **Principal Administrative Analyst (PAA):** This position oversees contract operations and fiscal operations, and ensures that contracted providers report conforming performance data consistently.

CQM leadership is supported by the following staff members:

- **CQM Coordinator:** This position provides technical, administrative, operational, and logistical support for CQM activities, including data collection related to established performance measures. The CQM Coordinator is responsible for scheduling and chairing the CQM committee, preparing agendas, minutes and other materials for all meetings of the CQM committee, and coordinating training activities.
- **Community Health Program Specialist:** This position reports to the AMSA and oversees the Ryan White program. This position provides subject matter expertise regarding funded services and works with the CQM Coordinator and Administrative Analysts to implement and monitor quality improvement activities.
- **Administrative Analysts:** These positions report to the PAA and oversee Ryan White-funded contracts. These positions work with the Community Health Program Specialist and the CQM Coordinator to review quality management plans, explain quality-related expectations to sub-recipients, implement quality improvement activities, and ensure that performance data is reported regularly by contractors and clinical quality management data analysts.

The CQM Committee is composed of the following individuals:

- Chief, HSHB
- Assistant Medical Services Administrator, HSHB
- Community Health Program Specialist/Ryan White Program Manager, HSHB
- Contract Analyst, HSHB
- CQM Coordinator
- Clinical Quality Management Data Analyst
- County Epidemiologist
- Consumer representatives
- Primary care service providers
- Coordinated HIV Services providers
- Behavioral Health service providers
- HIV prevention service providers

CQM activities occupy a fundamental role in San Diego County's Getting to Zero initiative. The fifth strategy of the plan is focused on improving outcomes along the HIV Care Continuum by:

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

Included in the CQM plan is the following quality statement and vision, “The County of San Diego is committed to delivering effective, efficient, and culturally responsive services to persons living with HIV by focusing on achieving the goals of the National HIV/AIDS Strategy and improving outcomes along the HIV Care Continuum. Clinical Quality Management monitors the effectiveness of all Ryan White services in the region by examining key performance measures, identifying areas for improvement, and implementing activities to improve and/or enhance performance.”

1) Changes to current CQM program & 2) Use of CQM data

The CQM Committee reviews data for several key measures annually, and this year committee members selected the following performance measures to review on a quarterly basis:

1. Newly Diagnosed: the percent of individuals newly diagnosed with HIV who also received a Ryan White-funded mental health and/or substance use service during the measurement year.
2. Linkage to Care: the percent of persons newly diagnosed with HIV during the measurement period who were linked to care, with a verified medical visit, within 10 days, 30 days, 60 days, and 90 days of diagnosis.
3. Engagement to Care: the percent of Case Management (non-medical) patients who had two CD4 or viral load tests three months apart (“retained”) or one CD4 or viral load test (“sporadic”) during the measurement year.
4. Lost to Care: the percent of Ryan White clients who received at least one Ryan White-funded service during the previous measurement year who haven’t received a Ryan White-funded service during the current measurement year.
5. Viral Load Suppression: the percent of Ryan White patients who had viral loads <200 copies/ml at last viral load test during the measurement year.
6. Housing Status: the percent of persons with an HIV diagnosis who were unhoused or unstably housed during the measurement period.
7. Medical Case Management/Medical Visits: the percent of medical case management clients who had two or more medical visits in an HIV care setting in the measurement year.
8. Case Management (non-medical) Viral Load Suppression: the percent of case management (non-medical) clients who had viral loads <200 copies/ml at last viral load test during the measurement year.

For each of these measures, data derives from one or more of the following sources:

- The AIDS Regional Information and Evaluation System (ARIES), a performance management system used by California jurisdictions for collecting and reporting Ryan White service utilization.
- Enhanced HIV/AIDS Reporting System (eHARS), a surveillance system used specifically for HIV.
- Local Evaluations Online (LEO), a performance management system used by California jurisdictions for collecting and reporting service utilization for HIV testing and HIV

prevention activities conducted under funding received from the California Department of Public Health.

- Results of an annual quality assurance review of Ryan White-funded Outpatient/Ambulatory Health Services providers.

The CQM Committee, in its selection of performance measures, was guided by previous years' quality improvement experiences and outcomes. The committee had observed an unfortunate trend toward increasing housing insecurity for Ryan White clients in San Diego County. And given the uncertainty and yet still unknown socio-economic consequences of COVID-19, the committee wanted to closely monitor the living situations of Ryan White clients. And even with a quick pivot toward offering more telehealth services during the early days of the pandemic, COVID-19 also made it difficult for many Ryan White clients to safely and easily access many Ryan White-funded services and laboratory testing. As such, the CQM Committee created a performance measure to identify the clients who had not yet received a Ryan White-funded service during the current measurement period even though they had during the last measurement period.

Additionally, given the success of its previous rapid linkage to care quality improvement project, the committee modified its linkage to care performance measure to track how quickly individuals newly diagnosed with HIV linked to care at 10-, 30-, 60-, and 90-day intervals.

Several committee members had also become increasingly concerned, and existing data and research validated their concerns, that many Ryan White clients also struggled with mental health and substance use disorders, so the CQM Committee created another performance measure to identify and track the percent of individuals newly diagnosed with HIV who accessed a mental health and/or substance abuse service during the measurement period.

Many of the ideas and observations that informed and guided the selection of performance measures came as a result of the "COVID-19 check-ins" that the CQM Coordinator initiated during the early days of the pandemic. The check-ins, which occurred at our monthly CQM Committee meeting, allowed providers and content experts to discuss new and/or existing concerns that had been caused or amplified by the COVID-19 pandemic as well as highlight new opportunities for change that resulted from providers and clients adapting and responding to the uncertainty and instability. The check-ins also created space for committee members to share how they were adjusting to the ever-changing HIV service provision landscape as the pandemic evolved on what felt like a daily basis.

Another component of the CQM Committee that was influenced by previous experiences was the introduction of the "CQM inbox" and "consumer engagement introspective." Several committee members had previously expressed appreciation for the collaborative nature of the committee's work. The CQM Coordinator proposed those two ideas to the committee hoping to foster more opportunities for collaboration and information sharing. The committee embraced both ideas and, in doing so, created even more space to share best practices, discuss successful consumer engagement initiatives, offer feedback and guidance to HIV service delivery providers, and discuss site/provider-specific service delivery challenges. Committee members have subsequently expressed gratitude and appreciation for the additional opportunities to share with and learn from one another.

The CQM Committee, which is currently conducting two quality improvement projects, hopes both are as successful and informative as its previous rapid linkage to care quality improvement project. The first project, "Improving Utilization of Emergency Financial

Assistance (EFA),” was selected in recognition of numerous years of underspending in Emergency Financial Assistance, despite its very small allocation (\$25,000) and the very high cost of living in many parts of San Diego County, including the Central region, which is home to the largest proportion of persons living with HIV.

The second project, “Acknowledging Trauma and Improving Viral Load Suppression among Housing Insecure Ryan White Clients,” was selected in recognition of the high likelihood that temporarily and unstably housed Ryan White Clients living in San Diego County have experienced and/or are currently experiencing trauma that negatively impacts their ability to fully participate in services along the HIV continuum of care, particularly their ability to achieve and maintain viral suppression.

As the CQM Committee initiated the “Improving Utilization of Emergency Financial Assistance” quality improvement project in September 2019, it collected and reviewed data, including studying the 1,149 Ryan White clients who accessed and utilized EFA services between FY17 and FY21, to identify possible barriers that limited access to and utilization of EFA services. Between October 2019 and February 2020, several Ryan White providers conducted root cause analyses with their clinical staff, administrators, and clients, which were subsequently synthesized into one comprehensive root cause analysis. The CQM Committee then reviewed/discussed and utilized it as a point of reference on multiple occasions.

The committee also consulted with the National Alliance on Mental Illness (NAMI), the agency that processes and approves/rejects EFA applications in San Diego County. The CQM Committee’s review of the data and its discussions with providers and content experts helped it identify several potential barriers that affected how EFA was accessed and utilized by Ryan White clients.

Equipped with these findings, the CQM Committee prepared to select an intervention that would aim to alleviate and/or eliminate one or more of the barriers identified by the CQM Committee during the planning stages of the quality improvement project, but its efforts were thwarted in March 2020 by the COVID-19 pandemic, which prevented the CQM Committee from meeting for the next three months. Upon reconvening in June 2020, the CQM Committee faced a new EFA landscape. In response to the unprecedented nature of COVID-19 and the problems and dangers it created for Ryan White clients, the Recipient and the HIV Planning Group had already implemented several changes to the EFA program beginning in March 2020. Between March 2020 and June 2020, the Recipient and the HIV Planning Group updated the services funded under Emergency Financial Assistance and temporarily adjusted several programmatic guidelines and expectations. Many Ryan White clients and providers had previously identified existing EFA guidelines as overly-restrictive and/or overly-bureaucratic, so as part of its COVID-19 response, the Recipient suspended EFA application requirements that required applicants prove they weren’t “living beyond their monthly income,” required applicants to provide proof in the form of 3-day shut off notices or notices to pay rent or quit, or that an unexpected and non-recurrent financial emergency would be fully resolved by the allocation of EFA funding. Just as important, HSHB also increased its annual EFA utilities disbursement limit to \$1,000 and granted EFA referral authority to medical and non-medical case managers and peer navigators, thereby creating more opportunities for even more Ryan White clients to learn about, access, and utilize EFA services in San Diego County.

As the CQM Committee reconvened in June 2020 after a 3-month hiatus due to the emergence of the COVID-19 pandemic, it surveyed the new public health landscape in San Diego County. The committee subsequently took time to identify and study how the HSHB-

implemented EFA and EHA changes enacted between March 2020 and June 2020 affected the trajectory of the “Improving Utilization of Emergency Financial Assistance” quality improvement project.

At the request of the committee, the CQM Coordinator outlined all the programmatic modifications enacted by the Recipient during the nascent days of the COVID-19 outbreak as it attempted to simultaneously navigate and mitigate the pandemic’s worst effects. The analysis identified both the temporary and permanent changes implemented by the Recipient, assisting committee members as they grappled with understanding how and in what ways the EFA program had fundamentally changed over the course of 2020.

Over the next several months, the CQM Committee will finalize the “study” and “act” stages of the EFA quality improvement Plan, Do, Study, Act (PDSA) cycle, which will include examining data on both the number of unduplicated clients accessing Emergency Financial Assistance and the frequency to which those clients were utilizing the services between September 2019 and August 2021. The committee will also analyze if and to what extent EFA utilization changed after the Recipient implemented its responses to the COVID-19 pandemic. The CQM Committee will then subsequently produce a final report that presents programmatic data, identifies PDSA successes and recommended best practices, and addresses challenges and barriers moving forward.

In March 2021, as the CQM Committee initiated the second quality improvement project, “Acknowledging Trauma and Improving Viral Load Suppression among Housing Insecure Ryan White Clients,” which is also a collaboration with the Center for Quality Improvement and Innovation’s (CQII) create+equity Collaborative. The committee conducted a root cause analysis that explored the factors negatively impacting viral suppression rates for Ryan White clients in San Diego County who are currently temporarily or unstably housed. As the committee deliberated over the findings of the fishbone, five potential areas for improvement were identified. They included: (dis)alignment between provider goals and processes and patient expectations, service provision coordination, patient and provider communication (both interpersonal and institutional), trust-building between agencies and between patients and providers, and provider and recipient administrative policies and procedures.

As the CQM Committee then moved toward selecting an intervention for the quality improvement project, it consulted a list of potential interventions provided by CQII as part of the create+equity Collaborative. After additional discussion and debate that highlighted how several of the problems identified during the root cause analysis stemmed from potential disconnects between the goals and treatment strategies of clients and providers, the committee selected “Trauma-Informed Approaches” as the intervention for the project.

Over the next several months, as the CQM Committee continues to plan for the “do” phase of the PDSA cycle, it will consult with consumers to not only identify their service provision needs and concerns, but also partner with them to solicit feedback and guidance that will help inform how the committee develops and implements the quality improvement project. The committee will then finalize its AIM statement, gather the appropriate benchmark data, initiate and evaluate the chosen intervention strategy (“do” phase), and conclude the PDSA cycle (“study” and “act” phases) by producing a final report, implementing recommended changes, and establishing one or more new best practices for increasing the viral load suppression rates of housing insecure Ryan White clients in San Diego County via a more trauma-informed service delivery model.

ORGANIZATIONAL INFORMATION

A. Grant Administration

1) Program Organization

a) How RWHAP Part A funds are administered

Part A and Minority AIDS Initiative (MAI) funds received by the County of San Diego's Board of Supervisors are administered by the HIV, STD and Hepatitis Branch of Public Health Services (HSHB), a department within the Health and Human Services Agency. To assure these funds are managed appropriately, in-kind support is provided by several County departments, including the Health and Human Services Agency Financial and Support Services Division, Agency Contract Support, Public Health Services Administration, the Department of Purchasing and Contracting, Risk Management and the Auditor and Controller's Office. All original procurement and contract documents are electronically maintained, per established and approved records retention requirements, by the Department of Purchasing and Contracting. The documents remain electronically accessible not only to all Health and Human Services Agency offices, but also to members of the public.

As shown in Attachment 1, the recipient team responsible for Part A administration totals .96 full time equivalent (FTE) positions, including partial FTEs for the Chief, Assistant Medical Services Administrator, Principal Administrative Analyst, Community Health Program Specialist, and six Administrative Analysts for fiscal and contract responsibilities. MAI administration totals 0.29 FTE including partial FTEs for the Community Health Program Specialist, Principal Administrative Analyst, and six Administrative Analysts for fiscal and contract responsibilities.

The Chief, Assistant Medical Services Administrator, and Community Health Program Specialist have primary responsibility for liaison activities with local HIV Planning Group support staff. Additionally, all recipient staff interact with support staff as needed to clarify planning body direction or provide answers to questions concerning distribution of funds. Table 10 depicts recipient administration tasks and responsible parties.

Consistent with local ordinance and civil service rules, all vacant County positions are filled using processes overseen by the County of San Diego's Department of Human Resources. Employee recruitment is initiated by a personnel requisition listing the vacancy, budget limitations, special position requirements, and hiring contact. Recruitment consists of posting the vacancy on the County website and, when necessary, other online recruitment sources, including career placement centers at local community colleges and universities. Staff members within the Department of Human Resources rate candidates' qualifications and experience relative to the requirements of the position. Candidates meeting minimum requirements are placed on a list of persons eligible for interview. After interview and selection, the chosen candidate is then subject to a rigorous background check. Upon notification the chosen candidate has passed the background check, the requesting office is then authorized to issue an employment offer to that candidate.

HSHB also contracts with three fiscal intermediaries. United HealthCare serves as the claims administrator for Outpatient/Ambulatory Health Services, oral health care and psychiatric services. AIDS Healthcare Foundation serves as the claims administrator for Outpatient Medical Specialty, Oral Health Specialty, Home Health and Home Hospice services. Finally, the National Alliance on Mentally Illness of San Diego serves as the fiscal intermediary for housing, emergency financial assistance, and inpatient substance use treatment.

All subrecipients are required to conduct background checks, including criminal histories, federal exclusion/debarment lists, and the State of California Medi-Cal suspension websites. If the position requires a professional license, the State of California license list for that profession must also be checked. Administrative Analysts confirm that exclusion/debarment/Medi-Cal and professional license requirements are met during annual programmatic site visits. Additionally, Administrative Analysts verify subrecipient professional staff license information once per year by using the applicable State website.

Table 10: Program Administration Staff and Tasks

TASKS	RESPONSIBLE PARTY
Accounting and contracting responsibilities	Administrative Analysts
Contract development	Chief, Assistant Medical Services Administrator, Principal Administrative Analyst, Community Health Program Specialist, and Administrative Analysts in coordination with Public Health Services Administration and Department of Purchasing and Contracting
Monitoring of monthly invoices and expenditures and verification of payments	Fiscal Administrative Analyst in coordination with Financial and Support Services Division, and Administrative Analysts
Collecting information for HRSA reports and payment drawdowns	Community Health Program Specialist, Assistant Medical Services Administrator and Chief for program components of reports. Fiscal Administrative Analyst in coordination with Financial and Support Services Division for fiscal reports and payment draw downs
Assuring required activities are conducted under the Clinical Quality Management Program	Chief, Assistant Medical Services Administrator, Principal Administrative Analyst, Community Health Program Specialist and Administrative Analysts

b) Administration of Part A funds

Ryan White HIV/AIDS Program Part A funds are administered by the County of San Diego, not by a contractor or fiscal agent.

2) Grant Recipient Accountability

County of San Diego, Agency Contract Support (ACS) is part of the Health and Human Services Agency (HHS) management controls and provides contract support and oversight. ACS ensures that contracted services are managed, monitored, delivered and paid appropriately. ACS facilitates contract administration across HHS, as well as between County departments responsible for County contracting policies and procedures.

ACS is the HHS lead for contracting policies, procedures and protocols. ACS maintains Policies for Administrative Management, Contract Project Planning, Procurement, as well as Contract Administration Monitoring. Bulletins are also issued to coordinate periodic updates and implement approved changes.

The ACS Coordination Unit conducts annual Quality Assurance (QA) Reviews for each of the HHS Regions/Divisions. For those larger Regions/Divisions, and/or those that have a large number of contracts, two QA Reviews are conducted per Fiscal Year. The purpose of the QA Reviews is to ensure that Regions/Divisions are adhering to the HHS contracting policies and procedures and that contracting functions are carried out in accordance with the funding source established standards.

Each County contract has an assigned Contracting Officer's Representative (COR) who is the primary County contact for the provider. CORs have overall responsibility for administering contracts, which includes, but is not limited to, contractor orientations, monitoring assessment, development of monitoring plan, performance of required monitoring activities, periodic meetings with provider groups, compliance and quality assurance monitoring of contract Statements of Work, performance of in-depth invoice reviews, and review and approval of contractor budgets and invoices. The COR confirms the contractor's performance of criminal background check and exclusion/debarment/Medi-Cal screening, and monitors contract compliance, deliverables and outcomes through annual site visits and desk reviews.

All monitoring activities are based upon the assessed risk of each subrecipient. All subrecipients receive at least one programmatic site visit per year and one fiscal visit (known as an "in-depth invoice review") per fiscal year. Subrecipients that have been assessed as having higher risk have more programmatic and fiscal site visits scheduled annually. All site visits are conducted according to policies established by Agency Contract Support. The Recipient uses a site visit monitoring tool developed specifically to ensure compliance with the National Monitoring Standards for Ryan White Part A and Agency Contract Support policies and procedures.

Programmatic site visits focus on program performance (i.e., whether the program is meeting goals related to service delivery) and compliance with federal and other programmatic requirements (i.e., client eligibility assessment and documentation). In-depth invoice reviews look at invoices from two non-consecutive months and the supporting documentation related to those invoices. Contract auditors and Administrative Analysts who monitor the contracts, inform subrecipients in a report of any financial or program findings to be corrected. A Corrective Action Notice (CAN) is issued and contractors are given 30 days to respond and/or correct any issues with a Corrective Action Plan. Administrative Analysts and Contract auditors follow up with subrecipients within 30 days to receive verification in writing that any findings are corrected and if applicable, any inappropriate charges are reimbursed. Fiscal intermediary contracts are monitored with the same standard as all of our other service delivery contracts. Follow ups to recommendations pertaining to any of the programs are made by phone call, email, letter and/or during a contract audit to ensure that planned corrective action(s) have been implemented.

All competitive procurement documents, contract documents, monitoring reports and supporting documents are kept on file according to County's retention schedule.

a) Monitoring

i. Subrecipient monitoring during FY2021

For the FY2021 program year, site visits were not completed due to the COVID 19 pandemic. HRSA and the County of San Diego waived the annual subrecipient site visit monitoring requirement. However, County of San Diego continued to monitor subrecipient performance and compliance. In lieu of site visits, desk reviews were performed. Desk reviews included review of

program deliverables, monthly expenditures, background checks, EDM checks, in-depth invoice reviews, and insurance compliance reviews. In addition, virtual meetings were conducted to review and verify inventory, or address any program questions or concerns. Weekly provider meetings were conducted, and technical assistance was available to all providers.

ii. Process for ensuring subrecipient compliance with the single audit requirement

Agency Contract Support provides coordination and oversight of contracting processes for the entire Health and Human Services Agency (HHS). Because a single provider might hold multiple contracts with the HHS, Agency Contract Support ensures compliance with all entity-level requirements, such as insurance requirements as well as single audit requirements. Currently, all Ryan White Part A recipients which meet the dollar threshold for single audits, as outlined in 45 CFR Part 75, are required to submit the audits to Agency Contract Support. The Contracts Audit Unit is responsible for conducting financial and compliance audits of HHS contractors. The audits focus on the organization internal controls, accounting system, cost allocation plans, indirect rates, allowable contract expenses and compliance with federal cost principles and OMB Circulars. A risk assessment is performed annually to determine which contractors will be included on the Agency Contract Support audit plan. The risk assessment considers contract portfolio value, funding source, fiscal solvency, Single Audits filer, and prior issues. The audits may be conducted at the contractor's site or as a desk review.

The Contracts Audit Unit also has the responsibility for the centralized collection and review of all HHS contractor's independent financial statement audits and Single Audits. Contractors must submit their annual audits to Agency Contract Support each fiscal year as required by the contract. The Contracts Audit Unit also performs and presents financial evaluations of potential contractors during the procurement process.

iii. Description of what is done to ensure subrecipients take appropriate corrective actions for findings

After review, Agency Contract Support notifies the HIV, STD and Hepatitis Branch of any material and non-material findings that might impact funded programs. The Single Audit report for period ending June 2021 is not finalized yet, but the most recently completed single audit report for the period ending June 2020 identified three non-material findings for two Part A subrecipients. The first subrecipient had two financial statement findings regarding segregation of duties and account reconciliation. The second subrecipient had one financial statement finding regarding IT General Controls for Retirement System. For both subrecipients corrective action plans were prepared to prevent the finding from recurring and follow up to audit recommendations were made to ensure that planned corrective action(s) were implemented.

In the case of findings, the Recipient works with subrecipients to address the causes of the findings and provide assistance, if needed. Assistance could include training, technical assistance, and/or requirements for implementation of specific policies and procedures. Audit findings, depending upon their nature, can also impact how the County of San Diego assesses the risk of the subrecipient. Increases in the risk assessment lead to more frequent monitoring activities. Ongoing contract monitoring ensures compliance with Federal, State and local regulations.

b) Third Party Reimbursement

i. Process used to ensure that subrecipients are pursuing third party reimbursement

All Part A and B subrecipient contracts contain payor of last resort language. For example, contracts require HIV Outpatient/Ambulatory Health Services providers to screen applicants for whether they have existing medical coverage, such as employer-based health coverage or Medicare, and, if the applicant does have other coverage, they are expected to utilize those coverage sources or refer those applicants to medical providers within their plans. Applicants who report not having medical coverage are screened for eligibility for Medi-Cal (Medicaid), and if they are eligible, they can be enrolled temporarily in Ryan White to ensure that they begin care while the Medi-Cal eligibility determination is completed. For these clients, once Medi-Cal has been approved, providers are required to back-bill for any services provided and paid through Ryan White during the eligibility determination period; generally, Medi-Cal approvals are retroactive to the beginning of the first full calendar month prior to the approval date. The Administrative Services Organization is notified when an applicant is referred to Medi-Cal and monitors the Medi-Cal application process to ensure compliance. Screening is documented on the Ryan White Outpatient/Ambulatory Health Services application and is maintained in the client's file. Persons living with HIV with private health insurance are not eligible for Part A medical coverage and are linked to HIV service providers within their health care system. In compliance with HRSA directives, patients eligible for health care through the Veterans Administration or Bureau of Indian Affairs are nonetheless eligible to receive Part A Outpatient/Ambulatory Health Services if the client prefers. Clients who are eligible to enroll in Covered California (marketplace options for health care coverage) are encouraged to apply but not required to apply as a condition of receiving Ryan White. Compliance with these requirements is monitored annually during site visits.

i. Federal Poverty Level to determine eligibility

Consistent with the poverty level used by the California Department of Public Health for Ryan White Part B programs, San Diego County has established 500% of the federal poverty level or less as the income eligibility criterion to receive Ryan White services.

To assist with assuring payer of last resort compliance, every six months the Administrative Services Organization checks the current Outpatient/Ambulatory Health Services client eligibility list against client records of other medical providers, including Medi-Cal, Aetna, Cigna, HealthNet, Humana, Pacificare, Blue Cross of California, Blue Shield of California, Tricare, and Kaiser. Primary care patients found to have other coverage are removed from eligibility.

ii. How the source and use of any program income earned is monitored and tracked

Currently, subrecipients assess fees related to any service funded by Ryan White for clients who have income greater than 100% of the federal poverty level. However, subrecipients do not deny services based on a client's ability to pay. During annual site visits and quarterly unit cost price reconciliations with actual expenditures the Contract Officer Representative (COR) and the supporting Administrative Analyst confirm whether a program income is generated by a subrecipient and work with providers on proper tracking, reporting and use of generated income, if any. At year end subrecipients are required to provide final reconciliation of actual expenditures to unit cost price and return or use any generated program income. Any excess amounts that have been returned by subrecipients are reconciled with final cost report and grant drawdown and sent back to HRSA.

c) Fiscal Oversight

i. Coordination of fiscal activities. Recipient fiscal staff includes the Principal Administrative Analyst, Fiscal Administrative Analysts, and Financial and Support Services Division staff. The County of San Diego utilizes several systems to track, reconcile and report all program related finances to ensure appropriate expenditure of Part A, MAI and carryover funds. The County separately tracks expenditures in an Oracle Financials Application System (Oracle) using a Work Breakdown Structure methodology. Ryan White Part A funds are assigned a distinct task number to track related expenditures separately from other funding sources. Expenditure information is downloaded from Oracle to Excel spreadsheets for quarterly reconciliations and reporting of all costs. These Excel spreadsheets are prepared by the Financial and Support Services Division (FSSD) staff, they are reviewed by Fiscal Administrative Analysts and approved by Principal Administrative Analyst and Assistant Medical Services Administrator prior to the reimbursement drawdown from the Federal Payment Management System. Unspent funds are tracked in Oracle and on Excel by the Financial and Support Services Division and the Fiscal Administrative Analyst. Senior Accountant and Principal Administrative Analyst, provide oversight and make sure expenditures are tracked correctly and reports are prepared timely and accurately. Reports are generated monthly, quarterly or upon request.

In response to the COVID-19 pandemic, with many County and subrecipients staff teleworking, internal processes and procedures have been updated to reflect e-signatures and proper workflow in order to maintain normal operations. HSHB utilizes Microsoft Teams software to conduct voice communication and face-to-face meetings with internal staff and providers.

Recipient program, contract administration and fiscal staff meet monthly to review and assess subrecipient expenditures, and any formula and supplemental unobligated balances. Recipient managers meet monthly to assess fiscal status and review detailed fiscal reports. The Principal Administrative Analyst meets weekly with the Fiscal Administrative Analysts to discuss contract administration and fiscal impacts. The virtual meeting software enables the Principal Administrative Analyst and Lead Fiscal Administrative Analyst have immediate access to the Chief and Assistant Medical Services Administrator in case of urgent issues.

To ensure timely monitoring and redistribution of unexpended funds, recipient staff meets monthly through MS Teams to review expenditures and identify trends, and projected shortfalls, in spending for each service category. When a service category is identified as being overspent in relation to the amount of time elapsed in the contract period, staff identifies the causes and, if justified due to higher client demand or cost of services, presents a recommendation for action items to reallocate funding and allocates funds from an under-spent service category upon HIV Planning Group approval. To assist in meeting timeliness requirements, the HIV Planning Group has authorized the Chief to transfer up to \$50,000 among service categories without prior planning body approval. Contract amendments to move funding are planned in advance to allow for the County's processing time and to allow adequate time for the subrecipient to then utilize the funds by the end of the contract term.

ii. Fiscal tracking. The Recipient tracks Part A, MAI and carryover funds separately. Each funding source has a spreadsheet categorizing award amounts and showing HIV Planning Group allocated dollars for each service category, the subrecipients that comprise each service category, the Administration portion, and Clinical Quality Management part. Each component has a

beginning balance with an allocated dollar amount, allocation changes, month-by-month expenditure, year-to-date expenditure, remaining balance, and percent of funds expended. The HIV, STD and Hepatitis Branch tracks Part A formula and supplemental funding allocations and expenditures and the goal is to expend 95% of all formula funds prior to expending supplemental funds.

For reporting requirements, service contract expenditures are tracked by the Recipient on a monthly basis. County of San Diego administration and Clinical Quality Management costs are tracked by the Financial and Support Services Division on a quarterly basis. All spreadsheets are reconciled with Oracle Financial system and provider invoices before submitting for drawdown. This monitoring process allows the Recipient to have current information in order to make informed redistribution decisions with timely authorization and planning body direction.

iii. *Reimbursement.*

Subrecipients are required to submit invoices, using a Recipient-designed invoice template, by the 10th calendar day after the end of the reporting month in which services are provided. The assigned Administrative Analysts' date-stamp invoices upon receipt and then reviews and provides a preliminary approval as reasonable, allocable, and allowable expenditures. If issues are identified, the Administrative Analyst contacts the subrecipient for clarification/ additional documentation to support their invoice. If issues are not resolved, the Administrative Analyst elevates the concerns to the Fiscal Administrative Analysts and Principal Administrative Analyst. Once the review is completed, and requested clarification/documents are received, the invoice is sent to the Contracting Officer's Representative (COR) for final approval and signature, authorizing the payment. One of the Fiscal Administrative Analysts enters invoices into the internal payment tracking spreadsheet before sending the COR approved invoice to the Financial Support Services Division (FSSD) for payment processing. Disallowed expenses are reported to the subrecipient according to Recipient policy. FSSD personnel date-stamp invoices upon receipt and process the invoices for payment in Oracle using net 30 payment terms, according to contract documents. Invoices are entered into Oracle for payment via checks or Electronic Fund Transfer to the subrecipient. The Fiscal Administrative Analysts forward the invoice payment documentation to the Administrative Analysts who check Oracle to confirm the subrecipient has been paid and note the date paid and the amount. Following confirmation that the payment has been made, the Administrative Analyst maintains the invoice copies in the subrecipient files.

In response to the COVID-19 pandemic, a system was developed to process invoices entirely through electronic means due to recipient and subrecipient staff teleworking. Utilization of this system enabled timely processing of Ryan White Part A invoices and established a protocol to follow in the event of future need.

Invoices for the final month of the Ryan White fiscal year are sent to FSSD flagged as "Priority Validation", identifying the invoice as one that should be given priority for processing. By using this method, payments can be issued quickly and reflected in ORACLE. This practice assists with preparing the Ryan White Part A final quarterly cost report and yearend reporting requirements.

B. Maintenance of Effort (MOE)

See Attachment 12 for Maintenance of Effort table and a description of the process and elements used to determine the amount of expenditures in the MOE calculations.