



EAST BAY HIV STRATEGIC PLAN, 2021-2025

[Haga clic aquí para el plan en español. Click here for updates and to send feedback.](#)

OVERVIEW

In 2020 the United States launched a bold new HIV public health partnership called **Ending the HIV Epidemic (EHE): A Plan for America**, a ten-year nationwide initiative with the goal to achieve a 90% reduction of new HIV infections by 2030. The East Bay was identified as one of the 57 geographic areas in the US most heavily impacted by HIV transmissions and is supported by the national EHE initiative to develop and implement a local EHE plan.

East Bay Getting to Zero is the community coalition developing the EHE plan for Alameda and Contra Costa Counties. This is a community-driven “living” East Bay HIV strategic plan that is flexible and responsive to local needs, addresses structural inequities, and is used to make systemic change to achieve our vision of an East Bay with zero HIV stigma, zero health disparities, and zero new HIV transmissions.

Our core values of equity and healing include work that is people-first, trauma-informed, healing-engaged, anti-racist, sex positive, community-driven, data and science-driven, adaptive and resilient.

STRATEGIC PRIORITIES

OUR MISSION IS ADVANCING HEALTH EQUITY AND HEALING THROUGH:



COMMUNITY MESSAGING

- Determine messages that are inclusive and multilingual.
- Collaborate with local PLWH, youth, and other key cultural influencers.



IMPROVING COLLABORATIONS

- Build EBGZ.org to be an easy place to find local services, contacts, events, and resources.
- Strengthen warm hand-offs and rapid linkages to services.



INNOVATIVE MODELS

- “Test-everywhere,” including at home and other non-clinical community settings.
- Integrate HIV and PrEP linkages into other services.



YOUTH ENGAGEMENT

- Convene a regional youth and youth-serving provider network.
- Integrate youth-led community messaging.



HOUSING INITIATIVES

- Coordinate HIV and housing services and cross-train staff.
- Explore housing policy changes to increase safe and accessible housing.

Long-term goals
aligned with national
Ending the HIV
Epidemic (EHE) goals

- ≥75% reduction in new HIV infections
- 95% of people living with HIV know their HIV status
- 95% of people living with HIV are receiving HIV medical care
- 90% of people living with HIV are virally suppressed
- ≥50% of people with PrEP indications are on PrEP

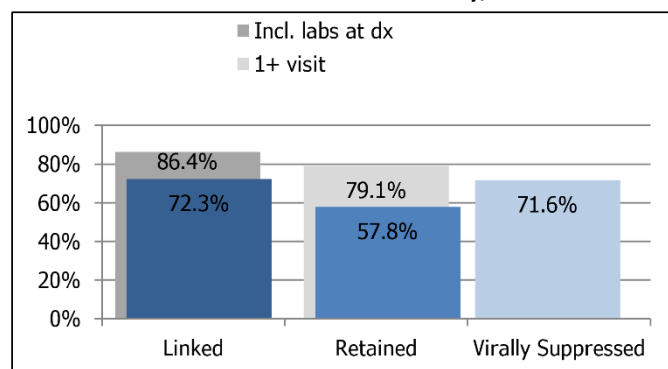
STRENGTHS AND OPPORTUNITIES

Strengths	Opportunities
<ul style="list-style-type: none"> Shared core values around equity and healing as described above. Coalitions: Linkage and retention network since 2011 working on warm handoffs, rapid linkage. PrEP network since 2017 scaling up PrEP services. East Bay Getting to Zero network since 2017. Strong, resilient community-based organizations with deep commitment to equity. Multiple HIV PrEP and care clinical sites with expert teams, including EtHE and Ryan White Parts A/B/C/D-funded sites, community health centers, public and private hospitals. Universal HIV testing projects in Alameda Health Systems and (previously) Sutter hospital emergency rooms, community health centers and street/shelter teams. Meeting people where they're at: community-based HIV testing and education projects. Public health departments committed to equity and addressing disparities. 	<ul style="list-style-type: none"> Confusing, complex, fragmented health insurance system. Complex and uncoordinated health service delivery system. Organizational and departmental silos. Competition for limited grant funds. Structural inequities: racism, sexism, classism, heterosexism, transphobia, xenophobia. Stigma and judgment: HIV-related and others related to structural inequities above. Unaddressed and inadequately addressed social determinants of health. Unmet needs in secure housing, mental health and substance use services. Barriers to services due to immigration status and lack of language access.

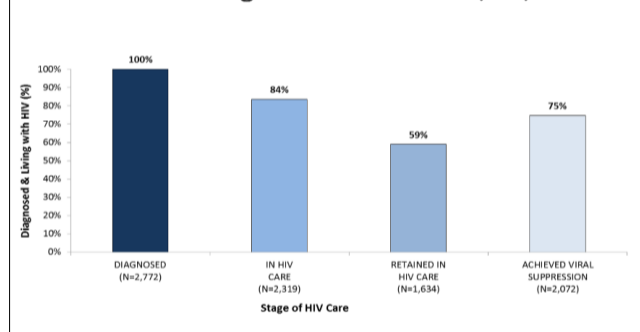
CONTINUUM OF HIV CARE, DATA, GAPS AND DISPARITIES

(detailed references [here](#))

Continuum of HIV Care in Alameda County, 2016-2018



Contra Costa County Continuum of Care
All Persons Living with HIV as of 12/31/2018



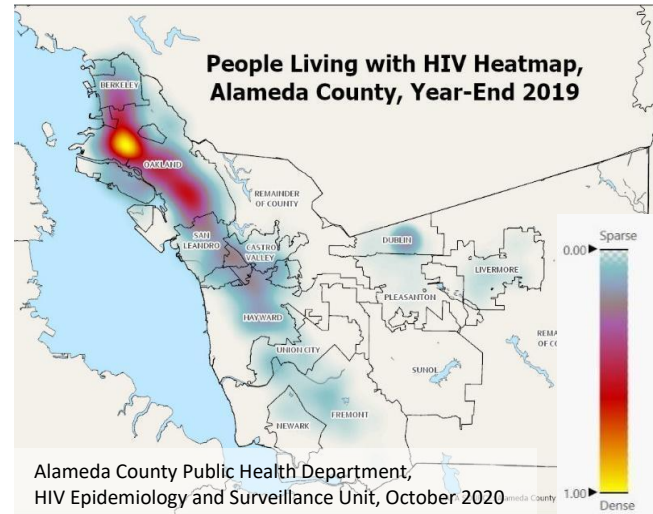
Alameda County data are from *ACPHD HIV in Alameda County, 2017-2019*, published December 2020. Contra Costa County data are for people diagnosed with HIV as of December 2018; data prepared October 2020.

Gaps in care to address in both counties combined:

- 309 people were newly diagnosed with HIV in 2018 and 299 in 2019.
- An estimated 1,369 people living with HIV (PLWH) are not yet diagnosed and
- 2,574 PLWH are not virally suppressed.
- 1,874 PLWH were not virally suppressed in Alameda County in 2018.
- 700 PLWH were not virally suppressed in Contra Costa County in 2018.

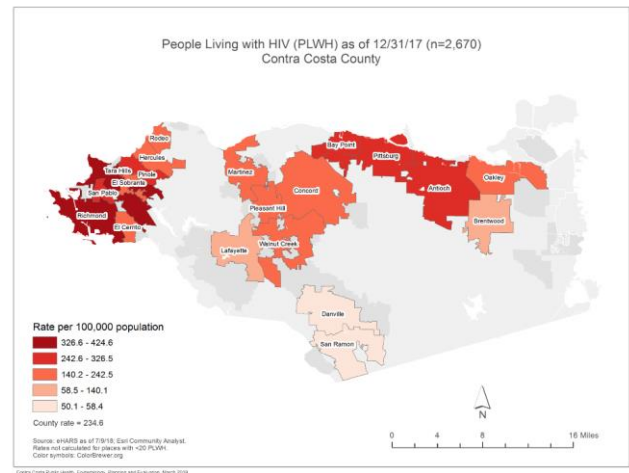
Alameda County-wide data are from *ACPHD HIV in Alameda County, 2017-2019*, published December 2020.

- There have been **199-300 new HIV diagnoses per year since 2006: 199 in 2018; 227 in 2019.**
- In 2019, there were **6,350 people living with HIV (PLWH)**; 380 PLWH per 100,000 (0.4%) residents.
- **Among people diagnosed 2017-2019:** 85% male sex at birth; 63% MSM (men who have sex with men); 36% African American; median age 33.
- **People living with HIV in Alameda County primarily live along the 880 corridor**, especially in Emeryville, downtown, West and East Oakland.



Contra Costa County-wide data are from the Contra Costa Public Health Epidemiology team, October 2020.

- There were **113 new diagnoses in 2018; 95 in 2019.**
- In 2019, there were **2,797 people living with HIV.**
- **Among people diagnosed 2017-19:** 86% cis male; 64% MSM; 28% African American; 27% ages 30-39.
- **People diagnosed 2016-18 live mostly in West County**, especially in the cities of Richmond and San Pablo. A second area with higher numbers of PLWH is in the cities of Pittsburg and Antioch.



SUMMARY OF KEY COMMUNITIES AND CORE VALUES

Key communities with disparities in HIV diagnosis	Key communities with disparities in HIV care	Core values
<p>People with disproportionately high HIV diagnoses:</p> <ul style="list-style-type: none"> • Black/African American people, including women • Latinx people • Youth/young adults (ages 20-39) • Transgender people • Men who have sex with men • People who use drugs • People who are incarcerated • People experiencing homelessness <p>Disproportionate late diagnoses:</p> <ul style="list-style-type: none"> • Older adults (ages 50+) • Latinx people • Asian and Pacific Islander people <p>Please see references here.</p>	<p>People less likely to be linked to care:</p> <ul style="list-style-type: none"> • People diagnosed in EDs • People who use drugs • People with mental health conditions <p>Less likely to be retained in care:</p> <ul style="list-style-type: none"> • Transgender people • People ages 20-29 > ages 30-39 • Uninsured people <p>Less likely to be virally suppressed:</p> <ul style="list-style-type: none"> • MSM who inject drugs • People ages 13-24 > ages 30-39 • People with Medi-Cal <p>Please see references here.</p>	<p>Focus on Equity and Healing by being:</p> <ul style="list-style-type: none"> • People-first • Trauma-informed • Healing-engaged • Anti-racist • Sex positive • Community-driven • Data and science-driven • Adaptive and resilient

STRATEGIC PRIORITIES, ACTIVITIES AND METRICS



Community Messaging	
Vision	An East Bay-specific campaign that includes multigenerational, multicultural and multilingual messaging that inspires hope and reaches all our communities.
Top priorities	<ol style="list-style-type: none"> Determine messages for the East Bay that reflect our diversity, are multilingual, inspire hope, break stigma, reach all communities on U=U/i=i and PrEP-for-All. Engage local civil & government leaders, sports figures, creatives, PLWH, youth and other influencers in this process and leverage political will to amplify our messages.
Equity Activities	<ul style="list-style-type: none"> Create messaging in Spanish from a Latinx cultural perspective (not translated). Same for other languages used in messaging campaigns. Integrate PLWH leadership, diverse community voices, patient/client lived experiences to create messaging that reflects and reaches all key communities. Strategically place messaging in public spaces, facilities, and social services agencies to reach those with limited technology and media access. Engage community gatekeepers, faith leaders, house ball community members, etc. by developing messaging materials and/or “care packages.”
Additional details	<p>Determining messages:</p> <ul style="list-style-type: none"> Interweave HIV messaging with STD, COVID-19 and other intersectional topics. Engage both youth and parents/guardians/adult family members using separate messaging to increase support for youth engagement and reduce stereotypes and stigma. <p>Message dissemination:</p> <ul style="list-style-type: none"> Engage local influencers including network members, PLWH, women, youth, political leaders, creatives, and sports influencers. Commission and curate art and music from the community, including Alameda, Contra Costa and Solano counties. Identify and integrate messaging into existing popular media, such as Instagram and Facebook Live, YouTube, and Spanish-language media.
Structural change	Cultural shifts to normalize HIV testing, prevention, care and destigmatize HIV.
Metrics, evaluation and improvements	<ul style="list-style-type: none"> Short-term (quarterly): <ul style="list-style-type: none"> Track and increase engagement on digital media platforms. Track placement and community response to non tech-based messaging campaigns in community spaces. Evaluate demographics of viewers when possible. Make adjustments to increase engagement in key communities. Medium-term (2-5 years): Increase HIV testing, PrEP uptake, Viral Load Suppression rates among key populations. Long-term: Decrease new HIV diagnosis rates.



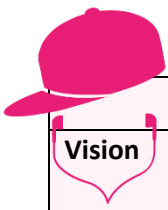
Improving Collaborations

Vision	A collaborative community of HIV service organizations, advocates and community members who work together on common goals and amplify each other's work.
Top priorities	<ol style="list-style-type: none"> 1. Build EBGTZ.org to become an easy place to find services and contacts, local events, resources and resource guides. Include materials created in Spanish. 2. Hold quarterly collaborative meetings to discuss shared goals, service directory, resources, strengthen warm handoffs & referrals, collaborative funding and events.
Equity Activities	<ul style="list-style-type: none"> Pursue funding opportunities that promote collaborations, measure quality over quantity, and prioritize collaboratively addressing needs and gaps in network of care over competition for funds. Improve the linkage process for patients diagnosed in the Highland Emergency Department who are disproportionately affected by persistent and severe mental health diagnoses, substance use disorders, and chronic housing instability. Provide ongoing training and dialogues about structural racism, sexual orientation and gender identity, and sensitive services for youth across our network. Hire multilingual and bicultural staff to normalize the use of Spanish and other languages as well as integrate diverse perspectives.
Additional details	<p>EBGTZ.org events calendar, service directory and guides:</p> <ul style="list-style-type: none"> Ensure agencies and advocates working with key communities provide input and learn from each other's work, collaborate on projects and coordinate efforts. Update the community events calendar and service directory at quarterly meetings. Collaborate on community events such as World AIDS Day, HIV testing days, etc. Ensure all agencies in the EBGZ lists are included in the directory and guides. Create East Bay (and eventually Bay Area-wide) resource guides, with one for community members and one for agencies to support referrals/coordination. <p>Strengthening warm hand-offs and rapid linkages:</p> <ul style="list-style-type: none"> Actively address gaps in linkages from the Highland Emergency Department (ED) and ensure Highland teams are integrated into the linkage and retention group. Prioritize client preferences and support choice when making linkages/referrals.
Structural change	<ul style="list-style-type: none"> Transparency in programs: Make all HIV services, resources and events freely accessible and transparent to all community members and healthcare staff. Continue to allow verbal consents from clients rather than requiring written consents when facilitating access to social services or coordinating care. Network-wide investment in improvements for linkages from the Highland ED. Grant/funding system revisions to integrate collaborations and prioritize collaboratively addressing needs and gaps over competition for funds.
Metrics, evaluation and improvements	<ul style="list-style-type: none"> Short-term (quarterly to biannually): <ul style="list-style-type: none"> Track service directory, event calendar and resource web page views. Review and update service directory and resources at quarterly meetings. Make updates to keep directory, calendar and resources current. Medium-term (2-5 years): <ul style="list-style-type: none"> Increase linkage and retention rates, especially from the Highland ED. Increase number of grant-funded collaborative projects. Increase HIV testing, PrEP uptake and HIV treatment rates. Long-term: Decrease new HIV diagnosis rates.



Innovative Service Models

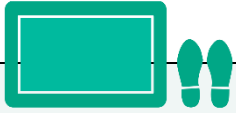
Vision	Healing-centered, integrated HIV prevention and care services anywhere and everywhere for all people, including rapid testing, same-day PrEP, rapid ART.
Top priorities	<p>1. Regional “test-everywhere” strategy: home testing and linkage protocol, cross-county referral system, address gaps in lab-based testing, and provide streamlined access regardless of immigration status.</p> <p>2. Integrate HIV and PrEP linkages into other services such as housing, food, re-entry and COVID testing with clear referral/linkage person for every organization.</p>
Equity Activities	<ul style="list-style-type: none"> ● Integrate PLWH leadership and voices from key communities to design new models of care and to identify which models work. ● Ensure services are holistic, trauma-informed, healing-engaged and people-centered. Include services addressing intersectional social determinants of health including immigration, housing, employment and insurance status in client care. ● Develop healing-centered one-stop shop model for LGBTQ-centered care. ● Design outreach activities that partner healthcare and community-based organizations together at local community events; reach community members where they are with health education and linkages to care focusing on: <ul style="list-style-type: none"> ○ streamlined and rapid benefits enrollment and ○ same-day access to mental/behavioral health and substance use services.
Additional details	<p>“Test-everywhere” strategy details:</p> <ul style="list-style-type: none"> ● Develop and publicly share home testing protocols, including the Contra Costa County “Home is where the swab is” and the Alameda County “Take Me Home” test kits. ● Develop and implement a cross-county linkage and referral protocol. ● Develop a plan to provide and/or fill gaps in phlebotomy (blood-draw) services for home-testing and STI swab collection at labs. ● Develop a system for tracking tests and outcomes – and for evaluating culture/stigma change, sex positivity, acceptability and improvements. <p>Integrating HIV and PrEP services into other services – more details:</p> <ul style="list-style-type: none"> ● Build one-stop shops with integration of multiple service needs whenever possible. ● Ensure that there is always a clear linkage to care information available for anyone conducting home/self-testing and wherever HIV tests are available. Distribute all self-test kits with a clear PrEP/HIV linkage contact attached. ● Integrate HIV and PrEP services into other services, such as housing, food, re-entry and COVID testing. Train staff and modify work flows to include HIV/STD history, testing and streamlined referral as part of intake in these settings.
Structural change	<ul style="list-style-type: none"> ● Support change CA policy to allow HIV test results be disclosed electronically. ● Support change in lab policies/practices to allow for self-collected HIV/STD swabs. ● Support a permanent change in policies to allow for immediate/remote RW enrollment. ● Support changes in clinic and reimbursement policies at FQHCs to allow same-day access mental health/substance use services. ● Encourage change in program and funding priorities to pay for tech resources (smartphones and data plans) and tech trainings that support technology-enabled multilingual access to services for staff and clients.
Metrics, evaluation and improvements	<ul style="list-style-type: none"> ● Short-term (quarterly to biannually): <ul style="list-style-type: none"> ○ Track home-based and self-HIV testing and linkage rates. ○ Track HIV testing and linkage done in non-health care settings (housing, jail). ○ Track opt-out HIV testing in public hospital and community clinic settings. ○ Review and evaluate testing in these settings for equity, access and coverage. ● Medium-term (2-5 years): <ul style="list-style-type: none"> ○ Increase testing and linkage rates from home/self-testing. ○ Increase HIV testing, PrEP uptake, linkage and HIV treatment rates. ● Long-term: Decrease new HIV diagnosis rates.



Youth Engagement

Vision	Engage youth advisory boards, LGBTQ youth teams, youth outreach workers, community-based youth organizations, providers and schools on community messaging and outreach, low-barrier PrEP and sexual health care, and build youth leadership pipeline.
Top priorities	1. Regional youth & youth-serving provider network: share best practices to increase PrEP uptake, integrate youth leadership & build a youth service sustainability plan. 2. Youth-led community messaging: utilize the network to develop and distribute education via youth-focused social media. Engage parents/guardians separately.
Equity Activities	<ul style="list-style-type: none"> • Train all youth-serving providers to refer patients to youth-specialized services with a focus on vulnerable youth (unstable housing, sex trafficking, YMSM/QTPOC). • Integrate the network of youth leaders and youth-serving providers into the larger EBGZ community messaging efforts. Foster culture changes to integrate youth voices into broader community messaging campaigns, including diverse, sex positive and creative messages. • Set up a system to build youth leadership capacity and an HIV/STD care/prevention pipeline including youth-to-youth, train-the-trainer education, and compensate youth appropriately for their work.
Additional details	Regional youth network details: <ul style="list-style-type: none"> • Include “youth” ages 13-24, including transitional age youth. • Develop and convene a network of youth-serving providers and youth leaders. • Collaborate with schools, job-training programs and innovative models. • Youth-serving providers in the network aim to: <ul style="list-style-type: none"> ○ Share best practices and build capacity to provide HIV prevention and testing. ○ Strengthen PEP-to-PrEP and PrEP services in emergency departments, juvenile justice centers, sexual assault support programs. ○ Increase the number of clinics with same-day PrEP and PrEP starter packs. ○ Develop sustainability plans, utilizing grants to increase service capacity and integrating services into existing longer-term processes. • Youth leaders from youth advisory boards, LGBTQ youth teams and youth outreach workers aim to: <ul style="list-style-type: none"> ○ Identify groups of youth who need additional support. ○ Identify sex-positive language for HIV prevention. Youth community messaging details: <ul style="list-style-type: none"> • Integrate the network of youth leaders and youth-serving providers into the larger EBGZ community messaging efforts. • Develop shared engagement and messaging priorities for East Bay youth. • Develop messaging using a sex positive approach to address stigma and support youth to find the “right door” for youth-friendly services.
Structural change	<ul style="list-style-type: none"> • Process changes for youth-serving providers to integrate universal, opt-out HIV testing, PEP and PrEP services in a wide variety of youth-centered settings. • Support policy change to extend minor-consent Medi-Cal recertification requirements from every month to every 6-12 months and allow electronic/remote re-certifications. • Support policy change to Family PACT to cover PrEP services.
Metrics, evaluation and improvements	<ul style="list-style-type: none"> • Short-term (quarterly to biannually): <ul style="list-style-type: none"> ○ Track number of youth-serving providers and youth leaders in the network. ○ Track the number of sites providing PEP and PrEP services. ○ Track PEP and PrEP prescriptions by age and in youth-focused settings. ○ Collect feedback from youth leadership on needs/gaps to improve services. ○ Track and share demographic data on HIV diagnoses among young people, including racial/ethnic, gender/sexual orientation, geographical location, etc.

	<ul style="list-style-type: none"> ● Medium-term (2-5 years): <ul style="list-style-type: none"> ○ Develop and implement new interventions to address needs and gaps and increase equitable access to PEP and PrEP for youth. ○ Increase the number of youth leaders and providers in the network. ○ Increase the number of providers and sites providing same-day PEP and PrEP. ○ Increase HIV testing, PrEP uptake and HIV treatment rates among youth 13-24. ● Long-term: Decrease new HIV diagnosis rates among youth 13-24.
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Housing Initiatives	
Vision	Local housing agencies coordinate with HIV organizations to rapidly and flexibly support people with immediate shelter and housing needs. Housing and HIV agencies work together to increase the supply of permanent affordable and supportive housing.
Top priorities	<ol style="list-style-type: none"> 1. Enhance cross-training, case coordination and information exchange between housing and HIV organizations while integrating trauma-informed care practices. 2. Explore housing policy and funding changes to increase access to housing, address complex needs, reduce eligibility barriers and create more housing resources.
Equity Activities	<ul style="list-style-type: none"> ● Promote changes in housing providers' resident selection criteria that increase housing access for PLWH who have complex health, mental health and substance use conditions and/or other barriers to housing such as past evictions, felony convictions, etc. ● Develop formal mechanisms for providing input into local utilization of HOPWA funds and explore the feasibility of recommending alternative uses for a portion of these funds (e.g., re-allocating funds to HOPWA vouchers as is done in other cities). ● Provide training on specific housing resources available to priority populations such as undocumented immigrants, youth, chronically disabled, transwomen, pregnant people, aging populations. ● Explore the creation of a LGBTQ+ shelter in the East Bay. ● Create a trusted resource/process to report and address housing discrimination faced by PLWH, LGBTQ, and POC community members and clients when it occurs.
Additional details	<p>Training HIV and housing staff – more details:</p> <ul style="list-style-type: none"> ● Partner with Alameda Care Connect and housing organizations to develop a training curriculum for HIV staff to build skills in assessing housing needs, addressing common barriers, and identifying appropriate short-term and long-term resources. ● Identify organizations and staff that provide housing and drop-in services for vulnerable populations and offer trainings in trauma-informed care and warm hand-offs for clients needing HIV services. ● Improve the level and degree of collaboration and information exchange between HIV organizations, agencies in the homelessness continuum of care, and agencies/providers of subsidized and affordable housing. ● Promote cross-training of staff and development of formalized protocols for referral and assessment of PLWH experiencing housing insecurity in keeping with Alameda County's Vision 2026 and Home Together Plan. <p>Housing policy changes – more details:</p> <ul style="list-style-type: none"> ● Explore areas where funding and policy changes could be made that would increase access to currently-available housing resources. ● Identify the political allies and champions at local, state and federal levels who could advocate for additional housing resources for PLWH. ● Explore avenues for attracting funding and resources for new small-scale housing development and rehabilitation to increase the supply of housing available to PLWH.

Structural change	<ul style="list-style-type: none"> ● Culture changes to have closer coordination of housing and HIV services. ● Practice changes to integrate HIV and LGBTQ+ friendly services into shelter/hotel and housing settings and for HIV staff to have increased capacity to provide housing support services. ● Policy changes that expand access to low-income housing and work to create a net increase in housing resources available to PLWH, especially those who are members of key communities.
Metrics, evaluation and improvements	<ul style="list-style-type: none"> ● Short-term (quarterly to biannually): <ul style="list-style-type: none"> ○ Track HIV testing and linkage rates in housing service programs. ○ Track housing trainings for HIV staff and HIV trainings for housing staff. ○ Review and evaluate testing, linkage and training rates. ○ Implement improvement interventions to increase these rates. ● Medium-term (2-5 years): <ul style="list-style-type: none"> ○ Increase HIV testing, PrEP uptake and linkage rates among people experiencing homelessness. ○ Develop a way to measure and decrease the number of people with HIV who are experiencing homelessness and/or have unstable housing. ● Long-term: Decrease new HIV diagnosis rates among people experiencing homelessness.