

**VALUES AND VISIONS OF THE 2017-2021  
SAN FRANCISCO REGION INTEGRATED HIV PREVENTION & CARE PLAN**

**Value: ENSURING ACCESS TO COMPREHENSIVE HIV PROGRAMS**

**Vision:** The three counties that make up the San Francisco HIV jurisdiction - Marin, San Francisco, and San Mateo - remain focused on timely access to comprehensive HIV outreach, testing, prevention, care and support programs. Our region is committed to the idea that the HIV system must be accessible to all who need it, and that it must ensure equal access, eliminate disparities, and achieve parity in relation to the quality and effectiveness of HIV programs. It is critical that clients within this system be able to easily identify needed resources; obtain them in a timely manner; and access them in welcoming and client-centered environments. Access means using culturally appropriate and consumer-informed approaches to reach out to those who do not know their HIV status or are not in care to help them identify their serostatus and receive all needed supportive services whether they are HIV-positive or HIV-negative, including ensuring access for underserved and complex populations. Access also means expanding system-wide linkages and integration to help clients move easily from one modality to another, and to access programs in different parts of the San Francisco region.

**Value: ENSURING CULTURAL COMPETENCE AND CULTURAL HUMILITY IN HIV PREVENTION AND CARE**

**Vision:** Cultural competence and cultural humility are complementary terms that refer to a systemwide approach that is able to respond to the full range of cultural needs and orientations of specific client populations in a manner that is responsive, respectful, effective, and safe. In general, cultural competence refers to a set of congruent skills and beliefs that allow programs and agencies to effectively serve the specific sub-populations with whom they come in contact. Cultural humility is an approach to prevention and care in which providers maintain an openness and respect for the clients serve, and in which they are able to effectively listen to, hear, learn from, and respond to client in an effective manner. This means not only incorporating approaches to respond to issues such as race, ethnicity, language, national origin, and immigration status, but additional factors that can define 'culture' such as sexuality, gender identity, family structure, personal beliefs, and socioeconomic background. In a region as diverse as San Francisco, these issues take on special meaning as both a challenge to prevention and care providers and as an opportunity for our system to benefit and grow from our region's rich cultural traditions. Cultural competency and cultural humility are critical for ensuring that clients feel comfortable, safe, respected, and welcomed in all HIV environments, and for ensuring that people living with or at risk for HIV find supportive social networks and remain in the system as long as needed. Our region has worked to attain this goal by developing services and programs that are tailored to the

needs of diverse ethnic populations including African Americans, Latinos, and Asians, transgender men and women, active substance users, men who have sex with men, and young people. Key approaches include training providers in a range of specific cultural issues; working to ensure that services are delivered – wherever possible – by individuals who embody the cultural and linguistic characteristics of the populations they serve; and involving diverse cultural groups as representatives on the Planning Council.

**Value: ENSURING TRAUMA-INFORMED HIV PROGRAMS**

**Vision:** The prevalence of past and current trauma has been recognized as one of the most important factors underlying negative outcomes in relation to HIV prevention and care access and retention. A meta-analysis conducted by the Women’s Health Program , for example, demonstrated that over 61% of HIV-positive women had experienced sexual abuse at some point in their lives - as compared 12% of women nationwide - and that HIV-positive women with a history of trauma had over four times the odds of antiretroviral failure as compared to women with no trauma history.<sup>1</sup> Implementing trauma-informed programs that respond effectively and sensitively to persons with a history of trauma and exposure to violence have achieved outcomes such as reduced post-traumatic stress disorder (PTSD) symptoms, reduced substance use, improved mental health functioning, and decrease in the frequency of unprotected sexual encounters. Trauma-informed programs are urgently needed that train staff in trauma issues and that alter HIV prevention and care environment to ensure welcoming, safe, and responsive spaces. Trauma-informed programs are critical for facilitating long-term engagement in HIV prevention and care and for providing linkage to supportive programs that help individuals overcome the long-term impacts of exposure to trauma and violence.

**Value: COMMITTING TO THE PRINCIPLE OF HOUSING AS HEALTH CARE**

**Vision:** Housing status is a critical factor affecting both access to and utilization of HIV prevention and treatment. Research has demonstrated that housing assistance is associated with reduced HIV risk behaviors and improved health care outcomes and that housing assistance coupled with health care decreases public expenses while making better use of limited public resources.<sup>2</sup> Without stable housing, persons with HIV experience difficulties in accessing HIV testing, pre and post-exposure prophylaxis, and primary medical care, along with challenges in maintaining safer behaviors, adhering to HIV-related treatments, and sustaining health and well-being. Individuals who are homeless also lack adequate transportation, lack awareness of programs and resources, and frequently face negative provider attitudes. Research has shown that stable supportive housing dramatically reduces both morbidity and mortality among homeless persons living with HIV and AIDS. The shortage of affordable and stable short-term and long-term housing in the San Francisco region greatly complicates the task of

securing safe and affordable housing for both HIV-negative and HIV-positive individuals. There is a paramount need for HIV prevention and care providers to ensure effective housing assessment, referral, linkage, and advocacy services, including for homeless persons, persons with disabilities, persons released from incarceration settings, and persons fleeing domestic and intimate partner violence. There is also critical need to support expanded low-income and supportive housing opportunities in our region both to reduce new HIV infections and to ensure the health and wellness of persons living with HIV.

**Value: CONFRONTING AND OVERCOMING HIV STIGMA**

**Vision:** HIV stigma is a crippling phenomenon that has limited our nation's response to the HIV epidemic and that continues to contribute to both the spread of the virus and to negative health outcomes for persons at risk for and living with HIV. HIV stigma both to infection with the virus and to the sexual and drug-using behaviors that transmit it, including homophobia related to same-gender love and sex. HIV stigma leads to unjust shaming and discrimination against persons at risk for and living with HIV. These consequences can be multiplied through the institutional discrimination experienced by historically marginalized populations such as persons of color, transgender persons, men who have sex with men, and non-English-speaking communities. HIV stigma can discourage at-risk persons from seeking testing or prevention support, and can result in HIV-infected persons not seeking care or accessing care intermittently. It is critical that community and population-specific anti-stigma activities, campaigns, and messages continue to be developed and delivered both to fight bias against persons affected by HIV and to combat bigotry and discrimination related to the activities that can lead to the virus' transmission.

**Value: INCORPORATING HARM REDUCTION PERSPECTIVES**

**Vision:** The term harm reduction refers to a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction programs do not marginalize or disrespect substance users, and do not make sobriety a pre-condition for receiving prevention or care. While often used to refer to syringe exchange alone, harm reduction in the context of HIV also refers to a broader movement to ensure the widespread availability and accessibility of prevention and care programs for substance users in a manner that is welcoming, non-judgmental, and embracing. Harm reduction programs incorporate tailored approaches to care and support for persons who are currently using drugs, and often offer services during non-traditional hours and in accessible community locations. The expansion of harm reduction approaches is critical for both reducing the spread of HIV and for linking and retaining substance users in HIV services.

**Value: FOSTERING MENTORSHIP AND PEER INVOLVEMENT**

**Vision:** Mentorship and peer involvement are critical approaches that involve persons living with and at risk for HIV in activities to reduce viral transmission and support persons with HIV in care. These approaches are gaining in importance as persons with HIV live longer and healthier lives and as the population of persons with HIV in the San Francisco jurisdiction continues to age. Persons who have lived for many years with HIV or who have maintained their negative status in the face of complex life challenges have much to teach high risk and newly diagnosed persons about preserving health, remaining in care, and adopting and maintaining safe behaviors. Peers can also play a critical role in shaping outreach and interventions for the communities of which they are a member, such as communities of young people, persons of color, women, transgender persons, MSM, and substance users. Paid and volunteer peers can serve effectively in a range of roles, including as program advisors, mentors, buddies, outreach specialists, and informal adherence and support counselors who develop supportive relationships with persons at risk for or living with HIV. Paid peer positions that do not exceed the threshold for maintaining Medi-Cal status offer a chance for individuals with HIV to return to work without losing their existing benefits. Peer involvement can also help persons living with HIV - particularly those 50 and older - to overcome loneliness and social isolation while offering meaningful community and inter-personal involvement. A broad commitment to providing expanded peer opportunities in HIV prevention and care has the potential to greatly enhance the effectiveness and responsive of the HIV entire system.

**Value: ENSURING GREATER CROSS-COUNTY COLLABORATION**

**Vision:** While the three counties that make up the San Francisco jurisdiction share common values and principles and work together effectively to prioritize needs and distribute resources, significant regional differences exist in regard to both HIV caseload and funding. These differences have unintentionally led to some capacity disparities among the three counties, particularly in terms of data systems and capabilities. The new integrated planning process has sparked a greater awareness of the problems these inequities create, and has fostered a renewed commitment to sharing resources, expertise, and information to address these inequities over the five-year Plan period.

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<sup>1</sup> Machtiger EL, Haberer JE, Wilson TC, Weiss DS. Recent Trauma is Associated with Antiretroviral Failure and HIV Transmission Risk Behavior Among HIV-Positive Women and Female-Identified Transgenders. *AIDS and behavior*. Nov 2012;16(8):2160-2170.

<sup>2</sup> Milloy, et al., "Homelessness as a structural barrier to effective antiretroviral therapy among HIV-seropositive illicit drug users in a Canadian setting" *AIDS Patient Care STDS*. January 2012; 26 (1): 60-7 and United States Interagency Council on Homelessness. "Opening Doors: Federal Strategic Plan to Prevent & End Homelessness." 2010

MARIN, SAN FRANCISCO, AND SAN MATEO COUNTIES, CALIFORNIA

2017 - 2021 INTEGRATED HIV PREVENTION AND CARE PLAN

DRAFT OBJECTIVES & STRATEGIES

**Goal # 1: Reduce New HIV Infections in the San Francisco Region**

**Objective # 1.1: By December 31, 2021, increase the percentage of people living with HIV who know their serostatus to at least 96%.**

**Strategies:**

- **1.1.1:** Continually investigate and analyze projected HIV-infected populations in San Francisco.
- **1.1.2:** Over the five-year Integrated Plan period, develop and implement strategies to empower Marin and San Mateo Counties to conduct estimates of their own HIV-infected populations in order to develop a region-wide projection of the percentage of persons who know their serostatus by December 31, 2021.
- **1.1.3:** Conduct annual community engagement activities designed to track the impact of HIV testing programs and identify HIV testing needs, barriers, opportunities, and new approaches in the San Francisco region.
- **1.1.4:** Continually assess, prioritize, initiate, and/or promote new HIV testing expansion activities such as the following:
  - Expand HIV outreach, awareness, and testing messages in Spanish to inform people of where to go to receive information and testing and to combat stigma and a growing lack of awareness of the importance of HIV.
  - Pilot test and expand standardized, opt-out HIV testing for all clients who seek STD testing, beginning with clients who test positive for one or more designated high-target STDs such as rectal gonorrhea or syphilis at San Francisco County-funded clinics.
  - Identify and replicate effective community sexual health clinic models in additional specific high-incidence neighborhoods in the San Francisco region.
  - Explore and develop new testing approaches to address the potential issue of “testing saturation” in which many repeat testers may be relatively low-risk individuals.
  - Promote a holistic health and wellness approach which explores the feasibility of

integrating chronic disease prevention efforts into HIV programs, including an analysis of underlying causes of death in persons with HIV to prioritize health screening for various populations.

- Develop messaging to promote HIV testing at health care sites while continuing to expand community-based testing options.
- Utilize the opportunity provided by HIV testing to link individuals to needed programs by improving protocols and referral resources for linkage to housing, mental health, substance use, and other ancillary services and reducing barriers to care access.
- Maximize third party billing for HIV testing in medical settings.
- Implement new strategies for increasing HIV testing among IDUs to address high rates of undiagnosed infections, including use of incentives and linking hepatitis C testing with HIV testing.

**Objective # 1.2: By December 31, 2021, reduce the number of annual new HIV diagnoses by at least 50%.**

**Strategies:**

- **1.2.1:** Conduct ongoing review of region-wide HIV epidemiological data and regularly summarize and discuss data with the Integrated San Francisco HIV Community Planning Council.
- **1.2.2:** Conduct annual community engagement activities designed to assess the impact of HIV prevention programs and to identify HIV emerging prevention needs, barriers, opportunities, and approaches in the San Francisco region.
- **1.2.3:** Continually assess, prioritize, initiate, and/or promote expanded non-biomedical HIV prevention activities, including public education campaigns, individual and group-level behavioral interventions, and widespread condom availability, and initiatives such as the following:
  - Increase the online presence of sexual health education and risk reduction when appropriate, incorporating information about PrEP and other emerging developments.
  - Implement a pilot mentoring program for young gay men and transfemales that supports the development and maintenance of personal strategies for supporting sexual health.

- Develop and implement a standard HIV curriculum for substance use and mental health providers, including culturally competent approaches for screening for HIV risk and referral and linkage resources.
- Prioritize communicable disease screening and develop an approach for implementing integrated screening guidelines.
- Integrate risk reduction into non-HIV programs such as substance use treatment) and provide appropriate staff training.
- Engage in dialogue with local businesses to explore their willingness in participating in the Condom Access Program as an effort to increase the availability of free condoms to jurisdiction residents.
- Address the impact of new attitudes and beliefs regarding condom use given the emergence of new prevention tools such as PrEP which may create a perception that condom use is out of date or a sign of non-embrace of sexuality (“condom shame”).

**Objective # 1.3: By December 31, 2021, increase the utilization of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) among high-risk HIV-negative persons by at least 50%, based on baseline data to be identified over the course of the Plan.**

- **1.3.1:** Continually review PrEP and PEP utilization and resources in the San Francisco region and expand the accuracy, scope, and reliability of PrEP and PEP utilization data.
- **1.3.2:** By December 31, 2019, develop a system to include data on PrEP and PEP utilization and populations in regular HIV epidemiological reporting, including potentially including PrEP use in the region’s HIV Care Continuum.
- **1.3.3:** Continually assess, prioritize, initiate, and/or promote PrEP and PEP expansion activities such as the following:
  - Assess the availability of PrEP and PEP services throughout the three-county region and expand PrEP and PEP sites as needed, with a special focus on Marin and San Mateo Counties.
  - Aggressively utilize PrEP and PEP screening and enrollment as an opportunity to link high-risk HIV-negative individuals to both health insurance coverage and an appropriate medical home
  - In collaboration with San Francisco Bay Area and North Coast AETC, expand PrEP and PEP education for clinicians and providers at all levels, including non-HIV-specific providers serving potential high-risk populations. Incorporate education on culturally appropriate risk reduction counseling and appropriate PrEP and PEP education. Include

modules on conducting risk assessment, providing counseling and linkage support, and providing benefits and insurance coverage counseling. Consider developing a model master PrEP and PEP education and/or certification program, with one track geared to clinicians and another geared to social service providers.

- Develop and disseminate a written training on PrEP to be integrated into standardized training for all new HIV test counselors.
- Ensure that PrEP and PEP information, education, and linkage support becomes a standard service for all persons who voluntarily seek HIV testing and are found to be HIV-negative.
- Create PrEP and PEP outreach and education efforts in Spanish to reach high-risk Spanish-speaking populations, including campaigns aimed at young Latino MSM in clubs and bars, making Spanish-language flyers on PrEP and PEP available in doctor's offices and at service agencies, and training paid or volunteer peers to provide community-based PrEP and PEP education and outreach.
- Expand PrEP and PEP education, outreach, and enrollment to persons of color, transgender persons, injection drug users, and women.
- Maintain and expand the current system of PrEP navigators available in the region using models similar to HIV navigation. Utilize models that merge HIV and PrEP navigation services in the same clinic setting.
- Develop and disseminate PrEP Standards of Care through the San Francisco Department of Public Health, including standards on administering, tracking, and managing PrEP
- Consider development of a PrEP clinical policy using relevant policies as a model such as San Francisco's universal offer of treatment policy or the PrEP policy of Kaiser Permanente.
- Explore and support efforts to increase research financing and insurance coverage of PrEP.

**Goal # 2: Increase Access to Care and Improve Health Outcomes for Persons Living with HIV in the San Francisco Region**

**Objective # 2.1: By December 31, 2021, increase the percentage of annual newly diagnosed persons linked to HIV medical care within one month of HIV diagnosis to at least 90%.**

- **2.1.1:** Continually assess and report rates of linkage to HIV medical care for newly diagnosed persons with HIV across the three-county region.
- **2.1.2:** Continually assess, prioritize, initiate, and/or promote effective HIV linkage activities such as the following:
  - Continue to support and enhance the highly successful San Francisco Linkage, Navigation, Integration, and Comprehensive Services (LINCS) program, and support expansion of the program into Marin and San Mateo Counties.
  - Utilize Ryan-White funds to temporarily pay for the cost of care and labs for patients participating in the Rapid ART Program Initiative for HIV Diagnoses (RAPID) program while being navigated to insurance and care, beyond the current 14-day medication subsidy period. This coverage would be temporary - lasting no more than 2 months - and would allow patients to receive HIV medications and treatment while they are applying for and awaiting insurance and other benefits.
  - Disseminate information which addresses the fears of undocumented persons related to disclosure of immigration or residency status when seeking HIV testing and care services
  - Review best practices and local pilot programs that link newly diagnosed clients to same-day treatment, and assess whether such rapid treatment programs should become a regional standard of care.
  - Adopt consistent definitions and measurement for linkage to care that can be used to assess linkage rates over time.
  - Enhance service system capacity to address the linkage barriers inherent in substance use and mental health disorders, such as expanding staffing to enhance the capacity for linkage programs to provide case management, mental health, and/or substance use interventions.
  - Address barriers to evening, night, and weekend linkage services.
  - Develop and implement county linkage plans that include non-DPH providers, so that all medical and non-medical sites conducting HIV testing have protocols for immediate linkage to care.
  - Consider and potentially expand the role of peer health educators / linkage experts within the broader service system in supporting linkage to and retention in care.
  - Train linkage staff to be eligibility / enrollment workers to facilitate access to health coverage.

**Objective # 2.2: By December 31, 2021, enhance critical HIV care retention and adherence-outcomes along the HIV Care Continuum as follows:**

- **Sub-Objective # 2.2.A: Increase the percentage of all persons living with HIV - including persons unaware of their HIV infection - who receive at least 1 CD4 or viral load test in a 12-month period to at least 85%.**
  - **Sub-Objective # 2.2.B: By December 31, 2021, significantly increase the percentage of persons living with HIV who fall out of care and are successfully re-linked to care within 90 days.**
  - **Sub-Objective # 2.2.C: By December 31, 2021, increase the percentage of all persons living with HIV - including persons unaware of their HIV infection - who are virally suppressed to at least 75%.**
  - **Sub-Objective # 2.2.D: By December 31, 2021, increase the percentage of newly diagnosed persons living with HIV who are virally suppressed within 12 months of diagnosis to at least 80%.**
- **2.2.1:** Continually track and report rates of HIV care retention, re-linkage, and viral suppression for all persons living with HIV across the region, including baseline rates as appropriate.
  - **2.2.2:** Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of HIV care retention, re-linkage, and viral suppression in the San Francisco region.
  - **2.2.3:** Continually assess, prioritize, initiate, and/or promote effective HIV retention, re-linkage, and medication adherence activities such as the following:
    - Develop and disseminate standardized assessment tools and approaches to identify when clients may be at risk of falling out of care and provide pro-active staff and peer-based support to prevent persons from falling out of care.
    - Provide more and sustainable funding for clinic-based navigators to retain complex patients in care, including persons living with HIV who serve in peer support / retention roles. The activities of case managers could also be expanded in some cases to include field-based work with patients to help remove barriers to retention in care.
    - As a strategy to expand the availability of short-term mental health services within the HIV clinic setting, employ Behaviorists who function as part of client care teams and provide short-term assessment and counseling that serves as a bridge to longer-term mental health engagement with therapists in community-based settings.

- Expand the availability of subsidized, long-term mental health services for persons with HIV, particularly in cases where annual insurance coverage of mental health counseling services has expired.
- Ensure the availability of on-demand, high-quality, and culturally appropriate psychiatric services for persons with HIV with severe and persistent mental illness (SPMI) and ensure that these services are integrated with HIV care through the client care team.
- Create a mechanism to pay for medications when there are delays in coverage or disruptions in treatment, particularly for patients who are awaiting Medi-Cal or other insurance coverage; are changing insurance plans; or who temporarily lose ADAP coverage because of changes in formularies or delays in re-certification.
- Expand the overall approach to client navigation services to focus on ongoing retention in care and not simply on re-linkage to care.
- Identify feasible and evidence-based retention strategies such as text messaging appointment reminder services and develop a plan for funding and implementing these efforts.
- Reframe the concept of retention as “preventing people from falling out of care” and develop corresponding indicators for assessing who is at risk for falling out of care and targeted services to prevention care attrition.
- Consider mechanisms for engaging patients’ families in HIV retention efforts.

**Objective # 2.3: By December 31, 2021, increase the percentage of Ryan White-funded clients living with HIV who are stably housed to at least 80%.**

- **2.3.1:** Continually track and report the housing status of low-income persons with HIV who are receiving Ryan White-funded services across the region.
- **2.3.2:** Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities related to housing stabilization and retention in the San Francisco region.
- **2.3.3:** Continually assess, prioritize, initiate, and/or promote effective HIV housing support activities such as the following:
  - Increase the annual cap on Ryan White Emergency Financial Assistance from \$500 per patient per year to \$1,000 per patient per year.

- Increase the maximum length of stay in the city's HIV Housing Stabilization Program from 28 days per year to 60 - 90 days per year to increase housing stability for persons with HIV.
- Continually expand and enhance the skills and expertise of case management, peer support, and other staff in relation to housing placement and referrals.

**Objective # 2.4: By December 31, 2019, cure hepatitis C among all persons living with HIV.**

- **2.4.1:** Identify, track, support, and promote collaborative activities to dramatically increase hepatitis C testing, referral, and treatment in HIV clinic settings and among all persons living with HIV in the region such as the following:
  - Increase HCV awareness among affected populations.
  - Increase community and clinic-based HCV screening.
  - Develop a community-based HCV linkage-to-care program.
  - Increase primary care provider capacity to treat HCV in the context of the HIV medical home.
  - Increase patient uptake of HCV curative therapies.
- **2.4.2:** Continually track hepatitis C infection and treatment rates among persons living with HIV and enhance programmatic responses to achieve an end to hepatitis C among persons with HIV by the end of 2019.

**Objective # 2.5: By December 31, 2021, increase the number of preliminarily diagnosed HIV-positive persons linked to the San Francisco RAPID program (Rapid ART Program Initiative for HIV Diagnoses) program by 30%.**

- **2.5.1:** Continually track utilization of the RAPID program, including establishing a baseline of program utilization in early 2017 and monitoring efforts to increase knowledge of and expand referrals to the program.
- **2.5.2:** Identify, track, support, and promote collaborative activities to increase knowledge and utilization of the San Francisco RAPID program, including supporting efforts to expand funding for the RAPID program where needed.

**Goal # 3: Reduce HIV-Related Disparities and Health Equities in the San Francisco Region**

**Objective # 3.1: By December 31, 2021, significantly increase levels of care linkage, retention, and viral suppression among persons 50 and older with HIV.**

- **3.1.1:** Continually track and report rates of care linkage, retention, and viral suppression among persons 50 and older with HIV.
- **3.1.2:** Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of care linkage, retention, and viral suppression among persons 50 and older with HIV.
- **3.1.3:** Continually assess, prioritize, initiate, and/or promote effective linkage, retention, and medication adherence activities among persons 50 and older with HIV such as the following:
  - Develop and implement new models for integrating geriatric specialists into the HIV clinic setting.
  - Recognize the growing shortage of physicians who are skilled in both HIV and geriatric care and advocate for the recruitment and training of specialists in these dual areas to address growing older HIV populations.
  - Create a new level of specialized training and certification to create case management staff who are expert in the distinct system of services that exists for persons 50 and older.
  - Explore potential points of interaction between the HIV care system and the system of aging and senior services in the three-county region both to take advantage of existing senior programs that could serve older persons with HIV and to explore collaborative initiatives and programs, including programs that expand volunteer opportunities for older adults with HIV.
  - Utilize existing aging resources to address the issue of long-term disability payments expiring at time of Social Security eligibility for between 400 and 1,200 San Francisco PLWHs, particularly through educational outreach and financial counseling,

**Objective # 3.2: By December 31, 2021, significantly increase the percentage of persons of color, women, and transfemale individuals with HIV who are linked to care, retained in care, and achieve viral suppression within 12 months of diagnosis.**

- **3.2.1:** Continually track and report rates of care linkage, retention, and viral suppression among persons of color, women, and transfemale individuals living with HIV.

- **3.2.2:** Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of care linkage, retention, and viral suppression among HIV-infected persons of color, women, and transfemale individuals.
- **3.2.3:** Continually assess, prioritize, initiate, and/or promote effective linkage, retention, and medication adherence activities among people of color, women, and transfemale individuals living with HIV such as the following:
  - Ensure culturally appropriate services for women, persons of color, and transgender populations, including outreach specific to these populations in both English and Spanish. Expand the availability of staff representative of these populations in clinical settings to ensure safer and more welcoming spaces, providing cultural humility training for existing staff wherever appropriate.
  - Expand PrEP education, counseling, and referral services in health and social services settings serving persons of color, women, and transfemale persons, and incorporate HIV and risk reduction counseling and insurance and health care linkage. Provide additional training and support to agency staff to facilitate this.
  - Develop transgender-specific sex and gender guidelines that adhere to specific data collection principles including the following: 1) Naming should be self-identified; 2) Transgender and sexual orientation data should be coded with caution and care when working with minors in consideration of the fact that health data are legally accessible by guardians; 3) information should be up-to-date; 4) Naming should allow for both consistency and relevance and compliance and comparability.
  - Assess transgender training and technical assistance needs of agencies and community providers.
  - Develop and make available support and implementation materials to ensure that gender self-identity data that follows the sex and gender guidelines can be collected appropriately in a variety of settings and that data systems have the ability to track data in accordance with the guidelines.
  - Continually evaluate sex and gender guidelines through data analysis and stakeholder feedback.

**Objective # 3.3: By December 31, 2021, significantly increase the percentage of persons who inject drugs (PWID) – including MSM who inject drugs - who are linked to care, retained in care, and achieve viral suppression within 12 months of diagnosis.**

- **3.3.1:** Continually track and report rates of care linkage, retention, and viral suppression among persons living with HIV who inject drugs.

- **3.3.2:** Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of care linkage, retention, and viral suppression among HIV-infected persons who inject drugs.
- **3.3.3:** Continually assess, prioritize, initiate, and/or promote effective linkage, retention, and medication adherence activities among persons living with HIV who inject drugs such as the following:
  - Explore the creation of new program approaches to reduce HIV and hepatitis C infection among persons who use injection drugs, including approaches that incorporate a harm reduction perspective.
  - Continue support of substance use and behavioral health integration models in primary care settings.
  - Align principles and philosophy of harm reduction across all applicable substance use treatment, HIV prevention and HIV care programs in San Francisco, ensuring its adoption wherever appropriate and feasible and facilitating cross-training of HIV prevention, care, and behavioral health providers.

**Goal # 4: Achieve a More Coordinated Response to the HIV Epidemic in the San Francisco Region**

**Objective # 4.1: By December 31, 2021, establish a stronger and more seamless HIV prevention and care partnership linking Marin, San Francisco, and San Mateo Counties.**

- **4.1.1:** By July 1, 2017, establish a formal or informal task force or working group of the San Francisco HIV Community Planning Council to identify potential points of expanded interaction and collaboration between the three counties along with activity areas in which technology transfer and technical assistance could help build HIV prevention and care capacity across the region.
- **4.1.2:** By July 1, 2018, present recommendations on expanded HIV collaboration and technical support to the San Francisco HIV Community Planning Council and create an action plan for improving collaboration and mutual support and achieving goals such as the following:
  - Expand the capacity of Marin and San Mateo Counties to identify and target populations at high risk for HIV infection using geo-mapping and other approaches.

- Expand the capacity of Marin and San Mateo Counties to track data along key points of the HIV Care Continuum, including linkage, retention in care, and viral load suppression.
- Include a section containing merged three-county HIV data in the annual San Francisco HIV Epidemiology Report by December 31, 2019.
- Produce a merged version of the HIV Care Continuum for the three counties of the San Francisco region by December 31, 2020.
- **4.1.3:** Through December 31, 2021, continually implement, track, and report outcomes of inter-county capacity building activities and modify and augment activities as needed to achieve the goal of a stronger and more seamless three-county partnership.

**MARIN, SAN FRANCISCO, AND SAN MATEO COUNTIES, CALIFORNIA  
2017-2021 INTEGRATED HIV PREVENTION & CARE PLAN**

**IMPLEMENTATION PLAN GRID**

**Goal # 1: Reduce New HIV Infections in the San Francisco Region**

**Objective # 1.1: By December 31, 2021, increase the percentage of people living with HIV who know their serostatus to at least 96%.**

<b>Activity</b>	<b>Target Populations</b>	<b>Timeframe</b>	<b>Responsible Bodies</b>	<b>Monitoring Strategies</b>
<b>1.1.1</b> Continually investigate and analyze projected HIV-infected populations in San Francisco.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Epidemiology Section</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>
<b>1.1.2</b> Develop and implement strategies to empower Marin and San Mateo Counties to conduct estimates of their own HIV-infected populations in order to develop a region-wide projection of the percentage of persons who know their serostatus by December 31, 2021.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Epidemiology Section</li> <li>▪ Marin and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reports to Planning Council on inter-county capacity building activities</li> </ul>
<b>1.1.3</b> Conduct annual community engagement activities designed to track the impact of HIV testing programs and identify HIV testing needs, barriers, opportunities, and new approaches in the San Francisco region.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes and summaries of input collected by Planning Council and the three jurisdiction counties</li> </ul>
<b>1.1.4</b> Continually assess, prioritize, initiate, and/or promote new HIV testing expansion activities such as those described in the Plan.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 1.2: By December 31, 2021, reduce the number of annual new HIV diagnoses by at least 50%.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>1.2.1</b> Conduct ongoing review of region-wide HIV epidemiological data and regularly summarize and discuss data with the merged San Francisco EMA HIV Community Planning Council.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>
<b>1.2.2</b> Conduct annual community engagement activities designed to assess the impact of HIV prevention programs and to identify HIV emerging prevention needs, barriers, opportunities, and approaches in the San Francisco region.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes and summaries of input collected by Planning Council and the three jurisdiction counties</li> </ul>
<b>1.2.3</b> Continually assess, prioritize, initiate, and/or promote expanded non-biomedical HIV prevention activities, including public education campaigns, individual and group-level behavioral interventions, and widespread condom availability, and other activities described in the Plan.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 1.3: By December 31, 2021, increase the utilization of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) among high-risk HIV-negative persons by at least 50%, based on baseline data to be identified over the course of the Plan.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>1.3.1</b> Continually review PrEP and PEP utilization and resources in the San Francisco region and expand the accuracy, scope, and reliability of PrEP and PEP utilization data.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>1.3.2</b> develop a system to include data on PrEP and PEP utilization and populations in regular HIV epidemiological reporting, including potentially including PrEP use in the region's HIV Care Continuum.	All	1/1/17 - 12/31/19	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>
<b>1.3.3</b> Continually assess, prioritize, initiate, and/or promote PrEP and PEP expansion activities such as those described in the Plan.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Goal # 2: Increase Access to Care and Improve Health Outcomes for Persons Living with HIV in the San Francisco Region**

**Objective # 2.1: By December 31, 2021, increase the percentage of annual newly diagnosed persons linked to HIV medical care within one month of HIV diagnosis to at least 90%.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.1.1</b> Continually assess and report rates of linkage to HIV medical care for newly diagnosed persons with HIV across the three-county region.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.1.2</b> Continually assess, prioritize, initiate, and/or promote effective HIV linkage activities such as those described in the Plan.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 2.2:** By December 31, 2021, enhance critical HIV care retention and adherence-outcomes along the HIV Care Continuum as follows:

- **Sub-Objective # 2.2.A:** increase the percentage of all persons living with HIV - including persons unaware of their HIV infection - who receive at least 1 CD4 or viral load test in a 12-month period to at least 85%.
- **Sub-Objective # 2.2.B:** By December 31, 2021, significantly increase the percentage of persons living with HIV who fall out of care and are successfully re-linked to care within 90 days.
- **Sub-Objective # 2.2.C:** By December 31, 2021, increase the percentage of all persons living with HIV - including persons unaware of their HIV infection - who are virally suppressed to at least 75%.
  - **Sub-Objective # 2.2.D:** By December 31, 2021, increase the percentage of newly diagnosed persons living with HIV who are virally suppressed within 12 months of diagnosis to at least 80%.

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.2.1</b> Continually track and report rates of HIV care retention, re-linkage, and viral suppression for all persons living with HIV across the region, including baseline rates as appropriate.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>
<b>2.2.2</b> Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of HIV care retention, re-linkage, and viral suppression in the San Francisco region.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> </ul>

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.2.3</b> Continually assess, prioritize, initiate, and/or promote effective HIV retention, re-linkage, and medication adherence activities such as those described in the Plan.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 2.3: By December 31, 2021, increase the percentage of Ryan White-funded clients living with HIV who are stably housed to at least 80%.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.3.1</b> Continually track and report the housing status of low-income persons with HIV who are receiving Ryan White-funded services across the region.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>
<b>2.3.2</b> Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities related to housing stabilization and retention in the San Francisco region.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> </ul>
<b>2.3.3</b> Continually assess, prioritize, initiate, and/or promote effective HIV housing support activities such as those described in the Plan.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 2.4: By December 31, 2019, cure hepatitis C among all persons living with HIV.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.4.1</b> Identify, track, support, and promote collaborative activities to dramatically increase hepatitis C testing, referral, and treatment in HIV clinic settings and among all persons living with HIV in the region.	All	1/1/17 - 12/31/19	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ San Francisco End Hep C Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties</li> </ul>
<b>2.4.2</b> Continually track hepatitis C infection and treatment rates among persons living with HIV and enhance programmatic responses to achieve an end to hepatitis C among persons with HIV by the end of 2019.	All	1/1/17 - 12/31/19	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ San Francisco End Hep C Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties</li> </ul>

**Objective # 2.5: By December 31, 2021, increase the number of preliminarily diagnosed HIV-positive persons linked to the San Francisco RAPID program (Rapid ART Program Initiative for HIV Diagnoses) program by 30%.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>2.5.1</b> Continually track utilization of the RAPID program, including establishing a baseline of program utilization in early 2017 and monitoring efforts to increase knowledge of and expand referrals to the program.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco Department of Public Health</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing reports to Planning Council from the San Francisco Department of Public Health</li> </ul>
<b>2.5.2</b> Identify, track, support, and promote collaborative activities to increase knowledge and utilization of the San Francisco RAPID program, including supporting efforts to expand funding for the RAPID program where needed.	All	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>▪ San Francisco Department of Public Health</li> <li>▪ Marin and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing reports to Planning Council from the San Francisco Department of Public Health</li> </ul>

**Goal # 3: Reduce HIV-Related Disparities and Health Equities in the San Francisco Region**

**Objective # 3.1: By December 31, 2021, significantly increase levels of care linkage, retention, and viral suppression among persons 50 and older with HIV.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<p><b>3.1.1</b> Continually track and report rates of care linkage, retention, and viral suppression among persons 50 and older with HIV.</p>	<p>Persons 50 and Older with HIV</p>	<p>1/1/17 - 12/31/21</p>	<ul style="list-style-type: none"> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ongoing epidemiology reporting</li> </ul>
<p><b>3.1.2</b> Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of care linkage, retention, and viral suppression among persons 50 and older with HIV.</p>	<p>Persons 50 and Older with HIV</p>	<p>1/1/17 - 12/31/21</p>	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> </ul>
<p><b>3.1.3</b> Continually assess, prioritize, initiate, and/or promote effective linkage, retention, and medication adherence activities among persons 50 and older with HIV such as those described in the Plan.</p>	<p>Persons 50 and Older with HIV</p>	<p>1/1/17 - 12/31/21</p>	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> <li>▪ Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 3.2: By December 31, 2021, significantly increase the percentage of persons of color, women, and transfemale individuals with HIV who are linked to care, retained in care, and achieve viral suppression within 12 months of diagnosis.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>3.2.1</b> Continually track and report rates of care linkage, retention, and viral suppression among persons of color, women, and transfemale individuals living with HIV.	Persons of Color, Women, and Transfemale Individuals	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing epidemiology reporting</li> </ul>
<b>3.2.2</b> Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of care linkage, retention, and viral suppression among HIV-infected persons of color, women, and transfemale individuals.	Persons of Color, Women, and Transfemale Individuals	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>San Francisco HIV Community Planning Council</li> </ul>	<ul style="list-style-type: none"> <li>Minutes of Planning Council and Council committee meetings</li> </ul>
<b>3.2.3</b> Continually assess, prioritize, initiate, and/or promote effective linkage, retention, and medication adherence activities among people of color, women, and transfemale individuals living with HIV such as those described in the Plan.	Persons of Color, Women, and Transfemale Individuals	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>San Francisco HIV Community Planning Council</li> <li>Marin, San Francisco, and San Mateo Counties</li> <li>Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>Minutes of Planning Council and Council committee meetings</li> <li>Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Objective # 3.3: By December 31, 2021, significantly increase the percentage of persons who inject drugs (PWID) – including MSM who inject drugs - who are linked to care, retained in care, and achieve viral suppression within 12 months of diagnosis.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>3.3.1</b> Continually track and report rates of care linkage, retention, and viral suppression among persons living with HIV who inject drugs.	Persons who Inject Drugs	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing epidemiology reporting</li> </ul>

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>3.3.2</b> Conduct an annual needs assessment, prioritization, and allocation process designed in part to identify, expand, change, and/or continue Ryan White Part A and B-funded activities that increase rates of care linkage, retention, and viral suppression among HIV-infected persons who inject drugs.	Persons who Inject Drugs	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>San Francisco HIV Community Planning Council</li> </ul>	<ul style="list-style-type: none"> <li>Minutes of Planning Council and Council committee meetings</li> </ul>
<b>3.3.3</b> Continually assess, prioritize, initiate, and/or promote effective linkage, retention, and medication adherence activities among persons living with HIV who inject drugs such as those described in the Plan.	Persons who Inject Drugs	1/1/17 - 12/31/21	<ul style="list-style-type: none"> <li>San Francisco HIV Community Planning Council</li> <li>Marin, San Francisco, and San Mateo Counties</li> <li>Getting to Zero Initiative</li> </ul>	<ul style="list-style-type: none"> <li>Minutes of Planning Council and Council committee meetings</li> <li>Ongoing reports to Planning Council from the three jurisdiction counties and Getting to Zero</li> </ul>

**Goal # 4: Achieve a More Coordinated Response to the HIV Epidemic in the San Francisco Region**

**Objective # 4.1: By December 31, 2021, establish a stronger and more seamless HIV prevention and care partnership linking Marin, San Francisco, and San Mateo Counties.**

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<b>4.1.1:</b> Establish a formal or informal task force or working group of the San Francisco HIV Community Planning Council to identify potential points of expanded interaction and collaboration between the three counties along with activity areas in which technology transfer and technical assistance could help build HIV prevention and care capacity across the region.	All	1/1/17 - 7/1/17	<ul style="list-style-type: none"> <li>San Francisco HIV Epidemiology Section</li> </ul>	<ul style="list-style-type: none"> <li>Minutes of Planning Council and Council committee meetings</li> </ul>

Activity	Target Populations	Timeframe	Responsible Bodies	Monitoring Strategies
<p><b>4.1.2:</b> Present recommendations on expanded HIV collaboration and technical support to the San Francisco HIV Community Planning Council and create an action plan for improving collaboration and mutual support and achieving goals.</p>	<p>All</p>	<p>7/1/17 - 7/1/18</p>	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Epidemiology Section</li> <li>▪ Marin and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reports to Planning Council on inter-county capacity building recommendations</li> </ul>
<p><b>4.1.3:</b> Continually implement, track, and report outcomes of inter-county capacity building activities and modify and augment activities as needed to achieve the goal of a stronger and more seamless three-county partnership.</p>	<p>All</p>	<p>7/1/18 - 12/13/21</p>	<ul style="list-style-type: none"> <li>▪ San Francisco HIV Community Planning Council</li> <li>▪ Marin, San Francisco, and San Mateo Counties</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minutes of Planning Council and Council committee meetings</li> <li>▪ Reports to Planning Council on inter-county capacity building recommendations</li> </ul>