County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
PUBLIC HEALTH SERVICES
3851 ROSECRANS STREET, MAIL STOP P-578

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES & STANDARDS COMMITTEE
Meeting Packet

Tuesday, April 04, 2023 11:30 AM

In-Person Meeting:
County Operations Center (COC)
5500 – 5570 Overland Ave. San Diego, CA 92123
Medical Examiner's Office – Room 1047 (Building 5570)

NOTE: This meeting is audio and video recorded.

The Charge of the Strategies & Standards Committee (updated June 4, 2019): To oversee the Getting to Zero (GTZ) Plan to direct objectives, strategies, and activities to get to zero new infections and continue to support those living with and vulnerable to HIV in living well in San Diego.

A quorum for this committee is 6

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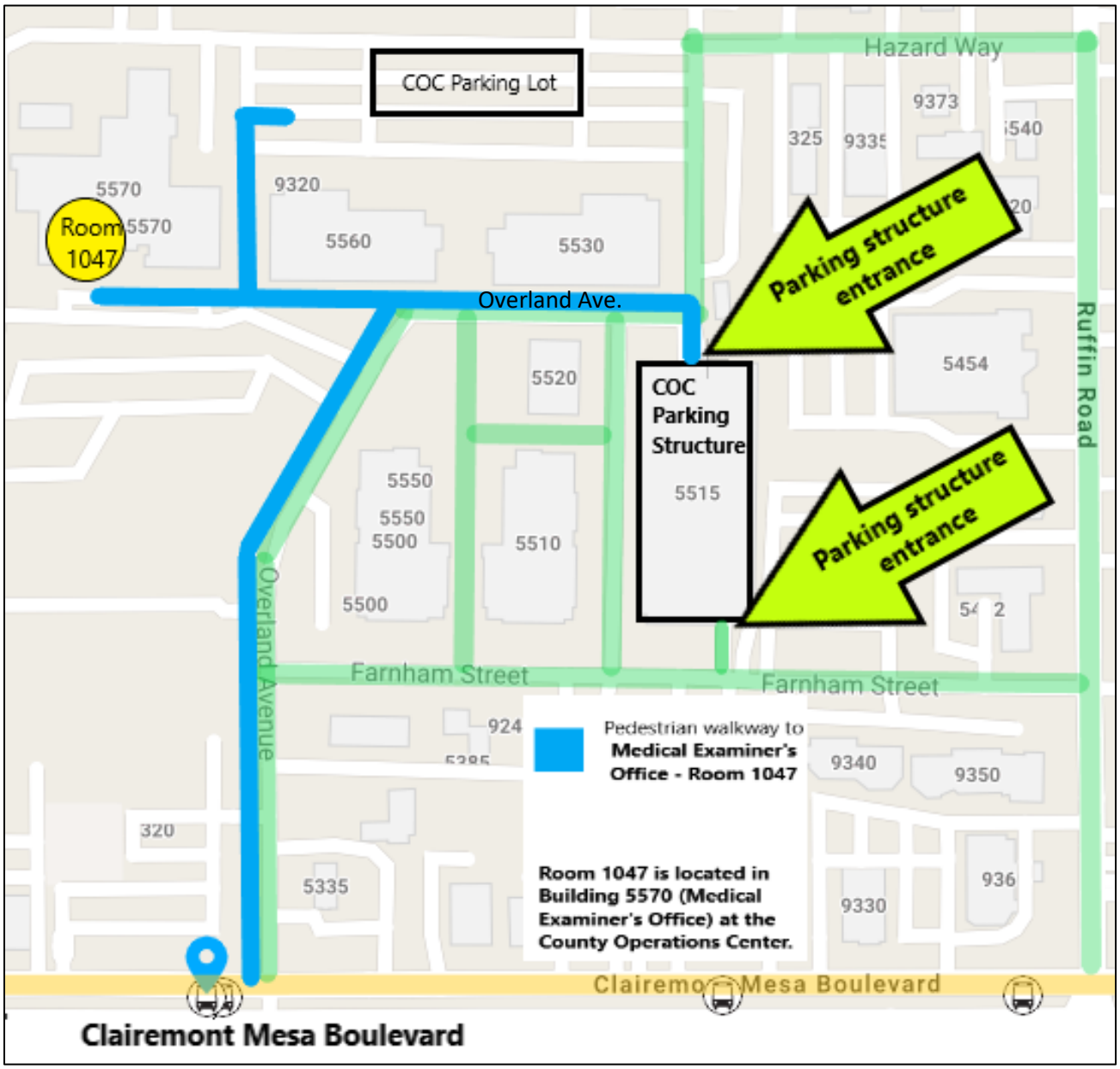
Strategies & Standards Committee

When: Tuesday, April 4, 2023 from 11:30 AM – 1:00 PM
Where: Medical Examiner's Office – Room 1047
(Building 5570)

Directions to COC and Parking:

San Diego County Operations Center
5500 – 5570 Overland Avenue
San Diego, CA 92123



Parking is free – All visitors parking is longer than the permitted time that is posted; you must park in an unmarked space.
There is very limited street parking along Farnham St.

From 163:

1. From 163, exit onto Clairemont Mesa Blvd – *Eastbound*
2. Turn left onto Overland Ave.

From I-15:

1. From 15, exit onto Clairemont Mesa Blvd – *Westbound*
2. Turn right onto Ruffin Rd
3. Turn left onto Hazard Way

Or

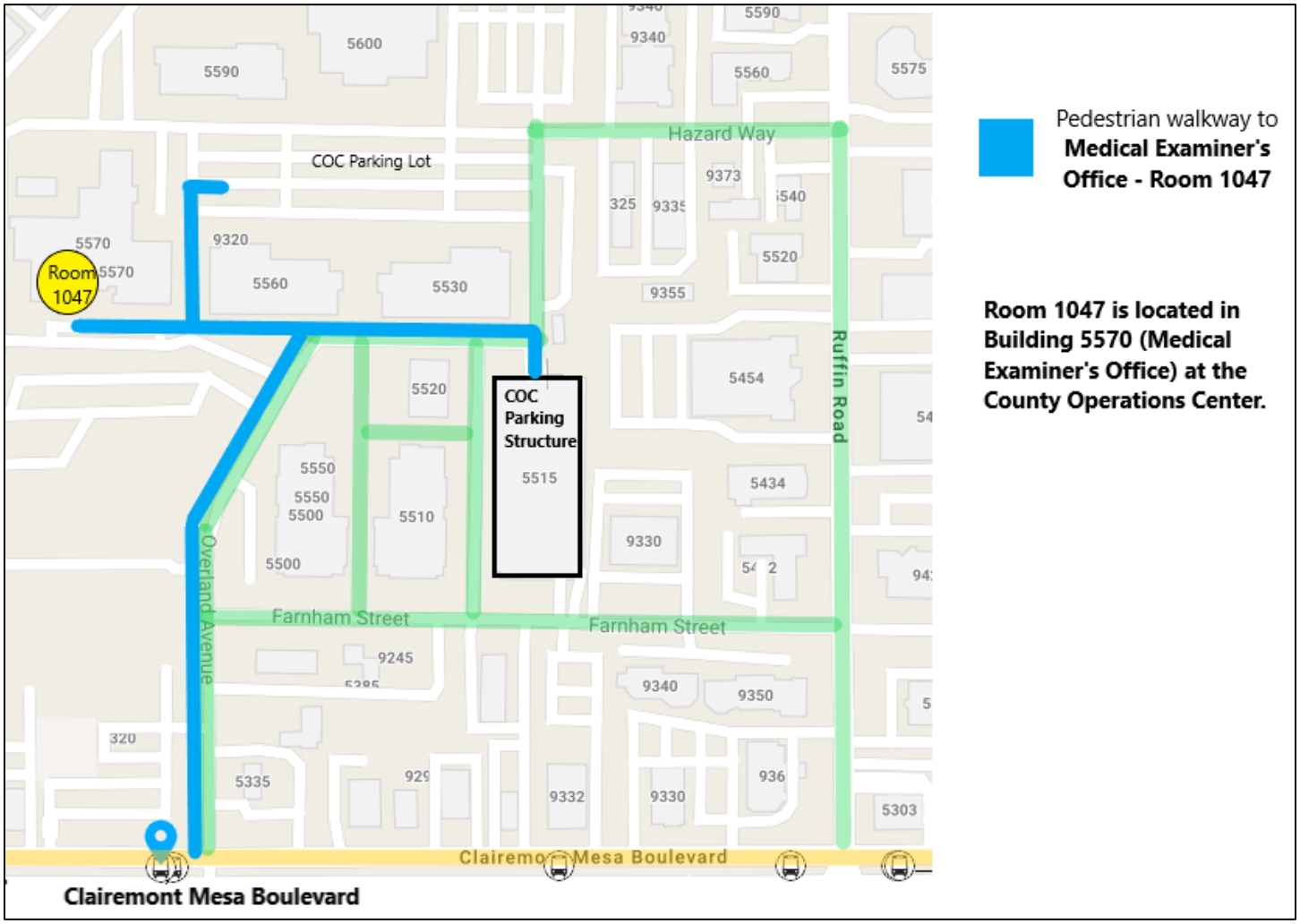
1. From 15, exit onto Clairemont Mesa Blvd – *Westbound*
2. Turn right onto Overland Ave

****ATTN:**

Please note that directions depicted on given directions to location may not reflect info on the MTS phone application.

Refer to HPG directions and County Operations Center map provided for detailed instructions on how to get to meeting location. Additional resource map available from County Operations Center on **PAGE 5** and Campus Directory on **PAGE 6**.

Via MTS/Public Transportation:



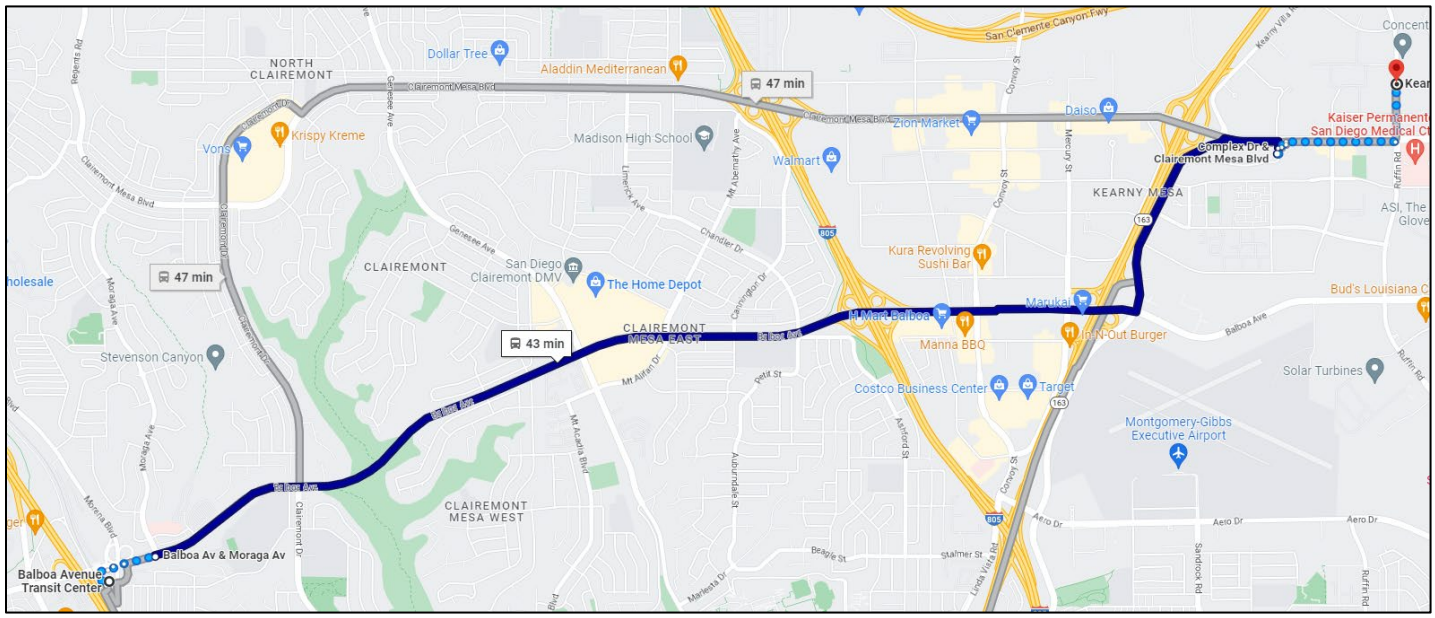
From Clairemont Mesa Blvd & Overland Ave Bus stop:

1. Head east on Clairemont Mesa Blvd toward Overland Ave.
2. Turn left onto Overland Ave.
3. Turn right onto Farnham St.
4. After coming to the cul-de-sac at the end of Overland, turn left and the **Medical Examiner's Office** building will be on the right (look for **5570** building).

If Using Trolley & Bus:

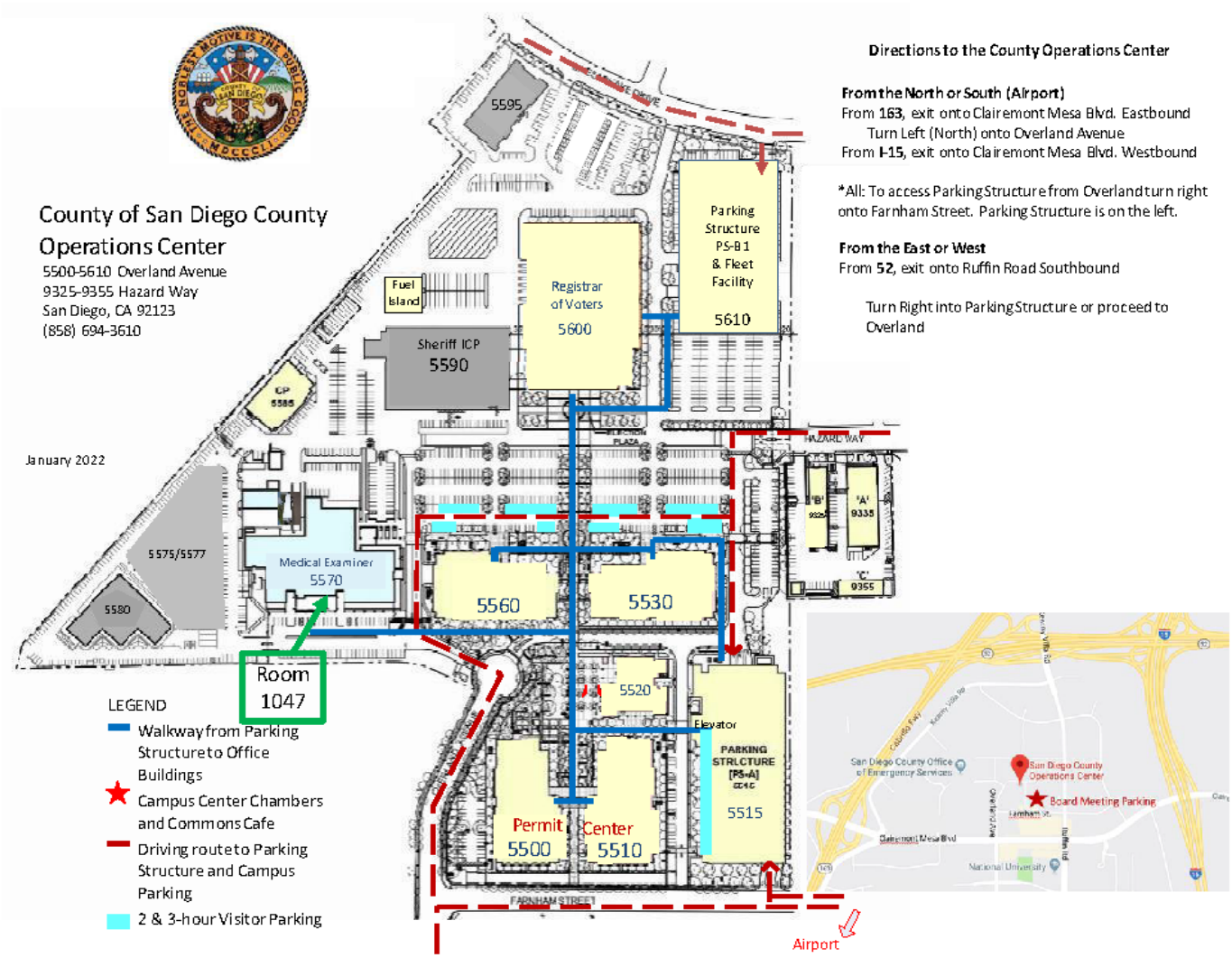
1. Take the **Blue Trolley Line** to the **Balboa Avenue Transit Center.**
2. Walk to **Balboa Ave & Moraga Ave** bus stop (about 7-minute walk, 0.3 miles).
3. Take **Route 27** bus from **Balboa Ave & Moraga Ave** to **Complex Dr & Clairemont Mesa Blvd**.
4. Head north on Complex Dr.
5. Cross the street and turn right on Clairemont Mesa Blvd (after U.S. Bank Branch on the right).
6. Cross the street and turn left onto Overland Ave.
7. After coming to the cul-de-sac at the end of Overland, turn left and the **Medical Examiner's Office** building will be on the right (look for **5570** building).

Map from Balboa Ave Transit Center to Overland Ave (if coming off Blue Line trolley):

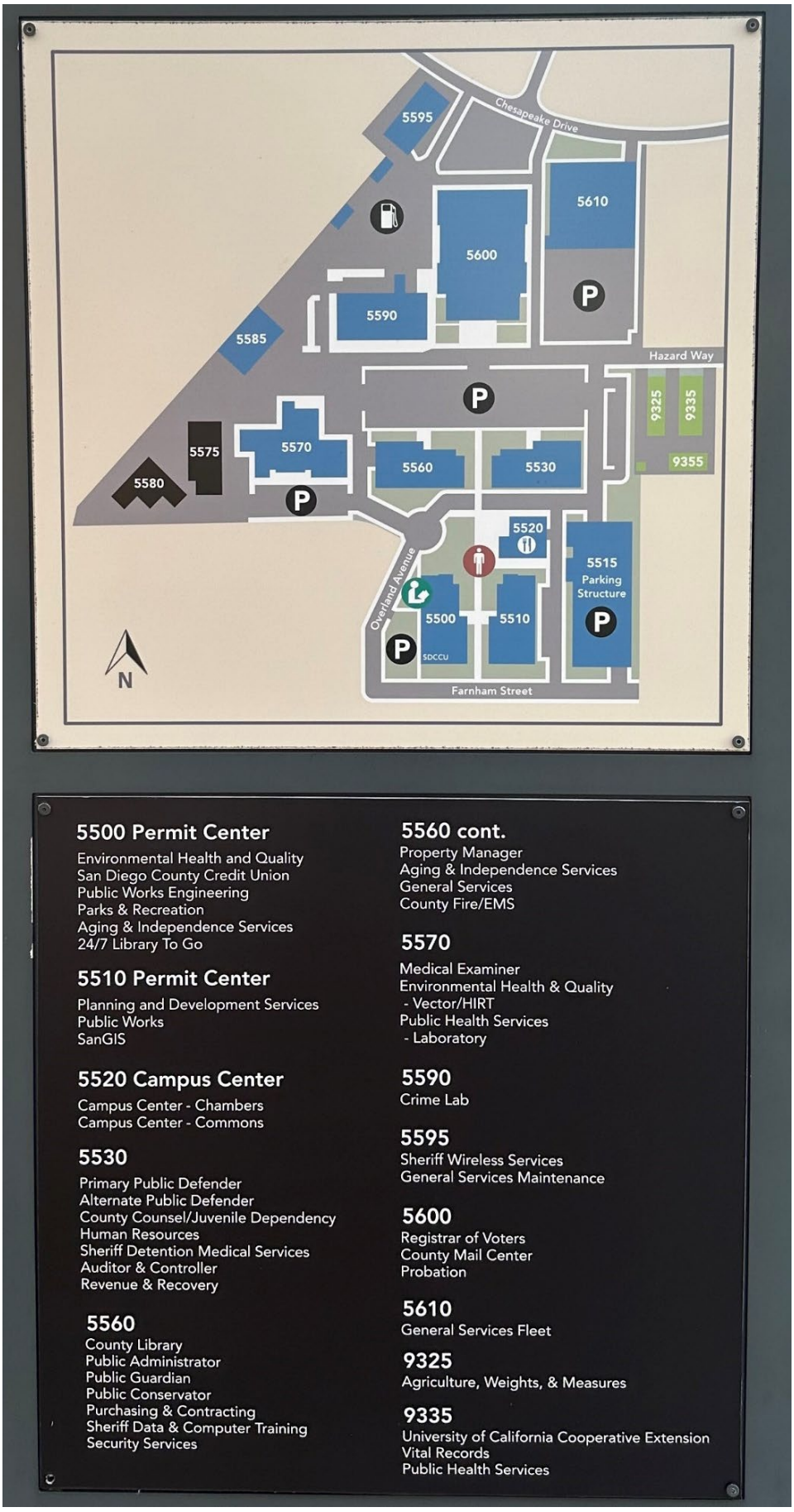


ADDITIONAL RESOURCES:

County Operations Center (COC)
CAMPUS MAP



County Operations Center (COC)
CAMPUS DIRECTORY



5500 Permit Center
Environmental Health and Quality
San Diego County Credit Union
Public Works Engineering
Parks & Recreation
Aging & Independence Services
24/7 Library To Go

5510 Permit Center
Planning and Development Services
Public Works
SanGIS

5520 Campus Center
Campus Center - Chambers
Campus Center - Commons

5530
Primary Public Defender
Alternate Public Defender
County Counsel/Juvenile Dependency
Human Resources
Sheriff Detention Medical Services
Auditor & Controller
Revenue & Recovery

5560
County Library
Public Administrator
Public Guardian
Public Conservator
Purchasing & Contracting
Sheriff Data & Computer Training
Security Services

5560 cont.
Property Manager
Aging & Independence Services
General Services
County Fire/EMS

5570
Medical Examiner
Environmental Health & Quality
- Vector/HIRT
Public Health Services
- Laboratory

5590
Crime Lab

5595
Sheriff Wireless Services
General Services Maintenance

5600
Registrar of Voters
County Mail Center
Probation

5610
General Services Fleet

9325
Agriculture, Weights, & Measures

9335
University of California Cooperative Extension
Vital Records
Public Health Services

County of San Diego

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3851 ROSECRANS STREET, MAIL STOP P-578
SAN DIEGO, CA 92110-3134
(619) 531-5800 • FAX (619) 542-4186

WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES & STANDARDS COMMITTEE
Tuesday, April 04, 2023 11:30 AM

In-Person Meeting:
County Operations Center (COC)
5500 – 5570 Overland Ave. San Diego, CA 92123
Medical Examiner's Office – Room 1047 (Building 5570)

For Members of the Public – to participate remotely via Zoom (click the following link):
https://us06web.zoom.us/j/85772860296?pwd=Ym1jWit6cWhnL05BOTlyR25LbWhqQT09
Meeting ID: 857 7286 0296 **Password:** 630634
Join the meeting via phone: 1-470-238-5742 US Toll / 52-55-6722-5298 Mexico Toll

NOTE: This meeting is audio and video recorded.

The Charge of the Strategies & Standards Committee (updated June 4, 2019): To oversee the Getting to Zero (GTZ) Plan to direct objectives, strategies, and activities to get to zero new infections and continue to support those living with and vulnerable to HIV in living well in San Diego.

Participants Requesting Spanish Translation: Translation services are available free of charge with at least **96** hours' notice. To arrange for these services, please contact **HIV Planning Group Support** via email at: **HPG.HHSA@sdcounty.ca.gov** .

Committee Members (11): Allan Acevedo (Co-Chair), Amy Applebaum, Dr. Beth Davenport, Lucia Franco, Moira Mar-Tang, Joseph Mora, Venice Price, Shannon Ransom (Chair), Dr. Winston Tilghman, Jeffery Weber, Michael Wimpie

A quorum for this committee is six (6)

AGENDA

1) Call to Order, Roll Call, Comments from the Chairs
2) Public comment/Sharing Our Concerns
3) Review and approve agenda for April 4, 2023
4) Review and approve minutes from February 7, 2023
5) Review follow up items from last meeting.
6) Old Business:

a) Getting to Zero Community Engagement Plan
   i) JEDI Principles Implementation
   ii) Follow up – consultant for HPG's JEDI workforce
b) **Review:** Integrated Statewide Strategic Plan – Next steps
c) Consider changes to Transportation Standards
   i) Review key findings from Clinical Quality Management (CQM) Committee
d) Review draft changes to Universal Standards
   i) **Brief Overview:** Competence in service design and delivery
   ii) **Discussion:** Review draft changes to Trauma-Informed Care
e) **Discussion:** Annual review of data requests to the Recipient
   i) Review the Priority Setting & Resource Allocation Committee (PSRAC) 2023 Workplan

7) New Business:
   a) **Discussion:** Frequency of Strategies & Standards Committee Meetings
      i) PSRAC decided to meet every other month in alteration with the Strategies & Standards Committee
8) Update Committee Work Plan
   a) Upcoming Trainings
9) Recommendations to HPG, HPG committees and requests of recipient
10) Suggested items for the future committee agenda
11) Announcements
12) Confirm next meeting:
   a) Scheduled **May 2, 2023 11:30 AM**
   b) **Location:**

      County Operations Center (COC)

      5500 – 5570 Overland Ave. San Diego, CA 92123

      Building 5530 – Training Room 124 (Building 5530)
13) Adjournment

County of San Diego

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SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE

Tuesday, February 7, 2023
11:30 AM – 1:00 PM
Meeting by ZOOM

DRAFT MINUTES
Quorum = Seven (7)

Committee Members Present: Amy Applebaum, Dr. Beth Davenport, Lucia Franco, Moira Mar-Tang, Joseph Mora, Shannon Ransom (Chair), Dr. Winston Tilghman, Jeffery Weber, Michael Wimpie

Committee Members Absent: Allan Acevedo (Co-Chair), Liz Johnson, Venice Price

Agenda Item	Action	Follow-up
1. Call to order	Shannon Ransom established that a quorum was present and called the meeting to order at 11:31 AM.	
2. ACTION ITEM: Continuance of Teleconferencing Meeting Option Pursuant to Government Code Section 54953(e)	**Motion:** Recognize that there is a continued proclaimed state of emergency, and State and local officials have imposed or recommended measures to promote social distancing authorizing teleconferenced meetings pursuant to Government Code section 54953(e). **Motion/Second/Count (M/S/C):** Davenport/Tilghman 7/0 **Abstention(s)**: Ransom **Motion carries**	
3. Public Comment/Sharing our Concerns	None	
4. Review and approve the agenda for February 7, 2023	**Motion:** Approve the agenda for the February 7, 2023 meeting as presented. **M/S/C:** Davenport/Wimpie 8/0 **Abstention(s)**: Ransom **Motion carries**	
5. Review and approve the Minutes for December 6, 2022	**Motion:** Approve the minutes for the December 6, 2022 meeting as presented. **M/S/C:** Davenport/Weber 7/0	

Agenda Item	Action	Follow-up
	Abstentions: Ransom **Motion carries**	
6. Review follow up items from the last meeting	a) Getting to Zero Community Engagement Plan i. **Pending:** HIV Planning Group (HPG) support staff will ask for a year of birth and home district to report member representativeness b) Review Universal Standards to include Competency Standards for Disability and Trauma-Informed Care i. **Complete:** Draft changes to Competency in Service Design and Delivery ii. **Pending:** Draft changes to Trauma-Informed Care c) Recommendation from Priority Setting and Resource Allocation Committee (PSRAC) to review service guidelines related to Psychosocial Services (regions, populations) i. **Complete:** Forwarded to Steering Committee on January 17, 2023.	HPG Support to forward demographics, year of birth, and home district report to Membership Committee to include in their reporting. Remove from Strategies agenda.
7. Old Business		
a) Getting to Zero Community Engagement Plan i. JEDI Principles Implementation	Discussion led by Dr. Delores Jacobs on Getting to Zero Community Engagement Plan updates. The HIV Planning Group retreat is scheduled to take place on Wednesday, March 22, 2023, at the Valencia Park/Malcolm X Library (5148 Market St. San Diego, CA 92114). Those who volunteered for workgroup can do a meet-and-greet with the consultant prior to the retreat before moving forward with diversity trainings. Part of the communication plan is reaching a wider audience with enhanced communication about HPG and what we do and how they can participate, etc. For example, if people are aware of existing groups who are welcoming to HIV members or members who are at risk of HIV, we would like for people to send people these groups, names of individuals, etc., to Joyce Ann Eclarino, HPG Support Staff, to get more information distributed.	

Agenda Item	Action	Follow-up
	The committee was asked to think about strategies to have providers make available on request the consolidation of appointments on the same site and possibly on the same day. This consumer request historically and currently is increasing as we return to in-person meetings—many desire to avoid having to go to multiple places/locations for care. There was concern from the public about the retreat is open to only committee members. There was also a concern for the diversity of HPG members.	
ii. **Follow-up:** Consultant for HPG's JEDI Workforce	The consultant is in the contracting process with the Recipient's office.	
b) **Update:** Integrated Statewide Strategic Plan	The Recipient's office had no additional updates and anticipated additional information after meeting with project officers. It was requested to keep this item be on the Strategies and Standards Committee agenda.	
c) Consider changes to Transportation Standards and/or Universal Standards to add a requirement that Consumers be assessed for transportation needs	The Recipient's office reported that they have a meeting with the Part A Project Officer at the end of this month about how transportation may be measured and linked towards health outcomes. The Clinical Quality Management (CQM) group had discussed universal enrollment and hoped that this process would roll out in March of this year to streamline services across the board. There was concern about the utilization of the Compass Card System and that the new system is Pronto, which can be utilized through a smartphone. The Recipient's office stated that the standard is to give a daily pass plus two (2) additional emergency passes. It was requested to keep this item be on the Strategies and Standards Committee agenda.	
d) Review draft changes to Universal Standards:	**Motion:** Approve and accept draft changes to 'Competency in Service Design and Delivery' in Universal Standards as included in the meeting packet. **M/S/C:** Mora/Weber 8/0	HPG Support Staff to put together draft of competency standards with tracked changes to

Agenda Item	Action	Follow-up
i. **For Approval:** Competency in Service Design and Delivery	**Abstention(s):** Ransom Motion carries The Pacific AIDS Education and Training Center and Christie's Place are participating in trainings on Trauma-Informed Care and Cultural Humility. If needed, they can help support the County and contractors and their team to get trained. Their curriculum is HRSA-approved. The section about the curriculum will be updated in the future. The need for a HRSA-approved curriculum will be discussed, however, that update still needs to be prepared to be included in the version of the draft presented.	present at next meeting.
ii. **Discussion:** Review draft changes to Trauma-Informed Care	Shannon Ransom and Rhea Van Brocklin have volunteered to work on finalizing the draft to Trauma-Informed Care for review at next Strategies and Standards Committee meeting. It was asked if it would be helpful for direct resources be mentioned in this section. If found not appropriate in this section, it would be appropriate to provide this information elsewhere. Important items mentioned to include in the draft are voluntary sexual experiences as well as adverse events and research on adverse events.	
8. New Business		
a) **Discussion:** Annual review of data requests to the Recipient	The committee discussed data that Strategies and Standards would want to review this year. Examples of data sets that the Priority Settings and Resource Allocation Committee (PSRAC) review annually were provided, including Co-Occurring conditions, PARS data, Housing Services data, HPG expenditures and budget, HIV epidemiology presentation by Dr. Tweeten, continuum of care for number of clients maintained in care and unmet need. Testing data is also reviewed at PSRAC on a regular basis as well as Service Utilization each month. There was a request to include filling out viral suppression data, more information on those	HPG Support to provide PSRAC workplan for the Strategies and Standards Committee to preview at next meeting. HPG Support to confirm that subpopulation data may be requested noting that this usually requires a

Agenda Item	Action	Follow-up
	who are inconsistent or falling out of care, and demographics breakdown of the data. It was stated that it would be helpful to view list of data reports that PSRAC provides, then can identify data gaps at Strategies and Standards Committee. It is on the radar for Prevention team to conduct a gap analysis, however, there is not yet an exact time frame. They review who is receiving prevention services and if there are gaps in prevention activities. If there is a request for gap analysis, Prevention compares data to epidemiologists' data. Suggestions were to consider including vulnerable populations and reviewing HIV testing reports. This request would be considered a separate request and/or added on request from the data that the Recipient's office provides. It was stated that the Recipient's office provides data on types of tests. It was stated that what will happen is that a request is made, and a subpopulation sample size is sometimes small to make an analysis. Regarding HIV impact and regional focus meetings, the goal is to have data collected by late summer/early fall of this year. Regional community meetings will be completed by staff and/or a consultant after we move into in-person meetings.	large sample size to get to that level of detail.
b) **Discussion:** In-Person Meetings	The new AB 2449 ruling is effective immediately after the local COVID emergency concludes at the State level. It was expressed that travel to meetings will be difficult. There were suggestions from the public change the meeting times to change the meeting times. There were several suggestions for meeting locations, however, meeting locations would need to meet several requirements and have considerations to connectivity, space, and ADA compliance. The March meeting is reserved to take place in the South Live Well Center (690 Oxford St., Chula Vista, CA 91911). The South Live Well Center will not be open from April through July. The Recipient's office is working to secure more permanent meeting space;	

Agenda Item	Action	Follow-up
	however, we will not have information until the new Southeast Live Well facility opens this summer. There is no given date for the grand opening. If any members have suggestions for potential meeting space, forward information to Shannon Ransom or HPG Support Staff.	
9. Update Committee Work Plan		
a) Upcoming Trainings		
10. Recommendations to HPG, HPG committees, and requests of recipient	None currently.	
11. Suggested items for the future committee agenda	None currently.	
12. Announcements	A new member of the HIV Planning Group Support Team will start on Friday, February 24, 2023. The Women's Conference, taking place on **Saturday, March 11th,** is now accepting registrations. Seats are filling up fast for the in-person event. It will cap at around 160 attendees.	
13. Confirm the next meeting date and time	**Tuesday, March 7, 2023** at **11:30 AM** **Location:** In-Person and via Zoom 690 Oxford St. Chula Vista, CA 91911	
14. Adjournment	Meeting adjourned at 1:02 PM.	

ENDING THE EPIDEMICS:

Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California

Integrated Statewide Strategic Plan
Overview
2022-2026

California Department of Public Health

MAKING A STATEMENT

The California Department of Public Health's (CDPH) Office of AIDS and Sexually Transmitted Diseases (STD) Control Branch are pleased to present the first integrated human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs) strategic plan for California. This plan reflects diverse voices from CDPH and other state agencies, local health jurisdictions, community-based organizations, and people with lived experience. In this plan, you will find a picture of what we hope the HIV, HCV, and STI landscape in California will look like in five years and some ideas for how to create it.

Addressing HIV, HCV, and STIs together is powerful, because these issues affect many of the same people and communities, making several separate epidemics into what is known as a "syndemic." In a syndemic, having one health issue places a person at greater risk for another one, and having two or more health issues at the same time makes one or both health issues worse. For example, having syphilis or gonorrhea can make it easier to get HIV; having HIV can make it easier to get HCV through unprotected sex; and having HIV and HCV at the same time can make liver disease get worse faster than having HCV alone.

Despite much progress, the populations in California that experience more than their share of new HIV, HCV, and STIs also experience many other health and social inequities. While specific behaviors may put individuals at increased risk for HIV, HCV, and STIs, social and environmental factors that can limit people's choices and influence their access to information and care. As we have seen with the syndemic of COVID-19 and structural racism, truly ending an epidemic requires both offering health services like vaccination, testing, and treatment and giving people and communities the resources they need to stay healthy and access health care. The same thing is true for HIV, HCV, and STIs, which is why this integrated strategic plan is organized around six "social determinants of health:" racial equity, housing, access to healthcare, mental health and substance use, economic justice, and stigma.

California has a long history of innovative leadership in the response to HIV, HCV, and STIs. Our existing public health interventions and services are designed to help us address these conditions: HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); outreach and health education; medication-assisted substance use treatment, syringe services, and harm reduction; rapid testing in mobile vans and routine testing in healthcare settings; peer navigation and linkage-to-care; case investigation and contact tracing; stigma-reducing U=U (Undetectable = Untransmittable) campaign efforts; data evaluation and epidemiology; and cutting-edge treatment all will continue.

At the same time, we need to confront structural and systemic health disparities fueled by racism, homophobia and transphobia, sexism, ableism, xenophobia, social and economic inequality, homelessness, and identity-based discrimination and stigma. This will be challenging and will require us to forge new collaborations with others throughout the state – but we believe it is necessary. Public health and medical systems have contributed to racism, homophobia and stigma over time, and we need to find ways to repair the community relationships severed by those actions. We commit to working towards a future where all our state's HIV, HCV, and STI service providers are equipped with the awareness, tools, and resources they need to address systemic problems that prevent Californians from receiving the care and support they deserve.

This plan builds on many years of the dedication of people affected by the HIV, HCV, and STIs syndemic, as well as public health, health care providers, and other partners across the state. Ending the HIV, HCV, and STIs syndemic will require being bold and reflective, centering communities that have frequently been neglected and mistreated. We look forward to working with our state, local, and community partners to co-create the California we want to live in together.

VISION

We envision a California free of systemic racism and new HIV, HCV, and STIs, where all people with these conditions easily obtain the services and resources needed to live healthy, dignity-filled lives free of stigma.

MISSION

To center equity and racial justice in our work and eliminate health inequities among those most affected by HIV, HCV, and STIs in California.

PURPOSE

To define key strategies to end the syndemic of HIV, HCV, and STIs in California, using a social determinants of health framework.

OUR VALUES

HUMAN DIGNITY

We recognize the strength, courage, and dignity of all people who seek medical and public health services, and strive to meet them with respect, humility, and openness.

COURAGEOUS LEADERSHIP

We value visionary leadership and taking risks needed to change historical patterns and end this syndemic.

RACIAL AND SOCIAL JUSTICE

We center the voices, experiences, and leadership of Black, Indigenous, and other People of Color (BIPOC) and people most affected by this syndemic. We commit to anti-racist policies and programs to improve the health of our communities.

COLLABORATION

We build strategic partnerships with other state agencies, health care providers, local public health departments, community-based organizations, and impacted communities, to ensure that our work reflects and addresses whole people and the systems with which they interact.

HARM REDUCTION

We invest in and value people who use drugs, honoring their rights, their journeys, and their expertise.

PERSON-CENTERED SOLUTIONS

We believe in focusing on finding creative solutions. We expect systems to change to meet the needs of people, not the other way around.

THE PEOPLE

Throughout this strategic plan, we have worked to center the work and voices of those most affected by HIV, HCV, and/or STIs in California.

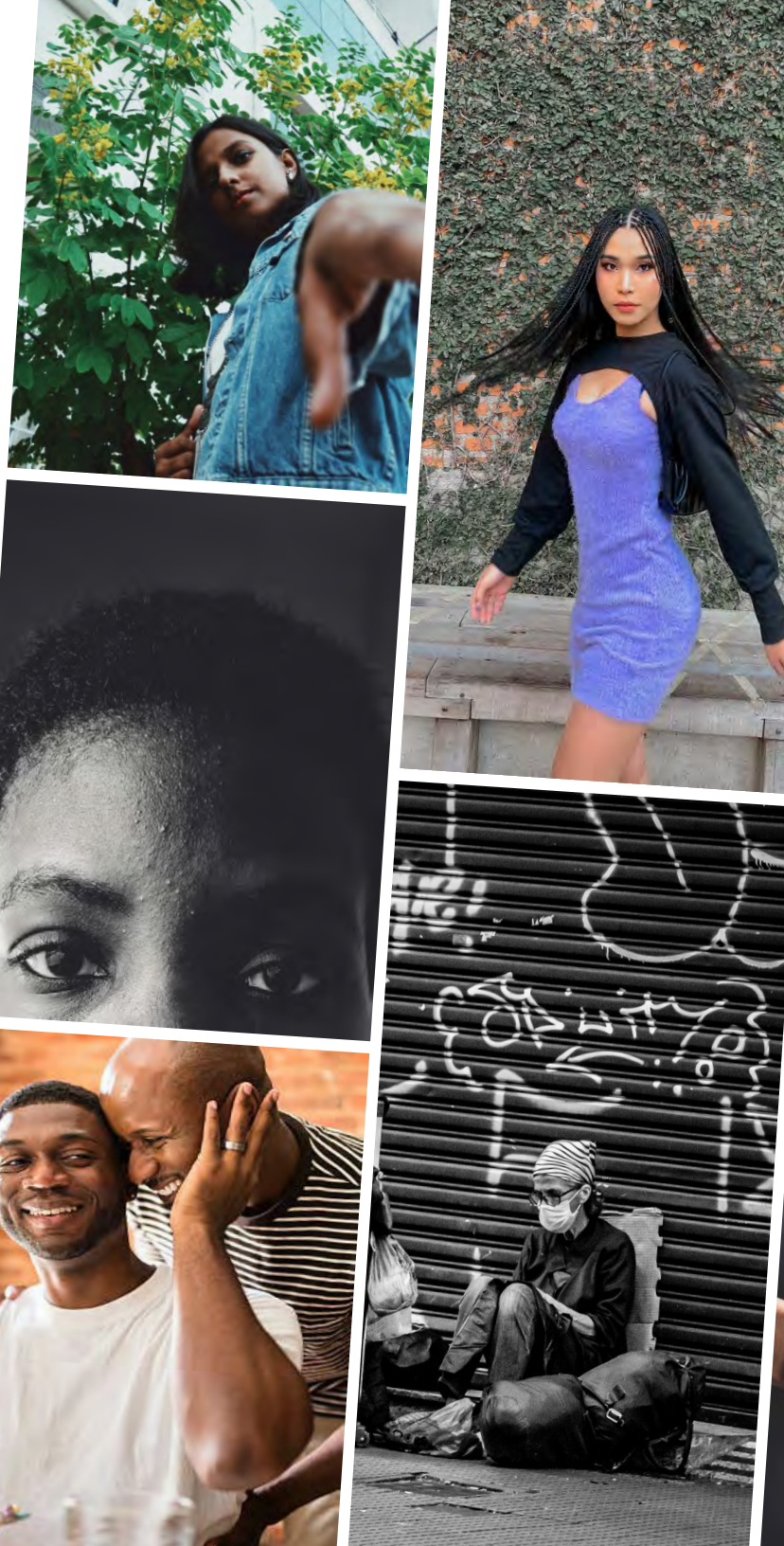
In California, the communities most impacted by HIV, HCV, and/or STIs include:

- People of Color, especially Blacks/African Americans, Latinx, & Indigenous people
- Young people (ages 15-29 years)
- Gay and bisexual men, and other men who have sex with men
- People who are trans or gender non-conforming
- People who use drugs, including people who inject drugs
- People experiencing homelessness
- People who are incarcerated
- People who exchange sex for drugs, housing, and/or other resources
- People who can become pregnant
- Migrant and immigrant communities, including people who are undocumented

These groups are not mutually exclusive. Many people identify with more than one of the groups in this list, and these intersecting identities can often mean people experience two or more forms of exclusion, discrimination, and stigma, making it harder for them to thrive.

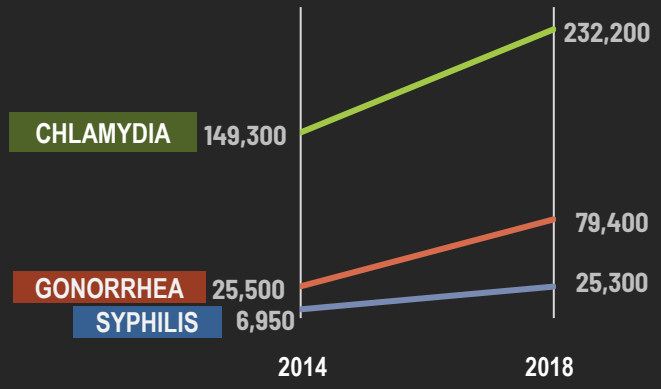
On the next three pages we provide data highlighting racial and gender disparities in HIV, HCV, and STI outcomes in California. Understanding where disparities exist is important, to guide our work improving racial and health equity.

Data here and on the following page comes from:
--The 2018 STD Surveillance Report: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx
--The 2018 Chronic Hepatitis C Infections in California Surveillance Report: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/2018-Chronic-HCV-Surveillance-Report-Exec-Summary.pdf
--The 2019 California HIV Surveillance Report: https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California_HIV_Surveillance_Report2019_ADA.pdf

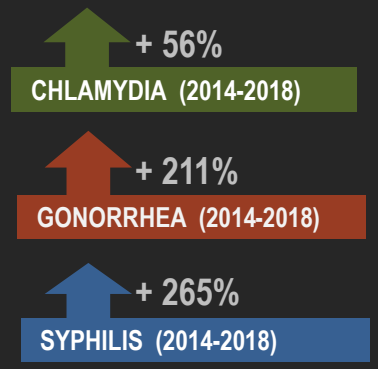


THE DATA: SEXUALLY TRANSMITTED INFECTIONS

The number of syphilis, gonorrhea, and chlamydia cases in CA increased between 2014–2018, in all regions of the state, among people of all genders.

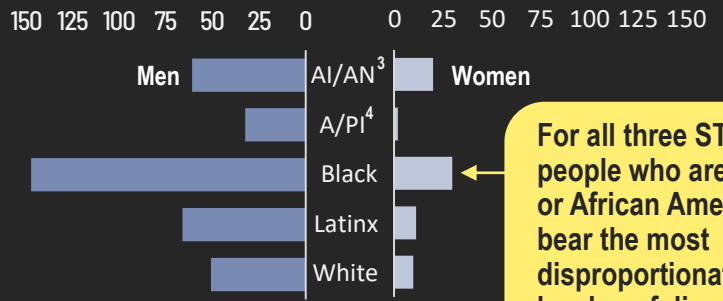


Although chlamydia cases are higher in number, syphilis and gonorrhea cases are increasing much more rapidly than chlamydia.



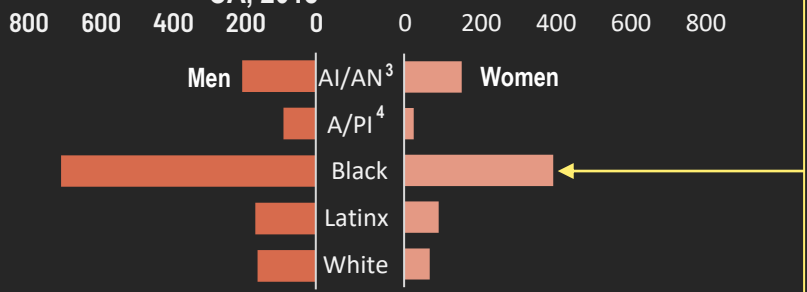
Syphilis and gonorrhea are more commonly diagnosed among men, while chlamydia is more commonly diagnosed among women.[1]

SYPHILIS: Number of early syphilis[2] cases per 100K people in CA, 2018



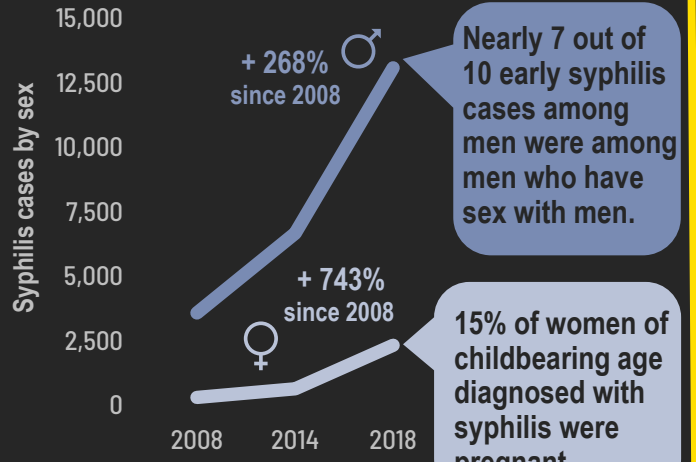
For all three STIs, people who are Black or African American bear the most disproportionate burden of disease.

GONORRHEA: Number of gonorrhea cases per 100K people in CA, 2018



CHLAMYDIA: Number of chlamydia cases per 100K people in CA, 2018

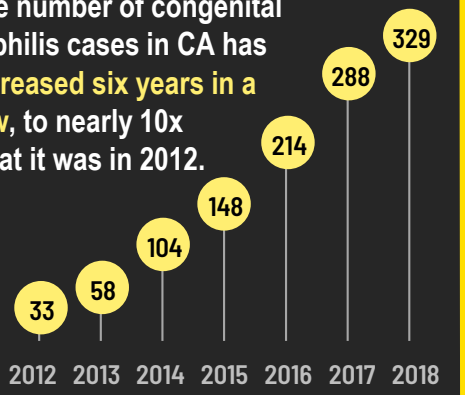
Men make up most syphilis cases in CA; however, cases among women are increasing rapidly, up 743% from only 273 cases in 2008 to more than 2300 in 2018.[1]



Nearly 7 out of 10 early syphilis cases among men were among men who have sex with men.

15% of women of childbearing age diagnosed with syphilis were pregnant.

The number of congenital syphilis cases in CA has increased six years in a row, to nearly 10x what it was in 2012.

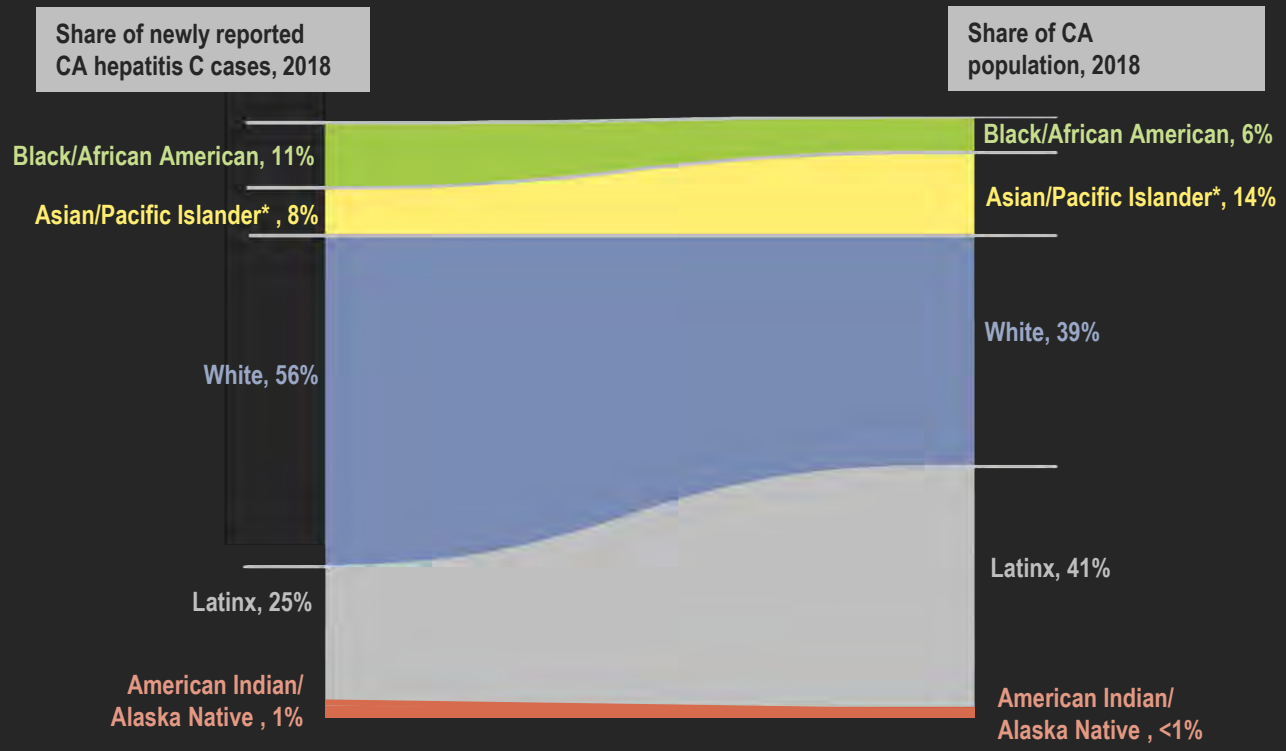


Of 329 congenital syphilis cases in 2018 alone, there were 19 infant stillbirths, 3 neonatal deaths, and 31 infants born with other symptoms or complications.

1. Note that transgender was not routinely a gender option during this data period, so trans people may be found in the categories of men or women.
2. Early syphilis includes primary, secondary, and early non-primary non-secondary syphilis
3. AI/AN = American Indian/Alaska Native
4. A/PI = Asian/Pacific Islander. Note that until 2018 STI data were not separately available for Asians and Native Hawaiians/Pacific Islanders. This will be different for future CDPH data reports.

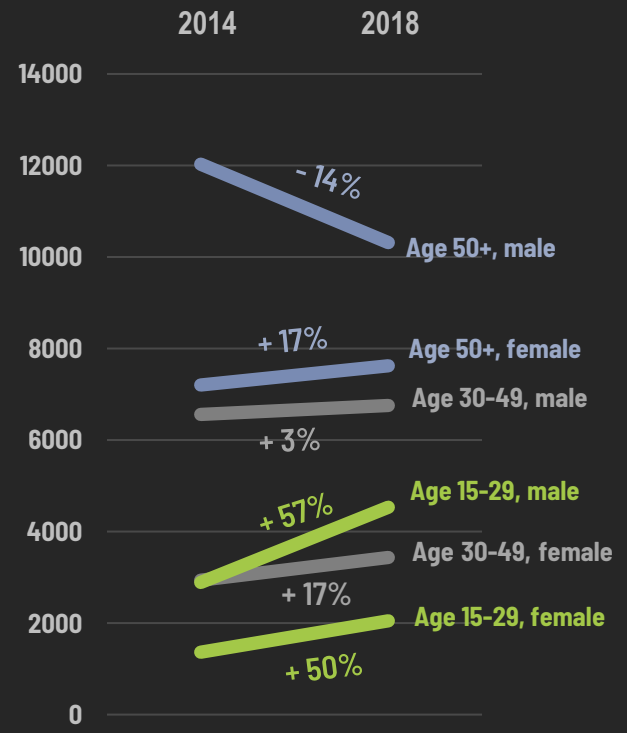
THE DATA: HEPATITIS C VIRUS

People who are Black/African American, White, and American Indian/Alaska Native, have disproportionate rates of hepatitis C in CA.



* Note that until 2018, HCV data were not separately available for Asians and Native Hawaiians/Pacific Islanders. This will be different for future CDPH data reports.

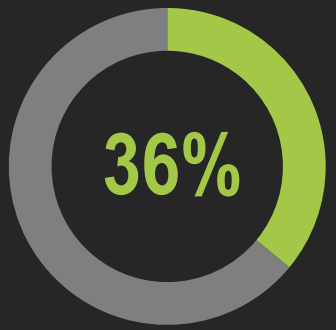
"Baby boomers" (born 1945-1965) make up most new hepatitis C cases, but new cases are increasing dramatically among younger people ages 15-29.



With respect to sex, there were:

110 new cases of chronic hepatitis C for every 100,000 males in CA in 2018.

66 new cases of chronic hepatitis C for every 100,000 females in CA in 2018.



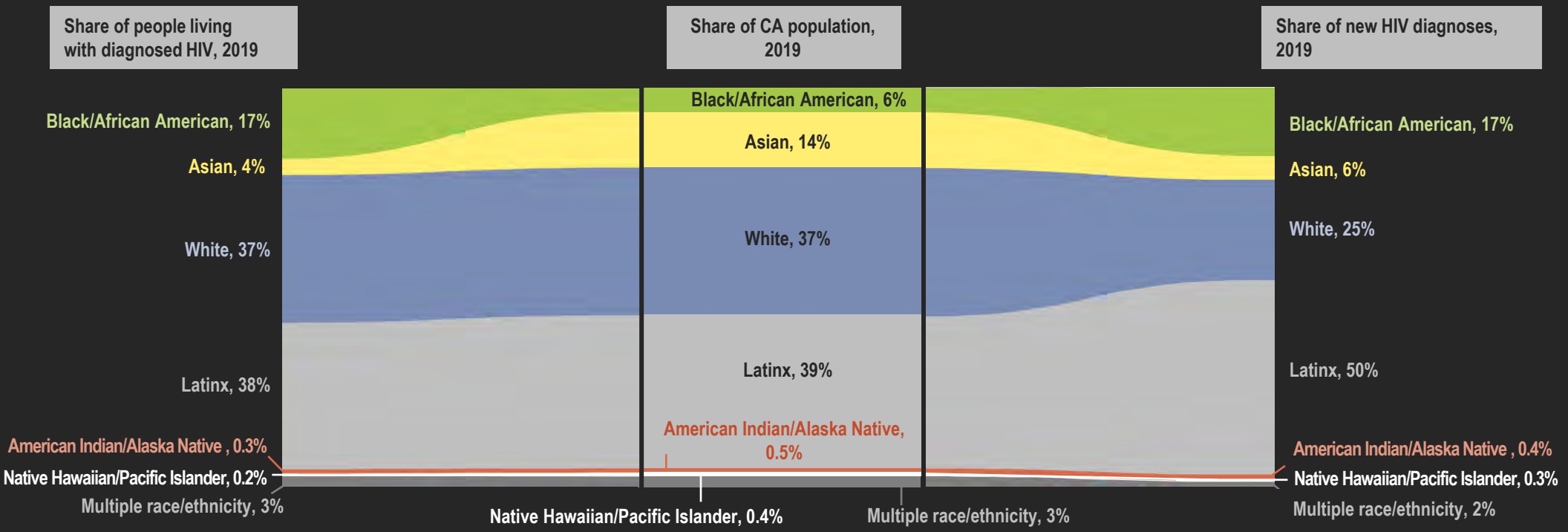
36% of youth aged 15-29 who tested positive for hepatitis C in an assessment conducted by the state[5] reported having injected drugs.

1 in 9 new chronic hepatitis cases in CA were reported among persons who are incarcerated in State prisons.

5. Oringher, et al., *BMC Public Health*, 2021. Note that since youth were being asked to report about a stigmatized behavior, the true percentage of youth having injected drugs may be even higher.

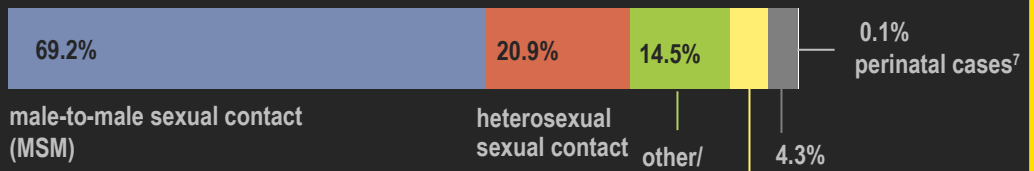
THE DATA: HIV

Compared to their population size, Black Californians are more likely to be living with diagnosed HIV. Both Black and Latinx Californians are disproportionately becoming newly infected with HIV as of 2019.



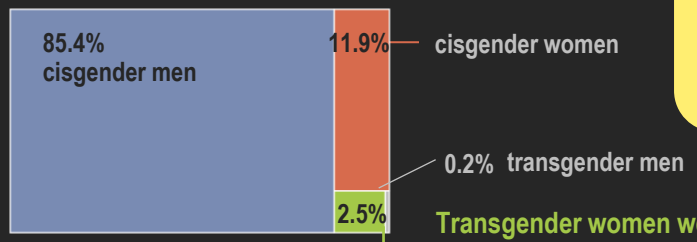
*People who are Native Hawaiian/Pacific Islander made up 0.5% of the population, 0.2% of people living with diagnosed HIV, and 0.3% of new HIV diagnoses.

Male-to-male and heterosexual sexual contact were the most common transmission categories for people newly diagnosed with HIV in 2019.



Young Black and Latino gay and bisexual men and Black heterosexual women are becoming infected with HIV at especially high rates.

Cisgender men made up most new HIV diagnoses among persons ages 12+ in CA in 2019.



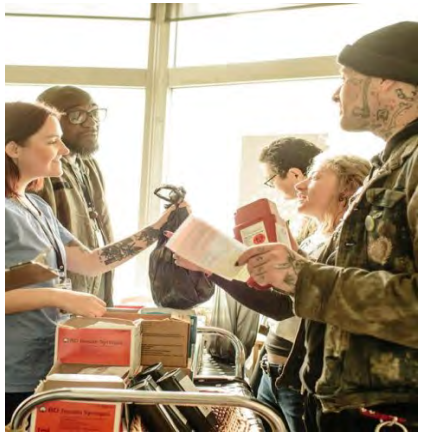
Transgender women were also overrepresented among new HIV diagnoses, especially trans women of color.

Both cisgender and transgender women have more limited access to HIV prevention services in California, including PrEP.

6. Other/unknown includes trans people exposed to HIV through sexual contact.

7. Perinatal cases refer to cases of HIV among children <12 years old. In 2019, there were 4 perinatal HIV cases in CA

HEALTH INEQUITIES, SOCIAL DETERMINANTS OF HEALTH, AND INTERSECTIONALITY



Living with Hep C?
New treatments have changed the game

AT OUR CORE

The next pages of this strategic plan focus on new strategies we will embrace in the next 5 years as we approach our work through the lens of social determinants of health. However, these new strategies only enhance the evidence-based, innovative, life-changing work our colleagues in public health do every day.

At the Office of AIDS and STD Control Branch of CDPH, we will continue to partner with local health departments and community-based organizations throughout California to expand access to the services we know work to prevent and treat HIV, HCV, and STIs, including:

- Offering more **routine, opt-out, HIV, HCV, and STI testing** and linkage to care in emergency departments, hospitals, primary care clinics, and jails
- **Expanding access to HIV, HCV, and STI treatment**, especially through non-traditional care settings
- Improving outreach and provider training to make it easier for people to access **PEP** and initiate and adhere to **PrEP**
- Promoting **comprehensive, medically accurate sexuality education** and condom access in schools
- Continuing to educate providers and patients about **U=U** (Undetectable = Untransmittable), which reduces stigma and fear for people living with HIV
- Increasing the number, size, and scope of **syringe services programs** and other harm reduction services, both in urban and rural areas throughout California
- Advancing our **use of data** to equip the local public health workforce with the information they need to reach out to people in need of care, and link them to life-saving services in a person-centered way

These efforts – and more – have been mainstays of our work to address HIV, HCV, and STIs, and we are committed to innovating and improving these services for all Californians, while recognizing that social determinants of health profoundly impact our ability to end HIV, HCV, and STIs in our state.

RACIAL EQUITY

8. CDPH, Racial and Health Equity Glossary of Terms, c. 2020

Black, Indigenous, and other People of Color (BIPOC) are disproportionately impacted by HIV, HCV, and STIs in the United States. This is not simply a matter of individual behaviors, education, or attitudes; research regularly finds that racism weakens the quality of services received by BIPOC compared to whites in the US. Challenges due to limited access to jobs, education, housing, and other growth opportunities for BIPOC contribute to the level of risk that these communities experience. These barriers contribute to a decline in access to services and information, and further delay the onset of treatment and care.

CDPH defines racial equity as the condition achieved when race can no longer be used to predict life outcomes and conditions for all groups are improved.[8] We clearly have a long way to go to reach racial equity in the HIV, HCV, and STI syndemic. To make racial equity real in California and across the country, we will need to root out racism, including structural racism. Racism refers to assumptions, beliefs and behaviors based on the presumed superiority of a dominant race over all others. In the United States, these beliefs and behaviors can be conscious or unconscious, personal or institutional, and generally result in the oppression of non-white people to the benefit of white people. A simple definition of racism is: (racial) prejudice + power = racism.

Structural racism is defined as the systems, social forces, and processes that create and keep in place inequities among racial and ethnic groups. Structural racism does not need individual people to intend to harm or discriminate; once racist systems are built, they are constantly added to and kept up by the way things already are. Even if at an individual level people were no longer racist, racial inequities would likely continue as long as structural racism was still in place.

STRATEGIES

CDPH is prioritizing these 5 strategies over the next 5 years to better address HIV, HCV, and STIs by promoting racial equity:

1. **Leadership and Workforce Development**

   Expand pathways and workforce development initiatives to increase the proportion of BIPOC public health staff, leadership, and administrators, including at CDPH.

2. **Racial/Ethnic Data Collection and Stratification**

   Identify, collect, analyze, and publicly share data that reflect the specific trends, needs, and outcomes of HIV, HCV, and STIs for BIPOC communities, to inform resource allocation and identify community-based strategies and solutions.

3. **Equitable Distribution of Funding and Resources**

   Review all CDPH OA and STD Control Branch contracts, budgets, guiding service formulas, policies, and program decisions with a racial justice lens, to advance equitable delivery of resources and opportunities to BIPOC.

4. **Community Engagement**

   Forge strategic partnerships to ensure more diverse public outreach, involvement, and engagement processes to reframe the structure, funding, and policies of HIV, HCV, and/or STI services and messaging to all Californians.

5. **Racial and Social Justice Training**

   Implement capacity building and training opportunities and requirements for all CDPH-funded HIV, HCV, and STI service providers, to strengthen our movement towards achieving cultural humility, equity, and racial justice in our prevention, testing, treatment, and care services.

HOUSING FIRST

[9] Welfare and Institutions Code [WIC] Section 8255
[10] WIC Section 8256

As of January 2020, California had an estimated 161,548 people experiencing homelessness on any given day, per the U.S. Department of Housing and Urban Development (HUD). Another 7.1 million Californians are housed but living in poverty, and 56% of that group spends more than half their paycheck on rent each month. A disproportionate number of these Californians are Black and Brown, and many are living in marginal housing that is unstable, overcrowded, or unsafe.

California law[9] defines "Housing First" as an evidence-based model that centers on providing or connecting people experiencing homelessness to permanent housing as quickly as possible. Housing First providers do not make housing contingent on participation in services. California law (WIC Section 8256) also requires state programs to adopt guidelines and regulations to incorporate core components of Housing First into their programs.[10]

People who are unhoused or marginally housed are at higher risk for HIV, HCV, and STIs, due in part to survival strategies used to secure a place to sleep inside, or stay alert while sleeping on the street. People who are unhoused are also less likely to be virally suppressed if they have HIV, or successfully be cured of their HCV or syphilis, even if pregnant. With housing, people can focus on their health and fully address other needs in their lives. Although Housing First is an evidence-based practice intended to serve the most marginalized populations, we acknowledge that those who choose not to seek housing resources still deserve and will be provided services addressing their HIV/HCV/STI needs with the utmost respect and dignity.

STRATEGIES

CDPH is prioritizing these 5 strategies over the next 5 years to better address HIV, HCV, and STIs by recognizing the importance of stable housing for all:

1. **Data Collection and Use**

   Improve the ability of state data systems to collect information on housing status so that we can better monitor differences in HIV, HCV, and STI rates and health outcomes by housing status and use this information to inform public health action.

2. **Infrastructure Changes**

   Ensure multi-disciplinary teams address HIV/STI/HCV screening and treatment programs statewide, including housing, substance use, mental health, and medical care providers.

3. **New Models of Housing Access**

   Collaborate with the Department of Housing and Community Development to explore development of a permanent housing model based on Project Roomkey, for people living with HIV and pregnant people who are unhoused and/or living with HCV or syphilis.

4. **Street Medicine Strategies**

   Provide basic medical care and other supportive services to people who remain unhoused (including those who choose to remain unhoused) through walking teams, medical vans, outdoor clinics, and other similar services.

5. **Low-barrier Housing Options**

   Collaborate with housing partners to expand low barrier housing options available in both urban and rural areas, including those that offer harm reduction approaches to substance use, are available to families and couples, and/or allow people to bring their pets.

HEALTH ACCESS FOR ALL

[11] Kaiser Family Foundation & California Health Care Foundation, 2018.

California has led the nation in expanding access to health coverage under the Affordable Care Act, and has since expanded Medi-Cal to include young people 25 years of age and younger and to adults 50 years of age and older regardless of immigration status (as of May 2022). Yet many people still struggle to afford medical care, with more than half reportedly delaying treatment due to cost. Almost three quarters of low-income residents in a 2018 statewide survey[11] said they had to cut overall expenses to pay medical bills, using life savings, forgoing paid time off or vacation time, or having to borrow money.

Even people who can afford care often have a hard time accessing it because they cannot find a primary care or specialty provider accepting new patients, there is a long wait time for appointments, their provider is too far and they cannot afford transportation or take time off work or afford childcare, the provider does not speak their language or understand their culture, and because of other barriers. For people who do access care, they may have negative experience that makes them not want to seek care again except in emergencies. Reports of mistreatment in medical settings are especially common among BIPOC individuals; people who use drugs; people who are lesbian, gay, bisexual, trans, and queer (LGBTQ+); people who are unhoused; and people whose first language is not English – the same communities also most affected by HIV, HCV, and/or STIs.

Ending the HIV, HCV, and STI syndemic will require increasing access to quality health care and removing barriers to care for all Californians, with a focus on serving people least likely to seek care in clinical settings.

STRATEGIES

CDPH is prioritizing these 5 strategies over the next 5 years to better address HIV, HCV, and STIs by increasing health access for all Californians:

1. **Redesigned Care Delivery**

   Work with health care providers, local health departments, public and private insurers, and private industry to increase access to care statewide through telemedicine, mobile healthcare, and at-home testing programs.

2. **Trauma-Informed and Responsive Services**

   Train medical and public health service providers in trauma-informed approaches to create trauma responsive care to minimize re-traumatization of patients, clients, and providers.

3. **Fewer Hurdles to Healthcare Coverage**

   Train more community-based organizations to support benefits enrollment in communities with high numbers of uninsured people; change policies so that all Californians can access Medi-Cal when in need, regardless of immigration or housing status.

4. **Culturally and Linguistically Relevant Services**

   Improve capacity of public health and health care providers to offer HIV, HCV, and STI services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

5. **Collaboration and Streamlining**

   Develop secure ways for clinical providers, local health jurisdictions, homeless services programs, and other community-based organizations to share information and resources to coordinate people's care while protecting their right to privacy.

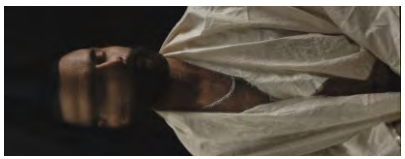
MENTAL HEALTH AND SUBSTANCE USE

People have been using various substances for thousands of years for celebration, ceremony, and comfort. Only a small portion of people who use substances develop a substance use disorder (SUD). Yet for the estimated eight percent of Californians with a SUD, the California Health Care Foundation (CHCF) estimates only 10 percent receive treatment. CHCF also estimates that 1 out of 6 Californians has a mental health concern, and 1 out of 24 has a mental disorder so serious it causes some life impairment. In fact, the two issues are often intertwined: A third of adults who received mental health services in California for serious mental illnesses in 2018 also had a substance use disorder. COVID-19 has only exacerbated the mental health concerns of people in California, with stressors highest in low-income and BIPOC communities.

Drug criminalization, racial profiling, and disjointed mental health services have resulted in incarceration of people who use drugs and of people with mental illness, with the greatest impact on Black, Latinx, and Indigenous communities. Studies have found that incarceration shortens lifespans and inflicts long-term damage on people's mental health. Incarceration also greatly increases the risk of fatal overdose — the death rate from drug overdose in California prisons is 3x higher than the national average,[12] and rising every year. Sharing injection drug use equipment increases HIV and HCV risk, and use of alcohol and stimulants such as methamphetamine can increase risk of HIV and other STIs by decreasing inhibition, yet stigma and criminalization of drug use often make people who use drugs afraid to access preventive services and health care.

To address HIV, HCV, and STIs we should continue to provide services tailored to the needs of people who use drugs, and people with mental health and substance use disorders. We should support and expand proven strategies like providing HIV and HCV screening and HCV treatment within opiate treatment programs or syringe services programs, and collaborate to improve behavioral health services and prevent overdose deaths.





[12] Kelso, 2018. CA Correctional Healthcare System: https://cchcs.ca.gov/wp-content/uploads/sites/60/Reports/Drug-Treatment-Program.pdf

STRATEGIES

CDPH is prioritizing these 5 strategies over the next 5 years to better address HIV, HCV, and STIs by addressing people's mental health and substance use:

1. **Overdose Prevention in Correctional Settings**

   Promote medication for opioid use disorder during incarceration in prison and jails and naloxone distribution and continuity of substance use disorder and medical care upon release.

2. **Mental Health and Substance Use Disorder Treatment Access through Telehealth**

   Leverage telehealth to increase access to mental health and SUD services, especially for people newly linked to stable housing and people who are monolingual in a language other than English.

3. **Build Harm Reduction Infrastructure**

   Expand syringe services in federally qualified health centers, hospitals, and SUD treatment facilities; build up staffing, brick and mortar locations, and comprehensive (health, legal, housing, benefits, employment) support services in existing syringe services programs.

4. **Expand Low-Threshold SUD Treatment Options**

   Expand options for harm reduction-based treatment, including contingency management programs and easier access to buprenorphine and methadone, including in street medicine programs.

5. **Cross-Sector Collaboration**

   Encourage collaboration between local and statewide mental health programs, substance use programs, harm reduction and HIV/HCV/STI programs.

ECONOMIC JUSTICE

[13] Ibragimov, et al., *PLOS ONE*, 2019.
[14] Moore, et al., *Journal of Infection and Public Health*, 2019.

If California were a country, it would have the fifth biggest economy in the world. Yet California has one of the top ten income gaps between the rich and poor of any state. According to the Public Policy Institute of California (PPIC), African American and Latinx families make up just one in eight of families with the highest-level incomes (90th percentile) despite comprising making up more than four out of every ten families in California. African American and Latinx families also had lower incomes overall in 2018. More than 1 in 5 LGBTQ+ Californians were living in poverty. According to PPIC, there are many reasons for these differences, including low-paying jobs, gaps in employment due to incarceration, disparities in education, limited job opportunities, and discrimination in the labor market. Unfortunately, the COVID-19 pandemic has only made these disparities worse.

These types of economic inequalities have direct implications for HIV, HCV, and STIs. Hundreds of studies have demonstrated that poverty does not just increase people's risk of becoming infected with HIV, HCV, or STIs, but also becomes a barrier to engaging in care that could lead to life-saving treatment or cure. One study found that increasing the minimum wage was associated with decreased STI rates across 66 U.S. metropolitan areas.[13] Another found that U.S. "baby boomers" living in poverty were 2.7x more likely to be living with HCV than those above the poverty line.[14] Ending the HIV, HCV, and STI syndemic will require continuing to serve people of all incomes, with a focus on increasing access to care for people with low or no income. It will also require improving the economic well-being of all Californians so they have the resources they need to be healthy.

STRATEGIES

CDPH is prioritizing these 5 strategies over the next 5 years to better address HIV, HCV, and STIs by working toward economic justice:

1 Workforce Development

Create pathways to employment in public health for people from communities most affected by HIV, HCV, and STIs, including but not limited to offering paid internships and entry level positions with clear opportunities for professional advancement.

2 Employment for People with Lived Experience

Give extra points when scoring grant applications to programs that employ people with lived experience in the communities the program serves, programs that can demonstrate frontline staff are paid a living wage, and/or programs that have BIPOC people serving in meaningful leadership positions.

3 Equitable Hiring Practices and Fair Pay

Examine state and local health jurisdiction hiring practices to promote equity and inclusion; look to remove barriers such as college and advanced degree requirements; offer extra pay to people who speak languages other than English or who have lived experience with HIV, HCV, STDs, substance use, mental health challenges, or homelessness.

4 Leadership Development

Fund and support pilot training programs for development of leadership and management skills among frontline and mid-level workers in HIV, HCV, and STI programs.

5 Universal Hiring and Housing Policies

Work with community partners and other State agencies to move toward universal "ban the box" hiring and housing policies in California, which remove questions about criminal history from the job application process until after a candidate has been given a chance to show whether they qualify for the position.

STIGMA FREE

CDC defines stigma as negative attitudes and beliefs about a group of people, and "the prejudice that comes with labeling an individual as part of a group that is believed to be socially unacceptable."[15] The extent to which people will reach out for care or support around a disease they think (or know) they have is directly related to their past experiences with discrimination and stigma, including racism, homophobia and transphobia, sexism, and ableism, among others, and their guesses about whether a provider will be supportive. A review[16] of the ways in which stigma affects access to care among people with HIV found that people tried to avoid stigma by seeking informal care, delaying telling health care providers their HIV status, going to large medical centers, commuting to care outside of their community, and avoiding HIV organizations and care altogether. The review also found that people found relief from stigma by joining with other people living with HIV to find social support, educate others about HIV, volunteer with HIV organizations, and organize together with others to fight for their rights. Some people with HCV or STIs have adapted these strategies as well.

While progress has been made, many people still experience stigma about their health or behaviors, especially related to sex and drug use. There is also additional stigma associated with homelessness, incarceration, sex work, and many of the other things that increase people's vulnerability to HIV, HCV, and STIs. Efforts such as the U=U (Undetectable = Untransmittable) Campaign, which focuses on ending stigma and empowering people living with HIV through education and awareness, should be promoted and integrated into every day health practices. Ending the HIV, HCV, and STI syndemic will require breaking down these negative beliefs to make it safer for people to share their status with others and seek the preventive services and health care they need and deserve, knowing that they can expect to be treated with dignity and respect.

STRATEGIES

CDPH is prioritizing these 5 strategies over the next 5 years to better address HIV, HCV, and STIs by counteracting stigma:

1. **Nothing About Us Without Us**

   Meaningfully and consistently involve people living with HIV, HCV, and STIs in state and local planning, decision-making, and service delivery.

2. **Reframe Policies and Messaging**

   Work with communities to reframe the structure and policies of HIV, HCV, and STI services and associated messaging, so they do not stigmatize people or behaviors.

3. **Positive, Accurate Information**

   Ensure images and language used in communications show accurate and diverse depictions of communities, and do not reinforce stereotypes; speak out against and correct negative language.

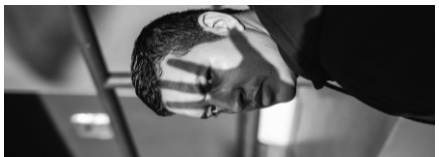
4. **Acknowledge Medical Mistrust**

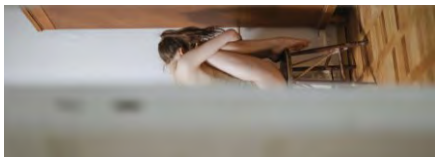
   Recognize medical mistrust as a rational response to stigmatizing treatment, rather than a failure of individuals or communities; work to build trust and correct misperceptions by example.

5. **Ongoing Partnerships**

   Use *promotores* and other models of paid peer engagement by people from the communities being served to educate, support, advocate, and link to care people who have historically been mistreated by public health services and the health care system.

15 https://www.cdc.gov/hiv/basics/hiv-stigma/index.html
16 Chambers *et al.* BMC Public Health, 2015.





FUTURE ROADMAP

So, what happens next? This document is just the beginning of our 5-year plan. In 2022 we will undertake a 7-step process in close collaboration with health department and community partners throughout the state, to develop a blueprint for realistic activities to implement the strategies in this plan. This will include:

1. Reaching out to stakeholders throughout the state of California, to invite them to inform our continued planning in a variety of virtual and in-person sessions.

2. Significant community engagement throughout the first half of the year

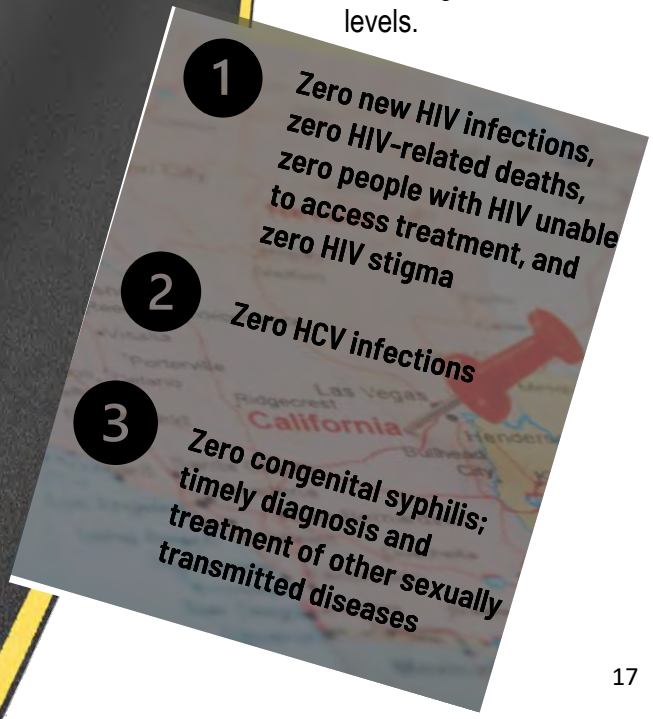
3. Determining the logistics and resources that will be necessary to successfully implement our prioritized strategies.

4. Identifying key milestones and measures of success, to hold ourselves accountable.

5. Drafting a comprehensive statewide blueprint to guide our activities at the state, regional, and local levels.

6. Circulating the proposed plan for community review and final broad input.

7. Disseminating the final plan to community, State, and federal partners.



EST 2021

PROCLAMATION

CALIFORNIA'S COMMITMENT TO THE PEOPLE

We, the California Department of Public Health (CDPH), set forth our commitment to an equitable, coordinated response to human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs),

WHEREAS, we promote a vision for health and well-being that advances inclusion, equity, and racial and social justice; and

WHEREAS, all people work together to build a future that ensures dignity, security, and justice for all regardless of race, religion, ethnic origin, documentation status, gender, gender-identity, sexual orientation, or legal involvement; and,

WHEREAS, we envision a California that gives people a chance to live healthy; now

THEREFORE, we pledge to promote the strategies laid out in this plan in collaboration with the necessary partners to encourage a just and equitable approach to the HIV, HCV, and STI syndemic.

On behalf of the
California Department of Public Health

Marisa Ramos
Marisa Ramos, PhD
Chief, Office of AIDS

Kathleen Jacobson
Kathleen Jacobson, MD,
Chief, STD Control Branch

KEY TERMS

Partial selection adapted from Racial and Health Equity Glossary of Terms (Rev. 01/2020), Copyright © 2020 – State of California, California Department of Public Health, available electronically at http://www.learn.calcasa.org/hub/wp-content/uploads/2020/06/CDPH-Racial-and-Health-Equity-Glossary-of-Terms_FINAL_2020-1.pdf

BIAS describes an inclination or preference that interferes with impartial judgment and decision-making. Bias can be implicit (subconscious) or explicit (conscious and direct).

CULTURAL HUMILITY is a mindset for understanding the cultures of others and acknowledging differences. Cultural humility requires a commitment to lifelong learning, continuous self-reflection on one's own assumptions and practices, respect for others' viewpoints, empathetic and humble engagement with new perspectives, and recognition of power and privilege imbalances.

A **DISPARITY** is a difference in outcome between population groups. A health disparity is a difference in physical or mental health status between groups.

HEALTH EQUITY describes circumstances in which all people have the opportunities and resources necessary to lead healthy lives. Efforts to achieve health equity often require giving special attention to the needs of those at greatest risk.

An **INEQUITY** is a difference in outcome between population groups that is unfair or unjust. Inequities are generally disparities — differences between groups — that are avoidable or warrant moral criticism and condemnation.

INTERSECTIONALITY is a term used to describe how people experience the connection between their multiple identities — such as their race, gender, sexual orientation, and class — and how those identities are valued within existing systems of power.

OPPRESSION is the use of power to systematically devalue, undermine, and disadvantage certain social identities in contrast to a privileged identity.

RACISM is a complex system of beliefs, behaviors, and historical conditions based on the presumed superiority of a dominant race over all others. These beliefs and behaviors generally result in the oppression of non-white people to the benefit of white people.

- ***Institutional Racism*** describes the ways in which policies and practices perpetuated by institutions, including governments and private groups, produce different outcomes for different racial groups.
- ***Structural Racism*** is defined as systems, social forces, ideologies, and processes that generate and reinforce inequities among racial and ethnic groups

RACIAL EQUITY is the condition achieved when race can no longer be used to predict life outcomes and conditions for all groups are improved.

SOCIAL DETERMINANTS OF HEALTH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[16]

[16] US Department of Health and Human Services

We thank the following individuals for coming together as part of the California Integrated Statewide Strategic Plan Workgroup:

California Department of Public Health

- Alessandra Ross – Injection Drug Use Specialist, Chief of Harm Reduction Unit, State Office of AIDS (OA)
- Artnecia Ramirez – Asst Division Chief (Equity Component), OA
- Ashley Dockter – Congenital Syphilis Program Coordinator, Program Development Section, STD Control Branch (STD)
- Edwin Lopez – Chief, Disease Intervention Section, STD
- Eric Tang, MD – Chief, Medical and Scientific Affairs Section, STD
- Jessica Frasure-Williams – Chief, Program Development Section, STD
- Kathleen Jacobson, MD – Chief, STD
- Kevin Sitter – Ending the HIV Epidemic Project Manager, OA
- Marisa Ramos – Chief, OA
- Melissa Marston – Branch Chief Executive Assistant, STD
- Phil Peters, MD – Medical Officer, OA
- Rachel McLean – Chief, Policy and Viral Hepatitis Prevention Section, STD
- Tiffany Woods – Transgender Sexual Health and Community Engagement Specialist, High-Impact Unit, OA

Community Stakeholders

- Anne Donnelly – California Hepatitis Alliance (CalHEP)
- Craig Pulsipher – Ending the Epidemics consortium
- Demisha Burns – Ending the Epidemics consortium
- Kim Hernandez – CA Communicable Disease Controllers Association
- Laura Guzman – National Harm Reduction Coalition
- Natalie Sanchez – CA HIV Community Planning Group
- Robyn Learned – CA HIV Community Planning Group
- Sergio Morales – Essential Access Health
- Sonali Kulkarni – California STD/HIV Controllers Association
- Virginia Hedrick – Consortium for Urban Indian Health

Consulting Partner

FACENTE CONSULTING
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California Department of PublicHealth

San Diego HIV Planning Group

Key Findings Summary
Transportation Services: Barriers

Draft September 16, 2022

The Clinical Quality Management (CQM) Committee met on August 16, 2022 to discuss/review barriers in providing Ryan White Medical Transportation Services.

Nine service provider organizations participated as well as staff from the HIV, STD, and Hepatitis Branch (HSHB) of the Public Health Services of the County of San Diego.

Ryan White providers currently offer medical transportation via:

1. Ridesharing
2. Daily and monthly bus passes
3. Assisted transportation vouchers

Key points from the discussion:

Proving medical transportation is an administratively complex and time-consuming process. Reasons include:

1. HRSA/HSHB/HPG requirements
    a. Service administration
        i. Budget limitations
        ii. Enrollment requirements
        iii. All “new” clients
    b. Staff time and resources
        i. Interdepartmental work (including case managers, accounting, billing, admin, legal)
            1. Schedule, coordinate, and monitor rides
            2. Track rides and appointments in agency logs
            3. Collect and store receipts
            4. Solicit client signatures
            5. Identify and allocate additional monies (pay for MTS passes in advance)
        ii. Consumers must “plan” for transportation, virtually disallowing emergency rides and approvals
2. MTS issues
    a. Contracts required to offer passe
    b. Time consuming and/or counterproductive customer service (blame providers)
    c. Documentation required for disability pass

3. Ease/cost of transportation services
    a. Ridesharing easier but costlier
    b. Housing issues and tech access for unhoused individuals using ridesharing
    c. Time-consuming to identify MTS bus routes for stretching/saving funds
    d. Uncompensated labor
        i. Call clients
        ii. Purchase MTS rides
        iii. Share data with IT
        iv. Replace Pronto cards
        v. Track ridesharing in real time
        vi. Submit agency reimbursements
        vii. Enter services into ARIES
        viii. Invoice expenditures with accounting
4. Past and current reforms
    a. Consistent messaging
    b. Share with HPG committees
    c. HSHB modifications when appropriate and possible

Universal Standard: Competence in Service Design and Delivery

Local epidemiology in San Diego County indicates that HIV disproportionately impacts some of the County's communities, including gay, bisexual and other men who have sex with men, Black/African American persons, Hispanic/Latinx persons, Transgender persons, persons who inject drugs, and persons who are age 50 or older. These disproportionalities and disparities result largely from marginalization, oppression, discrimination and stigma, along with historical and current structural racism, homophobia, transphobia/gender non-binary phobia, and ableism. These disproportionalities also show up in socio-economic status, poverty, educational attainment, stable employment, stable housing, involvement with carceral systems, and access to systems that support whole-person well-being. Finally, other San Diego communities experience disparities in access to services due to their low proportion of the overall epidemiology, such as women and youth living with or vulnerable to HIV.

In 2020 and 2021, the HIV Planning Group conducted a community engagement project, resulting in several recommendations to ensure the HIV service delivery system funded by the County of San Diego can better serve its residents. These recommendations include developing, implementing and evaluating the effectiveness of systems that:

1. Ensure staff who interact with clients or who have control over systems that clients interact with receive education about the realities of lived experiences of clients served, including discussions of inequitable access, inequitable outcomes, and how both personal interactions and systemic barriers can lead to disparate outcomes.
2. Ensure clients receive education and support to advocate for what they need, speak out when their needs are not being adequately addressed, and receive timely and adequate responses and supports to address their needs.
3. Ensure that clients can communicate in ways they are most comfortable (*e.g.,* Spanish, American Sign Language, Adaptive and Assistive Communication.)
4. Ensure that all entry points can assess whole-person and whole-family wellness, and when requested can provide support in accessing additional services and supports.
5. Ensure that client support needs are assessed and reasonable accommodations are available to allow clients to participate in and receive benefit from services.
6. Recruit staff members with lived experience at all levels of the organization and provide appropriate supports to ensure their success.

To eliminate disparities, all providers must have the ability to provide appropriate and acceptable services to potential and current clients, including persons of color; gay men and other men who have sex with men; men or women vulnerable to HIV; bisexual men and women; transgender individuals; gender non-binary and gender non-conforming individuals; persons who use substances; persons with mental health concerns; and disabled persons. Providers who serve any of these groups must make reasonable accommodations in service provisions to ensure all clients can participate fully in services and achieve the same outcomes.

All providers must have policies and procedures that address cultural humility and competence, diversity, and inclusiveness. Provider's intake procedures will assess client access issues, including linguistic, literacy and cultural needs, physical accessibility, adaptations and accommodations for disabilities, and service location. Staff working directly

with clients must receive a minimum of four hours of cultural humility and competency training each year.

Providers will identify staff and volunteers who can provide bilingual/bicultural services to individuals who need or prefer to communicate in other languages. If there are no staff members or volunteers who can perform this function, the provider will develop alternate methods to ensure language appropriate services are available.

Providers will assess and ensure the training and competence of individuals who deliver language services to assure accurate and effective communication between clients, staff, and volunteers to transcend language barriers and avoid misunderstanding and omission of vital information.

Standard	Measure
Agency policies address cultural humility and competence, diversity, inclusiveness.	Documentation in policies of cultural humility and competence, diversity and inclusion requirements.
Intake procedures **assess client access issues**, including linguistic, literacy and cultural needs, physical accessibility, adaptations and accommodations for disabilities, and service location needs.	Intake documents, policies and/or procedures that demonstrate assessment of required components.
Staff receive a **minimum of four hours of annual training** on cultural humility and competence	Documentation of all staff trainings on cultural humility and competence
	Copies of curricula, handouts, and any other documentation kept on file that indicate discussions related to inequitable outcomes and interpersonal and systemic sources of disparate outcomes
Staff and volunteers are bilingual and can address the language needs of the populations they serve. If there are no appropriate bilingual staff or volunteers, a plan is in place to ensure language needs are met	Copies of staff credentialing or other indicators that staff are bilingual and can address language needs of client populations served. Copy of written plan to address language needs
Provider has **available written materials in languages appropriate** for communities being served	Materials available in appropriate languages
Clients receive education and support to advocate for what they need, speak out when their needs are not being adequately addressed, and receive timely and adequate responses and supports to address their needs.	Documentation that clients received support and education to advocate for what they need. Documentation that client concerns were documented and addressed timely and adequately.
All entry points assess whole-person and whole-family wellness, and when requested can provide support in accessing additional services and supports.	Documentation that all entry points assess whole-person and whole-family wellness and linkage to needed services and supports.

Client **support needs are assessed and reasonable accommodations are available** to allow clients to participate in and receive benefit from services.	Documentation of assessment of client needs
Recruit **staff members with lived experience at all levels of the organization** and provide appropriate supports to ensure their success.	

PRIORITY SETTING & RESOURCE ALLOCATION COMMITTEE 2023 WORKPLAN

January 12, 2023
• Discuss and plan for the three components of the **Needs Assessment** process
  ○ **Regional Community Meetings** (timeframe)
  ○ **Survey of HIV Impact** planning (2023)
  ○ **Provider Survey** (timeframe)
• Special data needs from the Recipient
• Review service categories that underspend (monthly)
• Service utilization report (monthly report)
	June 15, 2023
	• No meeting scheduled

February 9, 2023
• Review service categories that underspend(monthly)
• Service utilization report (monthly report)
	June 22, 2023 (4-hour meeting for review of data)
	• Review data on **HIV Care Continuum/ Unaware Estimate** & discuss findings
	  ○ incl. data on **RW clients vs. all clients**
	  ○ Incl. data on **viral suppression rates in the African American/Black population** (incl. of RW clients vs. all clients)
	• Review data on **Unmet Need Estimate** and discuss findings
	• Annual report on **percent of individuals linked to care, and retention rates and viral suppression**
	• Review 2021 **Survey of HIV Impact** data & discuss findings, esp. Out-Of-Care data
	• Review **HRSA and Ryan White Part A guidelines (PCN 1602)**
	• Review YTD data on **service utilization** and discuss findings
	• Review information on **non-Ryan White services in the community**, esp. **mental health and drug and alcohol services.** (County's budget includes some of this detail) https://www.sandiegocounty.gov/openbudget/
	• Review data on **regional focus groups** and **GTZ Action Plan Community Feedback Report** and discuss findings
	• Summarize/Finalize data on HIV Care Continuum/Unaware Estimate
	• Summarize/finalize data on HIV Epidemiology
	• Summarize/Finalize data on regional distribution of RWTEA Part A services

	• Summarize/Finalize data on Ryan White service eligibility criteria and other service guidelines • Summarize/Finalize data on regional focus groups • Review service categories that underspend(monthly) • Service utilization report (monthly report)
March 9, 2023 • Review **Co-occurring conditions, poverty, and insurance** • Review Integrated (Comprehensive) Plan/Getting to Zero Plan goals related to PSRAC • Address change in FY 23 Part A funding (if needed) • **PARS Report** • Review service categories that underspend(monthly) • Service utilization report (monthly report)	**June 29, 2023** • No meeting (Thursday before Independence Day weekend)
April 13, 2023 • No meeting scheduled	**July 6, 2023** • No meeting scheduled
May 11, 2023 • Address change in FY 23 Part A funding (if needed) • Summarize/finalize data on co-occurring conditions, poverty, and insurance. • Review data on **regional distribution of RWTEA Part A services & discuss findings** • Review data on **Ryan White service eligibility criteria & other service guidelines** and discuss findings • Review updated **HIV/AIDS Epidemiology** data & discuss findings (if available) • **PARS Report** • Review service categories that underspend(monthly) • Service utilization report (monthly report)	**July 20, 2023 (4-hour meeting for FY 24 priority setting budget allocation** • Summarize updated HIV/AIDS Epidemiology data (if available) • Review/summarize any additional data that is available • Review/finalize summary data findings Recommendations with justifications to HIV Planning Group for service priority ranking, and how services should be organized and delivered in FY 24 • Review all data findings and summaries • Complete recommendations with justifications for changes in funding allocations for FY 24
June 1, 2023 • No meeting scheduled	**July 27, August 3 and/or 10, 2023 (if needed)** • As needed to complete for FY 24 priority setting and budget allocation process (next fiscal year) and/or FY 23 reallocations (current fiscal year) • Review/summarize any additional data that is available • **PARS Report** • Review service categories that underspend (monthly)

	• Service utilization report (monthly report)
<u>June 8, 2023</u> • No meeting scheduled	**<u>September 7 and/or October 12, 2023</u>** • Debrief the FY 24 priority setting and budget allocation process • Develop 2024 PSRAC work plan • **PARS Report** • Review service categories that underspend(monthly) • Service utilization report (monthly report)

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
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WILMA J. WOOTEN, M.D., M.P.H.
PUBLIC HEALTH OFFICER

APPENDIX

(Page 043)

AB 2449 Checklist

(Applicable January 1, 2023 to December 31, 2025)

Procedures for Public Participation

- ☐ Public must be able to remotely hear, visually observe, and address the legislative body either remotely or in person in real time
- ☐ Public must have the opportunity to participate via: 1) two-way audio or 2) a telephonic service with a webcasting service
- ☐ Public cannot be required to submit comments prior to the meeting

Procedures for Member to Teleconference from a Remote Location

- ☐ Member must participate through both audio and visual technology
- ☐ Member must disclose adults who are present in the room at the remote location with the member and the general nature of the relationship with those individuals
- ☐ Member must submit a general description of the need to teleconference to the legislative body at the earliest opportunity (do not disclose any medical diagnosis or disability)
- ☐ Member may teleconference for just cause. Just cause is limited to 2 meetings per calendar year (see "Limits per Member" below). Just cause is defined as:
  - Child care or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse or domestic partner
  - Contagious illness that prevents member from attending in person
  - A need related to a physical or mental disability
  - Travel on official business of the legislative body or another state or local agency
- ☐ Member may teleconference due to emergency circumstances, which requires approval of the legislative body and which is defined as a physical or family medical emergency that prevents a member from participating in person
- ☐ Limits per Member: Just cause and emergency circumstances cannot be invoked collectively for more than: 1) two meetings if the legislative body has fewer than 10 meetings per calendar year, or 2) three consecutive months or 20 percent of regular meetings per calendar year if the legislative body has 10 or more meetings per year. Just cause cannot be invoked more than twice per calendar year.

Procedures for the Board/Commission/Committee/Group

- ☐ Include instructions on the agenda how the public can participate remotely
- ☐ A quorum of the members of the legislative body must participate in person at the noticed location that is open to the public
- ☐ A majority of the membership must approve a request by a member to teleconference due to emergency circumstances; include the request on the agenda if received in time
- ☐ All votes must be taken by roll call
- ☐ Meeting must be stopped and no action taken if the broadcast of the meeting or ability of the public to comment is disrupted

TELECONFERENCING RULES UNDER THE BROWN ACT

	Default Rule	Declared Emergency (AB 361)	Just Cause (AB 2449)	Emergency Circumstances (AB 2449)
In person participation of quorum	Required	Not Required	Required	Required
Member participation via teleconferencing	Audio or Audio-visual	Audio or Audio-visual	Audio-Visual	Audio-Visual
Required (minimum) opportunities for public participation	In-person	Call-in or internet-based	Call-in or internet-based and in person	Call-in or internet-based and in person
Disruption of broadcast or public's ability to comment	Meeting can proceed	No further action taken	No further action taken	No further action taken
Reason must be approved by legislative body	No	Yes (initial findings and renewed findings every 30 days)	No, but general description to be provided to legislative body	Yes and general description to be provided to legislative body
Votes must be taken by roll call	Yes	Yes	Yes	Yes
Member's remote location included on agenda	Yes	No	No	No
Declared emergency and health official's recommendation for social distancing	No	Yes	No	No
Annual limits	None	None	Twice per calendar year (limits for emergency circumstances also apply for collective number of times AB 2449 can be used per year)	3 consecutive months/ 20% of regular meetings per calendar year; or 2 meetings per calendar year if body meets less than 10 times per year (collectively with just cause)
Effective Dates	Ongoing	Expires 12/31/2023	Expires 12/31/2025	Expires 12/31/2025

If the physical attendance quorum requirement is met, AB 2449 permits a member who is not physically present to request virtual attendance at the local legislative body's meeting under two circumstances: ***(1) for "just cause"*** *and* ***(2) due to "emergency circumstances"****.*

Qualifying Reason	Provisions to attend remotely	Requirements/Limitations
"**Just Cause**"	▪ There is a childcare or caregiving need (*for a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner*) that requires the member to participate remotely ▪ A contagious illness prevents the member from attending the meeting in ▪ There is a need related to a defined physical or mental disability that is not otherwise accommodated for ▪ Traveling while on official business of the legislative body or another state or local agency	A member is limited to **<u>two (2)</u>** virtual attendances based on "just cause" per calendar year
"**Emergency Circumstances**"	**"*A physical or family medical emergency that prevents a member from attending the meeting in person.*"** A member is ***<u>not</u>*** required to disclose any medical diagnosis or disability, or any personal medical information that is already exempt from existing law.	A member of the legislative body **must make a request to the body** to allow the member to meet remotely due to an emergency circumstance, and further **must provide a general description of the circumstance** justifying such attendance. A request from a member to attend remotely due to an emergency circumstance requires that the legislative body take action and <u>approve</u> the remote attendance at the start of the meeting for the member to be allowed to participate remotely for that meeting[1].

[1]If the request does not allow sufficient time to be placed on the agenda as a proposed action item, then the legislative body may take action at the beginning of the meeting.

Additional Requirements for a Member Participating Remotely:

In addition to making a request either for “just cause” or due to an “emergency circumstance” for remote appearance, AB 2449 imposes the following three (3) additional requirements on legislative body members seeking to appear remotely at public meetings:

1. Before any action is taken during the meeting, the member must publicly disclose whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member’s relationship with any such individuals.

2. A member of the legislative body participating from a remote location must participate through both audio and visual technology.

3. A member’s remote participation cannot be for more than three consecutive months or 20 percent of the regular meetings for the local agency within a calendar year. And if the legislative body regularly meets fewer than 10 times per calendar year, a member’s participation from a remote location cannot be for more than two meetings.

April 2023 – HIV Planning Group Committee Meetings

Location: County Operations Center (COC)
5500 – 5570 Overland Ave. San Diego, CA 92123
(Various Room and Building Locations – *See Below*)

	Meeting	Date	Time	Location
1	Strategies & Standards Committee	**Tuesday, April 4, 2023**	11:30 AM – 1:00 PM	**Building 5570 – Room 1047**
2	Membership Committee	**Wednesday, April 12, 2023**	11:00 AM – 1:00 PM	**Building 5530 – Training Room 124**
3	Steering Committee	**Tuesday, April 18, 2023**	11:00 AM – 1:00 PM	**Building 5530 – Training Room 124**
4	Community Engagement Group	**Wednesday, April 19, 2023**	3:00 PM – 5:00 PM	**Building 5530 – Training Room 124**
5	HIV Planning Group Committee	**Wednesday, April 26, 2023**	3:00 PM – 5:00 PM	**Building 5530 – Training Room 124**

FYI: *PSRAC switched to every other month starting with no meeting in April.*

Training Room 120

- **Building: 5500** Overland Ave.
- 1st Floor

Training Room 124

- **Building: 5530** Overland Ave.
- 1st Floor

Medical Examiner Conference Room – Room 1047

- **Building: 5570** Overland Ave.
- 1st Floor

As of 3/29/2023

April 2023 – MPOX Task Force

Location: County Operations Center (COC)
5500 – 5570 Overland Ave. San Diego, CA 92123
(Various Room and Building Locations – See Below)

Meeting	Date	Time	Location
MPOX Task Force	**Thursday, April 20, 2023**	3:00 PM – 4:30 PM	**Building 5530 – Training Room 124**

April 2023 – CARE Partnership

Location: County Operations Center (COC)
5500 – 5570 Overland Ave. San Diego, CA 92123
(Various Room and Building Locations – See Below)

Meeting	Date	Time	Location
CARE Partnership	**Monday, April 17, 2023**	11:00 AM – 1:00 PM	**Building 5530 – Training Room 124**

May 2023 – HIV Planning Group Committee Meetings

Location: County Operations Center (COC)
5500 – 5570 Overland Ave. San Diego, CA 92123
(Various Room and Building Locations – *See Below*)

	Meeting	Date	Time	Location
1	Strategies & Standards Committee	Tuesday, May 2, 2023	11:30 AM – 1:00 PM	**Building 5530 – Training Room 124**
2	Medical Standards & Evaluation Committee	Tuesday, May 9, 2023	4:00 PM – 5:30 PM	**Building 5530 – Training Room 124**
3	Membership Committee	Wednesday, May 10, 2023	11:00 AM – 1:00 PM	**Building 5530 – Training Room 124**
4	Priority Setting & Resource Allocation Committee	Thursday, May 11, 2023	3:00 PM – 4:30 PM	**Building 5530 – Training Room 124**
5	Steering Committee	Tuesday, May 16, 2023	11:00 AM – 1:00 PM	**Building 5530 – Training Room 124**
6	Community Engagement Group	Wednesday, May 17, 2023	3:00 PM – 5:00 PM	**Building 5530 – Training Room 124**
7	HIV Planning Group	Wednesday, May 24, 2023	3:00 PM – 5:00 PM	**Building 5530 – Training Room 124**

HIV PLANNING GROUP
12-MONTH COMMITTEE TRACKING
Mar 2022 - Feb 2023

STRATEGIES	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	#
Total meetings	1	1	1	1	1	0	1	1	1	1	0	1	10
Member													
Acevedo, Allan[U,CC]	*	*	1	*	*	NM	*	1	*	1	NM	1	4
Applebaum, Amy	*	*	*	1	*	NM	*	*	*	*	NM	*	1
Davenport, Beth	*	1	1	1	*	NM	*	*	*	*	NM	*	3
Franco, Lucia[N]	*	1	*	1	1	NM	*	*	1	*	NM	*	4
Johnson, Liz[N]	*	1	*	*	*	NM	*	*	1	1	NM	1	4
Mora, Joseph[N]	*	*	*	*	1	NM	*	*	*	*	NM	*	1
Mar-Tang, Moira	*	*	*	*	1	NM	*	1	*	*	NM	*	2
Price, Venice[U]	*	1	*	1	1	NM	*	*	*	*	NM	1	4
Ransom, Shannon[C]	*	*	*	*	*	NM	*	*	*	*	NM	*	0
Tilghman, Dr. Winston	1	*	*	*	1	NM	*	*	*	1	NM	*	3
Weber, Jeffery						NM	*	*	*	*	NM	*	0
Wimpie, Michael [U]	*	*	*	*	1	NM	*	*	*	*	NM	*	1

To vote, a member may not miss 4 consecutive meetings or 6 total meetings in a 12 month period.

U = Unaffiliated Consumer

= number of absences

C = Chair

CC = Co-Chair