SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES & STANDARDS COMMITTEE
MEETING PACKET
TUESDAY, AUGUST 1, 2023, 3:00 PM – 4:30 PM
COUNTY OPERATIONS CENTER
5560 OVERLAND AVE, SAN DIEGO, CA 92123 (TRAINING ROOM 172)

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.

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Meeting Location & Directions:

Strategies & Standards Committee
Tuesday, August 1, 2023
3:00 PM - 4:30 PM

County Operations Center
5560 Overland Ave.
San Diego, CA 92123
(Training Room 172)

Parking is **free**. 3-hour visitor parking is available in the parking lot and parking structure. For County business exceeding 3 hours, please park in the numbered spaces in the parking structure.

FROM I-163 SOUTH:

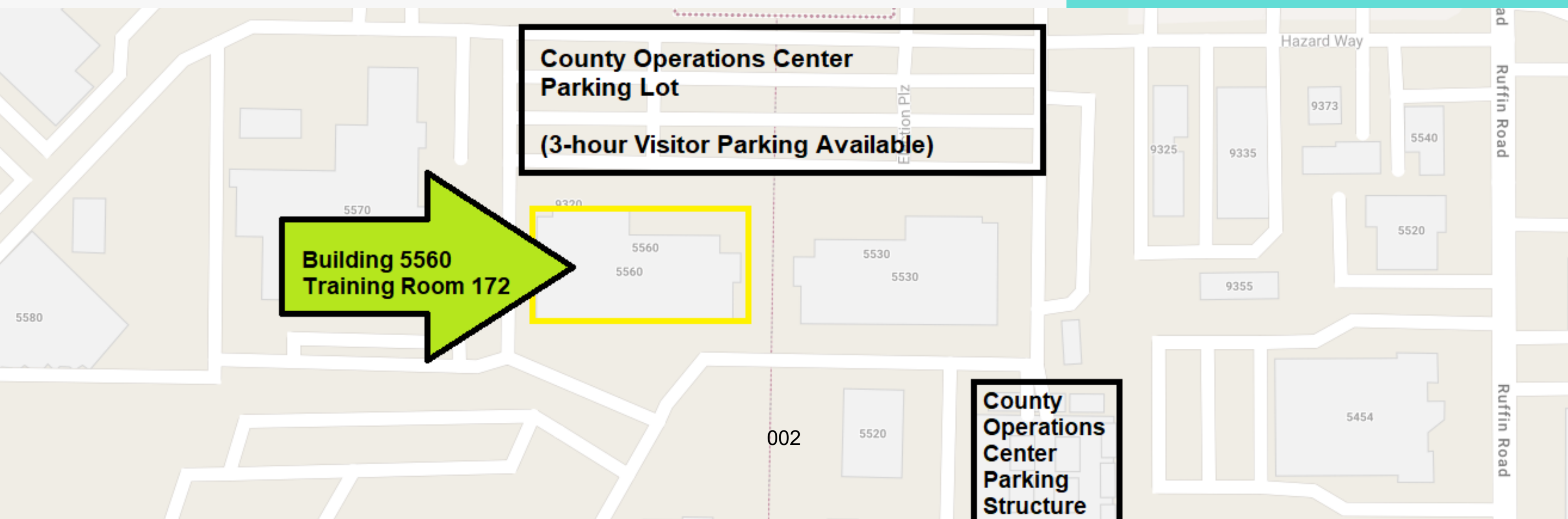
1. Take I-163 North to Exit 8 for Kearny Villa Road.
2. Keep right, follow signs for Kearny Villa Road.
3. Turn right onto Chesapeake Dr.
4. County Operations Center will be on your right.

FROM I-15 SOUTH:

1. Take I-15 North to Exit 10 for Clairemont Mesa Blvd.
2. Turn left onto Clairemont Mesa Blvd.
3. Turn right onto Overland Ave.
4. Continue straight to stay on Overland Ave.

PUBLIC TRANSPORTATION

MTS Bus Routes:
25, 235, 928



FROM 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. and head north.
7. Enter east through County Operations Center entrance/black gate. **Building 5560** will be on your left.

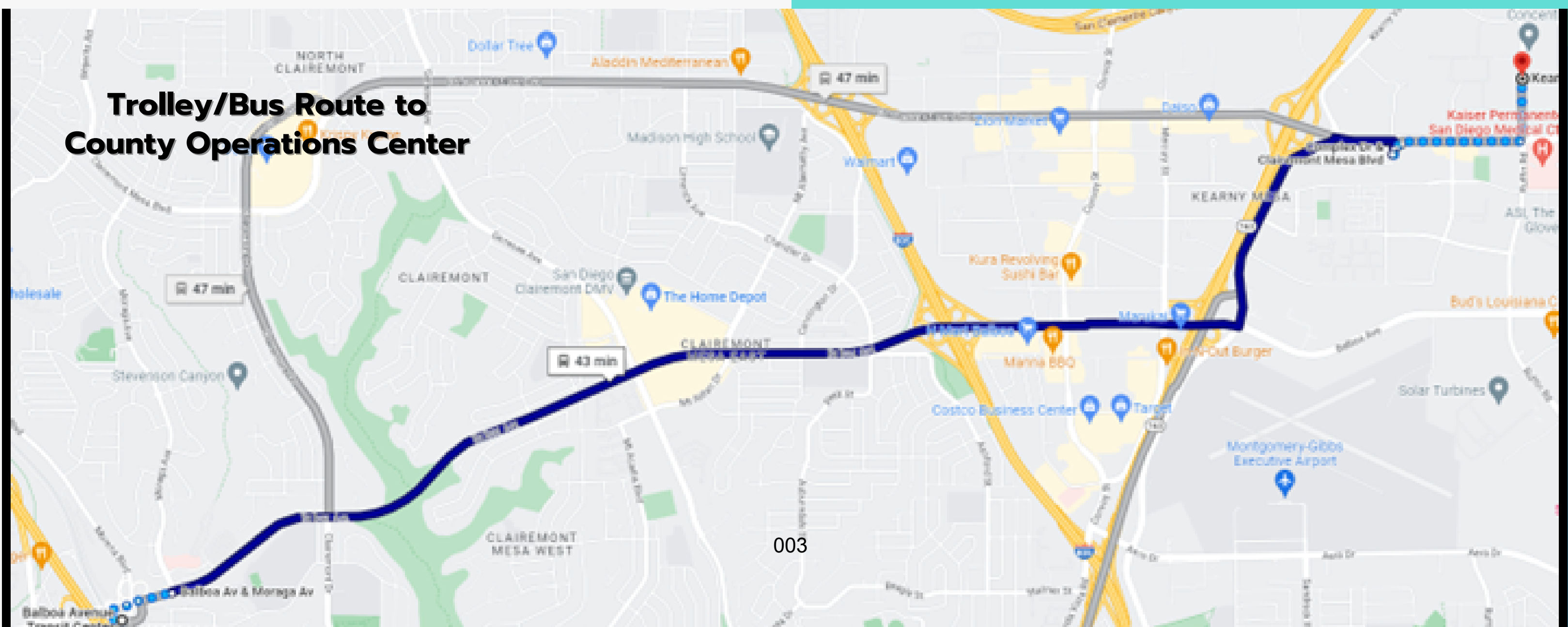
FROM BUS:

From Ruffin Road:

1. Walk north towards Ruffin Road.
2. Turn left on Hazard Way.
3. Enter through County Operations Center entrance/black gate and head further west. Access to County Operations Center buildings will be on your **left**.

From Overland Ave.:

1. Walk north on Overland Ave.
2. Enter east through County Operations Center entrance/black gate.
3. Turn left on pedestrian walkway. **Building 5560** will be on your **left**.



SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES & STANDARDS COMMITTEE
MEETING AGENDA
TUESDAY, August 1, 2023, 3:00 PM – 4:30 PM
COUNTY OPERATIONS CENTER
5560 OVERLAND AVE, SAN DIEGO, CA 92123 (TRAINING ROOM 172, BUILDING 5560)

To participate remotely via Zoom:
https://us06web.zoom.us/j/85772860296?pwd=Ym1jWit6cWhnL05BOTlyR25LbWhqQT09
Join the meeting via phone: 1-470-238-5742 US Toll / 52-55-6722-5298 Mexico Toll
Meeting ID: 857 7286 0296 **Password:** 630634

Language translation services are available upon request at least 96 hours prior to the meeting. Please contact HPG Support Staff at 619-403-8809 or via e-mail at hpg.hhsa@sdcounty.ca.gov.

A quorum for this meeting is six (6).
Committee Members: 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

ORDER OF BUSINESS

1. Call to order, roll call, comments from the chair and a moment of silence.
2. Public comment (for members of the public)
3. Sharing our concerns (for committee members)
4. **Action:** Approve the Strategies & Standards Committee agenda for August 1, 2023
5. **Action:** Approve the Strategies & Standards minutes for April 4, 2023
6. Review follow up items from last meeting.
    a. Universal Standards approved February 14, 2023 – update from HIV Planning Group Support
    b. Recipient's Office to reach out to Dr. Samantha Tweeten regarding data on predictors of nonviral suppression.
7. Old Business:
    a. Getting to Zero Community Engagement Plan
        i. Progress and next steps
    b. Consider changes to Transportation Standards
    c. Review draft changes to Universal Standards
        i. Review draft changes to Trauma-Informed Care
8. New Business:

a. **Presentation:** Integrated Statewide Strategic Plan – LeRoy Blea, California Department of Public Health (CDPH)
b. **Presentation:** 2021/2022 Gap Analysis – Erika Peralta, County of San Diego
c. HIV and Aging Working group – Mikie Lochner, HIV Planning Group
d. **Discussion:** Recommendations from Priority Setting & Resource Allocation Committee
e. **Discussion:** Service Standards to be updated:
    i. Testing Standard, Emergency Financial Assistance and Housing, Mental Health Services, and Eligibility Criteria for Basic Needs Support Categories

9. Recommendations to the HIV Planning Group, HIV Planning Group committees, and requests of recipient.
10. Suggested items for the future committee agenda.
11. Announcements
12. Next meeting date: **October 3, 2023, from 3:00 PM – 4:30 PM.**
    Location: **To be determined** AND online via Zoom.
13. Adjournment

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

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

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES AND STANDARDS COMMITTEE
Tuesday, April 4, 2023
11:30 AM – 1:00 PM

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

MINUTES
Quorum = Six (6)

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

Committee Members Absent: Allan Acevedo (Co-Chair), Amy Applebaum, Dr. Beth Davenport

Agenda Item	Action	Follow-up
1. Call to order	Shannon Ransom established that a quorum was present and called the meeting to order at 11:34 AM.	
2. Public Comment/Sharing our Concerns	A member of the public expressed concerns regarding possible meeting times for the Priority Settings and Resource Allocation Committee (PSRAC).	
3. Review and approve the agenda for April 4, 2023	**Motion:** Approve the agenda for the April 4, 2023 meeting as presented. **M/S/C:** Tilghman/Weber 6/0 **Abstention(s)**: Ransom **Motion carries**	
4. Review and approve the Minutes for February 7, 2023	**Motion:** Approve the minutes for the February 7, 2023 meeting as presented. **M/S/C:** Franco/Tilghman 6/0 **Abstentions**: Ransom **Motion carries**	
5. Review follow up items from the last meeting.	The draft changes to universal standards on trauma-informed care is in progress and will be ready to present at the next scheduled meeting.	

Agenda Item	Action	Follow-up
a) Draft changes to trauma-informed care		
6. Old Business		
a) Getting to Zero (GTZ) Community Engagement Plan i. Justice, Equity, Diversity, and Inclusion (JEDI) Principles Implementation	The Recipient's Office is awaiting recommendations from the consultant so that they can put it forward to HPG and Steering Committee regarding scheduling follow up training and future dialogs. Changes to universal standards were previously discussed and had approved competence in service design and delivery standards. Trauma-informed standards are a part of this standard. There are six (6) explicit points to be approved. Patrick Loose, Recipient's Office, reminded that a client cannot receive a service until a whole-person wellness assessment has been completed. Also, Ryan White case managers are not required to enroll people in MediCal as not all contractors can enroll clients to MediCal. Mikie Lochner, Chair of the HPG, explained that individuals enrolled under MediCal need to recertify due to the COVID Emergency ending. Regarding standards, at the next meeting the committee will review revisions to trauma-informed care. In addition, several areas of standards would follow: **1)** Review and update the standards for emergency financial assistance. **2)** To reevaluate the eligibility criteria for basic needs support. **3)** Mental health standard – access mental health weekly instead of monthly or every six (6) weeks Dr. Delores Jacobs to provide language based on some consumer suggestions. The current version of the universal standards uploaded on the HPG website include changes to Housing Case Management from October 2022. It does not include the recently updated competence in service design and delivery	HPG Support Staff to update the Universal Standards online to include the approved competence in service design and delivery standards in English and Spanish.

Agenda Item	Action	Follow-up
	standards, as it will need to be translated into Spanish.	
ii. **Follow-up:** Consultant for HPG's JEDI Workforce	JEDI Principles task force will formally start and receive recommendations and do follow up work.	
b) **Update:** Integrated Statewide Strategic Plan	An overview of the integrated plan is included in the meeting packet. Mikie Lochner, Chair of the HPG, reached out to the California Department of Public Health (CDPH), to provide an update on the Integrated Statewide Strategic Plan. They have offered to present at the following Strategies and Standards Committee. They have also been asked to present at the next HIV Planning Group meeting. Meeting date of the presentation from CDPH will be determined later due to the motion to update the Strategies & Standards Committee meeting frequency (Item 7b on the agenda).	
c) Consider changes to Transportation Standards i. Review key findings from Clinical Quality Management (CQM) Committee	Patrick Loose, Recipient's office, provided background on Policy Clarification guidance from HRSA in 2016, which defines how Ryan White dollars are spent. For example, one of the questions regarding transportation is whether medical transportation includes staff time required to arrange for transportation. The Project Officer will make an official determination regarding transportation. There was a suggestion to create a budget proposal. The recipient's office will assign staff to research recommendations for allocating funds towards transportation category. Changes to transportation standards will remain on the agenda for the next meeting.	Recipient's office to follow up with the Health Resources and Services Administration (HRSA) Project Officer to let them know the intention to make changes to transportation services. Recipient's office will assign staff to research recommendations.
d) Review draft changes to Universal Standards: i. **Discussion:** Review draft changes to	As mentioned in Agenda Item 5a, draft changes to trauma-informed care are currently in progress.	Shannon Ransom, Strategies & Standards Committee Chair, and Rhea Van Brocklin, Vice-Chair of the HIV Planning

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Agenda Item	Action	Follow-up
Trauma-Informed Care		Group, are to present draft changes to trauma-informed care at the next meeting.
7. New Business		
a) **Discussion:** Annual review of data requests to the Recipient i. Review the Priority Setting & Resource Allocation Committee 2023 Workplan	Recommendations for data requests include: ▪ HIV Testing Reports ▪ Breakdown of vulnerable populations ▪ Trends of people testing/not testing Concerns were expressed that some folks currently do not know their status. Transgender data is getting better over time. In 2020, testing rates dropped significantly. Also, the younger you are, the less likely you are to have positive health outcomes. It was recommended to investigate data on racial groups by age, housing categories, or housing status, as well as where people are not achieving these health outcomes.	Lori Jones, County of San Diego - HIV, STD, and Hepatitis Branch (HSHB) Office of Prevention, to find out additional information on testing data and gap analysis. Recipient's Office to reach out to Dr. Samantha Tweeten regarding data on predictors of nonviral suppression.
Connection lost from **12:26 PM – 12:33 PM**.		
b) **Discussion:** Meeting Frequency	PSRAC decided to meet every other month in alteration with the Strategies & Standards Committee. A new committee time will be determined at their next PSRAC meeting. Mikie Lochner, Chair of HPG, reminded that the chairs of each committee must ensure that work is completed should they choose to change the frequencies of their meetings. The intent is to move away from Hybrid settings and move to in-person. On December 31, 2025, committee meetings will be entirely in-person upon expiration of policy AB 2449.	
	Motion: Alternate meeting frequency with PSRAC to meet every other month. **M/S/C:** Franco/Weber 6/0 **Abstentions**: Ransom **Motion carries**	
	Motion: Approve Strategies & Standards Committee meeting time change to 3:00 PM. **M/S/C:** Wimpie/Weber 6/0 **Abstentions**: Ransom	

Agenda Item	Action	Follow-up
	Motion carries	
8. Update Committee Work Plan		
a) Upcoming Trainings	None.	
9. Recommendations to HPG, HPG committees, and requests of recipient	None.	
10. Suggested items for the future committee agenda	None.	
11. Announcements	University of California, San Diego - Mother, Child & Adolescent HIV Program (MCAP) is going to be having a community gathering to recognize Youth HIV AIDS Awareness Day and to recognize the launch of structural changes that are being made to service provided to youth, including a program called 'LYF-HAC.' This **Friday, 4/7**, there will be a Transgender Day of Empowerment event at the LGBT Community Center. Venice Price will be one of the keynote speakers for the event.	
12. Confirm the next meeting date and time	**Tuesday, June 6, 2023** at **3:00 PM** **Location:** County Operations Center (COC) 5560 Overland Ave. San Diego, CA 92123 **(Training Room 171 – Building 5560)**	
13. Adjournment	Meeting adjourned at 1:06 PM.	

Strategies and Standards Remaining GTZ Items

1. **Continue to recommend JEDI changes, trainings and conversations**
2. **Trauma-Informed Care components draft to be submitted in August Strategies Committee.**
3. Review and research successful strategies for **dismantling HIV-related stigma** among Black, Hispanic and transgender persons living with or vulnerable to HIV
4. Review models and resource requirements to support **drop-in services for primary care, mental health, and substance use treatment. In process currently with contract awarded. Services began March 01 2023. Awaiting data to evaluate resource requirements, particularly with regard to drop-in mental health, substance use treatments.**
5. Explore the feasibility and effectiveness of **further expanding HIV testing into nontraditional testing sites. In process currently with RFP/Award. Awaiting data to evaluate resources and effectiveness.**
6. **E**xplore the potential effectiveness and feasibility of funding **mobile health clinic**

Standards

1. Update standards for **emergency financial assistance** to identify circumstances where same-day response is warranted
2. Review and **re- evaluate eligibility criteria for basic needs support categories**
3. Research and further clarify **standards for mental health treatment** access and frequency

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.

VISION

PURPOSE

MISSION

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

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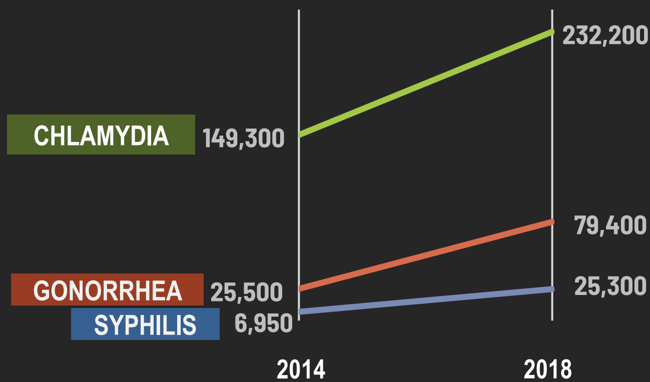
These groups are not mutually exclusive. Many people identify with more than one of the groups in this list, and these intersecting identities can often mean people experience two or more forms of exclusion, discrimination, and stigma, making it harder for them to thrive.

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.

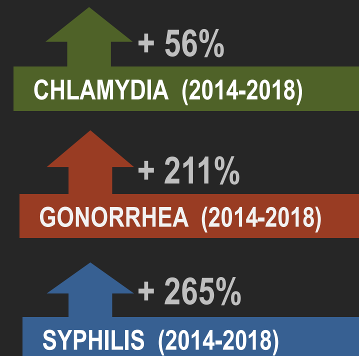
Data here and on the following page comes from:
--The 2018 STD Surveillance Report: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STD-Data.aspx
--The 2018 Chronic Hepatitis C Infections in California Surveillance Report: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/2018-Chronic-HCV-Surveillance-Report-Exec-Summary.pdf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

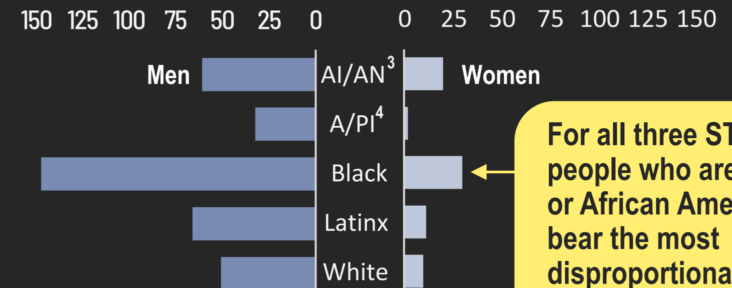


Although chlamydia cases are higher in number, syphilis and gonorrhea cases are increasing much more rapidly than chlamydia.



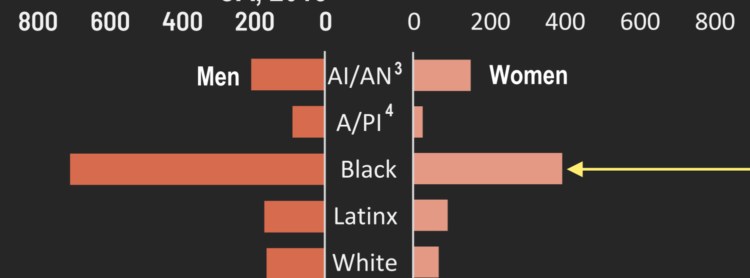
Syphilis and gonorrhea are more commonly diagnosed among men, while chlamydia is more commonly diagnosed among women.[1]

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

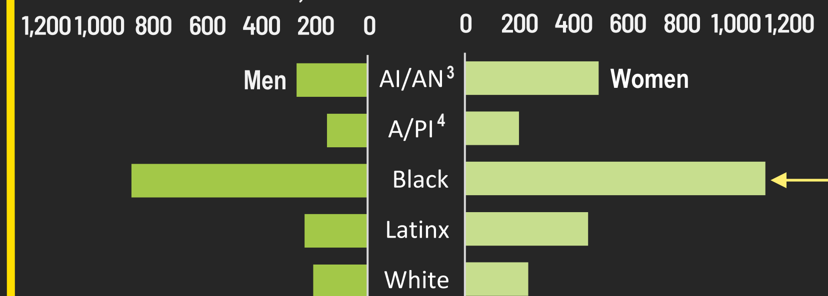


For all three STIs, people who are Black or African American bear the most disproportionate burden of disease.

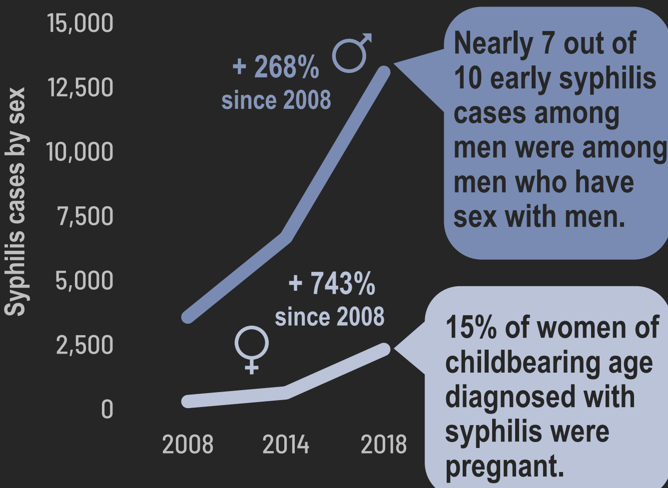
GONORRHEA: Number of gonorrhea cases per 100K people in CA, 2018



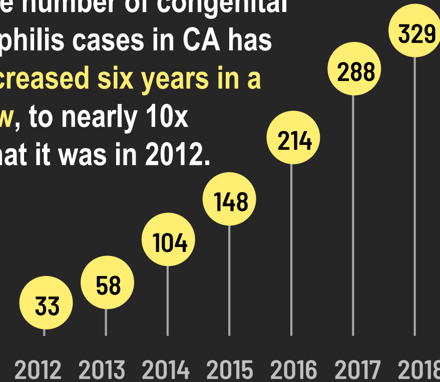
CHLAMYDIA: Number of chlamydia cases per 100K people in CA, 2018



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]



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

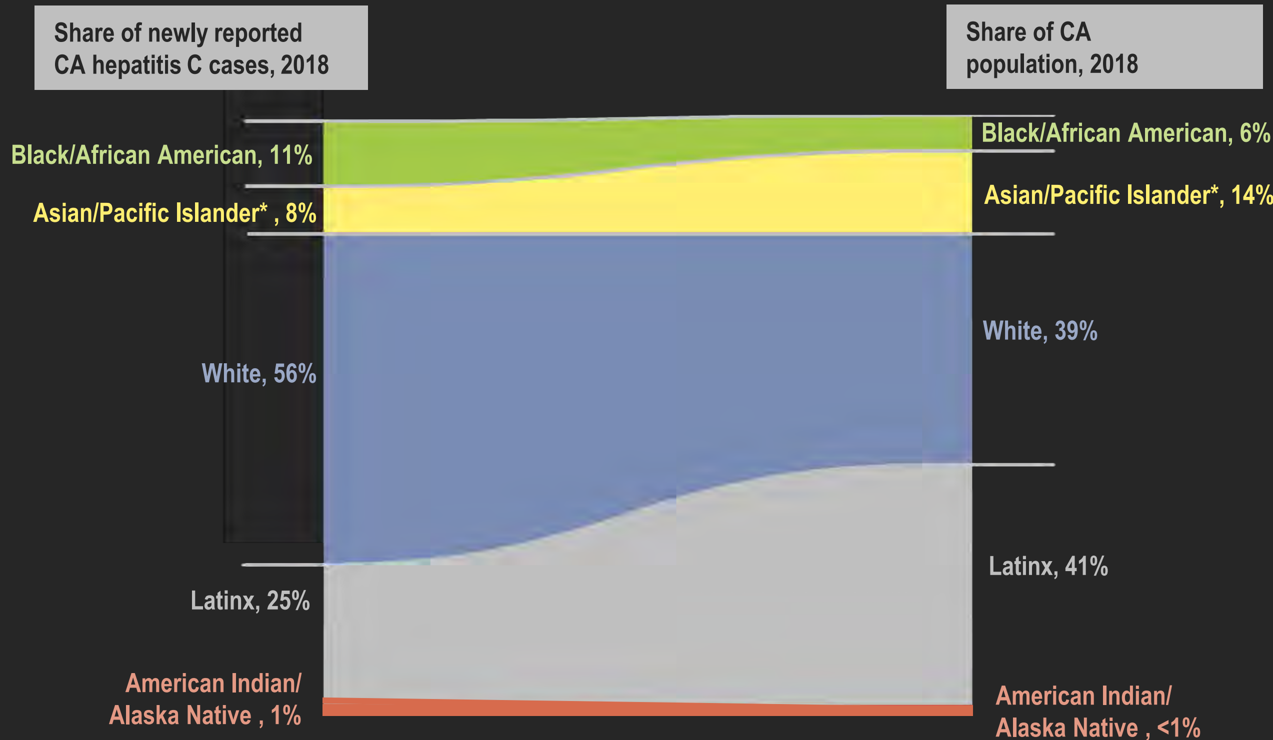


Of 329 congenital syphilis cases in 2018 alone, there were 19 infant stillbirths, 3 neonatal deaths, and 31 infants born with other symptoms or complications.

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.

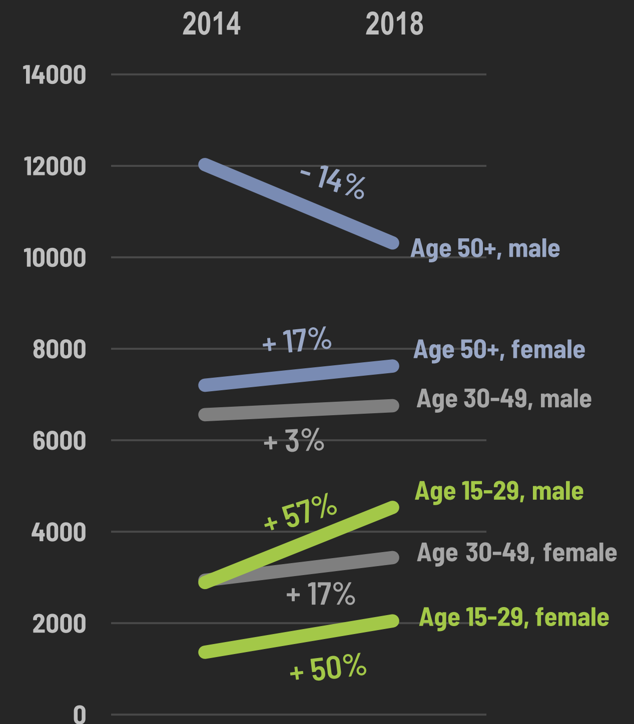
THE DATA: HEPATITIS C VIRUS

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.

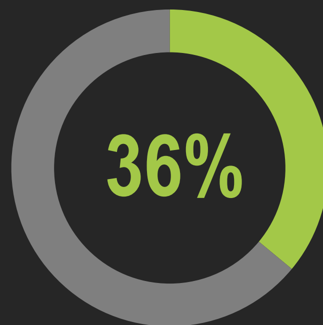
"Baby boomers" (born 1945-1965) make up most new hepatitis C cases, but new cases are increasing dramatically among younger people ages 15-29.



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.

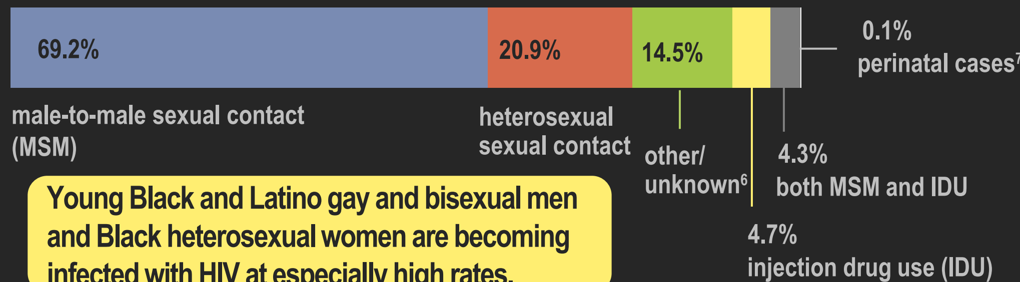
THE DATA: HIV

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.

Share of people living with diagnosed HIV, 2019	Share of CA population, 2019	Share of new HIV diagnoses, 2019
Black/African American, 17%	Black/African American, 6%	Black/African American, 17%
Asian, 4%	Asian, 14%	Asian, 6%
White, 37%	White, 37%	White, 25%
Latinx, 38%	Latinx, 39%	Latinx, 50%
American Indian/Alaska Native , 0.3%	American Indian/Alaska Native, 0.5%	American Indian/Alaska Native , 0.4%
Native Hawaiian/Pacific Islander, 0.2%	Native Hawaiian/Pacific Islander, 0.4%	Native Hawaiian/Pacific Islander, 0.3%
Multiple race/ethnicity, 3%	Multiple race/ethnicity, 3%	Multiple race/ethnicity, 2%

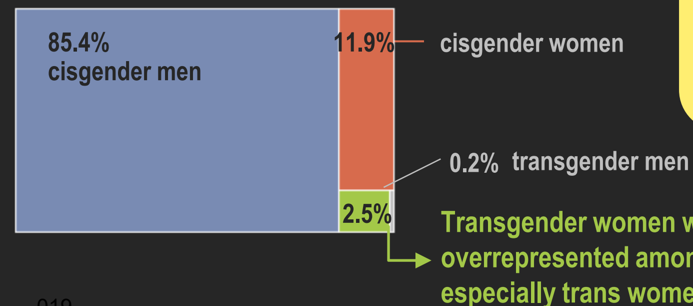
*People who are Native Hawaiian/Pacific Islander made up 0.5% of the population, 0.2% of people living with diagnosed HIV, and 0.3% of new HIV diagnoses.

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

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.

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

HEALTH ACCESS FOR ALL

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.

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

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.

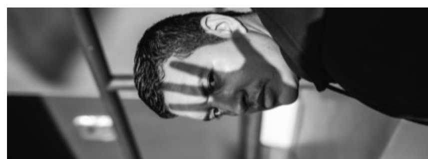
4. **Acknowledge Medical Mistrust**

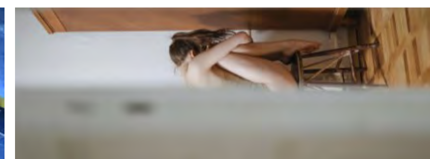
   Recognize medical mistrust as a rational response to stigmatizing treatment, rather than a failure of individuals or communities; work to build trust and correct misperceptions by example.

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.

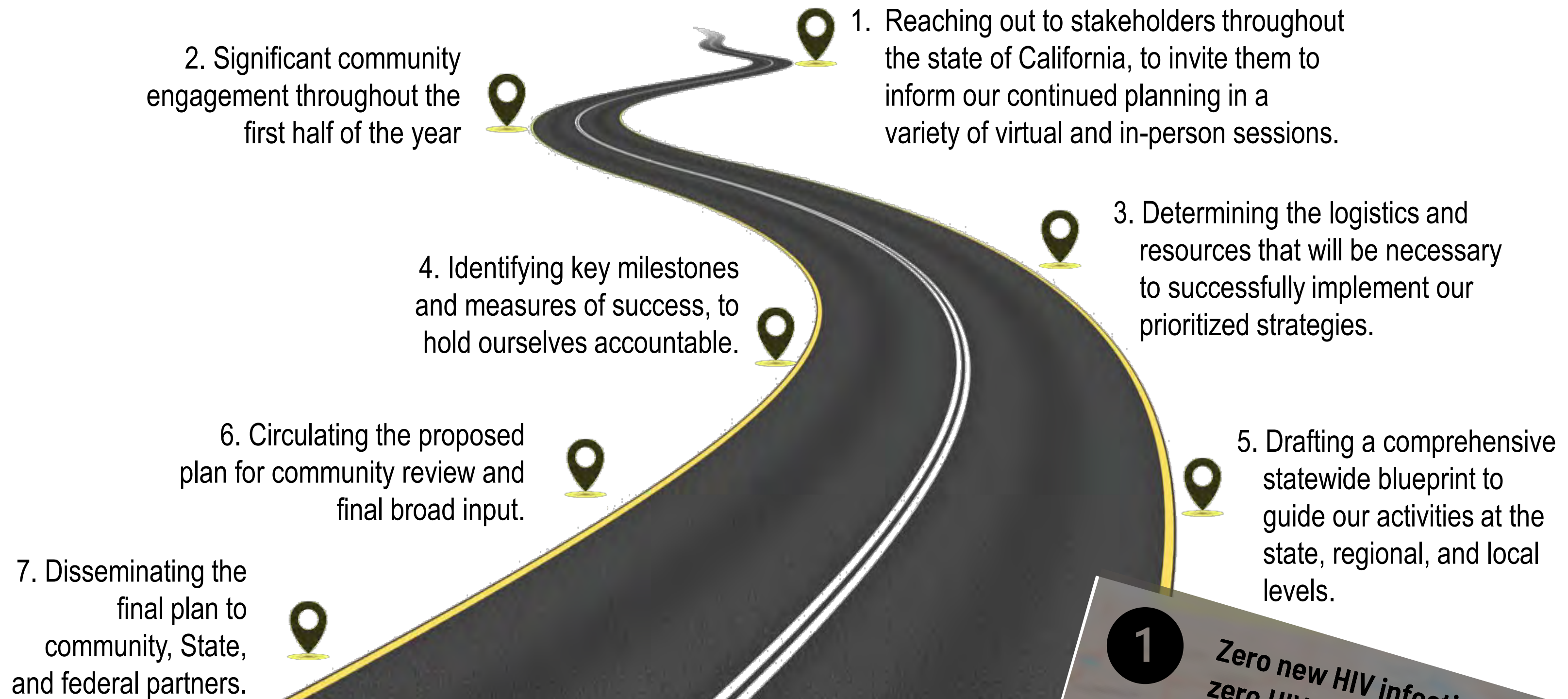
15 https://www.cdc.gov/hiv/basics/hiv-stigma/index.html
16 Chambers *et al.* BMC Public Health, 2015.





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.

1 **Zero new HIV infections, zero HIV-related deaths, zero people with HIV unable to access treatment, and zero HIV stigma**

2 **Zero HCV infections**

3 **Zero congenital syphilis; timely diagnosis and treatment of other sexually transmitted diseases**

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)
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- Marisa Ramos – Chief, OA
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- 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

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* Note service categories also funded under Ryan White Part B via the California Department of Public Health (CDPH) and are subject to the standards developed by the CDPH.

Approved 12/16/2020, Additions Approved: 1/27/2021, 3/25/2021, 6/22/2022, 10/26/2022, 02/22/2023

SAN DIEGO HIV PLANNING GROUP (HPG)
STRATEGIES & STANDARDS COMMITTEE
MEETING PACKET

APPENDIX

(Page 033)

*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 **two (2)** 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 ***not*** 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 approve 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.

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

HIV PLANNING GROUP
12-MONTH COMMITTEE TRACKING
Jun 2022 - Jun 2023

STRATEGIES	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	#
Total meetings	1	1	0	1	1	1	1	0	1	0	1	0	0	8
Member														
Acevedo, Allan	*	*	NM	*	1	*	1	NM	1	NM	1	NM	NM	4
Applebaum, Amy	1	*	NM	*	*	*	*	NM	*	NM	1	NM	NM	2
Davenport, Dr. Beth	1	*	NM	*	*	*	*	NM	*	NM	1	NM	NM	2
Franco, Lucia	1	1	NM	*	*	1	*	NM	*	NM	*	NM	NM	3
Mora, Joseph	*	1	NM	*	*	*	*	NM	*	NM	*	NM	NM	1
Mar-Tang, Moira	*	1	NM	*	1	*	*	NM	*	NM	*	NM	NM	2
Price, Venice	1	1	NM	*	*	*	*	NM	1	NM	*	NM	NM	3
Ransom, Shannon	*	*	NM	*	*	*	*	NM	*	NM	*	NM	NM	0
Tilghman, Dr. Winston	*	1	NM	*	*	*	1	NM	*	NM	*	NM	NM	2
Weber, Jeffery			NM	*	*	*	*	NM	*	NM	*	NM	NM	0
Wimpie, Michael	*	1	NM	*	*	*	*	NM	*	NM	*	NM	NM	1

To vote, a member may not miss four (4) consecutive meetings or six (6) meetings within twelve (12) months.

***** = Present

1 = Absent for the month

1 = Absence when there are multiple meetings that month. Member needs to attend at least one (1) meeting for attendance to count for that month.

JC = Just Cause

EC = Emergency Cause

NM = No Meeting