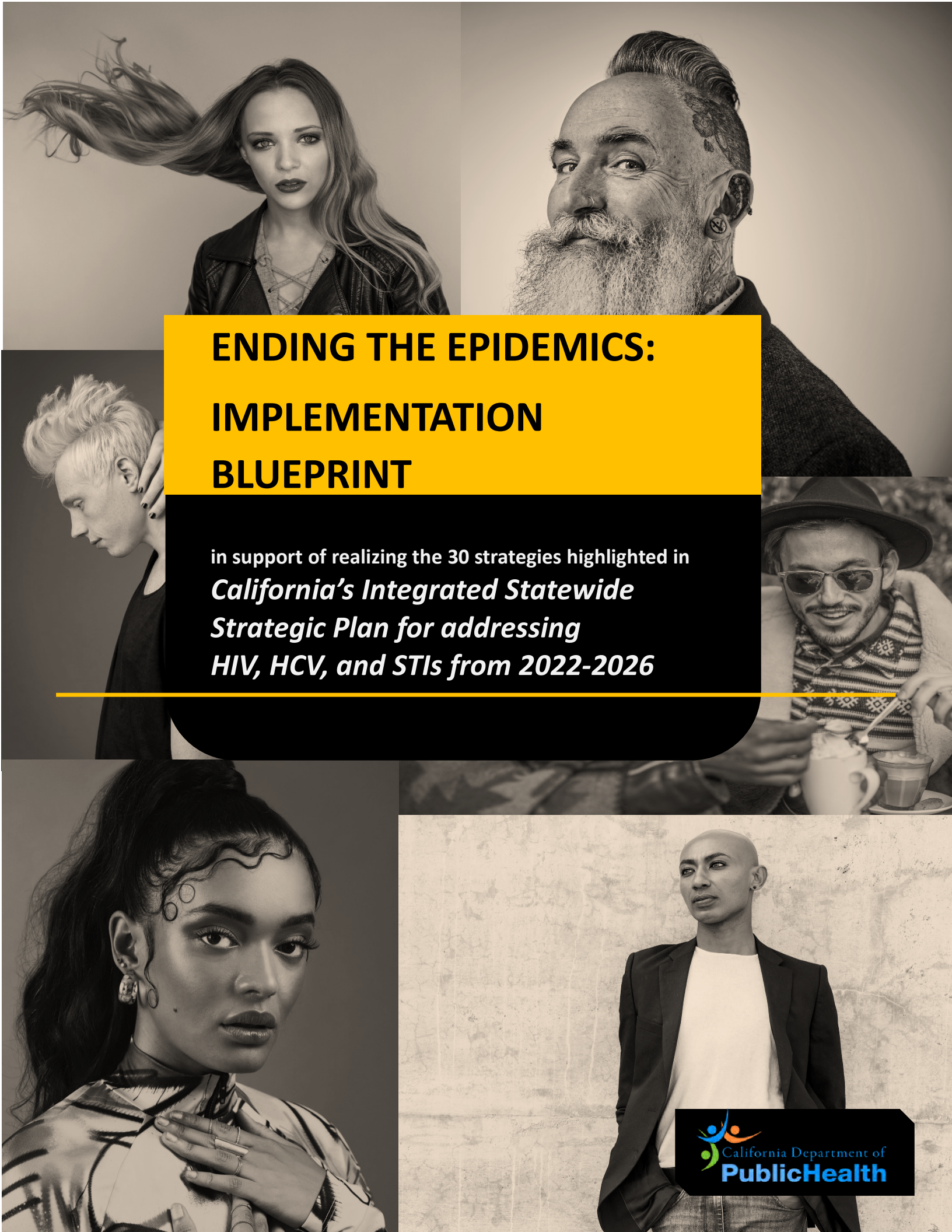


ENDING THE EPIDEMICS: IMPLEMENTATION BLUEPRINT

in support of realizing the 30 strategies highlighted in *California's Integrated Statewide Strategic Plan for addressing HIV, HCV, and STIs from 2022-2026*

California Department of PublicHealth

“Equality is not in regarding different things similarly, equality is in regarding different things differently.”

Thomas Eugene Robbins,

American novelist

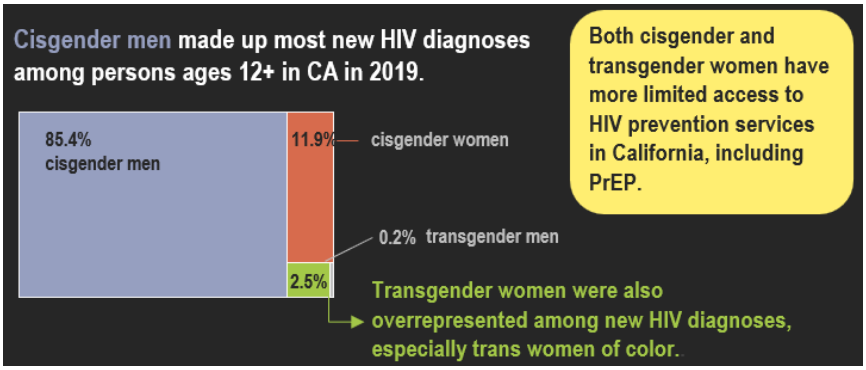
TABLE OF CONTENTS

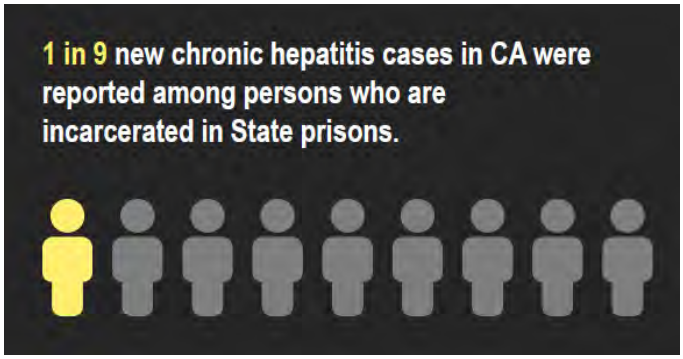
[To update the page numbers on this table of contents after editing, highlight the text on this page, right click, and select "Update Field" from the menu that appears.]

INTRODUCTION

California has made substantial progress in responding to and slowing new human immunodeficiency virus (HIV) infections, as well as improving the outcomes for people living with HIV. The state is beginning to address the emerging syndemic of HIV, hepatitis C virus (HCV), and other sexually transmitted infections (STIs), marking progress towards more equitably addressing the health needs of its residents. However, STI rates continue to increase, recent HCV trends are not well understood, and not all communities have experienced equitable gains because of structural racism, gender-based discrimination, stigma, and unfair distribution of economic, systemic, or physical resources. Today, these challenges can be seen through a number of vivid inequities in HIV, HCV, and STIs outcomes across the state.

HIV: Blacks/African Americans are more likely to be living with diagnosed HIV than any other race/ethnicity in California compared to their population size (17% of Blacks living with diagnosed HIV despite being only 6% of the population in California). As of 2019, a disproportionate number of new HIV infections are among Black (17% of new infections vs. 6% population size) and Latinx (50% of new infections vs. 39% population size) Californians. Young Black and Latino gay and bisexual men and Black heterosexual women are becoming infected with HIV at especially high rates. Transgender women were overrepresented among new HIV diagnoses in 2019, especially trans women of color.

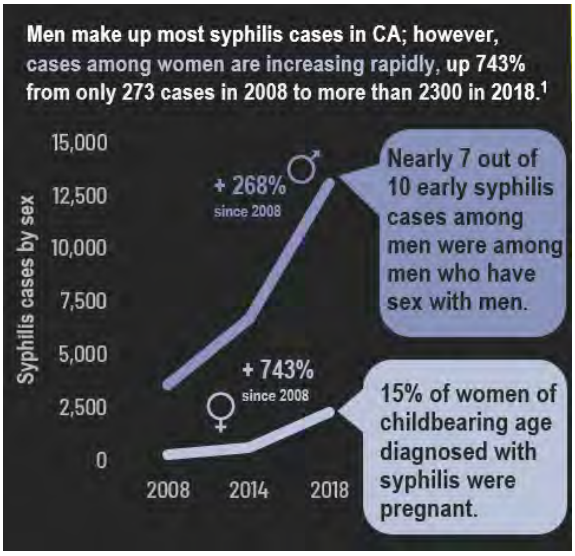




Hepatitis C: In California, people who are Black/African American, White, and American Indian/Alaskan Native bear a disproportionate burden of chronic HCV infection. People who are incarcerated also have disproportionate rates of HCV infection, as 1 in 9 new chronic HCV cases in California were reported among people who are incarcerated in State prisons in 2018, despite 1 out of 17 people being in prison that year.[1] Although most new cases of HCV are among those born between 1945-1965, new cases are dramatically increasing among younger people ages 15-29. In an assessment published in 2021, 36% of youth ages 15-29 in eight local health jurisdictions who tested positive for hepatitis C reported having ever injected drugs.[2]

[1] Vera Institute of Justice, 2019. Incarceration Trends in California.
[2] Ohringer et al., *BMC Public Health,* 21: 1435. https://doi.org/10.1186/s12889-021-11492-3 Note that since youth were being asked to report about a stigmatized behavior, the true percentage of youth having injected drugs is likely higher.

Sexually transmitted infections: The number of syphilis, gonorrhea, and chlamydia cases in California increased between 2014-2018, in all regions and among all genders. Men make up most syphilis cases in California and nearly 70% of early syphilis cases among men are among men who have sex with men. However, cases among women are increasing exponentially, up 743% in the decade from 2008 to 2018 (from 273 cases to over 2300 cases).[3] 15% of women of childbearing age diagnosed with syphilis were pregnant during this timeframe. The number of congenital syphilis cases in California has increased six years in a row to nearly 10 times 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. For syphilis, gonorrhea, and chlamydia, people who are Black/African American bear the most disproportionate burden of disease by far, due to a complex mix of systemic racism and other social determinants.



To address these marked inequities, the strategic plan and this blueprint are focused on priorities that will help deepen and reframe California's use of the tools in our HIV, HCV, and STI prevention and care toolbox to help address the inequities faced by our priority populations, through the lens of six social determinants of health.

The priority populations are:

People of color, especially Blacks/ African Americans, Latinx, & Indigenous people	Young people (aged 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
Cisgender women and other people who can become pregnant	Migrant and immigrant communities, including people who are undocumented

[3] Note that gender identity information was not routinely collected for STI data during this data period, so trans people may be found in the categories of men or women.

OVERVIEW OF THE STRATEGIC PLAN

This implementation blueprint is intended to accompany the Integrated Statewide Strategic Plan (2022-2026) for Addressing HIV, HCV, and STIs in California, and make it actionable and relevant at the local level. More details about history, process, and approach are available there. This blueprint does not replace that document.

This strategic plan is built on the purpose, goals, and core principles that reflect a greater California.

VISION

A California that is 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.

CORE VALUES

Human dignity, courageous leadership, racial and social justice, collaboration, harm reduction, and person-centered solutions.

How the Strategic Plan was developed

The California Department of Public Health (CDPH) Office of AIDS and Sexually Transmitted Diseases (STD) Control Branch set out to develop a 5-year strategic plan for addressing HIV, HCV, and STIs, in collaboration with Facente Consulting. To do this, we formed a 25-person workgroup of about half CDPH employees and half community representatives. The workgroup met weekly from July through October 2021 to create the strategic plan. We wanted to treat HIV, HCV, and STIs as a "syndemic" – a situation where 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 – and we did not want a strategic plan with different chapters focused on HIV, hepatitis C, and STIs individually. We did not want to recreate silos of prevention, care, testing, or data - even though we know those are the cornerstones of our work on these issues. Ultimately, the group decided that to best enhance our work, we needed to look at these issues through the lens of social determinants of health to ensure that all Californians have an opportunity to thrive.

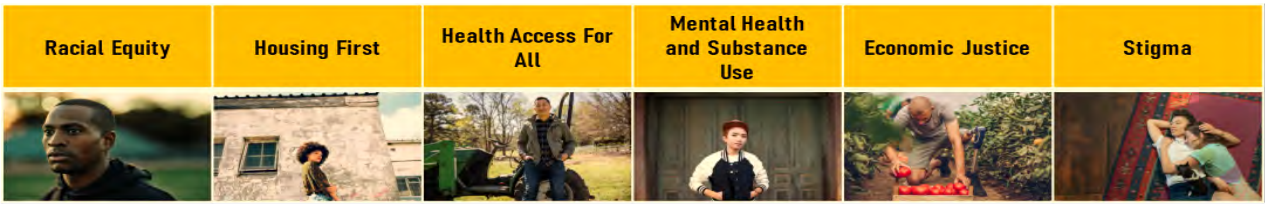
We invited more than two dozen speakers from entities like the California Department of Corrections and Rehabilitation, the Department of Health Care Services, the Department of Education, the Department of Social Services, the University of California Los Angeles (UCLA) Williams Institute, the California Pan-Ethnic Health Network, and the Transitions Clinic Network to talk to us about the relevant work they were doing and collaborate with us to develop the strategies that appeared in the final plan. We released an open survey in both English and Spanish that was taken by more than 640 people throughout California, to gather ideas and insights from the greatest range of people possible. We had multiple rounds of revisions, to land on a plan that was visionary, yet actionable – especially once combined with an implementation blueprint.

We recognize that the structure of this plan is a paradigm shift for most people who are working in the HIV, HCV, and STI field. It comes as no surprise that social determinants of health drive the inequities we all see with regard to HIV, HCV, and STIs; however, we need to challenge ourselves to consider what role *we* have in changing those social determinants of health. This strategic plan is built on the idea that we *must* find new ways to address HIV, HCV, and STIs by going "upstream" to address the social factors that influence the health and well-being of Californians. This does not mean we turn away from the core public health strategies we know work so well to prevent and treat these diseases. It means we recognize that we must build on our successes and deepen our commitment to undoing systematic injustices by reframing and reshaping our work while maintaining the core functions of public health. The strategic plan – and this implementation blueprint – is dedicated to helping California do just that.

OVERVIEW OF THIS IMPLEMENTATION BLUEPRINT

This implementation blueprint is intentionally designed as a template, so programs in local health jurisdictions (especially health departments and community-based organizations) can modify it to suit their needs. It is not a local workplan *in its current form*, but is designed so you can make it into a workplan if that would be useful.

The six social determinants of health outlined in this Implementation Blueprint are:



How the Implementation Blueprint was developed

After completing the Strategic Plan, the CDPH Office of AIDS and STD Control Branch, in partnership with Facente Consulting, engaged in an extensive community engagement process to ensure a wide variety of perspectives and opinions shaped our recommended activities. This process incorporated 16 community-based meetings throughout the State in rural and urban locations, and in collaboration with local health jurisdictions to ensure a locally-focused conversation. In conjunction with the in-person meetings, Facente Consulting also facilitated five virtual meetings to ensure broad statewide representation and to provide an opportunity for involvement for those who could not attend an in-person meeting. California residents were also able to provide input via an online survey. More than 300 service providers, public health staff, and community members participated in this interactive process.

Facente Consulting collected, sorted, and analyzed the input gathered through these activities to identify concrete action items for each strategic priority along with local and overall considerations and factors related to specific priority populations. Items that were not within the scope of the blueprint were provided directly to CDPH for follow up. The draft implementation blueprint was reviewed by the strategic planning workgroup members, who provided edits, comments, and further considerations for integration into a revised version. The blueprint was then widely released for public comment using an electronic platform during a two-week period in November. After the public comment period, the blueprint proceeded through CDPH's internal clearance process and was released to local health jurisdictions and other community partners for adaptation.

How does this Implementation Blueprint work?

The pages that follow include one table for each of the 30 strategies found in the strategic plan.

1. Social Determinant of Health: At the top of each table, you will see listed one of the six social determinants of health in this plan. This tells you whether the table refers to an HIV/HCV/STI-focused strategy using a lens of racial equity, housing first, health access for all, mental health and substance use, economic justice, or stigma free.

2. Strategy: In the table header under the social determinant of health, you will see the strategy the table refers to, numbered 1 through 5. These strategies correspond to the numbered strategies under each social determinant of health in the strategic plan. You may see a strategy referred to as "Racial Equity, Strategy 5" and you'll know it means the fifth table under that social determinant of health. The strategies are not in any order of importance or priority.

3. Recommended Activities: The next section of the table is labeled "Recommended Activities." Note that these are not required activities for any jurisdiction; rather, they are actionable steps recommended by stakeholders to best make progress toward the overall strategy in the next 5 years. Activities that begin with action verbs (e.g. "Implement") are to be taken on at the local level – ideally in jurisdictions throughout the state. Activities that begin with "CDPH will…" are activities that the California Department of Public Health Office of AIDS and/or STD Control Branch will contribute to the overall goal. Note that each activity has a recommended timeframe (the right-hand columns) but this is simply to help prioritize activities and is not a time-bound requirement.

4. Overall Considerations: Under the recommended activities is a numbered section called "Overall Considerations." This is the place where we have noted recommendations, caveats, or other notes that are generally relevant to this strategy. Some strategies have multiple considerations, and others have none. In all cases there is a place for local jurisdictions to note any additional considerations they would like to add.

5. Local Considerations: The next section is for "Local Considerations." This is where we have noted opportunities, barriers, or other unique factors that people in specific regions may want to consider. It was very clear from community engagement activities that each region of California is different, and applying these 30 strategies will not look the same in all regions. Where there were not region-specific considerations we omitted the row. Feel free to delete any rows that do not apply to your region, and add any additional local considerations that you think apply to you.

6. Key Population Notes: Next we included any extra considerations for implementation of activities under that strategy that are specific to priority populations. Where there were not population-specific considerations we omitted the row. Add any extra population-specific considerations that apply to your jurisdiction.

7. Monitoring and Metrics: Non-traditional strategies will likely require non-traditional indicators to evaluate our progress. As a beginning, we have included a crosswalk of indicators from the last integrated plan to this blueprint at the end of this blueprint (beginning on page 84). Note that monitoring and metrics are not specific to each recommended activity but rather provide information about how CDPH will monitor progress toward statewide accomplishment of the overall strategy. This appendix is a beginning of how will approach measuring progress towards each strategy; however, monitoring will be an iterative process. In the first year after release of this plan CDPH will develop additional indicators, which will be made available at this website when developed: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/Strategic-Plan/Indicators.aspx. There is also a table under each strategy where we invite you to add any local metrics to measure your progress toward this strategy at the local level (this is optional).

8. Partners and Resources: In the last section of each table, we have listed resources or information about potential partner organizations that may be helpful in accomplishing this strategy. There is ample space to add your own local resources to this page as well.

9. Icons: Throughout the document we have used 5 icons to identify important themes that cut across the 30 strategies. The key to these icons is in the table to the right. To apply these icons to strategies you add in your local version of this document, copy them from this table and paste them in the margins of the adapted document. Feel free to add your own new icons for new themes – add them to this table and apply them throughout the document as you wish.

KEY TO ICONS IN THIS DOCUMENT	
	**Mobile/street medicine**
	**Self-testing**
	**Biomedical interventions**
	**Telehealth/technological solutions**
	**Key collaborations**

How to adapt the Implementation Blueprint at the local level

This blueprint is designed to be a tool for CDPH and local health jurisdictions to plan the ways they can most successfully implement changes that will advance the strategies under the statewide strategic plan to address HIV, HCV, and STIs, while maintaining core public health functions we know work.

To this end, the document is a template designed for local customization. The [bracketed red text] is especially designed for you to fill in and edit. You can add or delete *any* of the text you find throughout the document (including deleting whole activities or rows in any of the tables) – this is meant to be helpful for YOU and support you in your work. We also encourage you to set your own timeline for implementation.

We suggest that this customization is complete by December 31, 2023, and that your version of the blueprint is shared with CDPH. As co-authors of this blueprint, you are active partners in the implantation of this strategic plan. It is through our collective work that we will make the fastest progress!

Important Disclaimer **Please note that CDPH does not endorse any specific company, organization, or products.** Any specific products or organizations named in this document are solely offered as potential examples, resources, or models of implementation, without endorsement.

Strategy 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			
Recommended Activities	**2022-2023**	**2024-2025**	**2026 & beyond**
Develop a comprehensive workforce development project, such as community college seminars to promote public health careers, resumé development webinars, and professional development workshops for people in fields related to public health, with special emphasis on Black, Indigenous, and other people of color (BIPOC) and people from other priority communities not yet well represented in the HIV, HCV, and STI workforce.	X		
Explore opportunities to partner with colleges and universities to provide scholarships and/or paid internship opportunities to BIPOC who are majoring in public health, medical, mental health, or related fields.		X	X
Implement a professional development course for BIPOC leaders and managers through a collaborative process with the region's system of care. Meaningfully involve BIPOC in all phases of design, implementation, and evaluation of this course. By collaborating with a wide variety of stakeholders (including major care providers in the region), create broad recognition of the course throughout the region and buy-in that the course is a good use of employee time. In [county name] County, this training will be coordinated by [insert name/entity here], and the collaborative will involve [insert key stakeholders here]. We will take special care to market this course to [Describe here the people who would most benefit by enrollment in the course].			X
Ensure Requests for Proposals (RFPs), Request for Qualifications (RFQs), and other formal application or bidding processes encourage applying organizations to recruit, hire, and retain BIPOC and others from priority communities, emphasizing lived experience as an equivalent to degree requirements.	X	X	X
CDPH will leverage the California Pathways into Public Health Initiative (Cal-PPH) to expand reach and to include leadership development programming, especially for BIPOC interested in public health, and to create sustainable job opportunities for trainees transitioning from COVID-19 focused work to other areas of public health.		X	X
Scan current recruiting, hiring, and retention practices for barriers to developing a BIPOC-inclusive and led workforce, including reviewing platforms to post new opportunities, job requirements and qualifications, applicant assistance offered, and other considerations.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Wage equity must be a central component of all workforce development efforts and ties in with *Economic Justice* related strategies. Wage equity relates to the practice of compensating employees who perform the same or similar job functions the same regardless of race, ethnicity, gender, sexual orientation, disability, or other status.
2. Workforce development should consider the overall needs of those entering the workforce, including introducing trauma-informed approaches to onboarding, coaching, and professional development.
3. In September 2022, Governor Newsom issued Executive Order N-16-22 directing state agencies and departments to take additional actions to embed equity considerations in their mission, policies and practices. The order promotes a more inclusive and diverse state workforce and encourages contracting opportunities for California businesses in disadvantaged regions and communities.
4. Throughout California, it would be especially valuable to undertake additional opportunities to support Spanish-language speakers to become mental health therapists, substance use disorder counselors, and medical care providers, as this is currently a gap in linguistically competent care.

Local Considerations (delete or add rows as appropriate to your location)

In the Bay Area, University of California San Francisco (UCSF) is teaching researchers to implement antiracism into their research (see Pilot for Anti-Racism Research). This could be leveraged to help build a foundation for workforce development efforts.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People who are incarcerated: The disproportionate impact of incarceration on BIPOC populations requires work towards "Ban the Box" efforts to expand opportunities for employment in the public health workforce, and overlaps with efforts in *Economic Justice* strategies. The "Ban the Box" Campaign was started in 2004 by *All of Us or None*, a national movement of formerly incarcerated people and their families. The Campaign asks employers to remove questions related to conviction history from employment applications (e.g., removing the commonly-used checkbox to indicate whether the applicant has ever been convicted of a felony). In 2018, the California Fair Chance Act (AB 1008) took effect, which prohibits employers with five or more employees from asking about conviction history from job applications. However, there is still more work to be done to improve employment opportunities for people who have had experience with the criminal justice system in California.

Migrant and immigrant communities, including people who are undocumented: Leadership and workforce development strategies often exclude people from migrant and immigrant communities due to language barriers, unjust structures, and immigration policies. Partner closely with organizations serving members of this priority population, to try to mitigate these barriers where possible.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources
1. The UCLA website has more information on the Cal-PPH Training and Pathways Program.
2. CDPH has an internship program that offers exposure to public service, and equips aspiring public health leaders with professional development opportunities and a career pathway – including aspiring BIPOC leaders.
3. The Civil Rights Department of the State of California has guidance for California employers and job applicants related to the Fair Chance Act (i.e., 'Ban the Box' law).
4. [Insert local resource here]
5. [Insert local resource here]

Social Determinant of Health

RACIAL EQUITY

Strategy 2: Racial and Ethnic Data Collection and Stratification

Identify, collect, analyze, and publicly share data that reflects 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Train all Communicable Disease Investigators/Disease Intervention Specialists (CDIs/DISs) to collect consistent variables for race/ethnicity, sexual orientation/gender identity (SOGI), and housing status, as well as offer connections to housing resources, when interviewing patients.	X	X	X
CDPH will develop sample data-sharing agreements and establish ongoing processes to improve race/ethnicity and SOGI data quality and completeness for people living with HIV, HCV, and STIs, such as by matching records with external data sources (i.e. birth and death records, electronic health records, Medi-Cal data, state prison data, and CA Rural Indian Health Board data).		X	X
CDPH will assess HIV, HCV, and STI outcomes using ecological data on social determinants of health (e.g., from the U.S. Census, Social Vulnerability Index, and the Healthy Places Index) to examine how well these and other related measures help explain the racial disparities in HIV, HCV, and STI health outcomes in California.	X	X	X
Routinely analyze HIV, HCV, and STI data and social determinants of health metrics to identify racial disparities in prevention, care, and treatment outcomes and their root causes. Specifically, [CDPH/County name] will assess [metrics to review] stratified by race/ethnicity and by social determinants of health.	X	X	X
Develop and share infographics, fact sheets, talking points, slides, videos, and other ways of ensuring that racial disparities data are presented within the larger social context that creates those disparities.		X	X
Establish and maintain a community stakeholder engagement process to share HIV, HCV, and STI data that includes race/ethnicity stratification. Collaborate with affected communities for community-informed messaging and work together to identify solutions for undesirable trends in the data.	X		
CDPH will share sample funding formulas and tools that incorporate racially/ethnically-stratified data, and are designed to guide resource distribution to better address racial inequities.	X	X	
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Data collection and reporting can be a barrier to serving populations most impacted by the syndemic, because a high burden from data collection, entry, and reporting requirements can negatively impact service provision, particularly for smaller jurisdictions and service organizations. As such, the burden of data collection, etc. should be weighed with the importance of the data being requested, and the plan for its use. CDPH is currently developing a statewide community advisory board on data use that will guide best practices on data collection and use.
2. When collecting data, special attention should be placed on consistently asking for racial identity rather than assuming it. Indigenous people are often under-counted due to racial assumptions made by providers and other practitioners.
3. Data about BIPOC should be presented through an equity lens that recognizes complex socio-ecological conditions (i.e. poverty, homophobia, stigma, racism, and generations of systemic discrimination that created limited opportunities and resources). Stigmatizing language should be scrutinized and eliminated. There are nuances that should be considered when it comes to identity language – in particular the term Latinx may not be used by everyone, and some people may use Latino/Latina, Chicano/Chicana, Hispanic, Mexican, Brazilian, etc. to define themselves. Community engagement is critical for ensuring non-stigmatizing language that is appropriate to the local context.

Local Considerations (delete or add rows as appropriate to your location)

In Southern California, consider cross-border data analysis to understand HIV, HCV, and STI among binational communities.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People of Color, especially Blacks/African Americans, Latinx, & Indigenous people: Relationship building and building back trust with Black, Latinx, and Indigenous populations is a vital activity to address concerns about data used for public health surveillance. The American Association of Medical Colleges' Center for Health Justice has an excellent resource on building trustworthiness. Further, racial misclassification of Indigenous people in communicable disease surveillance systems is common and can make it difficult to assess the true burden in Indigenous populations.

Gay and bisexual men, and other men who have sex with men and **People who are trans or gender non-conforming:** SOGI data collection and reporting need to be improved across most databases to better understand intersectionality of race/ethnicity and SOGI, and best serve all BIPOC. It is also necessary to improve SOGI data collection and reporting so that CDPH can better comply with state law promoting complete SOGI data (Government Code 8310.8). Specifically, it is important to ensure that gender options are not only binary (man/woman), and ask sex assigned at birth AND current gender identity, as separate questions. Terminology continues to change, and organizations/agencies should be prepared to modify questions and response options to better reflect the local community, including using culturally preferred terminology. For example, some Indigenous communities use the term Two Spirit for both sexual orientation and gender identity.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				

[Insert your local ideas]				

Partners and Resources
1. For further information on race/ethnicity data collection in healthcare check out: Dania Palanker, Jalisa Clark, and Christine H. Monahan, "Improving Race and Ethnicity Data Collection: A First Step to Furthering Health Equity Through the State-Based Marketplaces," *To the Point* (blog), Commonwealth Fund, June 9, 2022.
2. To review one way in which racial and ethnic data collection can be used to understand equity, see the National Equity Atlas' work.
3. The Centers for Disease Control and Prevention (CDC) has suggested questions and other resources for collecting SOGI data.
4. [Insert local resource here]

Social Determinant of Health

RACIAL EQUITY

Strategy 3: Equitable Distribution of Funding and Resources

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

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Simplify funding applications, reporting requirements, and other administrative burdens to expand opportunities for funding organizations that are led by and predominantly serve BIPOC. Provide technical assistance to increase the capacity of BIPOC-led organizations to apply for, receive, and manage state and federally funded grants.	X		
CDPH will review funding and resource allocation formulas to account for racial/ethnic health disparities, such that those with disproportionate impact in their communities receive funding and resources to account for those inequities.		X	X
CDPH will develop and share policy guidance and examples of how to allocate funding to ensure a more equitable distribution of resources to BIPOC communities for integrated work, such as by sharing existing HIV, STD, and HCV funding formulas that account for racial disparities, by applying the Government Alliance for Racial Equity Toolkit. This process will be intentional and transparent, and will include a pilot funding phase with a continuous quality improvement process embedded throughout.	X		
Utilize race/ethnicity and social determinants of health data to determine current funding and resource allocation in the region. Present this information to relevant community groups to discuss areas of concern and strategize solutions to achieve more equitable funding and resource allocation.	X		
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Recognize that funding an HIV/HCV/STI program requires more support than funding direct service staff (such as clinical supervision, program management, front office or other support staff, promotion and marketing of the program/services, etc.) and many contracts do not include funding for those tasks. When possible, contracts should also allow for cost-of-living increases and opportunities for promotion and professional growth for staff.
2. Many community-based organizations that serve historically neglected communities have limited budgets and infrastructures. As a result, they may have difficulty competing in RFP funding processes, and would suffer if required to incur costs for several months prior to reimbursement once in contract. Administrative burdens should be diminished as possible during pre-award, award, and

renewal processes by implementing a grant management system that shifts the burden from non-profit organizations to the funder where possible.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People of Color, especially Black/African American, Latinx, & Indigenous people: While Indian Health Services (IHS) funds are used for a range of tribal and Urban Indian Health services, IHS is a payer of last resort and is not insurance coverage, resulting in fragmented care. Not all tribal members are eligible for IHS-funded services. Additionally, some Indigenous people may not seek care in their tribal communities due to concern about sharing personal information with people they know (and resulting stigma). As such, data on indigenous communities should be combined across health systems to account for people accessing multiple care points, and clinic-specific data should be reviewed with caution when considering resource and funding allocations.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. Visit the People Power for Public Health Report to better understand BIPOC experiences with medical care and how local health jurisdictions utilize healthcare funding.
2. The California Rural Indian Health Board, California Consortium for Urban Indian Health, and National Indian Health Board websites have more information on the health infrastructure for indigenous people in California.
3. [Insert local resource here]
4. [Insert local resource here]

Social Determinant of Health

RACIAL EQUITY

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Build local and regional collaboratives of community health workers (CHWs) serving the same priority populations to ensure a "no wrong door" approach for re/engaging in preventive services and care. Leverage existing outreach initiatives (e.g., California Emergency Department Bridge, HIV, STI, and HCV grants, homeless outreach services, Medi-Cal community health worker benefit and enhanced care management) wherever possible.	X	X	X
Partner with tribal entities in the region to share information, and facilitate communication between local health departments, tribal communities, and other organizations in outlying areas. Work to ensure seamless patient navigation and care coordination for people living with and at risk for HIV, HCV, and STIs who are served by tribal health, Urban Indian Health, and other local and regional programs.	X	X	X
Promote and leverage the new Medi-Cal benefit and other funding services to support CHW/*promotore*/peer models to meet community members in their own spaces, with providers and health educators that reflect the community being served. People from affected communities with lived experience should be appropriately and equitably paid for their labor and expertise, including community knowledge and connections.		X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Ensure the language used during community engagement is simple and accessible. Documents should have glossaries that define jargon and acronyms, and be available in Spanish and other threshold languages (languages that are spoken in high proportions throughout the state). Materials should be developed in compliance with the Americans with Disabilities Act (see resource below) and in consideration of consumer information processing theory (see resource section) and other communication theories that help to ensure that information is understandable and accessible.
2. Some community members may live in remote areas, have limited mobility, or may otherwise be unlikely to visit centralized services – thus requiring nontraditional methods of community engagement. Some options for this include discussions at service provider settings during appointment times, home visits, or virtual/telephone conversations.

Local Considerations (delete or add rows as appropriate to your location)

In Northern California, there has been an emphasis on partnership with tribal/indigenous communities to increase community engagement and data sharing. Work in this area must include acknowledgment of the violent harms perpetuated by the US and California governments against tribal communities, and must be designed to intentionally build trust between local public health departments and tribal government and service providers.

In counties that receive funding through the federal Ending the HIV Epidemic initiative, community engagement is a requirement of funding, and specific engagement with BIPOC communities should be leveraged to ensure work is community-driven and tailored to the unique needs of the region's population. (See resources below for more information.)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

Young people (ages 15-29 years): Youth outreach and engagement can be especially challenging because of the separation between school health education and public health, along with competing priorities. Partnerships with local education agencies, youth-serving organizations, youth advisory councils, and incentivized engagement activities can increase engagement among youth.

People who use drugs, including people who inject drugs: Due to direct and repeated experiences of societal and provider mistreatment and stigma towards people who use drugs, many members of this population do not trust the medical and public health systems and may be reticent to engage in discussions with health department staff. Public health and service providers should institutionalize harm reduction practices and integrate positions for people with lived experience of drug use, and engage people who use drugs in their spaces and on their terms (e.g., at syringe services programs) to ensure robust and respectful engagement with members of this community.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. Visit the CDC's Ending the HIV Epidemic in the US – Community Involvement website to learn more about the engagement requirement for Ending the HIV Epidemic initiative communities.
2. Learn more about consumer information processing through the National Cancer Institute's "Pink Book" about health communication, James R. Bettman's book entitled *An Information Processing Theory of Consumer Choice,* and the National Cancer Institute's resource "Theory at a glance : a guide for health promotion practice."
3. Visit the United States Access Board website for the Guide to the Americans with Disabilities Act Accessibility Standards.
4. [Insert local resource here]

Social Determinant of Health

RACIAL EQUITY

Strategy 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 out movement towards achieving cultural humility, equity, and racial justice in our prevention, testing, treatment, and care services.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will partner with racial and social justice experts and service providers to promote racial and social justice trainings that take an antiracism approach, emphasize inclusion, acknowledge the root causes of medical mistrust, and provide concrete and feasible solutions to structurally racist influences within public health systems, and can be used statewide. (See duplicate activity under *Stigma*, strategy 4.)	X	X	
CDPH will offer racial and social justice training free-of-charge to service providers, county/organizational leadership, and jurisdiction program planning groups, with certificates of completion.		X	X
CDPH will require the HIV, HCV, and STI counseling and testing training contractor to integrate racial and social justice training into the training and require completion in order to become certified and/or recertified.		X	X
CDPH will strategically fund and require all local health jurisdiction staff and directly contracted HIV, HCV, and STI service providers to attend virtual, in-person, or asynchronous CDPH racial and social justice training (or equivalent, approved training) to receive HIV, HCV, or STI funding from CDPH.			X
CDPH will continue to include racial equity-focused discussions in HIV, HCV, and STI technical assistance calls, webinars, and tools with local health jurisdictions and other community partners. CDPH will also provide a forum for peer-to-peer sharing of best practices for centering racial equity in public health, health care and community-led projects locally.	X	X	X
Hire a health equity officer to ensure culturally appropriate services, provide guidance for programming, and review policy and practice related to racial equity and social justice.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Racial and social justice training should be part of a comprehensive approach to ensuring equity in public health work and in the workplace. This cannot be accomplished through one-time training efforts, and instead requires follow-up to the training, continuous evaluation of individual training and practice, and a review of local policy and practice.
2. All racial and social justice trainings should incorporate voices of people with lived experience, include information about implicit bias, and instruct how to implement a social justice approach in the work.

3. Additional training to ensure non-stigmatizing, non-judgmental, and trauma-informed service provision should be offered with consideration for specific populations of focus.
4. Some agencies may be funded via federal or local dollars, rather than through state funds. Make sure to make appropriate adaptations to the proposed activities so that they best address need and appropriate funding streams.

Local Considerations (delete or add rows as appropriate to your location)

In Northern California, health equity is closely tied to geography as rural communities often suffer from health disparities and access to care concerns. Students for Quality Education are working toward incorporating racial justice training. This may be an opportunity for collaboration in the region.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

[Insert your local ideas]

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. Check out Race Forward's Racial Justice Training series that includes Building Race Equity, Organizing Racial Equity, and Decision-Making for Racial Equity.
2. The Social Justice Training Institute may provide an opportunity for partnership to develop social justice training.
3. The National Association of County and City Health Officials has an online learning collaborative for local health departments called Roots of Health Inequity.
4. Both STDCB and OA participated in versions of CA4Health's 21-Day Racial Equity & Social Justice Challenge, which is regularly offered for free to individuals and institutions.
5. [Insert local resource here]

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will review HIV testing forms, case report forms, sample risk assessment templates, and other tools to promote consistent collection of information on housing status among people with HIV, HCV, and STIs, such as during case investigation, patient interviews, patient navigation, care coordination, and special projects. Train state and local staff on use of these tools and modify data systems to collect this information.	X	X	
CDPH will explore developing data-sharing agreements and establishing ongoing processes to improve housing status data quality and completeness for people living with and at risk for HIV, HCV, and STIs, such as by matching records with external data sources (e.g., California Inter-Agency Council on Homelessness, Business, Consumer Services, and Housing Agency, Department of Social Services, Department of Health Care Services, Homeless Management Information Systems, Department of Health Care Access and Information (HCAI), and birth and death records) while ensuring client confidentiality. Leverage the census-tract level housing status metrics in the Healthy Places Index.			X
Analyze HIV, HCV, and STI-related health outcomes stratified by housing status statewide, regionally, and locally to inform resource allocation and program design, including building interagency collaborations and additional housing supports.			X
Work with agencies responsible for local Point-in-Time counts to augment surveys with HIV, HCV, and STI-related questions to better understand these conditions within homeless populations. However, do not solely rely only on Point-in-Time counts, which have severe limitations. Instead, incorporate housing status data from screenings at traditional and non-traditional primary care settings, such as emergency departments or other sources of housing data when possible.		X	
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Understanding housing status data is essential to understanding the need in a region, in order to optimally tailor homelessness prevention activities. This requires the collection of housing status, including those at risk for losing housing among those living with HIV, HCV, and STIs, as well as those at risk for HIV, HCV, and STIs.

2. Good quality housing data variables should differentiate between those who are unhoused, unstably housed, and at risk of losing their housing. Data collection efforts should be improved to understand the spectrum of housing needs and advocate for resources for people at each place on that spectrum. Homelessness prevention interventions should reach people at risk of losing their housing *before* they become unhoused, and support rapid re-housing interventions.
3. Definitions of housing status differ between organizations and/or data systems. A consistent and shared definition of different housing statuses would be ideal to ensure data collection and reporting is uniform across different systems.

Local Considerations (delete or add rows as appropriate to your location)

In Humboldt County and other areas with large camps/encampments, consider keeping records on camps as a patient's or client's residence, which can be helpful to clinics and hospitals in the region when needing to contact a patient.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

Migrant and immigrant communities, including people who are undocumented: Tracking health outcomes and housing status for people who are migrants may be challenging if they move often and live in camp environments, whether or not they identify as homeless. Community health workers and other mobile health education efforts can help to support data collection and tracking for this community. Considerations should be made to partner and collaborate with migrant-serving organizations such as United Farm Workers Foundation, La Cooperativa Campesina de California, and California Farmworkers Foundation to increase coordination of prevention and care services throughout California migrant employment sites. Immigration status should not be collected or documented for HIV, HCV, or STI case follow-up or prevention activities.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. For more information on the HUD Point-in-Time Count and Housing Inventory Count visit the HUD Exchange website. Keep in mind that Point-in-Time counts are typically done on a single evening and only count people who are visible outdoors at the time of the count. There have been many critiques of this method, although in many jurisdictions they are the only source of homelessness data.
2. For more information about the burden of disease borne by people experiencing homelessness in California, see Liu *et al*, 2020.
3. [Insert local resource here]

Social Determinant of Health

HOUSING FIRST

Strategy 2: Infrastructure Changes

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

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will identify and share funding opportunities for housing solutions that incorporate support for substance use disorders, mental health, and prevention, screening and treatment for HIV, HCV, and STIs.	X	X	X
Leverage the flexibility in the 2022 Budget Act (SB 184) allowing state HCV and STD Prevention and Collaboration grant funds to be used for material supports, including blankets, sleeping bags, and shelter for people living with and at risk for HCV or STIs, respectively, in addition to delivery of integrated HIV, HCV, STI, and overdose prevention services to people who are unhoused.	X	X	X
Build systems that allow people to access housing supports through public health and community-based HIV, HCV, and STI programs, by developing collaborative partnerships, cross-training, and bidirectional referral agreements between public health, healthcare for the homeless, and community-based organizations delivering HIV, HCV, and STI services and coordinated entry systems.		X	X
Provide training to HIV, HCV, and STI service providers to screen for housing insecurity and link those who are unstably housed *or at risk of losing housing* to specialized multidisciplinary support services, with a special emphasis on people who are pregnant or parenting.		X	X
Develop communicable disease control prevention and control guidelines for homeless encampment outreach and resolution programs, with an emphasis on participant choice of permanent supportive housing. Ensure people can maintain contact with public health and health care services during periods of transition. Promote stability and safety for people who are living in encampments, such as through providing regular access to hygiene facilities.	X	X	X
In collaboration with other state agencies, CDPH will review state policy and practices regarding managing, supporting, or moving homeless encampments to ensure they conform with United Nations and World Health Organization standards for treatment of internally displaced persons.	X	X	X
[Insert your local ideas]			

Overall Considerations

1. Many programs and services are available only during traditional hours; people who are struggling to find and maintain safe housing may have a need for evening and weekend hours to be able to seek HIV/HCV/STI services, which may be one of the reasons so many people access care in emergency departments.

Local Considerations (delete or add rows as appropriate to your location)
In San Bernardino County, the health department has an opportunity to support partnership with Innovative Remote Onsite Assistance Delivery (InnROADs), a program of the San Bernardino Department of Behavioral Health, to provide direct links to testing and treatment for people who are unhoused.
In Tulare County, the Task Force on Homelessness is a multidisciplinary team who works on identifying, developing, and implementing strategies to respond to homelessness; they may be a good partner in this work moving forward.
In [Insert local jurisdiction]…[insert other considerations as desired].
Key Population Notes
People who are incarcerated: Release plans should be coordinated with community service providers to ensure stable services and assistance are available, including access to housing options (even if emergency shelter). This is critical to ensuring people remain in HIV care, complete treatment for HCV or STIs, and have access to ongoing HIV, HCV, and STI testing and prevention programs.
People experiencing homelessness: Anti-homeless architecture does not just impact the individual experiencing homelessness but promotes stigmatizing behaviors and attitudes. People experiencing homelessness experience their environment as more hostile than the general population. Advocacy for the removal of spikes along walls, slanted or segmented benches, and boulders under bridges supports a less hostile environment for people experiencing homelessness. This is especially important around public health and social services buildings, to help these government entities build trustworthiness with people experiencing homelessness.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. [Insert local resource here]
2. [Insert local resource here]

Social Determinant of Health

HOUSING FIRST

Strategy 3: New Models of Housing Access

Collaborate with the Department of Housing and Community Development (HCD) to explore the 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will partner with the California Department of Social Services (CDSS) and Department of Housing and Community Development (DHCD) to understand lessons and challenges from implementation of homeless services programs under their purview, which provided housing to people experiencing homelessness who were at risk for complications or in need of isolation and quarantine during the COVID-19 pandemic.	X		
Identify and leverage funding opportunities to permanently house people living with HIV who are experiencing homelessness, with an emphasis on people who are pregnant or parenting.		X	
Develop a program that provides safe and stable housing using a harm reduction framework for unhoused people living with HCV for the duration of a HCV treatment regimen, with supportive services provided during this time to link them to other housing options upon treatment completion.		X	X
Develop a program that provides safe and stable housing for unhoused people who are pregnant and living with or at risk of contracting syphilis, providing access to STI testing and treatment through the housing program in an effort to eliminate congenital syphilis in California.	X	X	
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Development of a permanent housing model is the gold standard, yet a long-term goal. In the meantime, short-term/temporary housing options are necessary to provide services to people experiencing homelessness, while permanent housing pathways are being created.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

Cisgender women and people who can become pregnant: People who are pregnant and unhoused and/or living with HCV or syphilis should be provided with emergency housing, along with opportunities for permanent housing.

People who use drugs, including people who inject drugs: California law (Welfare and Institutions Code 8255) requires all housing programs in California to adopt the Housing First model. However, adherence

to Housing First principles varies and can be challenging while drugs remain criminalized. Supportive housing options that will not evict tenants for drug use are necessary, as are sober living environments to support those who are in recovery.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The California Department of Social Services website has more information on Project Roomkey.
2. The California Department of Housing and Community Development has a fact sheet on the Housing First model. This model emphasizes housing without conditions, such as sobriety, drug treatment, or participation in support services.
3. [Insert local resource here]
4. [Insert local resource here]

Social Determinant of Health

HOUSING FIRST

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Develop or integrate with existing street medicine models to expand modalities of care, including field-based HIV PrEP/PEP, injectable treatments, buprenorphine, mental health services, reproductive health services, wound care, and other medical services. Leverage California's federally qualified health center (FQHC) Alternative Payment Methodology pilots and similar innovations to garner reimbursement models for street-medicine based care delivery, especially through CalAIM.	X		
CDPH will expand funding opportunities and provide guidelines and technical assistance for use of existing funding for street medicine strategies including walking teams, medical vans, outdoor clinics, suitcase clinics, and similar services. Funding may be used for point-of-care HIV, HCV, and STI testing, on-site Bicillin L-A, harm reduction supply and naloxone distribution, wound care, phlebotomy, and other services.		X	X
CDPH will explore funding opportunities to support data management solutions for street medicine services, such as tablets, phones, and other easily mobile devices that use limited to no internet or cell connection while functioning as data collection tools. Pilot programs should consider using Disease Investigation Specialists (DIS) or other outreach workers to do field outreach and use this method of data collection.		X	X
Expand syringe service programs by co-delivering street medicine strategies for wound care, vaccination, HIV/HCV/STI screening, and referral to care and social services. Street medicine and syringe service programs can coordinate shared auxiliary support while efficiently and effectively reaching priority populations including people experiencing homelessness and people who use drugs.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. CDPH and local health jurisdictions should partner with universities and colleges to identify new and leverage existing public health workforce development initiatives to provide opportunities to students, medical residents, and other entry-level and mid-career public health professionals to learn how to serve people experiencing homelessness, and to seek employment in the field of street medicine.

Local Considerations (delete or add rows as appropriate to your location)
In [Insert local jurisdiction]…[insert other considerations as desired].
Key Population Notes
People experiencing homelessness: The disruption of encampments throughout the state make continuous care through street medicine more difficult. Street medicine strategies should incorporate methods of building trust and engaging the community to link them to ongoing primary care services.
People who exchange sex for drugs, housing, and/or other resources: Street medicine can be employed to better meet the needs of this population. Service providers should provide education, prevention, screening, and treatment of HIV, HCV, and STIs alongside other medical services. Supportive resources may include offering condoms and lubricants, and routinely offering to talk about sex, birth control, and safety issues.
Monitoring and Metrics
The table below outlines how progress toward this strategy will be measured:

Level	**Indicator**	**Who measures?**	**How frequently?**	**Why this measure?**
[County name] County				
[Insert your local ideas]				

Partners and Resources
1. The Street Medicine Institute provides various program resources including clinical guidelines and manuals.
2. The University of Southern California Keck School of Medicine's Street Medicine program is a possible partner for street medicine training, curricula, and service provision.
3. The California Primary Care Association has more information on the Alternative Payment Methodology pilots.
4. In San Francisco, the encampment health fair model is an example of providing pop-up medical care, substance use treatment, harm reduction services, and referral to services in through a collaboration of community providers. The San Francisco Department of Public Health has developed a toolkit so that this model can be replicated in other communities. Given the small geographic size and high population density of San Francisco, implementation in other geographic areas may require adapting the model to best reach the intended community.
5. [Insert local resource here]
6. [Insert local resource here]

Social Determinant of Health

HOUSING FIRST

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will convene an ongoing collaborative to include other state departments, service providers, community members, housing advocates, and funders to identify and disseminate funding opportunities related to low-barrier housing options throughout the state.	X	X	X
Develop, identify and leverage, and/or expand programs to provide rent subsidies to low-income residents in priority populations to ensure they pay a reasonable portion of their income towards rent as long as they are in workforce development programs, substance use treatment programs, and/or were recently unhoused.		X	X
CDPH will seek opportunities to ensure shelters, cooling and heating centers, and other short-term temporary housing options are supportive environments that include integrated harm reduction services, HIV, HCV, and STI testing, food and basic needs assistance, peer support, and job opportunities.		X	X
Leverage the Cal-AIM Justice Involved Adults and Youth Initiative to support public health and community-based organizations to participate in establishing routine pre-release Medi-Cal applications and housing supports for all people returning to the community from prisons and jails. Identify opportunities to provide similar supports prior to discharge from hospital stays, and before the end of temporary shelter/hotel room stays. Stop gap measures are necessary during transitions from one situation to another to prevent homelessness.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Temporary housing assistance will only work in the long-term if it is paired with employment/economic opportunities and permanent affordable housing options. Integrated workforce development programs and eligibility guidelines that do not punish, but instead encourage, increased pay and benefits over time should be explored.
2. There is still skepticism among some housing providers regarding Housing First models and their efficiency. Concerns should be discussed and addressed, when possible, to build partnership and best meet the varying needs within the community of unhoused people.

Local Considerations (delete or add rows as appropriate to your location)

In Southern California, Housing First San Diego provides various programs to prevent homelessness and to work with those who are homeless to ensure that they have access to temporary and permanent housing options. Programs include help to pay rent, identification of alternative permanent housing options, rapid rehousing, new permanent supportive housing units, and landlord engagement to rent to people experiencing homelessness.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People who are incarcerated: Release from prison or jail should include a plan for housing with linkage to care after release to ensure adequate treatment and follow-up for STIs and HCV that are diagnosed while in custody, and to health care services that support ongoing HIV care as needed, as well as HIV, HCV, and STI testing and prevention opportunities.

Migrant and immigrant communities, including people who are undocumented: People who are undocumented often do not qualify for, or are afraid of, housing programs. As such, those who are undocumented and unhoused have limited access to services, options, and are particularly vulnerable to police involvement from moving encampments. Street medicine strategies that do not require insurance, do not document immigration status, and provide care to highly mobile populations can help to keep this population engaged in medical care.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The California Department of Social Services has links to resources and housing programs.
2. See the Department of Health Care Services website for a fact sheet about the Cal-AIM Justice-Involved Adults and Youth Initiative.
3. The National Alliance of State and Territorial AIDS Directors (NASTAD) has a webinar series on providing harm reduction-based housing for people who use drugs.
4. [Insert local resource here]

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Use telemedicine to improve access to HIV, HCV, and STI preventive services (e.g., HIV PrEP), screening, and treatment and substance use disorder treatment for people who use drugs, are unhoused or marginally housed, or live in more remote areas, by establishing dedicated and flexible telehealth spaces in supportive housing buildings or community-based organizations serving these priority groups, and using tablets to make telehealth access mobile during street outreach efforts. Leverage and expand the flexibility of funding resources to support delivery of telemedicine, such as reimbursement by Medi-Cal, Medicare, and other payers, and state and federal grants that allow funds to be used for telehealth for all people.	X	X	X
Promote HCV antibody to HCV RNA reflex testing policies in laboratories and health care settings (e.g., hospitals, EDs, primary care), leveraging AB 789 implementation.		X	X
Partner with the California Department of Corrections and Rehabilitation (CDCR), California Correctional Health Care Services (CCHCS), and local county partners to expand HIV, HCV, and STI testing and treatment in prisons and jails, including access to HIV PrEP. To address skyrocketing congenital syphilis rates, correctional facilities in California should consider implementing universal opt-out syphilis screening with a rapid treponemal test and STAT Rapid Plasma Reagin (RPR) upon intake, ensuring rapid return of results and initiation of treatment with Bicillin L-A before release when indicated. Establish relationships with Disease Intervention Specialist (DIS) staff in the local health department to facilitate contact tracing for people diagnosed with syphilis within correctional facilities. In the event that a person is released from prison/jail with untreated syphilis, the local health department should be urgently informed so they can conduct follow-up activities and help ensure treatment is completed.		X	X
Leverage the Cal-AIM Justice-Involved Adults and Youth Initiative and other resources to partner with local community organizations or clinics to support engagement in medical and supportive care to aid continuity of HIV and HCV treatment as people are released from jail or prison (and potentially re-incarcerated); release planning should include (a) naloxone distribution, (b) mental health evaluation, (c) referral to at least one community organization experienced in supporting people with a recent history of incarceration, and (d) if living with HIV or HCV, a warm hand-off to a clinic or clinical provider who can see the person within one week of release.		X	X

Leverage the 340B program, state-purchased medication, and other strategies to ensure access to Bicillin L-A for treatment of syphilis, by improving stock in health department clinics, creating provider delivery programs for private or non-governmental clinics and field or other non-traditional delivery programs.	X	X	X
Better utilize mobile vans to expand access to HIV, HCV, and STI testing; syringe services programs; buprenorphine; HIV, HCV, and STI treatment; COVID, MPX, hepatitis A and B, influenza, and HPV vaccinations; reproductive care services; and basic wound care or other urgent care services. Mobile vans providing comprehensive services can be especially helpful in expanding access to people living in rural/frontier areas, youth in schools in communities with limited health access, people living in homeless encampments, and others who may not regularly engage in traditional medical care. Consider sites frequently accessed by priority populations such as flea markets, warehouse and industrial worksites, migrant farm communities, schools, and community sites in off-hours (e.g., for sex workers or others who may need nighttime access to services).		X	X
CDPH will work to expand flexibility of funding for mobile health, including to purchase medications for use in mobile settings when possible, and will explore allowing funds to be used for vehicle leasing. CDPH will also promote the Alternative Payment Methodology initiative, which will soon allow federally qualified health centers to bill for street medicine and mobile health services.		X	X
Partner with hospital emergency departments (EDs) to expand care to priority populations, recognizing that for many people with limited healthcare access the ED is their sole source of medical care. Leverage state funds, along with other resources, to implement comprehensive opt-out screening for HIV, HCV, and syphilis in EDs. Pilot programs for expanded diagnostic, preventative, and curative care for priority populations entering the ED for any reason. Anyone with a positive pregnancy test should receive an opt-out rapid syphilis test, and be treated empirically if likelihood to return for treatment is low. ED-based navigators for HIV, HCV, and STI treatment are often the key to successful implementation of ED-based screening programs, both because they improve outcomes for patients and because they increase willingness of hospital administration to take on the responsibility of a screening program.			X
CDPH, in partnership with the Department of Health Care Services, will work with EDs to provide technical assistance regarding billing Medi-Cal managed care plans for navigation services, to leverage the new community health worker benefit effective in Medi-Cal July 1, 2022, along with Enhanced Care management and Community Supports program under CalAIM.			X
Use academic detailing and other efforts at the local level to ensure prenatal and birth care providers follow California's expanded syphilis screening recommendations and are compliant with Senate Bill 306, including testing for pregnancy and syphilis concurrently, drawing blood at the time of prenatal visits for on-site syphilis testing (including during the third trimester), utilizing STAT Rapid Plasma Reagin (RPR) testing at time of delivery, and immediately	X	X	X

treating all patients who are or could become pregnant who report exposure to syphilis, without waiting for test results.			
CDPH will partner with the Department of Health Care Services to monitor syphilis screening during pregnancy and HIV viral load suppression among DHCS managed care plans, and encourage local collaborations between MCPs and local health jurisdictions to implement quality improvement efforts.	X	X	X
Through *TakeMeHome, DontThinkKnow*, or other similar programs, CDPH will work with local health jurisdictions to expand access to self-testing for HIV, HCV, and 3-site testing for STIs. Where possible, disease intervention specialists (DIS) in health departments should distribute self-test kits during contact tracing efforts.	X	X	X
Where possible, offer free HIV PrEP, as well as HIV and HCV treatment starter packs of medications to start or re-start patients on regimens.	X	X	X
Promote reach and use of Project ECHO (a collaborative model of medical education and care management), communities of practice, and clinical mentorship programs to improve provider education about successful treatment of HIV, HCV, and syphilis in primary care settings.	X	X	X
CDPH will set a statewide standard to implement comprehensive, routinized sexual and drug user health screening programs (screening for HIV, HCV, and STIs) at critical touchpoint locations. To facilitate this, CDPH will work to expand access to 4th generation rapid HIV testing, along with rapid HCV and syphilis test kits, and HIV test counselor training for clinics and community organizations. CDPH will also work with local partners to promote awareness and implementation of SB 306, which requires health plans to cover at-home STI testing.	X	X	X
Partner with the Pacific AIDS Education and Training Center (PAETC), the California Prevention Training Center (CA PTC), and other clinical training programs throughout the state to help ensure clinical providers know how to take a thorough sexual history; know how to assess patients for pregnancy intention and refer to services accordingly; can screen for, diagnose, and treat HIV, HCV, and STIs; understand the importance of reporting positive results for HIV, HCV, and STIs to the local health department; and know how to correctly and completely report cases of syphilis within one working day, documenting pregnancy status, gender of sex partners, partner information, syphilis staging, and treatment provided.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. In rural/frontier areas, many people may not have access to cellular service and/or broadband internet. This can greatly impact access to telemedicine services; consider special outreach efforts for very rural communities rather than expecting that telemedicine or other remote services will suffice to extend care.

2. There are some programs that promote "at-home testing," though some people who want to access this type of testing may not have a home where they can take the tests. For this reason, CDPH typically refers to these tests as "self-collection testing" – and with creativity, self-collection tests can be used with people who do not have regular mail delivery (either because of being houseless or rural location). For example, the self-tests could be shipped to a centralized pick-up spot (library, grocery, or community organization) or be brought to the person through mobile or street-based outreach efforts.
3. More research is needed to support improved strategies to combat rising rates of congenital syphilis. Especially, research is needed related to (a) efficacy of routine syphilis screening programs in emergency departments and corrections settings as a method of congenital syphilis prevention; (b) accuracy of existing point-of-care syphilis tests during pregnancy, and potential for updated test technologies with improved performance; and (c) effectiveness of doxycycline as pre-exposure or post-exposure prophylaxis to prevent syphilis and other STIs for people who could become pregnant.

Local Considerations (delete or add rows as appropriate to your location)

In Northern California, it may be beneficial to partner with the Shasta Substance Use Coalition, and broaden its scope to include HIV, HCV, and STIs.

In rural/frontier areas, public transportation options have limited hours and in more rural areas taxis, Uber/Lyft, and medical transportation programs do not frequently operate. Rigid appointment windows where a patient/client must reschedule if more than 10-15 minutes late may be major barriers to care in this region; where possible program and clinic flow should be designed to accommodate more flexible structures. A further challenge to healthcare access in these areas include a lack of compliance with the California Healthy Youth Act (CHYA), meaning that comprehensive sexual and health education are severely lacking for youth in school settings, which limits the awareness and resources that youth receive about HIV/HCV/STI prevention, treatment, and care services. Lastly, expensive medications (such as direct acting antivirals for HCV, Bicillin-LA for syphilis, or injectable, long-acting HIV medications) may be very difficult to access in these areas without special programs, as pharmacies typically do not stock these types of medications until they receive a prescription that requires it to be dispensed.

In San Bernardino County, Amazon is one of the major employers of low-wage workers; this could be an opportunity for partnership to engage people in services and improve health. (Note that CDPH does not endorse any company or its products.)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

Young people: Young people have unique challenges related to communication and privacy, as they may not have control over their access to supportive health professionals or payment for services. If a young person is accessing their insurance for reproductive care/sexual health services (including HIV PrEP), the clinic/provider may not tell their parents, but the insurance carrier may send detailed itemized bills home that include services rendered to the young person. Avoiding this requires a Confidential Communications Request waiver or similar process, and not all providers or youth may be aware of this. Providing services at or near locations youth frequent (such as schools or youth venues) and providing easy ways for youth to connect to providers (such as inexpensive mobile phones with pre-paid phone minutes) can really help improve access to care. Note that these concerns may extend to people of all ages in abusive relationships, or other situations where a partner is the policy holder and privacy is required for a person

to seek needed health services. The Confidential Communications Request waiver can also apply in these situations, and is not limited to use by minors.
People who use drugs: People who use drugs often find it difficult to access healthcare through traditional settings – or if they can, they are often stigmatized and mistreated. To improve health access for people who use drugs, it is helpful to incorporate HIV, HCV, and STI testing within harm reduction programs and substance use disorder treatment programs; train pharmacists to dispense HIV PrEP or other medications; and create a local resource list of "friendly" providers and clinics for people who use drugs, to help others make referrals that are likely to be positive experiences.
People who are unhoused: When people are unhoused or marginally housed, they likely experience poor treatment from others on a regular basis and have developed an understandable distrust of others. For this reason, providing person-centered care that demonstrates patience, caring, and warmth is critical – and building trust may take many interactions. Providing food, basic clothing (like socks), basic wound care, etc., may help to build a more trusting relationship that later will facilitate more focused care related to HIV, HCV, and STIs. Offering services in partnership with food banks, meal programs, shelters, or housing programs are other ways to reach members of this group. Finally, consider medication lockers in clinics or community-based organizations, to allow people to keep their HCV or HIV medications in a place where they will not be stolen.
People who are incarcerated: California Penal Code Section 4023.8 says that a person incarcerated in a county jail who is identified as possibly pregnant or capable of becoming pregnant during an intake health examination or at any time during incarceration shall be offered a pregnancy test upon intake or by request, within seventy-two hours of arrival at the jail. To ensure compliance, corrections staff throughout the state should be trained in pregnancy intention assessment and educated about congenital syphilis and perinatal HIV and HCV, as well as the testing, treatment, and family planning services available to people in their facility. There are some models of successfully implementing screening programs: In Fresno, the local health jurisdiction modified the county contract with a private contractor delivering health care in Fresno County jails to add requirements for syphilis screening for priority populations. This strategy can help to ensure sustainability for jail screening programs, rather than relying on grants. Other counties, such as Santa Clara, have leveraged their 340B program to support jail-based screening, diagnosis, and treatment for HIV, HCV, and/or STIs.
Cisgender women and people who can become pregnant: Some cisgender women and people who can become pregnant are at high risk for HIV or other STIs, and may not realize they can access preventive services such as HIV PrEP. Bringing HIV PrEP to women's health programs and community organizations frequented by cisgender women may improve HIV prevention strategies for this group.
Migrant workers: Working hours and conditions, fear of deportation, and fear of public charge may keep migrant workers from seeking the health care they need. Outreach that includes on-site visitation and service provision at migrant workplaces is an important strategy to improve healthcare access, which should be carefully framed to reinforce that *all* people deserve treatment, and be transparent about whether and why immigration status information is collected. Questions about immigration status during healthcare should be avoided unless absolutely necessary.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				

[Insert your local ideas]				

Partners and Resources
1. See the CDC's Guide to Taking a Sexual History to learn more about the five "P's" (partners, practices, protection from STIs, past history of STIs, pregnancy intention).
2. More information about the requirements and process for reporting HIV, HCV, or STIs via the Confidential Morbidity Report (CMR) can be found on CDPH's website.
3. The STD Clinical Consultation Network (CCN) is available online through the National Network of STD Clinical Prevention Training Centers, and can be accessed at no cost by providers requiring STD-related consultation.
4. Continuing Medical Education opportunities related to syphilis/congenital syphilis screening, diagnosis, and treatment are available through the California STD/HIV Prevention Training Center and Essential Access Health's Learning Portal.
5. The Max (Maximum Assistance) Clinic was developed in Seattle, Washington, as an experimental clinic to engage people living with HIV who had the greatest barriers to retention in care. This clinic has resulted in impressive outcomes related to care retention and viral suppression, and is now promoted by CDC as an evidence-based practice.
6. The California Telehealth Resource Center has extensive information on up-to-date federal and state telehealth billing and reimbursement policies, including related to Medi-Cal.
7. The UCSF Viral Hepatitis Center runs an HCV Project ECHO initiative training urban and rural across Northern and Central California to treat HCV and manage liver disease in primary care settings. University of Southern California (USC) runs a complementary HCV Project ECHO initiative serving Los Angeles (and Southern California).
8. California Correctional Health Care Services publishes a health care services dashboard, which includes the number and percentage of people in CA state prisons screened and treated for HCV. See the June 2022 dashboard, as one example.
9. CA Primary Care Association has information on the Alternative Payment Methodology, which will allow federally qualified health centers to bill for services delivered outside the "four walls" of a brick and mortar clinic, including street medicine and mobile health services.
10. Teen Source has information for minors on accessing sexual and reproductive health care confidentially, including how to submit a Confidential Communications Request telling your insurance plan to send all information about the sensitive health care you accessed directly to the minor, and not to their parent.
11. [Insert local resource here]
12. [Insert local resource here]

Social Determinant of Health

HEALTH ACCESS FOR ALL

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Include screening questions around housing stability, food security, substance use, and mental health in medical intakes at emergency departments, medical clinics, and health care centers, to better understand the needs of patients and improve or expand services based on their needs. Care should be taken to focus on the historical legacy of trauma enacted on entire groups of people, and not individual failings, as the contributor to individual patient needs.	X	X	X
Integrate annual Adverse Childhood Experiences (ACE) screening into primary care settings. The State of California provides free provider training on ACEs through the ACEs Aware initiative and Medi-Cal providers are reimbursed for most ACE screening. Providers should be prepared with referral resources for patients with intermediate or high risk, discuss ACEs with those of unknown and low risk, and provide follow-up with all patients regarding ACEs, risk factors, and resilience factors.		X	X
Expand trainings for providers in trauma-informed and trauma-responsive services. Consider special emphasis on providing tailored modules for people who work in correctional health, police, ambulance drivers and EMTs, hospital staff, front office staff (including receptionists and security staff), and phlebotomists. Phlebotomists should receive training that includes anti-stigma and trauma-responsive training for working with people who inject drugs. This training will also be incorporated into the training and mentorship that the STDCB provides to disease intervention specialists (DIS).		X	
CDPH will incorporate trauma-informed care training and resources into technical assistance for local health jurisdictions, to support their provider engagement and detailing efforts.	X	X	X
CDPH will explore solutions with licensing boards and other state departments to discourage “firing” clients/patients with no connection to other services, and provide guidance for alternative strategies. Providers have the right to provide care free from abuse; however, providers should integrate policies that allow clients to return, e.g. with behavior contracts or others strategies in place to protect providers.		X	
Provide sample standards and policies and procedures and best practices (e.g., from the National Health Care for the Homeless Council) for serving people experiencing homelessness, trauma, and other structural barriers. Protocols should be adjusted where necessary, with an understanding of the impact and prevalence of trauma, including missed appointments, adherence to chief complaint, and attending appointments under the influence. Strategies may		X	

include increasing open access 'same day' appointment times, providing flexible appointment times, or staffing 'on-call' providers who can see patients as walk-ins.			
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Incorporating people with lived experience into medical and social service settings can be an incredibly meaningful tool in ensuring trauma-informed service provision and fostering resilience. There are several toolkits to help inform the integration of peers into service settings. Integrating Peers into Multidisciplinary Teams, Building Blocks to Peer Program Success, and Trauma-Informed Care Improving Services Saving Lives are just a few examples of toolkits that can be used to implement peer programs.
2. Engaging in trauma-informed and responsive service provision is not only about the understanding of the impact of trauma among the populations served, but also about understanding the impact among those in helping professions. In addition to personal experience, historical and cultural trauma, and intergenerational trauma, many public health professionals experience vicarious or secondary trauma as well as vicarious resilience. Supportive organizational environments help to recognize signs of burnout, prevent work-related chronic stress, and normalize conversations related to vicarious experiences. In addition, organizations should provide access to Employee Assistance Programs (EAPs) or other outlets that allow for nonjudgmental open discussion without fear of disclosure to other staff or leadership.
3. Research has clearly found a syndemic relationship between HIV and trauma, and it is likely that there is a similar syndemic between HCV/STIs and trauma histories. As such, understanding the impact of trauma, and fostering resilience-based practices, is an important component to providing services to any and all people living with HIV, HCV, or STIs.
4. [Insert your local ideas]

Local Considerations (delete or add rows as appropriate to your location)

In Sacramento and the Eastern Sierras, the California Violence Intervention and Prevention (CalVIP) grant program allows for a police officer and social officer to respond jointly to crisis calls. However, this service is not available everywhere, and ideally could be replicated/expanded. In Plumas County, the Plumas Crisis Intervention & Resource Center (PCIRC) offers excellent trainings on trauma-informed care.

In San Diego, the Psychiatric Emergency Response Team (PERT) provides emergency assessment and referral during crisis situations. The Mobile Crisis Response Teams (MCRT) provide in-person support to those experiencing a crisis. In addition, the Access and Crisis Line receives thousands of calls per month and provides crisis intervention, referrals, and supportive services.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People who exchange sex for drugs, housing, and/or other resources: People who do sex work may have very complicated relationships with HIV, HCV, and STI testing; some sex workers may still be falsely prosecuted despite state laws criminalizing HIV and solicitation being repealed in 2017. Some sex workers report that they have been forced to test upon being charged with solicitation, and may remain wary of

being tested. These are examples of situations under which providing trauma-informed testing services will be critical to success and why laws criminalizing infectious disease transmission should be re-examined.

Cisgender women and people who can become pregnant: People who are pregnant, may become pregnant, or have young children living with them may also be concerned about testing, especially for syphilis. Fear of an unborn child being taken away at birth may not be grounded in law or policy, but it is still a fear that may affect a person's willingness to be tested. Beyond syphilis testing, people who are pregnant may be concerned that HIV, HCV, or STI testing could link them to substance use that could result in a child being taken away.

Migrant and immigrant communities, including people who are undocumented: People who are victims of abuse while undocumented face especially complex challenges, as diagnoses of HIV, HCV, or STIs can increase abuse, and can increase fear of deportation. Privacy issues are always important when it comes to HIV, HCV, and STI testing and treatment, but for people who are undocumented special care should be taken to explain privacy steps and risks, screen for abuse, and provide an opportunity for patients/clients to ask questions.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. For more information on the advanced access system that promotes the use of open access scheduling, visit this publication by the American Academy of Family Physicians.
2. NASTAD has an excellent toolkit for using Trauma-Informed Approaches to your work.
3. ACEs Aware also has a number of organizational toolkits available.
4. TIA/CHANGE is an excellent E2i multimedia toolkit for implementing a trauma-informed and resilience-focused systemic intervention. E2i was a four-year, HRSA funded project where 11 evidence-informed effective interventions were tested in Ryan White HIV/AIDS Program-funded care settings.
5. AIDS United has published a series of best practices for integrating peers into HIV models of care.
6. Strength United provides a unique interdisciplinary approach to ending abuse and violence through the collaboration of mental health professionals, educators, researchers, students and volunteers. Services include: 24-hour hotline, 24-hour sexual assault response team, counseling, education, case management, bilingual services, services for deaf, LGBT, elderly, disabled, and recent immigrants.
7. HIV Criminal Law Reform, Before and After: California, Center for Health Law and Policy (2020) summarizes state laws affecting sex workers before 2017 and how those laws were repealed.
8. National Health Care for the Homeless Council has extensive best practices guidelines and training resources.
9. [Insert local resource here]

Social Determinant of Health

HEALTH ACCESS FOR ALL

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will work with local health jurisdictions to increase the number of clinics and other healthcare centers that are ADAP/PrEP-AP and Medi-Cal certified enrollment sites. On-site enrollment programs will be supplemented with an increase in trained HIV PrEP and care navigators who can assist patients to navigate insurance systems, complete applications for medical coverage and HIV PrEP access, and enroll into patient assistance programs as needed to cover out-of-pocket costs associated with HIV PrEP or other care.	X	X	X
CDPH will partner with Covered California and California Family Planning, Access, Care, and Treatment (PACT) to learn from their strategies of outreach to increase enrollment.	X		
CDPH will work with the Department of Health Care Services to promote and reduce barriers to Medi-Cal access where possible, including sharing information about DHCS' Unwinding Plan with local health jurisdictions.		X	X
Improve healthcare coverage for people who are incarcerated, through establishing programs or procedures so that that people living with HIV who are incarcerated are automatically enrolled in ADAP (similar to the Massachusetts model), are assisted with reinstating their Medi-Cal insurance upon release from jail.			X
CDPH will partner with the Department of Health Care Services (DHCS) and local health departments to promote the Justice-Involved Initiative, which requires counties and state/local correctional agencies to collaborate on pre-release application processing to help individuals either attain or unsuspend their Medi-Cal prior to release from a state/ local correctional setting effective January 1, 2023.	X		
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. In many regions, the limited number of clinical providers who accept Medi-Cal and/or Denti-Cal can be a main restricting factor for access to care. Expanding Medi-Cal and Denti-Cal coverage is important, but work must be done at the local level to increase the number of care providers – especially specialists – who accept Medi-Cal and Denti-Cal.

Local Considerations (delete or add rows as appropriate to your location)

In Sacramento and the Eastern Sierras, SAC Health has a resource center on-site, and uninsured patients can receive assistance with applying for benefits when in-house referrals are generated.
In [Insert local jurisdiction]…[insert other considerations as desired].
Key Population Notes
People who are trans or gender non-conforming: Medi-Cal covers transgender health care; however, there is some variation in Medi-Cal coverage by county. For assistance in navigating coverage for gender-affirming care, trans or gender non-conforming patients or their advocates can contact Health Consumer Alliance.
Migrants and immigrants: Although the "public charge" rule was reversed in March 2021, lingering fears over application of this rule continue to discourage many immigrants from accessing healthcare or utilizing other public benefits for which they are eligible. Substantial effort is needed to inform immigrants and undocumented individuals of insurance options, and reassure them that there are no repercussions for seeking care.
Young people: Although young people under age 26 can be on their parent's health plan, this is not a viable option for some youth in California. People under 30 have special options for health insurance, including minimum coverage health plans (AKA catastrophic plans), which are relatively inexpensive. For youth not covered by their parent's insurance, healthcare enrollment information in high schools and community colleges can be extremely helpful.
Monitoring and Metrics
The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources
1. CDPH OA has a webpage dedicated to providing PrEP-AP resources, including relevant forms and information for clients, enrollment workers, clinical providers, and pharmacists.
2. The Immigrant Legal Resource Center has updated information on public charge and how it relates to Medi-Cal and other health programs in California.
3. In Kern County, Community Health Initiative of Kern County helps people with low income enroll in health insurance.
4. [Insert local resource here]

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Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Promote people-first language in all HIV, HCV, and STI materials and services statewide, and train providers in updated language usage as part of cultural humility trainings that offer Continuing Medical Education credits (CMEs). Leverage state laws and policies requiring cultural competency training for health care providers (e.g., AB 2194 [Chapter 958, Statues of 2022), which requires pharmacists and pharmacy technicians to complete a continuing education course in cultural competency focusing on LGBTQ patients and covering recognized health disparities faced by BIPOC people; and SB 923 [Chapter 822, Statutes of 2022], which requires health plans and insurers to require all of its support staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI). This bill also adds processes to existing continuing medical education requirements related to cultural and linguistic competency for physician and surgeons).	X	X	X
CDPH will review policies and practices that allow community who do not speak English as a primary language to participate in consumer surveys, advisory boards, and other avenues for documenting service needs, filing grievances, and directing future investments.	X	X	X
CDPH will ensure HIV/HCV/STI test counselor training is available in Spanish and languages other than English to improve the number of people in the community who can become certified and support service provision in clinics and community-based organizations. Staff providing bilingual services should be paid a differential salary.		X	X
CDPH will promote adherence to Cultural and Linguistic Appropriate Services (CLAS) standards in partnership with communities of focus, so that interpretation services are intelligible and approachable to the intended recipients. Interpretation services should be dialect-specific, colloquial and not technically dense, culturally relevant, at a 5th grade reading level and tailored to the health literacy levels and communication needs of the populations being served.		X	X
Improve options for telehealth interpretation in multiple languages, with robust outreach to communities that have been neglected for provision of care through telehealth. Members of these communities may need additional support learning how to access telehealth services, and to work with an interpreter while using telehealth technology. Extra time should be built into	X	X	

appointments to account for learning the technology and interpretation lag time, so that patients without technological ease and English fluency do not feel rushed through their appointment.			
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Although the contracting process may be cumbersome, there is an important role for contracts going to smaller agencies that provide tailored support to specific communities for whom mainstream services may not be culturally or linguistically appropriate.
2. Language translation services are a critical part of program that should be prioritized and thoroughly integrated into programing. Remember that it may not be sufficient to translate materials into Spanish; Latinx individuals may speak Portuguese or indigenous languages, and others in the region may speak a language that is not commonly spoken. Regardless of the language spoken, all people must be able to have their needs met in a language they can understand.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People who are unhoused: Many people who are unhoused have mental health challenges and/or may have experienced traumatic brain injuries (TBIs). People with TBIs or some types of mental health challenges may require interpretation services by someone skilled in working with people with these types of disorders. Further, clinics should evaluate paperwork for address and identification requirements that may be a barrier to care for some unhoused patients.

People who are undocumented: Clinics should evaluate paperwork for address and identification requirements that may be a barrier to care for patients who do not have typical forms of identification, and/or who fear deportation for seeking care.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. CLAS standards are a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity. This CLAS standards toolkit has a range of resources and appears to be in the 5th to 8th grade level.
2. [Insert local resource here]
3. [Insert local resource here]

Social Determinant of Health

HEALTH ACCESS FOR ALL

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will provide examples of Memoranda of Understanding (MOUs) and Business Associate Agreements (BAAs) that allow for streamlined data sharing and collaboration between community-based organizations, county jails, hospitals and health departments while complying with HIPAA.		X	X
CDPH will share examples of ways for local health jurisdictions, health care, and community-based organization partners to establish multidisciplinary case conferencing between providers in different agencies who are serving the same individuals, while complying with HIPAA and other data privacy rules. Case conferencing can be in-person or using a virtual video platform and should be prioritized for members of key populations who are most likely to be receiving disjointed care from multiple providers and community-based partners, such as people who use drugs; are unhoused; exchange sex for drugs, housing, and/or other resources; and migrant workers.		X	X
Foster local coalitions and collaborations among staff of the health department, jail health, and community-based organizations in a local jurisdiction to consolidate outreach efforts for people who may not be engaged in care.	X	X	X
Foster local coalitions and collaborations to create warm referral systems between prenatal care, housing, mental health, emergency department, and primary care or specialty care providers, especially for key populations identified in this plan.	X	X	X
Develop and/or participate in local congenital syphilis task forces or case review processes, e.g., congenital syphilis morbidity and mortality review boards, to synthesize strategies for change and lessons learned (such as missed opportunities for prevention or follow-up actions) across a city or region.	X	X	X
Pilot collaborative initiatives for sharing information between STI prevention, treatment, and contract tracing programs across local health jurisdictions, including across Oregon, Nevada, and Mexico borders where relevant to local communities.		X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Effective January 1, 2024, Assembly Bill 133 (Budget Act, 2022), requires most large health systems and health care entities to participate in California's Health and Human Services Data Exchange

Framework (DxF). This is a first-ever, statewide data sharing agreement that will accelerate and expand the exchange of health information among health care entities, government agencies, and social service programs beginning in 2024, including local health departments.

2. [Insert your local ideas]

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

Young people: Minors face particular challenges related to data sharing, as some organizations may face restrictions related to non-parental consent for services, or believe they have a duty to inform guardians. Special care should be taken when implementing systems to share sensitive information about young people for care coordination.

Indigenous people: In most locations in California, there is an unrealized opportunity for local health jurisdictions or community-based organizations to collaborate with tribal communities. Sharing information and resources between local health jurisdictions and tribal communities, including through tribal epidemiology centers (California Rural Indian Health Board) and health networks (such as the California Coalition for Urban Indian Health), could greatly improve the health outcomes and access to health-promoting resources for indigenous people in the region.

Immigrants and migrants: For counties that have large communities of migrants who live or work part-time in Mexico, partnership for data-sharing and collaboration should include partners on both sides of the border to support comprehensive services related to HIV, HCV, and STIs.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. More information on Community Information Exchanges (CIEs) and a toolkit for establishing a CIE is available from the 2-1-1 San Diego.
2. The National Center for Youth Law has excellent summaries of minor consent laws regarding confidentiality and access to health care.
3. The CA Bridge program integrates SUD treatment into hospital emergency departments throughout the state. CA Bridge provides funding, training, technical assistance, and coaching to help hospitals take a key role in responding to the overdose crisis.
4. [Insert local resource here]

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Provide up-to-date resource lists with Syringe Services Program (SSP) providers' schedules, naloxone inventory and dispensing information, and medication for opioid use disorder (MOUD) resources to provide to people in jail and upon release.	X	X	X
Leverage the Department of Health Care Services (DHCS) *Expanding MAT in County Criminal Justice Settings* Learning Collaborative and other related training efforts to coordinate harm reduction and overdose prevention and response trainings specifically for: 1) clinical providers in jails or prisons, 2) correctional officers, and 3) people who are incarcerated.	X	X	X
Leverage and expand state and local naloxone distribution efforts to partner with jail staff to provide all people who are incarcerated with a supply of naloxone upon release either by placing it in their personal property or via use of a free vending machine. CDPH will partner with the California Department of Corrections and Rehabilitation to advance similar efforts in state prisons.	X	X	X
Integrate overdose prevention education and naloxone distribution into the roles of HIV/HCV/STI navigators and case managers working with incarcerated or formerly incarcerated populations, such as by funding a position that provides HCV linkage and overdose prevention services to individuals at county jails. Leverage language in state STD and HCV prevention and collaboration grants that allows funds to be used for delivery of integrated services for HIV, HCV, STIs, and drug overdose.		X	X
Provide ongoing overdose prevention education in jails, and adapt substance use and sexual health treatment to include overdose risk assessments (with connection to MOUD when appropriate) during all clinical visits for people who are incarcerated. Continue to increase MOUD access for incarcerated individuals in county jails, and create systems to prioritize linkage to appropriate treatment upon release. CDPH will partner with the California Department of Corrections and Rehabilitation to advance similar efforts in state prisons.	X	X	X
Create an active partnership between the [insert local jurisdiction] health department and [insert names of local correctional facilities] to address HIV, HCV, and STI prevention and overdose challenges. Active partnerships may include data sharing agreements, permanent jail clearance for health department staff who can provide direct service, or ongoing cross-department meetings to discuss existing situations and strategize solutions.	X		
[Insert your local ideas]			

[Insert your local ideas]			

Overall Considerations

1. Health care in state prisons is centralized and run by the California Correctional Health Care Services; local health jurisdictions and county jails can establish data-sharing agreements to facilitate linkages to care upon release but the high volume of people entering and leaving state prisons may exceed local capacity for care coordination. The CalAIM Justice-Involved Initiative is hoping to improve these care transitions.
2. Local sheriff's departments and health departments may be able to leverage partnerships with local community-based organizations to provide overdose prevention and response trainings and education inside correctional facilities if the county does not have the capacity to manage these programmatic functions in-house. However, getting jail security clearance for community health workers and staff with lived experience can be difficult.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People of Color, especially Blacks/African Americans, Latinx, & Indigenous people are disproportionately incarcerated as a result of the legacy of institutional racism in California and the US as a whole. This legacy compels us to look at strategies that address overdose prevention in correctional settings with a strong racial equity focus.

People who are incarcerated are often no longer eligible for public benefits or assistance after being convicted of crimes, which necessitates cross-cutting strategies with economic justice and housing advocacy groups.

People who use drugs who historically have not been opioid-seeking may nevertheless be at risk of opioid overdose due to fentanyl contamination of drugs. The infusion of fentanyl into the community has increased overdoses related to use of methamphetamine. This makes overdose education and naloxone distribution necessary for groups of people who use drugs beyond those identified as opiate users.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. Transitions Clinic Network is a national network of programs providing patient-centered, peer-supported primary care for chronically ill individuals returning to the community from prison.
2. Legal Services for Prisons with Children (LSPC) organizes communities impacted by the criminal justice system and advocates to release incarcerated people, to restore human and civil rights, and to reunify families and communities.

3. With funding from the Department for Health Care Services, Health Management Associates (HMA) created the project Expanding Access to MAT in County Criminal Justice Settings to help counties increase access to MOUD during incarceration and throughout involvement in the justice system. In this Learning Collaborative, participating county teams access technical assistance and ongoing guidance from HMA experts to expand access to MOUD and evidence-based treatment for psychostimulant use disorder in jails and drug courts.
4. California Correctional Health Care Services maintains an Integrated Substance Use Disorder Treatment Dashboard to show their progress in expanding access to MOUD and other SUD treatment modalities in California state prisons.
5. Local sheriff's departments can use their own funds to purchase naloxone for distribution in county jails, or can access naloxone through the Department of Health Care Services Naloxone Distribution Project.
6. [Insert local resource here]
7. [Insert local resource here]

Social Determinant of Health

MENTAL HEALTH AND SUBSTANCE USE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Provide temporary smartphones in conjunction with the national *Lifeline Program* or other devices upon release from jail or prison, to support appointment setting and telehealth services through assistive technology programs designed to support linkage to community-based care for people who have been recently incarcerated.	X	X	
Create virtual introductory modules and onboarding materials and tools that are freely accessible and easy to download, to explain to consumers how telehealth services work.	X		
Integrate telehealth services and programming into existing MOUD programs, syringe services programs, and supportive housing programs.	X	X	X
Support the creation and maintenance of private spaces in libraries and other community venues where technology and Wi-Fi connection is available free-of-cost to access telehealth appointments.	X	X	
Increase the number of trained and licensed providers that are available to provide telehealth services in various languages for people who are incarcerated.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Telehealth is most needed in rural areas due to transportation barriers and low density of behavioral health providers; however, it is important to remember that Wi-Fi access may be limited in remote and rural areas, and telehealth strategies must ensure non-traditional forms of access (e.g. access through kiosks in community organizations or libraries).
2. Increased access to telehealth will require provision of technology for consumers, along with an increased number of providers offering services.

Local Considerations (delete or add rows as appropriate to your location)

San Francisco's DeLIVER Care Van, a program of UCSF, provides mobile HCV treatment in highly impacted communities through the use of telehealth. This model could be expanded to provide behavioral health services as well.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People who use drugs often identify the restrictive policies surrounding methadone provision as a barrier to treatment; buprenorphine provided via telehealth offers a more flexible approach to medications for opioid use disorder (MOUD).

Migrant and immigrant communities may benefit from telehealth-based behavioral health services, because when technology is made adequately accessible the model creates more possibilities for matching patients with providers who speak their first language, and are knowledgeable about their culture.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The Department of Health Care Services has a Medi-Cal and Telehealth webpage that shares updates and highlights about relevant telehealth policies for people who have Medi-Cal insurance.
2. CA Bridge has a list of telehealth MOUD providers in California.
3. The California Health Care Foundation explicitly supports expanding telehealth services throughout California and funds projects accordingly.
4. Lifeline is a federal program that provides eligible low-income individuals with a free smartphone and free wireless phone service (free data, free monthly minutes and unlimited texting).
5. [Insert local resource here]
6. [Insert local resource here]

Social Determinant of Health

MENTAL HEALTH AND SUBSTANCE USE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Provide comprehensive funding for syringe services programs (SSPs), allowing for support of SSP staff and people with lived experience as subject matter experts on the health and wellness of PWUD, along with medication lockers, outreach to jails, encampments, and supportive housing sites as State-funded SSP activities. Recognize SSP staff as subject matter experts on the health and wellness of people who use drugs (PWUD).	X	X	X
Normalize harm reduction strategies as part of health care in California by investing in harm reduction training that offers continuing education credits for a wide range of medical and behavioral health providers.	X	X	X
Prioritize funding for programs who hire people with lived experience of substance use, and encourage the creation of professional pathways for PWUD in the HIV/HCV/STI workforce. Invest in models that incentivize facilitation of peer-based support groups, mentoring, secondary syringe exchange, and other activities led by PWUD.	X	X	X
CDPH will partner with the other state agencies and the California Pharmacy Board to promote awareness, improve access, and support implementation of states laws allowing non-prescription syringe sales and furnishing naloxone in pharmacies. These efforts will be supported and reinforced at [insert local jurisdiction] by [describe strategies to partner with pharmacists to improve local pharmacy access to naloxone and syringes].	X		
Assess gaps in harm reduction services and fund the development of SSPs in areas that have little to no services. Invest in harm reduction vending machines, public health pantries, and/or mail-based harm reduction supplies in areas that lack harm reduction programs/supplies and where privacy is a key concern for people who fear accessing services.	X	X	X
Improve SSP alignment with harm reduction best practices. For example, encourage the distribution of pipes and other materials for people who smoke or use drugs through other routes of administration, and create program standards that discourage limits on the number of syringes that can be exchanged or obtained at an SSP. Research has clearly demonstrated that needs-based syringe distribution (as opposed to 1:1 exchange or other restrictions or requirements) reduces risk of HIV, HCV, or other infectious disease transmission, and does *not* increase syringe litter or reduce safety to others in the community. Needs-based distribution is evidence-based and supported by CDC and CDPH.	X	X	X

Create program standards that allow for the funding, planning, and programmatic support of evidence-based interventions including supervised consumption services (also known as supervised injection facilities or overdose prevention sites) in California. As health department staff cannot participate in policy advocacy efforts, taking strides in this area may require partnership with community organizations or other local activists.	X	X	X
Partner with community health centers to integrate syringe services, overdose education and naloxone distribution and other harm reduction services into street medicine, mobile clinics and brick-and-mortar clinics during regular clinic hours.	X	X	X
CDPH will develop responses to support local jurisdictions to respond to NIMBYism efforts to prevent harm reduction program expansion or maintenance, through the leadership of the OA Harm Reduction Unit.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. NIMBYism ["*Not In My Back Yard*"], a phrase used to denote opposition to efforts to provide supportive community services to people in need by neighbors and local stakeholders, is often a barrier to storefront-model harm reduction services. It is important for health departments and community organizations to have proactive plans to address community pushback should this become an issue.
2. Workers from within the harm reduction sector often become "de facto" or go-to trainers about harm reduction and substance use for all other community providers. It is important to recognize, validate, and adequately compensate harm reduction staff for these activities to ensure ongoing sustainability of programming and services.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People who use drugs can and should be involved in the design and delivery of harm reduction services, as is decreed by the principles of harm reduction.

People of Color, especially Blacks/African Americans, Latinx, & Indigenous people have often been underrepresented as recipients of harm reduction services. It is crucial for harm reduction programs to monitor and analyze client utilization of services, and proactively outreach to and partner with BIPOC populations to improve culturally relevant access.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources
1. The National Harm Reduction Coalition (NHRC) and In the Works are two of several organizations that provide in-person and online training and capacity-building services for health departments, clinics, and community-based organizations. NHRC's free three-part training series covers harm reduction fundamentals.
2. There are more than sixty programs in California that provide syringe services. The OA harm reduction webpages include a list of SSP providers throughout the state, as well as resources for program development, staff training, and best practices.
3. CDC's National Harm Reduction Technical Assistance Center provides technical assistance webinars, learning collaboratives, and other resources to support SSPs, local health jurisdictions, and State health department programs.
4. CDPH has a non-prescription syringe sale toolkit and other resources to help improve access to syringes from pharmacies without a prescription.
5. CDPH's syringe services and harm reduction webpages include information about integrating harm reduction services into clinics, health departments and pharmacies as well as community-based organizations and includes training, technical assistance and legal resources for starting and strengthening programs.
6. California has joined multiple lawsuits against manufacturers, distributors, and other entities responsible for aiding the opioid epidemic and anticipates receiving several billion dollars from opioid judgment and settlement agreements. The majority of this money will be provided to county mental health and substance use disorder departments to be used for opioid abatement activities. The Department of Health Care Services' Opioid Settlement webpage offers guidance related to opioid settlement funds, including a new resource outlining allowable expenditures with J&D Settlement funds. Allowable expenditures include many harm reduction-related activities. Contact OSF@dhcs.ca.gov to be added to the Opioid Settlement Fund listserv.
7. [Insert local resource here]
8. [Insert local resource here]

Social Determinant of Health

MENTAL HEALTH AND SUBSTANCE USE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Prioritize funding and support for, and ensure delivery of, harm reduction-based substance use disorder treatment programs in [insert local jurisdiction].	X	X	X
Leverage the DHCS California Bridge program, which funds emergency departments (EDs)to expand access to medications for opioid use disorder (MOUD), to partner with local drug treatment providers, local community-based clinics that provide medications for addiction treatment, and hospital staff to expand ED-based treatment for substance use disorders and linkage to non-hospital substance use disorder treatment services after discharge.		X	X
Fund and promote placement of medical providers with expertise in treating substance use disorders in syringe services programs to increase access to low-threshold buprenorphine treatment and contingency management programs.	X	X	X
Offer low-threshold support groups, contingency management services, and other harm reduction services designed for people who use methamphetamine.	X	X	X
Expand mobile MOUD and MOUD access in general, via telehealth services.	X	X	X
Partner with SAMHSA to make Drug Addiction Treatment Act (DATA 2000) "X Waivers" easier to attain, thus increasing access to buprenorphine.	X	X	X
Promote awareness among local health jurisdiction and community-based organizations about the California Medication-Assisted Treatment (MAT) Expansion Project and the CalAIM Contingency Management pilots. Develop partnerships to assure that these programs reach people using opioids and/or methamphetamine who are not otherwise engaging in treatment. Share lessons learned with other regulatory agencies (e.g., California Department of Managed Health Care, California Department of Insurance) to promote broad adoption of and access to contingency management services.	X	X	X
Collaborate with agencies that serve pregnant people to ensure access to harm reduction and trauma-informed services for this priority population. .	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. In order to integrate low-threshold substance use disorder treatment services, existing syringe services programs and other community-based organizations need a sustainable infrastructure. It's important to assess the capacity of existing programs for growth before adding on services.

2. Having services available does not mean they will be well-delivered or well-utilized; intentional outreach strategies are necessary to increase awareness of programming among people who use drugs and other service providers and to ensure services are delivered in a non-stigmatizing and non-punitive manner, such as by acknowledging that polydrug use is the norm and people on MOUD may continue to use stimulants or even opioids.
3. The Department of Health Care Services (DHCS) is planning to pilot contingency management programs for stimulant use in Drug Medi-Cal Organized Deliver System counties. Several California counties will be participating, and are listed on the DHCS website.

Local Considerations (delete or add rows as appropriate to your location)

Humboldt Area Center for Harm Reduction (HACHR) and several other SSPs in the state have partnered with Bright Heart Health to offer telemedicine buprenorphine to their program participants.

The Stonewall Project of the San Francisco AIDS Foundation is an evidence-based contingency management model that provides harm reduction-based substance use treatment, counseling, and HIV prevention and education that could be adapted for use in other jurisdictions and contexts.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People of Color, especially Blacks/African Americans, Latinx, & Indigenous people: Research has demonstrated that BIPOC people – especially Blacks/African Americans – have less access to buprenorphine than their white counterparts, and instead are more likely to be treated with methadone, which is prescribed under much more restrictive conditions. It is crucial to design low-threshold substance use disorder treatment programs with an eye toward racial equity to correct this imbalance.

Many (but not all) **people experiencing homelessness** are also **people who use drugs**, and vice versa. These populations regularly experience trauma and challenges to meet their basic needs; services for these groups must be low-threshold, as well as non-judgmental.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The National Harm Reduction Coalition's Pregnancy & Substance Use Harm Reduction Toolkit reviews harm reduction strategies for pregnant clients, help for navigating health care and legal systems, and prenatal care tips and timeline.
2. The Academy of Perinatal Harm Reduction has training and best practices guidelines for delivering prenatal care to pregnant people who use drugs.
3. [Insert local resource here]
4. [Insert local resource here]

Social Determinant of Health

MENTAL HEALTH AND SUBSTANCE USE

Strategy 5: Cross-Sector Collaboration

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

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Include contractual language for both State and local-funded programs that requires concrete collaboration among HIV, HCV, and STI prevention, disease control, and behavioral health departments.	X	X	X
Incentivize providers of medication for opioid use disorder (MOUD) to improve HIV/HCV/STI education and, where feasible, testing and treatment, by providing grant funds for infectious disease programming within MOUD settings, and support these efforts by having public health mentors (within the health department, or as paid community workers) who provide free trainings and ongoing guidance to MOUD staff.		X	X
Leverage the Alternative Payment Methodology initiative and other related efforts to modify or remove policies that pose barriers to comprehensive care for people with behavioral health concerns and needs related to HIV, HCV or STI prevention or care, such as not paying for mental health visits that occur the same day as medical visits.	X	X	
Establish an advisory committee comprised of people who actively use drugs and those with a history of substance use disorder who are committed to a harm reduction approach, which can provide perspective and recommendations to the health department prior to the implementation of new cross-sector public health strategies.		X	X
Offer cross-sector trainings where drug treatment providers receive continuing education credits for attending tailored trainings about HIV, HCV, and STIs in behavioral health settings, and HIV/HCV/STI-focused providers receive continuing education credits for attending behavioral health-focused trainings tailored to their own work.	X	X	X
Integrate HIV/HCV/STI testing into settings that serve people with mental health or substance use concerns, such as mental health facilities, rehabilitation facilities, and housing programs.	X	X	X
CDPH will create templates for data sharing agreements that local health jurisdictions and their community partners can adapt for their cross-collaboration needs.	X		
CDPH will create opportunities to have formal and informal conversations with and across local health jurisdictions to discuss ideas and lessons learned for cross-sector collaborations with local behavioral health programs, SSPs, and other partners.	X	X	X
CDPH will assist in developing training that addresses how school-based educators can integrate harm reduction - including HIV, HCV, STI, and overdose	X	X	

prevention - into comprehensive sexual health education, and collaborate with the California Department of Education to promote as professional development for educators implementing the California Healthy Youth Act.			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Behavioral health and public health programs are siloed at the federal level; cross-sector collaboration on the statewide and local levels will require creative solutions and discussions with federal funders about the limitations of siloed funding, communication, and practice.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

Young people: High schools and colleges provide numerous opportunities to integrate sex-positive and harm reduction-based HIV, HCV, and STI prevention and education for young people in both classroom and school-based health center settings. Where local health departments and community-based organizations can partner with educational settings to reach young people in age-appropriate ways, this can help prevent HIV, HCV, and STI infections while addressing substance use and mental health concerns in a time when young people are gaining independence and forming their own paths to health.

People experiencing homelessness: Shelters and supportive housing for people experiencing homelessness are important collaborators in public health work. It is helpful to create partnerships with these providers for HIV, HCV, and STI prevention, testing, education, and treatment programs, especially while integrating these services within support services for people with mental health and substance use disorders.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The fourth goal of the National HIV/AIDS Strategy (2022-2025) focuses on cross-sector collaboration, particularly between behavioral health and public health services. As this goal is parallel to our 5th strategy related to mental health and substance use as a social determinant of health, it will be important to monitor the federal government's steps to address this goal.
2. More information on the state requirement for narcotic treatment programs to test for HCV can be found at Hepatitis C Testing FAQs for Narcotic Treatment Programs in California.

3. The Department of Health Care Services allows same-day billing for some services in Drug Medi-Cal Organized Delivery System programs. See Changing Same Day Billing Requirements for Counties that Opt-In to the Drug Medi-Cal (DMC) Organized Delivery System (ODS) 1115 Demonstration Waiver; and the Same-Day Billing Matrix (2016).
4. The California Primary Care Association has information on the Alternative Payment Methodology initiative, which, starting in late 2023, will allow participating federally qualified health centers to receive a per-member, per-month payment rate, rather than only being reimbursed for services rendered by a billable provider within the four walls of a brick and mortar clinic. This will enable delivery of integrated services on the same day (addressing the "same-day billing" issue) and allow delivery of mobile health services and street medicine
5. The California Department of Education has information on implementing the California Healthy Youth Act and is working on resources to implement SB 224, the mental health education requirement.
6. CDPH STD Control Branch collaborates with the California Prevention Training Center to maintain a Sexual Health Educator training program, which could cross-promote behavioral health and sexual health education resources.
7. Resources for training Disease Investigation Specialists on harm reduction are available via the CDPH OA Harm Reduction Unit and the Online Learning Center of the National Harm Reduction Coalition.
8. [Insert local resource here]
9. [Insert local resource here]

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Work with health departments, clinics, and other community partners to identify low-threshold opportunities for mentorship and workforce shadowing in the fields of HIV, HCV, and/or STIs. For people with no experience in this field, opportunities for learning "on the job" through hands-on fieldwork are critical to success; formalized mentorship programs will also help inexperienced workers prepare for future, formal employment.		X	X
Develop or leverage local programs to assist people to prepare for the job market, including collaborations for shower/clean clothing access, resume and application support, access to computers for preparing or submitting applications, and practicing/training for successful job interviews, both as training programs and one-off workshops. Consider mobile job placement assistance in pop-up locations in communities where unemployment rates are high.			X
Examine policies such as drug testing, background checks, and substance use policies, which limit opportunities for many people who might otherwise be strong employees in these roles. If they are not required for safety reasons specific to the job position, these barriers to employment should be removed.	X		
Revise local hiring processes to ensure that (a) recruitment is advertised equitably, with broad reach to non-traditional venues in communities most affected by HIV, HCV, and STIs (prioritizing recruitment via community-based organizations over academic institutions where possible), and (b) pilot and validate interview questions include questions related to social justice, racial health equity, and lived experience.	X	X	
Partner with local programs to facilitate nurses with a BSN to obtain Public Health Nurse certification, by promoting enrollment opportunities and subsidizing fees.		X	X
Expand HIV/HCV/STI tester trainings in California to be more accessible and low- or no-cost, so that more people can be trained as HIV/HCV/STI test counselors to gain work experience and provide a needed service to members of their own communities. Encourage HIV/HCV/STI test counselor training of people with lived experience who are serving in jobs such as peer navigators, and community health workers.	X		
Recruit people for youth, BIPOC, and other priority population-focused Community Advisory Boards (CABs), and pay people for the expertise they contribute as CAB members; when possible, provide professional development		X	X

opportunities to CAB members to assist them in taking future steps to become more formal members of the HIV, HCV, and STI workforce.			
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Leadership from human resources departments and executive-level staff at local health jurisdictions and community-based organizations should be included in discussions about the value and importance of hiring people with lived experience, to cultivate buy-in, ensure hiring practices align with laws related to protected classes, and help to create systems and structures that will support these employees once hired.
2. Community health worker and internship positions are legitimate and valuable labor – often benefiting from community connections and lived expertise – and should be paid at or above the minimum wage. To truly develop the workforce, entry-level positions should not only be paid but should include full benefits.
3. To improve racial equity in the workplace, it is critical to ensure that hiring decisions are made in partnership with BIPOC staff. BIPOC staff should be recruited into, and mentored to grow into, management positions to permanently shift this dynamic and avoid the need for temporary strategies to improve diversity in hiring efforts.
4. There is concern over the longevity of general fund dollars at the state or local level, which do not allow for hiring of positions that will include a lengthy development period, or opportunities for professional advancement. When possible, more sustained sources of funding should be used for workforce development efforts.
5. Some jurisdictions throughout the state have been able to leverage third-party organizations to hire people with lived experience, which may be easier to navigate than civil service systems.

Local Considerations (delete or add rows as appropriate to your location)

In the Bay Area, the San Francisco Department of Public Health is supporting the Community Health Leadership Initiative (CHLI) and The Academy job training program at the San Francisco AIDS Foundation, both of which are designed to aid entry into the HIV, HCV, and STI workforce for people from highly impacted communities. This may provide opportunities for collaboration and training to increase accessibility of the workforce for priority populations in the region.

In Sacramento and the Eastern Sierras, there are opportunities to partner with Chico State, Feather River College, and the University of Nevada Reno to recruit future workers and encourage professional development for current workers, so they can continue to advance in their roles.

In the Central Valley and Inland Empire, the America's Job Center and Kern County Employers' Training Resource are excellent resources that have low stigma and are skilled at working with many of the priority populations listed in this plan.

In Southern California, San Diego County funds job readiness trainings through the San Diego Workforce Partnership.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People experiencing homelessness: Many people who are unhoused have useful skills and are willing and able to work, but need a chance to be hired and housed. Programs that help people who are unhoused to access clean clothing and basic hygiene services are absolutely critical to workforce development efforts.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. In response to the COVID-19 pandemic, CDPH created the California Pathways into Public Health (Cal-PPH) Initiative, in partnership with UCSF, UCLA, and California's local health jurisdictions. CA-PHC is a paid training and job placement program for early-career public health professionals to gain experience working in local health departments.
2. The California Department of Healthcare Access and Information oversees the statewide requirements for community health worker (CHW) certificate programs, with the aim of training 25,000 CHWs in California by 2025.
3. The Family PACT provider trainings may be a good model for CHW trainings that are easy to access and complete, and provide high-quality education that prepares workers for success. The Department of Health Care Services has information on the anticipated training requirements for CHWs, which includes a work experience pathway.
4. [Insert local resource here]
5. [Insert local resource here]

Social Determinant of Health

ECONOMIC JUSTICE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will develop internal templates and processes for Request for Applications (RFA) development and application scoring that advantage health departments and other programs that employ people with relevant lived experience, employ Black, Indigenous, and other People of Color (BIPOC) staff in meaningful leadership positions, and pay a living wage to frontline staff. These templates and processes will be shared widely to encourage replication in competitive funding processes at the local level.	X		
Examine contracts at the state and local level to incentivize or expect hiring from priority populations; contractual obligations of this sort will help overcome local human resources barriers that prevent hiring people with lived experience.		X	X
Assess California labor laws to identify ways to develop flexible funding structures within programs that allow people from priority populations to be paid meaningfully (i.e., not just paid in small, store-specific gift cards) for their time and participation providing input into programs via surveys, focus groups, key-informant interviews, speaking engagements, and part-time jobs.	X	X	X
CDPH will develop understandable formulas and dashboards to share local demographics of the people living with HIV, HCV, and STIs; these demographics should ideally match the demographics of people employed in the HIV, HCV, and STI workforce in that jurisdiction, and where they do not, specific actions should be taken to reduce workforce inequities.			X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. People with lived experience who are new to the HIV, HCV, and STI field should receive adequate support in hiring, onboarding, and throughout their tenure in their role, to ensure that employment for people with lived experience is meaningful and sustainable.
2. Effective January 1, 2020, AB 5 changed the ways that "gig" workers can be hired and compensated in California, and who can be considered an independent contractor. This has had major implications for the ability of local health jurisdictions and community-based organizations to compensate participants for their contributions to program planning, implementation, and evaluation without hiring them outright (beyond providing incentives).

3. The CDPH scope of work for local health jurisdictions receiving CDC Disease Investigation Specialist (DIS) Workforce grants requires funded jurisdictions to "incorporate a focus on diversity, health equity, and inclusion by delineating goals for hiring and training a diverse workforce across all levels who are representative of, and have language competence for, the local communities they serve." It also requires funded jurisdictions to report back to CDPH on how the jurisdiction will recruit DIS from impacted communities.
4. [Insert your local ideas]

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

[Insert your local ideas]

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. [Insert local resource here]
2. [Insert local resource here]

Social Determinant of Health

ECONOMIC JUSTICE

Strategy 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, STIs, substance use, mental health challenges, or homelessness.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Work with hiring agencies to encourage the development of processes for honoring the importance of lived experience in job postings and applications; all postings in the HIV, HCV, and STI field should present educational and lived experience options (e.g. a bachelor's degree or 4 years of experience providing direct service in a similar role).		X	
Locally determine appropriate pay differentials for fluently speaking additional languages, as well as having the ability to translate documents or provide interpretation services. These pay differentials should be applied in a standard way throughout the sector, with the encouragement of the health department (including as a funder of community-based services, when applicable). Even bilingual people who do not regularly interpret, translate, or provide direct service to patients/clients use their knowledge of languages other than English in their work, and are an asset to their organization as a multi-lingual employee.	X	X	
Explore alternatives for people living with or highly impacted by HIV, HCV, or STIs to obtain part-time employment without losing SSI/SSDI benefits, healthcare coverage, subsidized housing, and/or eligibility for Ryan White-funded services, as needed to access supportive care.		X	X
Assess the living wage of the local region using the calculator at livingwage.mit.edu or another similar tool; use living wage calculations and local income data to set minimum salary levels when issuing RFAs, and require employers to publicize salary range for posted positions funded by these RFAs. Minimum salary levels should be set with the expectation that direct client service providers can afford to live in the county where they are being hired to work.			X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. AB 5 – *a California law that requires the application of the "ABC test" to determine whether workers are employees or independent contractors* – may make it difficult for organizations to appropriately compensate community members for their time and expertise; CDPH plans to partner with the Employment Development Department to explore options for mitigating these barriers and will share any lessons learned with local health jurisdiction and community-based organization partners.

2. While lived experience has typically been devalued in the workplace compared to academic training, more recently public health entities are recognizing the importance of lived experience as a link to communities most in need of culturally competent services. When hiring people with lived experience, it is important to compensate individuals sufficiently for their community expertise, which may come with both unique strengths and a history of trauma, and be prepared to provide trauma-responsive employment support.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

[Insert your local ideas]

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. Open Society Foundations has produced an excellent guide for organizations employing people who use drugs, which may be applicable when prioritizing hires of people with lived experience in the communities most impacted by HIV, HCV, and STIs.
2. [Insert local resource here]
3. [Insert local resource here]

Social Determinant of Health

ECONOMIC JUSTICE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Promote virtual and onsite internship opportunities made possible at CDPH through the Office of Professional Development and Engagement (OPDE). Students of any California State University (CSU) system or the University of California Center Sacramento (UCCS) Program can apply, and others have an opportunity to volunteer as interns to develop leadership and management skills in a large health department. More information on this internship program is available on the CDPH website.	X	X	X
Encourage medical residents to seek training in clinical sexual health care through a residency program with a focus on sexual health care.	X	X	X
CDPH will identify and share best practices for a professional development model that shares accountability for individual growth among different levels of organizational hierarchy, to best support a leadership pipeline that is diverse, well-skilled, and prepared to take on additional responsibility over time.		X	
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Leadership from human resources departments and executive-level staff at community-based organizations should be included in discussions about the value and importance of professional development that facilitates promotion of frontline and mid-level workers from the communities most affected by HIV, HCV, and STIs into leadership and management positions in the organization.

Local Considerations (delete or add rows as appropriate to your location)

In Southern California, partners in the region may include the city or county Chamber of Commerce, the Cottage Health system (Santa Barbara), and the Santa Barbara County Workforce Resource System.

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

[Insert your local ideas]

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources
1. Download research on Mitigating Bias in Succession Management from Gartner.
2. [Insert local resource here]
3. [Insert local resource here]

Social Determinant of Health

ECONOMIC JUSTICE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
CDPH will promote resources for training and education about the importance of "Ban the Box" hiring, education, and housing policies in California. Where possible, these resources will be made available for adaptation and use at the local level.		X	
Partner with local housing organizations (public and private) to promote fair housing policies and reduce oppressive qualifications requirements that inhibit access to safe and affordable housing for priority populations in the local region (e.g., high credit scores, a history of never missing a rent payment, demonstrating income requirements that are 3x the cost of rent, having 3-5 years' rental history, and having no criminal history).			X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Consider working with human resources departments to develop innovative review processes that allow for gaps in employment, which currently can trigger disqualification for positions. Gaps in employment from incarceration, substance use disorder, or other reasons should not preclude employment opportunities.
2. Effective January 1, 2018, the California Fair Chance Act (AB 1008) ensures that employers fairly consider job applicants with a record by delaying when an employer can ask about an applicant's conviction history or run a background check.
3. Effective in the fall term of the 2021-22 academic year, SB 118 law bans all segments of postsecondary education in California, except for professional degrees and law enforcement basic training programs, from inquiring about a prospective student's criminal history on an initial application form or at any time during the admissions process.
4. According to the CA Civil Rights Department, California law provides some protections to address the barriers faced by housing applicants with criminal histories. It is lawful for housing providers to perform background checks of applicants. However, it is unlawful for a housing provider to have a "blanket ban" on all applicants with criminal histories or those with certain types of convictions.
5. [Insert your local ideas]

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes				
[Insert your local ideas]				
Monitoring and Metrics				
The table below outlines how progress toward this strategy will be measured:				
Level	**Indicator**	**Who measures?**	**How frequently?**	**Why this measure?**
[County name] County				
[Insert your local ideas]				
Partners and Resources				
1. The National Employment Law Project has a fact sheet on the California Fair Chance Act (AB 1008).				
2. [Insert local resource here]				
3. [Insert local resource here]				

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Examine and adjust funding opportunities at the State and local level to require meaningful input by priority populations of focus in the development, implementation, and evaluation of programs and services. Where possible, update existing contracts to require similar community input. Input should include involvement in decision-making and leadership where possible.	X	X	
Recruit people from priority populations to serve on Community Advisory Boards (CABs) or local planning councils for HIV/HCV/STI-related services, and pay people for the expertise they contribute as CAB members. When possible, provide professional development opportunities to CAB members to assist them in taking future steps to become more formal members of the HIV, HCV, and STI workforce, including leadership roles.	X	X	X
Create or integrate with a Youth Advisory Council at the State and local level, to inform program and service development with respect to the HIV/HCV/STI-related needs of young people.		X	X
Identify and, where feasible, implement strategies within funding announcements and scopes of work to reward community representation in staffing and program planning, implementation, and evaluation.		X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Develop policy, programs, services, and associated messaging with the full and direct participation of members of key group(s) that are most affected by those efforts. This helps to honor the collective dignity of all persons, and acknowledges that expertise often arises from direct experience.
2. Plan engagement of key populations carefully; meaningful engagement to inform service provision should include concrete efforts to share power, demonstrate respect, and genuinely value the contributions made by people who are personally impacted, or whose friends and family may be personally impacted. Get creative about how to include community members, as attending meetings during the day or reviewing documents might not work for all priority populations. Be sure to develop some low-threshold input mechanisms.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People of Color, especially Blacks/African Americans, Latinx, & Indigenous people are among the most stigmatized groups in US society and often benefit from advancements in HIV/HCV/STI prevention, testing, and treatment interventions after their white counterparts, furthering health inequities. There is an urgent need for increased meaningful participation by BIPOC to inform and lead services, placing value on their input to break down stigma and ensuring that interventions are available to priority populations first, improving health outcomes and reducing racial inequities.

Indigenous people are often not included in decision-making or program planning efforts in their area. In most locations in California there is an unrealized opportunity for local health jurisdictions or community-based organizations to collaborate with tribal communities. Sharing information and resources between local health jurisdictions and tribal communities could greatly reduce stigma and misinformation, as well as improve the health outcomes and access to health-promoting resources for indigenous people in the region.

People who use drugs often find it difficult to access healthcare through traditional settings – or if they can, they are often stigmatized and mistreated. To understand their unique needs it is critical to incorporate their voices in program development efforts. It is also helpful to integrate sexual health services within harm reduction programs and opiate treatment programs where services are already frequently being accessed, in addition to creating local resource lists of "friendly" providers and clinics for people who use drugs to support positive and safer experiences.

People who exchange sex for drugs, housing, and/or other resources are highly stigmatized and discriminated against in almost all sectors. Stigma is compounded for sex workers with intersecting identities, such as people who also use drugs, are unsheltered, are trans or gender non-conforming, BIPOC, or are parents; people who are members of these groups and exchange sex for drugs, housing, and/or other resources experience disproportionate levels of policing, harassment, and criminalization. Sex workers living with HIV have been incarcerated, despite no evidence they have transmitted HIV or engaged in unsafe practices. However, since California HIV criminalization laws were repealed in 2017 through SB 239, felony prostitution convictions based on HIV status were automatically vacated and, if asked, people who were convicted before 2017 no longer need to say they were convicted of a felony. However, these convictions still appear on people's record and may show up in background checks; sex workers can file a petition for dismissal in the county where they were convicted to have the conviction permanently removed from their record. To reduce stigmatization of sex workers, it is necessary to meaningfully involve people who exchange sex for drugs, housing, or other resources in all levels of HIV, HCV, and STI program planning and implementation.

People who experience mental health challenges experience high levels of prejudice and discrimination, which for BIPOC people is further compounded by systemic racism. The negative attitudes, beliefs, and behaviors that the public enact toward people with mental health disorders may lead people to deny or conceal their mental health symptoms and avoid mental health treatment and HIV,HCV, and STI care.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. *Nothing About Us Without Us,* The Canadian HIV/AIDS Legal Network, Open Society Institute, and International HIV/AIDS Alliance collaborated on a guidance document called *Nothing About Us Without Us* that is focused on greater, meaningful involvement of people who use illicit drugs as a public health, ethical, and human rights imperative.
2. The World Health Organization has released a great resource about meaningful engagement for people living with non-communicable diseases (including mental health concerns), also called *Nothing About Us Without Us*.
3. The Center for HIV Law & Policy released a fact sheet about the impacts of SB 239 in 2020.
4. The Government Alliance for Racial Equity toolkit makes clear how community engagement is central to promoting racial equity in all aspects of public program planning, implementation, and evaluation.
5. All of Us Or None is a grassroots civil and human rights organization fighting for the rights of formerly- and currently-incarcerated people and our families, and launched the original "ban the box" campaigns.
6. [Insert local resource here]
7. [Insert local resource here]

Social Determinant of Health

STIGMA FREE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Update testing and screening practices to utilize a comprehensive, status-neutral sexual health model of care.	X	X	
Partner with persons from key populations and local community organizations to develop models of engagement that ensure input and ultimately decrease stigma.	X	X	X
Work with members of priority populations to create human-centered social marketing campaigns that are designed to reduce stigma.		X	X
CDPH will identify and share tools and templates for provider self-reflection bias assessments, patient-based feedback, and observational evaluations that will aid in recognizing and addressing stigma and biases among medical and social service providers.		X	
Identify and modify institutional policies and law enforcement practices that disproportionately impact priority populations in a way that increases risk of HIV, HCV, or STI transmission or falling out of care.		X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Shifts in attitudes, beliefs, and behaviors take time. Dismantling generations of oppression, stigma, and bigotry that people experience based on the intersections of their identities (i.e., being BIPOC, being trans or gender non-conforming, being young or elderly, living in poverty, using drugs, etc.) will necessitate ongoing, iterative, and intensive efforts.
2. Find ways to organically reframe and normalize language that reduces stigma. Ask all people to specify their pronouns (not just people whose pronouns may be unclear or unexpected); Only when relevant and necessary, ask directly and non-judgmentally about substance use and mental health; talk about sex directly, in positive ways that is non-shaming; use language that is empathetic; remove unnecessary jargon; and create materials with accessible language that can be understood and generally relatable to all.
3. *Undetectable = Untransmittable* (U=U) campaigns are powerful prevention tools in ending the HIV epidemic and reducing stigma. When communicated correctly and consistently, campaigns and messaging such as U=U can help convey the scientific fact that people living with HIV who have achieved stable viral suppression and maintain adherence to their medications do not put their intimate partners at risk for HIV acquisition.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

[Insert your local ideas]

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The Well Project offers great advice and information about implementing U=U campaigns, especially when tailoring them to cisgender women.
2. The Positively Trans program of the Transgender Law Center has excellent resources by and for trans people, useful for centering trans voices and leadership in the HIV response using an assets frame.
3. [Insert local resource here]
4. [Insert local resource here]

Social Determinant of Health

STIGMA FREE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Work with key populations and local groups to develop public information campaigns that reflect local faces, engaging and empowering individuals within the community by involving them in message creation.		X	X
CDPH will promote the use of positive and diverse image repositories, which can be used legally by HIV/HCV/STI workers statewide for messaging, materials, and other content.	X	X	
Develop community-driven strategies for information dissemination, to help ensure that all people (including those not in priority populations) have equal access to positive and accurate, relevant information to reduce stigma about HIV, HCV, and STIs. Consider using peer-to-peer models, such as *promotores,* homeless liaisons, and popular opinion leaders, to disseminate information and reduce stigma and mistrust. Encourage community-led dialogue focused on positive and accurate information facilitated by community stakeholders and popular opinion leaders from within priority communities.		X	X
Implement syphilis and congenital syphilis prevention public awareness campaigns developed by and for priority populations, using media that reaches those populations, such as billboards, public service announcements on TV and radio (tailored to specific ethnic communities but also the general English-speaking public), print materials, and social media. Partner with community-based organizations in your local region to help ensure the campaigns are relevant to populations most in need, and sufficiently positive in framing.	X	X	
Where possible, include BIPOC and/or trans or gender non-conforming people in public relations roles to check and approve information being disseminated before it is released to the community.	X	X	X
[Insert your local ideas]			
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Remember to use languages, idioms, and dialects that are used by the community as often as possible. Use simple words to make sure information is understood by all people in the community of focus. Avoid value-laden language and messaging, such as framing behaviors as “good” or “bad,” or items as “clean” or “dirty” (instead of “sterile” and “used”). Always co-develop messages with people from the communities of focus, and test them with representatives of those groups before disseminating more broadly.

Local Considerations (delete or add rows as appropriate to your location)
In [Insert local jurisdiction]…[insert other considerations as desired].
Key Population Notes
[Insert your local ideas]

Monitoring and Metrics				
The table below outlines how progress toward this strategy will be measured:				
Level	**Indicator**	**Who measures?**	**How frequently?**	**Why this measure?**
[County name] County				
[Insert your local ideas]				

Partners and Resources
1. CDC developed a social media toolkit with the input of key populations, entitled *Let's Stop HIV Together*.
2. #SpeakOutHIV is an LGBTQ youth-focused campaign from Greater Than AIDS that emphasizes conversations around relationships, healthcare, and community - a dialogue geared toward eradicating stigma.
3. San Francisco Community Health Center's Trans:Thrive program is an excellent example of programs and tools developed by community for community.
4. Gender Spectrum Collection, Sexual Health and Liberation stock photos, and the Harm Reduction & Pain Patient Community Illustration Project all have existing digital repository of images featuring positive and diverse depictions of members of priority populations.
5. Talking circles a foundational approach used by Indigenous communities that encourages dialogue, respect, the co-creation of content and social discourse.
6. Caring Ambassadors and the National Viral Hepatitis Roundtable offer training in community organizing for people with lived experience; within California, the Ending the Epidemics Coalition has a similar initiative focused on the syndemics of HIV, HCV, STIs, and drug overdose.
7. [Insert local resource here]
8. [Insert local resource here]

Social Determinant of Health

STIGMA FREE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Create intentional forums to acknowledge and discuss medical and pharmaceutical mistrust openly. When possible, offer individuals from key populations a chance to discuss why they might be suspicious of healthcare providers and the system, and whether they have fears related to their condition. Hear and validate community's concerns first, and then address them openly and honestly, resisting defensiveness or dismissing concerns as unfounded or invalid.		X	X
CDPH will partner with racial and social justice experts and service providers to promote racial and social justice trainings that take an antiracism approach, emphasize inclusion, acknowledge the root causes of medical mistrust, and provide concrete and feasible solutions to structurally racist influences within public health systems, and can be used statewide. (See duplicate activity under *Racial Equity*, strategy 5.)	X	X	
Build and strengthen partnerships with the community by visibly demonstrating a commitment to "meet community where they are at," rather than expecting them to come to health events hosted at the health department or governmental spaces, and care first about a health department agenda. Host community conversations in their trusted spaces of gathering, join the community at cultural and local events despite them not having an explicit HIV/HCV/STI focus, and lean on providers that have already built community trust to support other staff to develop better relationships with priority communities.	X	X	X
Collaborate with street medicine and mobile services providers to create opportunities for medical rotations, internships, and volunteer shifts so that HIV/HCV/STI clinical and social service providers who work in more traditional brick and mortar settings can learn to meet people where they are at (physically and mentally), and break down medical mistrust through respectful, humble community-based interactions.		X	X
CDPH will partner with BIPOC medical providers, researchers, and policy experts to promote resources that will help providers better understand and address current contributors to ongoing medical mistrust in California.			X
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Medical mistrust has been created through historical experiences of mistreatment by the medical and public health systems in this country, including medical apartheid and other types of medical experimentation, forced sterilization of BIPOC and poor people, and family separation as a result of engaging with the healthcare system. Understanding the history behind these issues and how they are relevant to your patient population is a critical first step to recognizing and responding to medical mistrust.
2. Incorporating trust-building visits into practice and programs can be a helpful strategy to address medical mistrust, so that members of priority communities can feel more comfortable with coming in on their terms and asking all the necessary questions to get to know the providers *before* they engage in direct care.
3. Communicate with—not at—priority communities. Listen to their needs. Follow through on any requests, to demonstrate a lasting commitment to their well-being (even when it does not serve your immediate agenda). Provide support for patients/clients to practice boundaries and assertive communication, and be empowered to decide for themselves when and how they choose to disclose sensitive health information to others.
4. Consider making broad language changes within the public health sector as a whole to help built trust and combat medical mistrust. Consider the implications epidemiologic language such as "surveillance," which is rooted in monitoring and watching people suspected of malicious activity, or using the term "infected", "spreader", or "target population." Use people-first, non-stigmatizing language whenever possible.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

People of Color, especially Blacks/African Americans, Latinx, & Indigenous people experience high levels of mistrust of the health care system. Historical events of medical apartheid and current reports of discrimination or poor treatment in healthcare settings may contribute to underuse of healthcare services, medication and other life-saving treatment, including engaging in sexual or drug user health services. It is important to continuously work to identify and understand current contributors to mistrust, to engage BIPOC patients/clients in supportive systems and ensure culturally appropriate experiences that may contribute to positive health outcomes.

People who are unhoused frequently experience poor treatment from those around them and as a result have developed an understandable distrust of others, including care providers. Building trust may take many interactions, providing person-centered outreach and care services that demonstrate patience, caring, and warmth. Providing food, basic clothing (like socks), and simple wound care may help to build a more trusting relationship that later will facilitate more focused care related to HIV, HCV, and STIs.

People who are trans or gender non-conforming: Members of this population anticipate (and experience) higher levels of discrimination and maltreatment than cisgender people. Those who feel mistreated and discriminated against by healthcare or social service providers are more likely to not initiate or disengage from health care services. Especially when combined with discrimination in other sectors, people who are trans or gender non-conforming often find themselves unemployed or underemployed, unhoused, economically marginalized, and/or sometimes turning to sex work to obtain housing or money, increasing their risk for HIV, HCV, and STIs.

Some **cisgender women and people who can become pregnant** may not feel safe seeking sexual health preventative care and treatment services given the current polarized political climate. Restricting access to adequate, safe family planning services and criminalization of abortion outside California has increased mistrust in medical providers and the system as a whole (even in California). Cisgender women may benefit from interventions that are designed address their safety, ultimately increasing utilization of sexual health and reproductive services.

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				
[Insert your local ideas]				

Partners and Resources

1. The American Lung Association has information and a video on their website that speaks to a history of medical mistrust by addressing the inherent racial bias in the U.S. healthcare system.
2. CA 4 Health's 21-day Racial Equity and Social Justice Challenge is an excellent resource to deepen understanding of racial justice and its intersection with public health over an extended period.
3. [Insert local resource here]
4. [Insert local resource here]

Social Determinant of Health

STIGMA FREE

Strategy 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.

Recommended Activities	2022-2023	2024-2025	2026 & beyond
Promote peer-based models of engagement for priority populations, where participants are trained and paid for their efforts in providing community education and helping peers engage in services, such as by leveraging the CHW benefit within Medi-Cal.	X	X	X
Connect with non-traditional partners, including local vendors and businesses, to share information about HIV, HCV, and STIs and invite leaders in those venues to participate in conversations and services, including rapid HIV, HCV, or STI testing if possible. This helps to bring information and services directly to the community, meeting them "where they're at" physically, emotionally, and financially.	X	X	X
Implement peer-to-peer models whereby people who are newly diagnosed with HIV or HCV can meet and partner with "a health veteran" who has been navigating living (and being treated) with that disease. These programs decrease emotional distress and fear of stigmatization, increase access to resources, and empower people who are newly diagnosed.		X	X
[Insert your local ideas]			
[Insert your local ideas]			

Overall Considerations

1. Existing grassroots community health initiatives and spaces, such as barber shops, beauty salons, and faith-based locations, can provide opportunities for community members and informed local leaders to discuss health in familiar spaces where they can identify and receive resources free of shame and stigma.

Local Considerations (delete or add rows as appropriate to your location)

In [Insert local jurisdiction]…[insert other considerations as desired].

Key Population Notes

[Insert other considerations as desired]

Monitoring and Metrics

The table below outlines how progress toward this strategy will be measured:

Level	Indicator	Who measures?	How frequently?	Why this measure?
[County name] County				

[Insert your local ideas]				
Partners and Resources				
1. Through a partnership between Tulare County and Altura Centers for Health, *promotores* go out to rural regions throughout the county 3 days a week to educate people in those communities about HIV and STI testing.				
2. [Insert local resource here]				
3. [Insert local resource here]				

California Integrated Strategic Plan Cross-Over: 2016-2021 and 2022-2026

	2016-2021, CDPH Integrated Plan, Goals and Objectives		2022-2026, CDPH Integrated Plan - New Indicators and Strategies
1	Increase the estimated percentage of Californians living with HIV who know their serostatus to at least 95 percent	»	• **Racial Equity,** Strategy 2: Monitor and adjust programming to eliminate disparities • **Housing First,** Strategy 2: Multidisciplinary housing teams can facilitate people's knowledge of their status • **Health Access for All:** All 5 strategies • **Mental Health and Substance Use,** Strategies 2,3,4,5: Increase addressing knowledge of status in mental health and substance use treatment sessions • **Stigma Free:** All 5 strategies
2	Reduce the number of new HIV diagnoses in California by at least 50 percent, to fewer than 2,500 per year	»	All key indicators and strategies; this is the essence of the entire proposed framework
3	Increase the number of Californians at high risk for HIV infection who are on PrEP to 60,000	»	• **Racial Equity,** Strategies 2,3,4: Involve PrEP-eligible people in the planning and implementation of PrEP promotion, enrollment and sustaining PrEP usage • **Housing First,** Strategy 2: Multidisciplinary housing teams can facilitate people's knowledge of their status • **Health Access for all:** All 5 strategies • **Mental Health and Substance Use,** Strategies 2,3,4,5: Increase identification of PrEP eligible people and facilitate linkage to PrEP providers in mental health and substance use treatment sessions • **Economic Justice,** Strategies 2,3,4: Employ PrEP users in PrEP education, navigation, and support others on PrEP • **Stigma Free,** all strategies with focus on 5: Diffusing PrEP promotion in other organizations such as SNAP, probation and parole, LGBTQ Centers, etc.
4	Decrease the percentage of persons with new HIV diagnoses in California that are	»	• **Housing First,** Strategy 4: Increase HIV screening during street medicine visits and 5: work with staff in public housing and migrant worker communities to promote HIV knowledge and benefits of early detection

	2016-2021, CDPH Integrated Plan, Goals and Objectives		2022-2026, CDPH Integrated Plan - New Indicators and Strategies
	diagnosed with Stage 3 (AIDS) within twelve months of diagnosis (i.e., late diagnosis) to less than 17 percent		• **Health Access for All,** all 5 strategies with emphasis in Strategy 5: Increase HIV testing as a part of the initial work up in people who are ill with symptoms that may be related to HIV, currently many missed opportunities are identified in people diagnosed late • **Mental Health and Substance Use,** Strategies 2,3,4,5: Increase benefits of ongoing knowledge of status in mental health and substance use treatment sessions • **Economic Justice,** Strategies 2,3 and 5: Focus on Hiring and Housing policies to not only ban the box, but clearly inform individuals of eligibility regardless of immigration status • **Stigma Free**: all 5 strategies, especially use of peers to promote testing routinely to avoid late diagnosis
5	Increase the percentage of sexually active PLWH in care who are tested at least once in a year for gonorrhea, syphilis, and chlamydia to at least 75 percent	»	This objective has been expanded to include not only sexually active PLWH, but also PrEP-eligible individuals as well. • **Racial Equity,** focus on strategy 2: Monitor STI disparities and develop programs to eliminate those disparities • **Housing First,** Strategy 1 and 2: Increase Electronic Medical Record assistance in recording STI screening with prompts for routine screening as needed and combining orders for STIs, HIV and HCV for easy ordering by health care professionals, strategy 4 to increase STI screening in street medicine visits • **Health Access for All,** Strategy 1: Increase Electronic Medical Record assistance in recording STI screening with prompts for routine screening as needed and combining orders for STIs, HIV and HCV for easy ordering by health care professionals, strategy 3 to make seeking STI screening efficient and easy, and strategy 5 for increased promotion of sexual heath and screening for STIs as needed • **Mental Health and Substance Use,** Strategies 2,3,4,5: Increase addressing knowledge of status in mental health and substance use treatment sessions • **Stigma Free**, all 5 strategies: Increase use of promotions such as *San Francisco's Healthy Penis social marketing campaign (www.healthypenis.org)*
6	Increase the percentage of newly diagnosed persons in California linked to HIV medical care within 1 month of their HIV diagnosis	»	• **Racial Health Equity,** Strategy 2: Emphasis on tracking days between knowledge of new diagnosis and first medical visit and commencement of anti-retroviral therapy (ART) • **Housing First,** Strategy 5: Quickly house people without housing at time of diagnosis • **Health Access for all**: All 5 strategies, especially strategy 3 and 4

	2016-2021, CDPH Integrated Plan, Goals and Objectives		2022-2026, CDPH Integrated Plan - New Indicators and Strategies
	to at least 85 percent		• **Mental Health and Substance Use,** Strategy 2 and 4: Quick access to mental health and substance use as needed for newly diagnosed individuals • **Economic Justice**: Focus on strategies 2 and 3 • **Stigma Free:** all 5 strategies, including using people recently diagnosed sharing their experiences to assess facilitators and barriers to early access to care
7	Increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75 percent	»	• **Racial Health Equity,** Strategy 2: Emphasis on tracking days between knowledge of new diagnosis and first medical visit and commencement of ART • **Housing First**, Strategy 5: Quickly house people without housing at time of diagnosis • **Health Access for All,** Strategy 2: Increase healthcare providers awareness of brief assessment for trauma and cultural approach to receiving health care • **Mental Health and Substance Use,** Strategy 2: Strong emphasis of working with people using drugs who are not choosing healthcare after diagnosis • **Economic Justice,** Strategies 2 and 3: Ensure peer employees supporting newly diagnosed individuals • **Stigma Free,** especially Strategy 4: Increase skills in assessing for and responding to medical mistrust
8	Increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 80 percent	»	• **Racial Health Equity,** Strategy 2: Emphasis on identifying populations with disparities in viral suppression, identify all individuals not on ART • **Housing First,** Strategy 5: House people with sustained viral load who do not have housing, as well as engage housing partners to support residents who are living with HIV who are not virally suppressed; Strategy 4 to increase services via street medicine for people living with HIV who are not virally suppressed • **Health Access for All,** Strategy 2: Increase healthcare providers awareness of brief assessment for trauma and cultural approach to receiving health care; strategy 3 to ensure people living with HIV who are not virally suppressed have medical coverage, strategy 5 to increase providers of other services used by people living with HIV to monitor for viral suppression and support those not virally suppressed • **Mental Health and Substance Use,** Strategy 2: Strong emphasis of working with people using drugs who are not choosing healthcare after diagnosis, also to ensure routine monitoring viral suppression status of PLWH receiving mental health or substance use treatment by

	2016-2021, CDPH Integrated Plan, Goals and Objectives		2022-2026, CDPH Integrated Plan - New Indicators and Strategies
			appropriate providers, Strategy 4 to ensure access to opiate agonist therapy as needed • **Economic Justice,** Strategies 2 and 3: Ensure peer employees supporting PLWH who do not have sustained viral suppression, use incentives including cash to assist individuals achieve and maintain viral suppression • **Stigma Free,** especially Strategy 4: Increase skills in assessing for and responding to medical mistrust, strategy 5 to link non-virally suppressed people to a peer who has sustained viral suppression
9	Increase the percentage of Californians with diagnosed HIV infection who are in HIV medical care (at least 1 visit per year) to at least 90 percent	»	• **Racial Equity,** Strategy 1: Increase percentage of staff from the communities they are serving, Strategy 5 to increase a culture inclusive, respectful and that reflects the communities being served. • **Housing First,** Strategy 1: Improve "data to care" list to respond to out of care individuals more immediately; strategy 2 to ensure all service providers are monitoring medical care status of people living with HIV, strategy 4 to inform street medicine teams of people out of care in order to offer services outside of brick and mortar clinics, strategy 5 to assess housing status of people out of care and prioritizing housing individuals not in care and identifying and removing housing policies that are barriers to homeless entering housing services. • **Health Access for All,** all strategies: Emphasis on strategy 5 to ensure more providers are monitoring and assisting individuals return to care • **Mental Health and Substance Use,** Strategy 2: Ensure rapid linkage as needed for those out of care, strategy 5 for ensuring providers assess care status of people living with HIV receiving mental health or substance use services • **Economic Justice,** Strategies 2 and 3: Provide peer support by people living with HIV in care to people living with HIV out of care • **Stigma Free,** Strategy 2: Change policies that "fire" patients or make it difficult to access healthcare providers, strategy 4 to increase assessment and response to individuals' medical mistrust
10	Increase the percentage of California AIDS Drug Assistance Program clients with public or private health insurance to at least 85 percent	»	Expand beyond ADAP programs to assess insurance status for all people living with HIV • **Racial Equity,** Strategy 2: Monitor and respond to communities with insurance disparities, monitor geographically as well as racially and by transmission modes; strategy 4 to partner with Covered California to market to people living with HIV more specifically • **Housing First,** Strategy 1: Ensure all people living with HIV receiving housing services are assessed for insurance and provide support when insurance is lacking

2016-2021, CDPH Integrated Plan, Goals and Objectives	2022-2026, CDPH Integrated Plan - New Indicators and Strategies
	• **Health Care Access for All,** Strategy 1: Increase simple, quick enrollment in Medi-Cal and Covered California, strategies 3 and 4 of course • **Mental Health and Substance Use:** Continue to increase parity of service reimbursement for mental health & substance use and ensure mental health & substance use access is not impeded by insurance policies and procedures (e.g. no mental health visit on same day as medical visit for Medi-Cal consumers) • **Economic Justice**: Ensure insurance is affordable and accessible with reasonable copays and deductibles; ensure all providers (healthcare, case managers, food bank, etc.) regularly assess insurance status of people living with HIV • **Stigma Free**: Acknowledge mistrust of receipt of services for those people living with HIV residing in California but not legally acknowledged

INDICES

Priority Population References:

Topic-Specific References:

For more information, visit:

https://www.cdph.ca.gov/

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