Sacramento County
Department of Health Services
HIV Health Services Planning Council
Executive Committee

www.sacramento-tga.com

Meeting Agenda
November 10, 2022, 3:00 p.m. to 5:00 p.m.

Meeting Location – Via teleconference. No in-person meeting.
Join Zoom Meeting
https://www.zoomgov.com/j/1606456746?pwd=TFUzS1R2bmxkTWJsaDFVelN6THBJZz09

Meeting ID: **160 645 6746**
Passcode: **400928**

Dial by your location: **1-669-254-5252 (San Jose, CA)**

Facilitator: Richard Benavidez – Council Chair
Scribe: Danielle Caravella**,** Paula Gammell – County Staff

Meeting Invitees:

Richard Benavidez – Council Chair, Kristina Kendricks-Clark – Vice Chair & QAC Chair

Melissa Willett – AdAC Chair, Zach B. - ACC Chair, Chelle Gossett – Recipient, Jake Bradley-Rowe – PAC Chair, Michael Ungeheuer – Gov Chair, and Ronnie Miranda - NAC Chair

- Open to the Public

*Action Items

Topic	Presenter	Start Time and Length
Welcome and Introductions	Benavidez	3:00 pm
Announcements	All	
Public Comments	Benavidez	
November 2022 Agenda*	Benavidez	

Sacramento County
Department of Health Services
HIV Health Services Planning Council
Executive Committee

www.sacramento-tga.com

Minutes of September 2022*	Benavidez	As Needed
Integrated Strategic Plan & Concurrence Presentation*	Blea	
Recipient Report: ➢ FY22 September Part A Monthly Fiscal Report* ➢ FY22 September 2022 Part B Monthly Fiscal Report ➢ SOA Ending the HIV Epidemic Update ➢ HRSA Part A Ending the Epidemic Update ➢ RFP Update	Gossett	
Committee/Work Group Updates ➢ Administrative Assessment Committee ➢ Affected Communities Committee ➢ Reflectiveness update ➢ Priorities and Allocations ➢ Quality Advisory Committee ➢ Needs Assessment Committee ➢ Governance	Willett Zach B. Bradley-Rowe Benavidez Kendricks-Clark Miranda Ungeheuer	
Set Planning Council Agenda for December 14, 2022*	All	As Needed
Technical Assistance	Benavidez	
Adjournment	Benavidez	5:00 pm

Attachments:
- Minutes of September 2022*
- Integrated Strategic Plan
- Integrated Plan Concurrence Letter*
- FY22 September Part A Fiscal Report*
- FY22 September Part B Fiscal Report
- Planning Council Agenda for December 14, 2022*

Next Meeting: January 12, 2023

HIV HEALTH SERVICES PLANNING COUNCIL Executive Committee

Meeting Minutes

September 8, 2022, 3:00 p.m. to 5:00 p.m.

Meeting Location:

Teleconference Meeting Only

Facilitator: Richard Benavidez –Council Chair

Scribe: Paula Gammell - Staff

Committee Member Attendees:

Via Teleconference: Richard Benavidez –Council Chair, Zach B. – ACC Chair, Jake Bradley-Rowe –PAC Chair, Melissa Willett – AdAC Chair, Chelle Gossett - Recipient, and Kristina Kendricks-Clark – Vice Chair

Members Excused: Ronnie Miranda – NAC Chair and Michael Ungeheuer – Governance Chair

Members Absent: N/A

Guests: N/A

Topic	Minutes
Welcome, Introductions and Announcements	Meeting began at 3:05 p.m. Sunburst Projects' Annual Golf Tournament is being held on Saturday, October 15, 2022. PFLAG is hosting a Trans Day of Remembrance event on November 19, 2022, from 6:30 p.m. to 8:00 p.m. at Trinity Episcopal Cathedral. Sierra Foothills AIDS Foundation is hosting a Monkeypox vaccination clinic on September 13, 2022.
Public Comments	Zach B. advised that he was informed that One Community Health is not providing Monkeypox Vaccinations to anyone with a CD4 count over 200.
September 2022 Agenda Review*	A copy of the September 2022 Agenda was presented for review and approval. Motion to approve the Agenda was made by Jake Bradley-Rowe with a second by Zach B. Discussion not a correction to the Agenda indicating the Council Agenda review was an action item. Jake Bradley-Rowe amended his motion to approve the Agenda with the changes noted. The amended motion was seconded by Melissa Willett and was unanimously approved. Approved: Gossett, Bradley-Rowe, Willett, Benavidez, Zach B. Opposed: None Abstained: None
August 2022 Minutes Review*	A copy of the August 2022 August Committee Minutes was presented for review and approval. Motion to approve the Minutes as presented was made by Melissa Willett with a second by Zach B. No corrections or changes were noted. Motion was unanimously approved. Approved: Gossett, Bradley-Rowe, Willett, Benavidez, Zach B.

Topic	Minutes
	Opposed: None Abstained: None
FY22 July Part A Fiscal Report*	A copy of the FY22 July Part A Monthly Fiscal Report was presented for review and approval. Expenditures through June should be within 41%. Overall, Sacramento's expenditures are on target at 38.9%. El Dorado County is 36.2% expended and Placer has expended 41.9% of its funds. Motion to approve the FY22 July Part A Fiscal Report was made by Zach B. with a second by Richard Benavidez. Motion was approved with one abstention. Approved: Bradley-Rowe, Willett, Benavidez, Zach B. Opposed: None Abstained: Gossett
FY22 July Part B Fiscal Report	A copy of the FY22 July Part A Monthly Fiscal Report was presented for informational purposes.
State Office of AIDS – Ending the Epidemic Grant Update	The Wellness without Walls mobile van has been delivered and efforts are being made to coordinate services.
HRSA – Ending the Epidemic Grant Update	The carryover request has been submitted. Construction at the Clinic is finished and equipment is being delivered. There are four new exam rooms.
RFP Update	The RFP was released yesterday, September 7, 2022.

Topic	Minutes
Committee Updates:	**Administrative Assessment Committee** (AdAC): The Administrative Assessment Committee will meet next on Thursday, November 17, 2022. **Affected Communities Committee** (ACC): Zach B. informed that ACC did not meet in September and that reflectiveness is 36.4% due to recent membership changes. **Priorities and Allocations Committee** (PAC): PAC will be meeting on Monday, September 12, 2022, to discuss FY22 Reallocation and FY23 Grant Application Allocations. Motion to move the FY22 Reallocation and FY23 Grant Application Allocations directly to the Council meeting on September 28, 2022 was made by Zach B. with a second by Richard Benavidez. Motion was unanimously approved. Approved: Gossett, Bradley-Rowe, Willett, Benavidez, Zach B. Opposed: None Abstained: None **Quality Advisory Committee** (QAC): The Chair position for QAC is currently vacant. Kristina Kendricks-Clark has submitted her name as a potential Chair. A vote will be held at the September Council meeting. QAC met and discussed the post card survey. The committee reviewed the number of unduplicated clients in each service between March 1 and August 31st. In an effort to increase the potential responses, the Committee decided to print surveys for each person who received a service in a category where there were 50 or fewer people having received the service through August 31st. If the service had more than 50 clients during the period, there would be a minimum of 50 surveys distributed or 25% of the category, whichever is

Topic	Minutes
	higher. **Needs Assessment Committee** (NAC): NAC met and discussed the Needs Assessment Survey. There have been 62 Needs Assessment Surveys completed to date. 20 surveys were also distributed to CommuniCare. There are more still pending in El Dorado and Placer Counties. The goal is 200 surveys. **Governance** (Gov): No report.
September 28, 2022 HHSPC Agenda*	A draft copy of the September 28, 2022 HHSPC Agenda was presented for review and approval. Motion to approve the Agenda as presented was made by Richard Benavidez with a second by Melissa Willett. Discussion resulted in updating the Attachments to include the FY23 Grant Application Allocations. Motion to approve the amended Agenda as noted was made by Richard Benavidez with a second by Zach B. and was unanimously approved. Approved: Gossett, Bradley-Rowe, Willett, Benavidez, Zach B., Kendrick-Clark Opposed: None Abstained: None
Technical Assistance	Richard Benavidez encouraged anyone needing technical assistance to contact himself.
Adjournment	The meeting adjourned at 3:52 p.m.

ENDING THE EPIDEMICS:

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

Integrated Statewide Strategic Plan
Overview
2022-2026

California Department of Public Health

MAKING A STATEMENT

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

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

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

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

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

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

VISION

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

MISSION

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

PURPOSE

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

OUR VALUES

HUMAN DIGNITY

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

COURAGEOUS LEADERSHIP

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

RACIAL AND SOCIAL JUSTICE

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

COLLABORATION

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

HARM REDUCTION

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

PERSON-CENTERED SOLUTIONS

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

THE PEOPLE

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

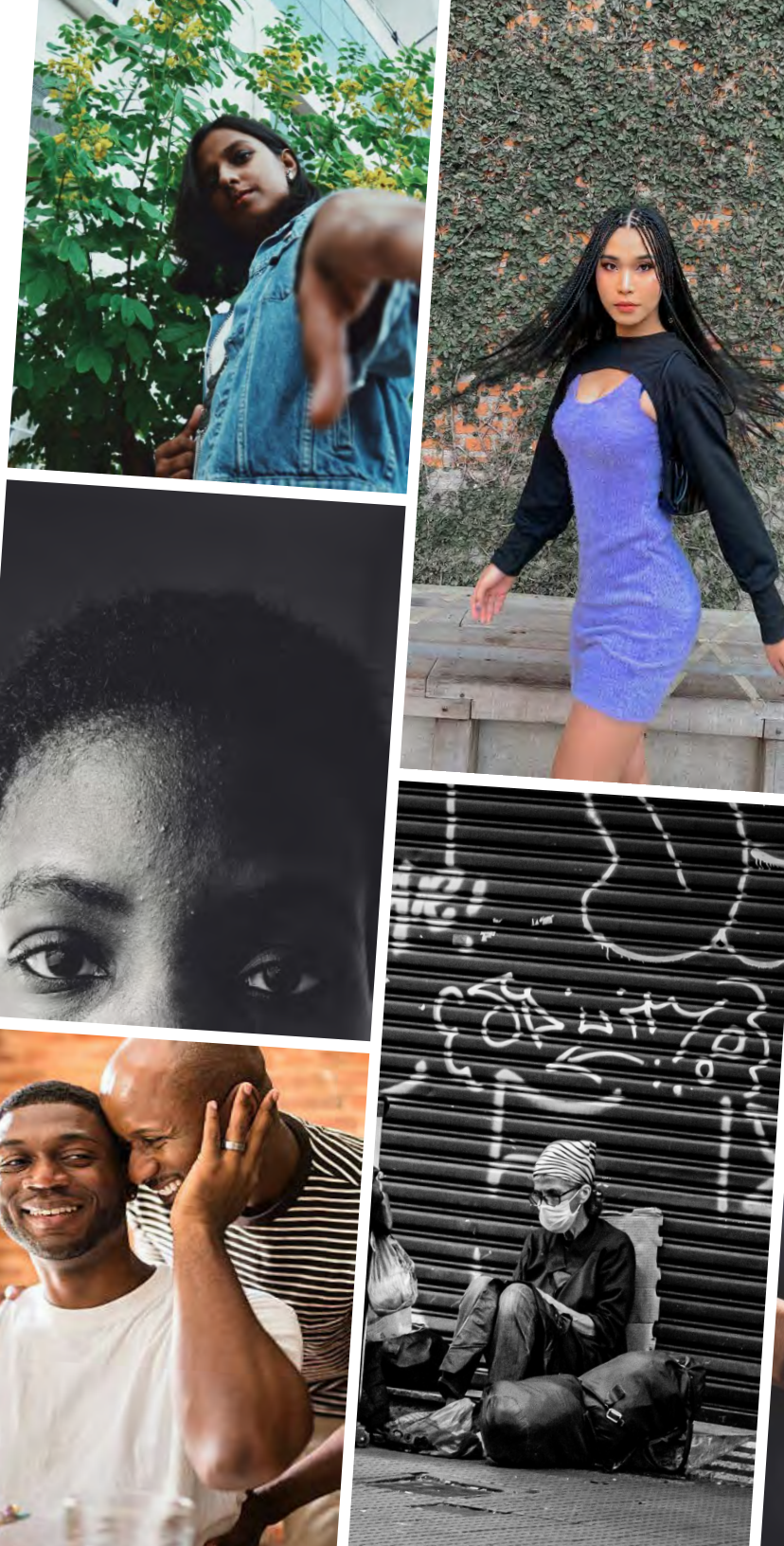
In California, the communities most impacted by HIV, HCV, and/or STIs include:

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

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

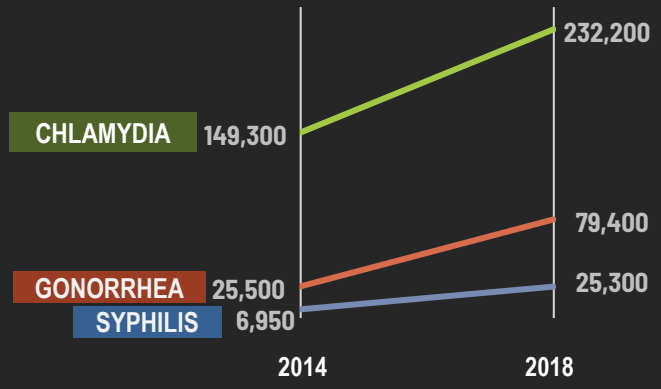
On the next three pages we provide data highlighting racial and gender disparities in HIV, HCV, and STI outcomes in California. Understanding where disparities exist is important, to guide our work improving racial and health equity.

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

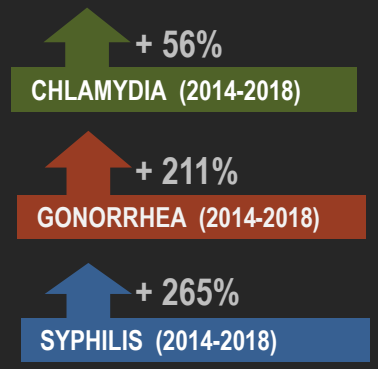


THE DATA: SEXUALLY TRANSMITTED INFECTIONS

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

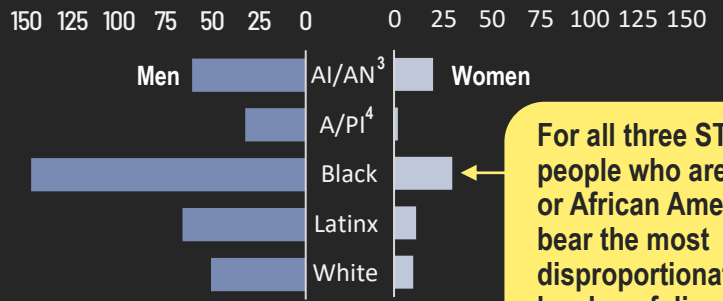


Although chlamydia cases are higher in number, syphilis and gonorrhea cases are increasing much more rapidly than chlamydia.



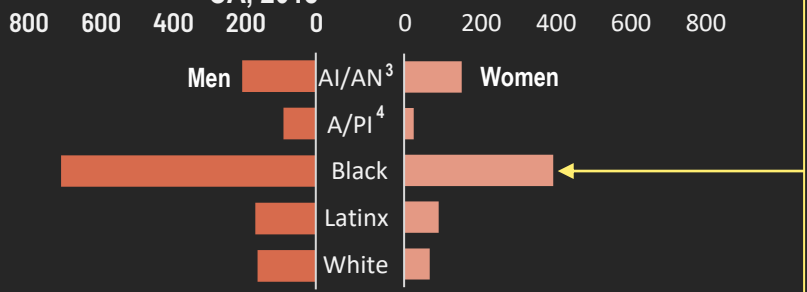
Syphilis and gonorrhea are more commonly diagnosed among men, while chlamydia is more commonly diagnosed among women.[1]

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



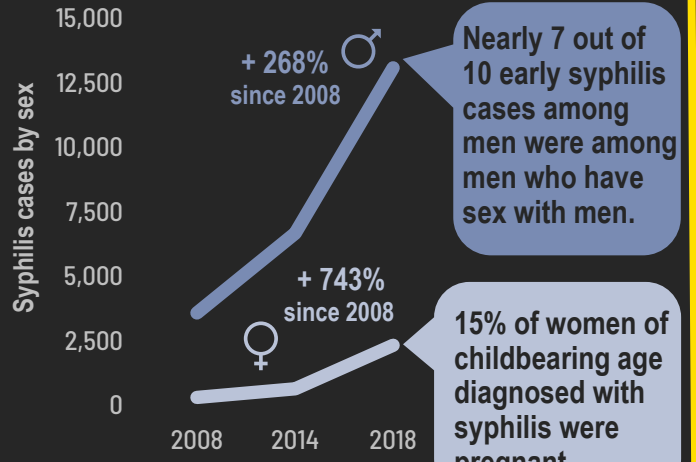
For all three STIs, people who are Black or African American bear the most disproportionate burden of disease.

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



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

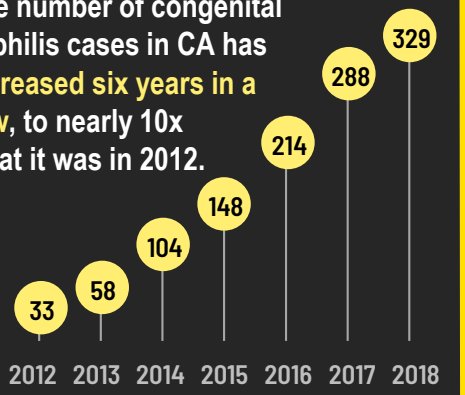
Men make up most syphilis cases in CA; however, cases among women are increasing rapidly, up 743% from only 273 cases in 2008 to more than 2300 in 2018.[1]



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

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

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

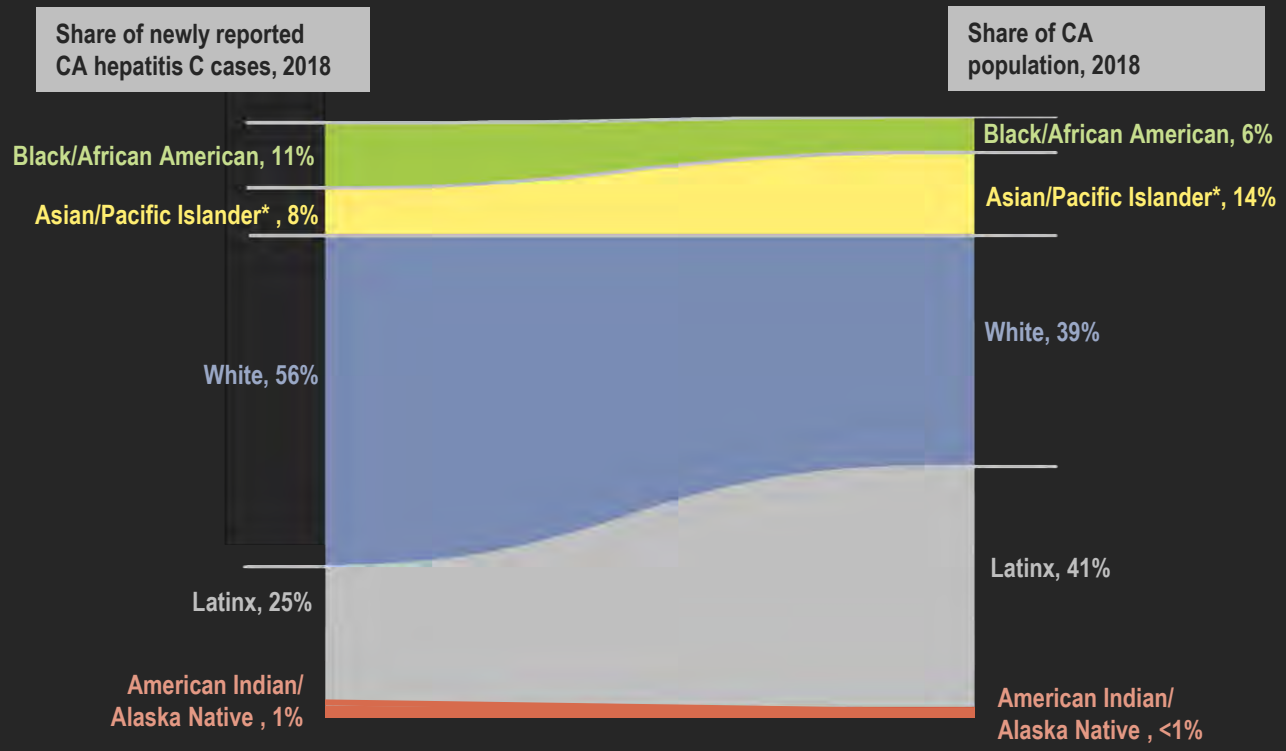


Of 329 congenital syphilis cases in 2018 alone, there were 19 infant stillbirths, 3 neonatal deaths, and 31 infants born with other symptoms or complications.

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

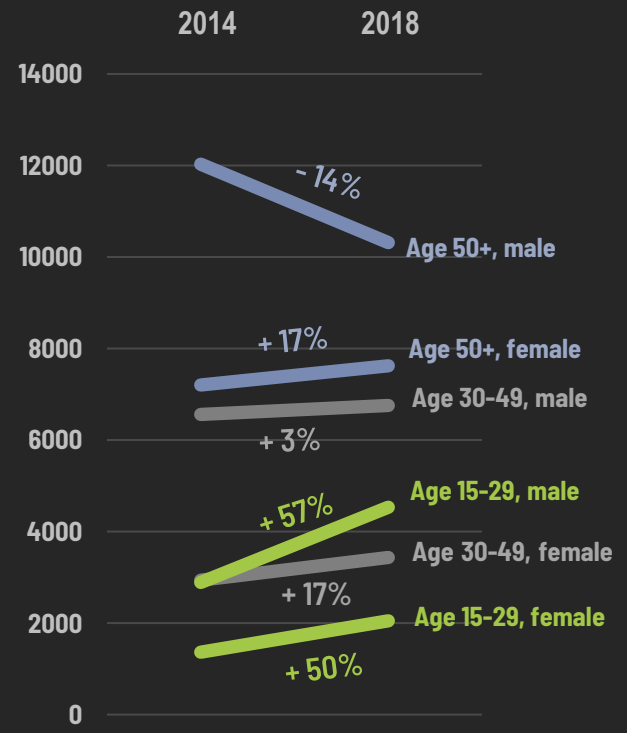
THE DATA: HEPATITIS C VIRUS

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



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

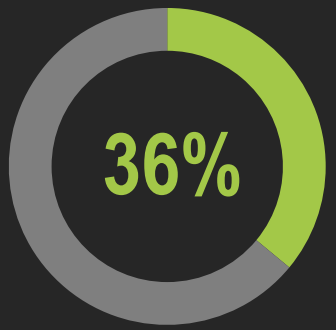
"Baby boomers" (born 1945-1965) make up most new hepatitis C cases, but new cases are increasing dramatically among younger people ages 15-29.



With respect to sex, there were:

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

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



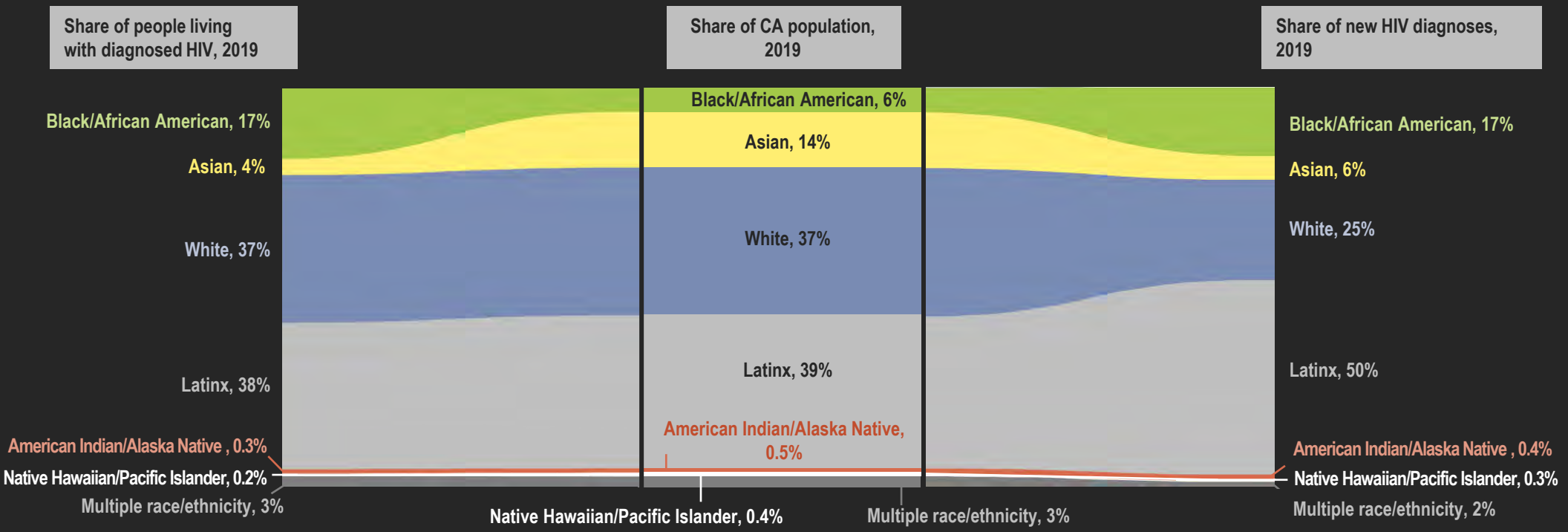
36% of youth aged 15-29 who tested positive for hepatitis C in an assessment conducted by the state[5] reported having injected drugs.

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

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

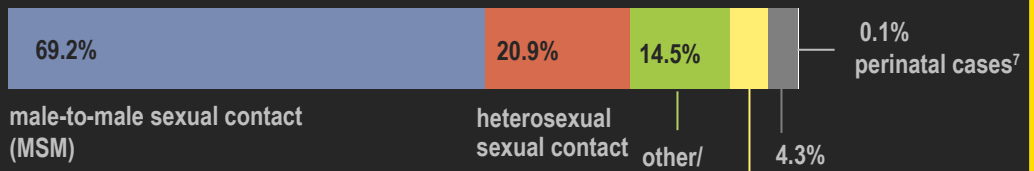
THE DATA: HIV

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



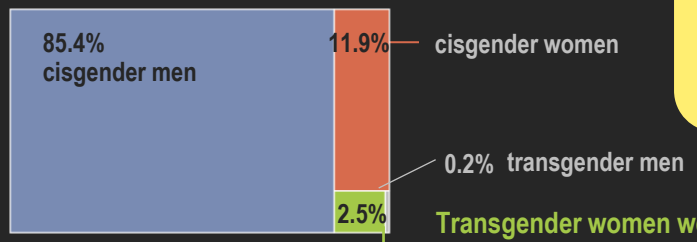
*People who are Native Hawaiian/Pacific Islander made up 0.5% of the population, 0.2% of people living with diagnosed HIV, and 0.3% of new HIV diagnoses.

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



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

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



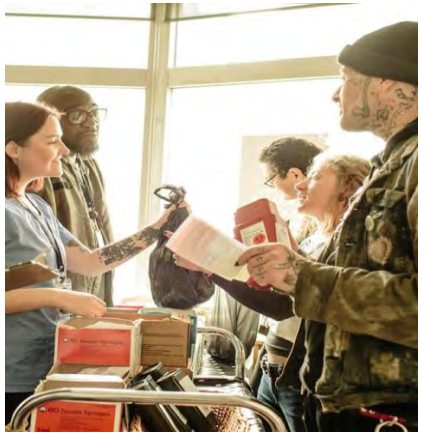
Transgender women were also overrepresented among new HIV diagnoses, especially trans women of color.

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

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

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

HEALTH INEQUITIES, SOCIAL DETERMINANTS OF HEALTH, AND INTERSECTIONALITY



Living with Hep C?
New treatments have changed the game

AT OUR CORE

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

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

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

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

RACIAL EQUITY

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

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

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

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

STRATEGIES

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

1. **Leadership and Workforce Development**

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

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

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

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

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

4. **Community Engagement**

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

5. **Racial and Social Justice Training**

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

HOUSING FIRST

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

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

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

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

STRATEGIES

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

1. **Data Collection and Use**

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

2. **Infrastructure Changes**

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

3. **New Models of Housing Access**

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

4. **Street Medicine Strategies**

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

5. **Low-barrier Housing Options**

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

HEALTH ACCESS FOR ALL

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

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

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

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

STRATEGIES

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

1. **Redesigned Care Delivery**

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

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

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

3. **Fewer Hurdles to Healthcare Coverage**

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

4. **Culturally and Linguistically Relevant Services**

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

5. **Collaboration and Streamlining**

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

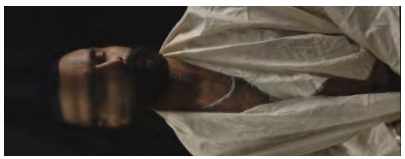
MENTAL HEALTH AND SUBSTANCE USE

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

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

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





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

STRATEGIES

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

1. **Overdose Prevention in Correctional Settings**

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

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

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

3. **Build Harm Reduction Infrastructure**

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

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

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

5. **Cross-Sector Collaboration**

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

ECONOMIC JUSTICE

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

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

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

STRATEGIES

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

1 Workforce Development

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

2 Employment for People with Lived Experience

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

3 Equitable Hiring Practices and Fair Pay

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

4 Leadership Development

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

5 Universal Hiring and Housing Policies

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

STIGMA FREE

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

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

STRATEGIES

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

1. **Nothing About Us Without Us**

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

2. **Reframe Policies and Messaging**

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

3. **Positive, Accurate Information**

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

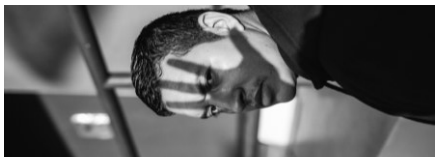
4. **Acknowledge Medical Mistrust**

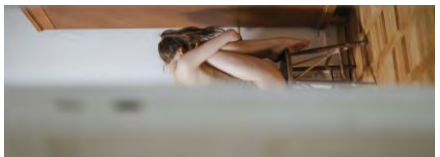
   Recognize medical mistrust as a rational response to stigmatizing treatment, rather than a failure of individuals or communities; work to build trust and correct misperceptions by example.

5. **Ongoing Partnerships**

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

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





FUTURE ROADMAP

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

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

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

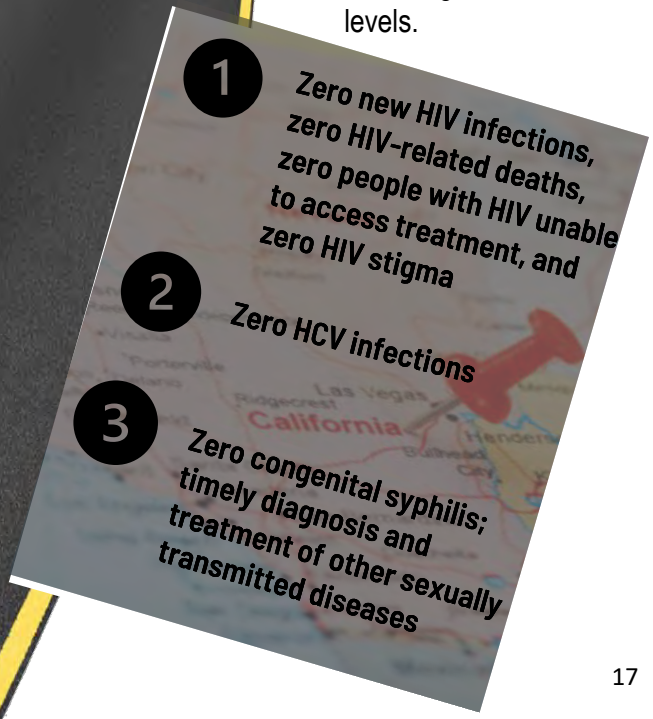
3. Determining the logistics and resources that will be necessary to successfully implement our prioritized strategies.

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

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

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

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



EST 2021

PROCLAMATION

CALIFORNIA'S COMMITMENT TO THE PEOPLE

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

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

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

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

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

On behalf of the
California Department of Public Health

Marisa Ramos
Marisa Ramos, PhD
Chief, Office of AIDS

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

KEY TERMS

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

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

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

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

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

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

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

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

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

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

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

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

[16] US Department of Health and Human Services

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

California Department of Public Health

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

Community Stakeholders

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

Consulting Partner

FACENTE CONSULTING
UNDERSTAND · IMPLEMENT · TELL YOUR STORY

CONTACT US

OFFICE OF AIDS
Center for Infectious Diseases
California Department of Public Health
MS 7700 P.O. Box 997426
Sacramento, CA 95899-7426

STD CONTROL BRANCH
California Department of Public Health
850 Marina Bay Parkway
Building P, 2nd Floor
Richmond, CA 94804-6403
(510) 620-3400

www.cdph.ca.gov

General Information:
(916) 558-1784

Mailing address:
PO Box 997377, MS 0500
Sacramento, CA 95899-7377

California Department of PublicHealth

Marisa Ramos, Ph.D.
Chief, Office of AIDS
Center for Infectious Diseases
California Department of Public Health
MS 7700, PO Box 997426
Sacramento, CA 95899-7426

Dr. Ramos,

This letter documents that the Sacramento Transitional Grant Area (TGA) HIV Health Services Planning Council (HHSPC) is in concurrence with integrated plan entitled ***Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California.*** We enthusiastically join the California Department of Public Health (CDPH) Office of AIDS (OA) and Sexually Transmitted Disease Control Branch (STDCB) in co-authoring this plan that will lead our work, not only in HIV prevention, care and surveillance, but also in addressing HIV as a syndemic with HCV and STIs through thirty innovative strategies organized across six social determinants of health: racial equity, housing first, health access for all, mental health and substance use, economic justice and stigma free.

The HHSPC also notes the extraordinary community engagement efforts in this planning process that our TGA undertook in partnership with CDPH-OA/STDCB. In January 2022, the draft of this plan was released to our TGA along with all other health jurisdictions in California. We received an overview of the draft plan at a presentation to the HHSPC and were allowed to ask questions and make suggestions about ways to improve the draft. Our TGA also hosted one of the 17 regional community listening sessions designed to get broad input from HIV advocates, prevention and care providers, and other community stake holders to improve our implementation efforts of this plan.

The process above resulted the final plan being submitted to HRSA and CDC as the fulfillment of our requirement as a Ryan White Part A recipient to have an integrated plan. The plan being submitted is in harmony with the other HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero and Ending the HIV Epidemic plans and other county documents that guide the delivery of HIV prevention and care services, and maintain a surveillance system in collaboration with the CDPH-OA Sacramento County.

The selected integrated strategies will expand our reach to priority populations in California and impact HIV/HCV/STIs as a syndemic across the continuum of care for these groups. We believe that this plan will result in more people being tested, treated, and being linked to prevention for HIV/HCV/STIs.

Our planning body will continue to monitor the implementation of the ***Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California*** and its family of interventions. We will also continue to engage the community to assure ongoing, real-time feedback so that the interventions are executed optimally for the populations they are serving.

Signed by the Planning Council Co-Chairs on behalf of the entire Part A Planning Body,

HIV Health Services Planning Council - FY22 Allocations
Sacramento TGA Monthly Fiscal Report
Expenditures should be at 58.3% through Sept. 30th

Part A Only

March 1, 2022 - February 28, 2023

EL DORADO COUNTY - September 2022 Service Category	Approved Budget	Current Month	Cumulative Expenses	% Shade	Percentage Used	Remaining Balance
Ambulatory/Outpatient Care	**$ 1,568**	**$0**	**$0**		**0.0%**	**$ 1,568**
Oral Health	**$ 24,673**	**$86**	**$3,512**		**14.2%**	**$ 21,161**
Health Insurance Premium & Cost Sharing Asst.	**$ 4,849**	**$65**	**$453**		**9.3%**	**$ 4,396**
Medical Case Management	**$ 140,000**	**$9,416**	**$74,898**		**53.5%**	**$ 65,102**
Medical Transportation Services	**$ 2,266**	**$468**	**$2,778**		**122.6%**	**$ (512)**
Emergency Financial Assistance	**$ 11,845**	**$990**	**$9,721**		**82.1%**	**$ 2,124**
Sub-Total El Dorado Counties	**$ 185,201**	**$11,024**	**$91,361**		**49.3%**	**$ 93,840**

PLACER COUNTY - September 2022 Service Category	Approved Budget	Current Month	Cumulative Expenses	% Shade	Percentage Used	Remaining Balance
Ambulatory/Outpatient Care	**$ 1,540**	**$0**	**$0**		**0.0%**	**$ 1,540**
Oral Health	**$ 2,329**	**$0**	**$0**		**0.0%**	**$ 2,329**
Health Insurance Premium & Cost Sharing Asst.	**$ 4,869**	**$0**	**$0**		**0.0%**	**$ 4,869**
Medical Case Management	**$ 127,728**	**$10,532**	**$76,927**		**60.2%**	**$ 50,801**
Medical Transportation Services	**$ 18,391**	**$1,815**	**$12,582**		**68.4%**	**$ 5,809**
Emergency Financial Assistance	**$ 33,240**	**$2,530**	**$26,041**		**78.3%**	**$ 7,199**
Sub-Total Placer County	**$ 188,097**	**$14,877**	**$115,550**		**61.4%**	**$ 72,547**

Missing Invoices
None

		September
Under 5%		**0-52%**
Within 5%		**53-63%**
Over 5%		**64% - Over**

TGA Direct Service Expenditures by $ Source	Approved Budget	Current Month	Accumulative Expenditures	% Shade	% Used	Remaining Balance
Part A	**$2,806,518**	**$203,547**	**$1,529,398**		**54.49%**	**$1,277,119**
Part A MAI	**$184,177**	**$23,286**	**$138,347**		**75.12%**	**$45,830**

Total Part A: 75/25 Expenditure Requirement	Allocations	Current	Cumulative	% of Alloc.	% Current Expenditure	% Cumulative
Core Services (Does not include MAI MCM)	$2,639,830	$211,910	$1,488,632	88.3%	93.4%	89.3%
Support Services	$350,805	$14,922	$179,114	11.7%	6.6%	10.7%

HIV Health Services Planning Council - FY22 Allocations
Sacramento TGA Monthly Fiscal Report
Expenditures should be at 58.3% through Sept. 30th

Part A Only

March 1, 2022 - February 28, 2023

Priority Number

	SACRAMENTO COUNTY - Sept. 2022 Service Category	Approved Budget	Current Month	Cumulative Expenses	% Shade	Percentage Used	Remaining Balance
1	**Ambulatory/Outpatient Care**	**$ 439,296**	**$22,487**	**$252,739**		**57.53%**	**$186,557**
	SS: Ambulatory/Outpatient Medical Care	$ 381,898	$22,487	$217,548		56.97%	$164,350
	SS: Vendor paid viral/load resistance lab test	$ 57,398	$0	$35,191		61.31%	$22,207
2	**AIDS Pharmaceutical Assistance**	Not Funded at this Time					
3	**Health Insurance Prem. & Cost Sharing Asst.**	**$ 10,821**	**$1,632**	**$1,632**		**15.08%**	**$9,189**
4	**Oral Health**	**$ 356,117**	**$33,639**	**$188,890**		**53.04%**	**$167,227**
5	**Medical Case Management**	**$ 907,955**	**$82,791**	**$545,925**		**60.13%**	**$362,030**
	SS: MAI	$ 184,117	$23,286	$138,347		75.14%	$45,770
	SS: Office Based Services inc. Pediatric Treatment Adherence	$ 355,487	$32,145	$237,733		66.88%	$117,754
	SS: Field/In-Home Services	$ 350,557	$23,315	$163,195		46.55%	$187,362
	SS: Case Mgmt. Child Care	$ 17,794	$4,046	$6,649		37.37%	$11,145
6	**Case Management (Non-Medical)**	**$ 54,582**	**$0**	**$22,933**		**42.02%**	**$31,649**
7	**Food Bank/Home Delivered Meals**	Funded by Part B					
8	**Mental Health Service**	**$ 399,764**	**$35,298**	**$245,414**		**61.39%**	**$154,350**
10	**Medical Transportation Services**	**$ 65,079**	**$2,233**	**$43,469**		**66.79%**	**$21,610**
11	**Substance Abuse Services - Outpatient**	**$ 201,661**	**$15,965**	**$97,051**		**48.13%**	**$104,611**
12	**Substance Abuse Services - Residential**	**$ 63,408**	**$0**	**$24,284**		**38.30%**	**$39,124**
13	**Housing**	**$ 21,861**	**$0**	**$1,373**		**6.28%**	**$20,488**
14	**Child Care Services**	**$ 30,931**	**$2,153**	**$12,243**		**39.58%**	**$18,688**
15	**Emergency Financial Assistance**	**$ 20,362**	**$1,705**	**$4,936**		**24.24%**	**$15,426**
16	**Medical Nutritional Therapy**	**$ 16,660**	**$0**	**$1,191**		**7.15%**	**$15,469**
17	**Health Education/Risk Reduction**	**$ 11,334**	**$1,309**	**$4,785**		**42.22%**	**$6,549**
18	**Outreach Services**	**$ 17,506**	**$1,720**	**$13,970**		**79.80%**	**$3,536**
19	**Outreach Services MAI**	Funded by Part B					
	Sub-Total Sacramento County	**$2,617,337**	**$200,932**	**$1,460,834**		**55.81%**	**$1,156,502**
	Sub-Total TGA Direct Service Expenditures	**$ 2,990,635**	**$226,833**	**$1,667,746**		**55.77%**	**$1,322,889**
	Recipient - Grantee Admin	**$ 351,840**	**$28,601**	**$153,357**		**43.59%**	**$198,483**
	Recipient - Quality Mgmt	**$ 175,919**	**$10,834**	**$59,442**		**33.79%**	**$116,477**
	Grand- Total Direct Services, Recipient	**$ 3,518,394**	**$266,267**	**$1,880,545**		**53.45%**	**$1,637,848**

Missing Invoices

		September
Under 5%		**0-52%**
Within 5%		**53-63%**
Over 5%		**64% - Over**

HIV Health Services Planning Council - FY22 Allocations
Sacramento Part B Expenditures through Sept. 2022
Expenditures should be at 58.3%

Part B Only

March 1, 2022 - February 28, 2023

YOLO COUNTY - September 2022 Service Category	Approved Budget	Current Month	Cumulative Expenses	% Shade	Percentage Used	Remaining Balance
Ambulatory/Outpatient Care						
Health Insurance Premium & Cost Sharing Asst.						
Oral Health	$ 2,500	$0	$0		0.0%	$ 2,500
Medical Case Management	$ 130,744	$5,691	$45,870		35.1%	$ 84,873
Medical Transportation Services	$ 3,094	$360	$1,330		43.0%	$ 1,763
Housing						
Emergency Financial Assistance	$ 1,002	$0	$1		0.1%	$ 1,001
Food Bank/Home Delivered Meals	$ 5,465	$300	$2,565		46.9%	$ 2,900
Sub-Total Yolo County	$ 142,804	$6,351	$49,767		34.9%	$ 93,037

Missing Invoices
None

		September	
Under 5%		0-52%	Underspending
Within 5%		53-63%	On Target
Over 5%		64% - over	Overspending

Total Part B Expenditures

TGA Direct Service Expenditures by $ Source	Approved Budget	Current Month	Cumulative Expenditures	% Shade	% Used	Remaining Balance
Part B	$ 1,224,819	$ 85,582	$ 652,842		53.30%	$571,977
Part B MAI	$ 43,569	$ -	$ 8,637		19.82%	$ 34,932

HIV Health Services Planning Council - FY22 Allocations
Sacramento Part B Expenditures through Sept. 2022
Expenditures should be at 58.3%

Part B Only

March 1, 2022 - February 28, 2023

Priority Number

	SACRAMENTO COUNTY - September 2022 Service Category	Approved Budget	Current Month	Cumulative Expenses	% Shade	Percentage Used	Remaining Balance
1	**Ambulatory/Outpatient Care**	**$ 398,612**	**$22,431**	**$211,339**		**53.0%**	**$ 187,272**
	SS: Ambulatory/Outpatient Medical Care	$ 398,612	$22,431	$211,339		**53.0%**	**$ 187,272**
	SS: Vendor paid viral load resistance lab test	Funded by Part A					
2	**AIDS Pharmaceutical Assistance**	Not Funded at this Time					
3	**Health Insurance Prem. & Cost Sharing Asst.**	Funded by Part A					
4	**Oral Health**	**$ 253,097**	**$ 18,434**	**$ 148,057**		**58.5%**	**$ 105,040**
5	**Medical Case Management**	**$ 57,326**	**$6,721**	**$30,372**		**53.0%**	**$ 26,954**
	SS: MAI	Funded by Part A					
	SS: Office Based Services inc. Pediatric Treatment Adherence	$ 12,000	$ 2,566	$ 2,566		**21.4%**	**$ 9,434**
	SS: Field/In-Home Services	$ 34,479	$ 4,155	$ 26,252		**76.1%**	**$ 8,227**
	SS: Case Mgmt. Child Care	$ 10,847	$ -	$ 1,554		**14.3%**	**$ 9,293**
6	**Case Management (Non-Medical)**	**$ 73,876**	**$ 7,441**	**$ 36,947**		**50.0%**	**$ 36,928**
7	**Food Bank - Part B Only**	**$ 11,982**	**$ 2,150**	**$ 6,100**		**50.9%**	**$ 5,882**
8	**Mental Health Services**	**$ 79,272**	**$ 1,958**	**$ 46,315**		**58.4%**	**$ 32,957**
9	**Psychosocial Support Services**	Not Funded at this Time					
10	**Medical Transportation Services**	**$ 113,991**	**$ 17,489**	**$ 80,152**		**70.3%**	**$ 33,838**
11	**Substance Abuse Services - Outpatient**	Funded by Part A					
12	**Substance Abuse Services - Residential**	Funded by Part A					
13	**Housing**	**$ 15,340**	**$0**	**$8,268**		**53.9%**	**$ 7,073**
14	**Child Care Services**	Funded by Part A					
15	**Emergency Financial Assistance**	Funded by Part A					
16	**Medical Nutritional Therapy**	**$ 53,220**	**$ -**	**$ 9,701**		**18.2%**	**$ 43,519**
17	**Health Education/Risk Reduction**	**$ 25,300**	**$ 2,608**	**$ 25,823**		**102.1%**	**$ (523)**
18	**Outreach Services**	Funded by Part A					
19	**Outreach Services MAI - Part B Only**	**$ 43,569**	**$ -**	**$ 8,637**		**19.8%**	**$ 34,932**
20	**Linguistic Services**	Not Funded at this Time					
21	**Home & Community Based Health Services**	Not Funded at this Time					
22	**Home Health Care**	Not Funded at this Time					
23	**Hospice**	Not Funded at this Time					
24	**Legal Services**	Not Funded at this Time					
25	**Permanency Planning**	Not Funded at this Time					
26	**Referral for Health Care & Support Services**	Not Funded at this Time					
27	**Rehabilitation Services**	Not Funded at this Time					
28	**Respite Care**	Not Funded at this Time					
29	**ADAP**	Not Funded at this Time					
30	**Early Intervention Services**	Not Funded at this Time					
	Sub-Total Sacramento County	**$1,125,584**	**$79,231**	**$611,712**		**54.3%**	**$513,872**
	Sub-Total TGA Direct Service Expenditures	**$1,268,388**	**$85,582**	**$661,479**		**52.2%**	**$606,909**

	Recipient - Grantee Admin	**$ 131,841**	**$15,307**	**$74,918**		**56.82%**	**$56,923**
	Recipient - Quality Mgmt	**$ 63,853**	**$5,203**	**$29,416**		**46.07%**	**$34,437**
	Grand- Total Direct Services, Recipient	**$ 1,464,082**	**$106,093**	**$765,814**		**52.31%**	**$698,269**

Missing Invoices

September			
Under 5%		0-44%	Underspending
Within 5%		45-55%	On Target
Over 5%		56% - Over	Overspending

Sacramento County
Department of Health Services
HIV Health Services Planning Council
www.sacramento-tga.com

Meeting Agenda

Dec 14, 2022, 10:00 AM – 12:00 PM

Meeting Location –Via teleconference. No in-person meeting.
Join Zoom Meeting
https://www.zoomgov.com/j/1618963027?pwd=RllXRExTczFmbmpnMW0xTWxtd2lkUT09

Telephone Number: 1 (669) 254-5252 (San Jose, CA)
Meeting ID: 161 896 3027 **Passcode: 983445**

Facilitator: Richard Benavidez, Council Chair

Scribe: Danielle Caravella, County Staff

Meeting Invitees:

- HIV Health Services Planning Council Members
- Open to the Public

Public Comment: This provides opportunities for the public to address the Council as a whole in order to listen to opinions regarding matters within the jurisdiction of the Council during Regular meetings and regarding items on the Agenda at all other meetings.

*Action Items

Topic	Presenter	Start Time and Length
Welcome and Introductions	Benavidez	10:00 am
Announcements	All	As
Public Comments	Benavidez	
December 2022 Agenda*	Benavidez	

Sacramento County
Department of Health Services
HIV Health Services Planning Council
www.sacramento-tga.com

Minutes of September 2022*	Benavidez	Needed
State Office of AIDS November 2022 Update	Lee/Pulupa	
CPG/HIV/STI Prevention Updates	All	
Recipient Report: ➢ FY22 October Part A Monthly Fiscal Report* ➢ FY22 October 2022 Part B Monthly Fiscal Report ➢ SOA Ending the HIV Epidemic Update ➢ HRSA Part A Ending the Epidemic Update ➢ RFP Update	Gossett	
Committee/Work Group Updates: Administrative Assessment Committee Affected Communities Committee ➢ Reflectiveness Priorities and Allocations Quality Advisory Committee Needs Assessment Committee Governance	Willett Zach B. Bradley-Rowe Kendricks-Clark Benavidez Miranda Ungeheuer	As Needed
Binder Updates	Gammell	
Public Comments – Non-Agenda Items	Benavidez	
Technical Assistance	Benavidez	
Adjournment	Benavidez	12:00 pm

Attachments:
- Minutes of September 2022*
- October & November 2022 OA Voice Update
- FY22 October Part A Fiscal Report*
- FY22 October Part B Fiscal Report
- FY22 Q2 Recipient Report

NEXT MEETING: January 25, 2023