California Integrated HIV Prevention and Care Plan, Including the Statewide Coordinated Statement of Need, CY 2027–2031

California Department of Public Health
Center for Infectious Diseases
Office of AIDS

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CDPH
California Department of Public Health

California Integrated HIV Prevention and Care Plan, including Statewide Coordinated Statement of Need, CY 2027- 2031

Prepared by:
Dr. Marisa Ramos and LeRoy Blea
Office of AIDS
Center for Infectious Diseases
California Department of Public Health
And

In partnership and co-authorship with:
Alameda County/Oakland Transitional Grant Area
Alameda County Health Department
Contra Costa County Health Services

Los Angeles County/Los Angeles Eligible Metropolitan Area
Los Angeles County Department of Public Health, Division of HIV and STD Programs

San Bernardino County/Inland Empire Transitional Grant Area
Riverside University Health Systems (Riverside County Public Health)
San Bernardino County Department of Public Health

Sacramento County/Sacramento Transitional Grant Area
Sacramento County Department of Health and Human Services
El Dorado County Public Health Division
Placer County Department of Health and Human Services
Yolo County Health and Human Services Agency

Santa Clara County/ San Jose Transitional Grant Area
Santa Clara County Public Health Department

San Francisco County/ San Francisco Eligible Metropolitan Area
San Francisco Department of Public Health
San Mateo County Health Department
Marin County Public Health

In collaboration with the
California Planning Group
Inland Empire HIV Planning Council
Los Angeles Commission on HIV
Oakland Transitional Grant Area Community Collaborative Planning Council
Sacramento Transitional Grant Area HIV Health Services Planning Council
Santa Clara HIV Commission
San Francisco HIV Community Planning Council

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DEDICATION

We dedicate this document to all people working toward a California free of 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. It is through their courageous leadership and collaboration that this vision will be achieved.

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SECTION I: Integrated Plan and Statewide Coordinated Statement of Need (SCSN) Executive Summary

1. Introduction and Approach

The California Department of Public Health (CDPH) is pleased to submit to the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) the California Integrated HIV Prevention and Care Plan (Integrated Plan) for calendar years (CY) 2027-2031, including our integrated Statewide Coordinated Statement of Need (SCSN). This plan showcases our collaborative and coordinated approach, informed by sound data analysis and community engagement and input, to develop strategies to make progress towards meeting the goals and priorities set out by the national HIV/AIDS strategies through 2030. This plan addresses the broader needs of California and the following Ryan White HIV/AIDS Part A jurisdictions: the Alameda and Contra Costa County/Oakland Transitional Grant Area (TGA), Riverside and San Bernardino County/Inland Empire TGA, Sacramento County/Sacramento TGA, Santa Clara County/San Jose TGA, Los Angeles County (EMA), and San Francisco County/San Francisco EMA. This collaboration of co-author jurisdictions represents a **collective action group**: working together to address in a more coordinated way, a common set of strategies impacting HIV health outcomes in California in a larger way than any one individual health jurisdiction could do on its own.

During the 2022-2026 Integrated Plan planning and implementation cycle, informed by a community-driven process, we began a paradigm shift in HIV-work in California: a long-term process of addressing HIV not as a condition on its own, but as a together as a **syndemic** with other Sexually Transmitted Infections (STIs) and Hepatitis C virus (HCV) though a social drivers of health lens.

Addressing HIV, HCV, and STIs together is powerful, because these issues affect many of the same people and communities. 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.

Over the last five years we have made some progress in this work, but California and its co-author jurisdictions consider this paradigm-shift to be a long-term strategy and investment. Thus, we developed California's 2027-2031 Integrated Plan as an update and revision to the 2022-2026 plan.

California's 2022-2026, and now its 2027-2031 Integrated Plan address the syndemic of HIV, HCV, and (STIs) in California through our core strategies that reduce new HIV infections by ensuring that all people living with HIV are diagnosed as early as possible; all people diagnosed with HIV are treated rapidly and effectively to reach sustained viral suppression; new HIV transmissions are prevented using evidence-based pharmacological and behavioral activities; and that we respond quickly to potential outbreaks, getting needed prevention and treatment services to people who need them the most. Through these strategies we have made progress, but as this plan will discuss, not enough progress, and not rapidly enough for all Californians.

Figure 1. Integrated Plan Goals

California's Integrated Plan addresses the following four goals:

1. Preventing new HIV infections by identifying all individuals potentially living with HIV
2. Improving HIV-related health outcomes for all Californians
3. Using a syndemic approach to achieve integrated, coordinated efforts that address the HIV, HCV, and STI epidemics synergistically
4. Addressing social drivers that impact health outcomes

We envision a California free of new HIV, HCV, and STI infections, where all people with these conditions can easily obtain the services and resources needed to live healthy, dignity-filled lives free of stigma. Quantitative and qualitative data continuously maintains that differences in HIV, HCV, and STI-related outcomes persist among specific populations and subgroups, and that social drivers of health are fundamental factors influencing health differences. In order to remove barriers to effective HIV, HCV, and STI prevention, care, treatment and sustained well-being, it is essential to expand beyond a biomedical approach and fully integrate social drivers of health into actionable strategies. The overview of these strategies is presented in **Section V** of this document.

To this end, CDPH proposes to continue a set of ambitious goals and strategies that leverage all available HIV prevention and care funding streams, utilizes existing public health measures and initiatives to guide our efforts, and collaborates with many partners throughout California to implement evidence-based strategies to achieve the vision set forth by national HIV/AIDS goals. The strategies proposed throughout this plan align public and private sectors, as well as nontraditional partners, to leverage strengths, resources, and opportunities to center evidenced-based strategies in our work and improve health outcomes among those most affected by HIV, HCV, and STIs in California. It is a cutting-edge plan that both honors the great work already happening throughout California and pushes us to redefine success and center those who traditionally have been underserved by our systems. It is organized around the four pillars established by the Ending the HIV Initiative: A Plan for America. These pillars are designed to address the full continuum of HIV from those at risk to people who are living with HIV and so they address the strategies suggested by the CDC and HRSA to prevent new HIV infections and to improve HIV-related health outcomes. To have a greater impact, our Integrated Plan aims to address critical social drivers of health including housing, health access for all, mental health and substance use, economic factors, and stigma.

To that end, we have developed this Integrated Plan through a joint effort between CDPH's Office of AIDS (OA), Office of Sexually Transmitted Infections and Hepatitis C (OSH), local health jurisdictions (LHJs), and Part A HIV planning bodies in California. The Integrated Plan was also developed in collaboration with other state programs that serve those at highest risk for HIV, HCV, and other STIs, and involved direct engagement of people living with HIV (PLWH), people at elevated risk for HIV infection, service delivery providers, and other community stakeholders throughout the state, using various community-centered mechanisms to gather input.

This Integrated Plan demonstrates the State of California's commitment 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 barriers that prevent Californians from receiving the care and support they deserve. This plan builds on many years of dedication by people affected by the HIV, HCV, and STI syndemic, as well as public health, health care providers, and other partners across the state.

2. Documents Submitted for SCSN

The following is a list of all source documents and materials referenced to meet submission requirements for the 2027-2031 California Integrated Plan, including content to update existing or newly developed materials for the required sections throughout this plan. Documents listed include a brief summary of the contents and use of each document for the noted Integrated Plan section. California is able to submit more extensive summaries upon request.

Table 1 -Source Documents

Document	Summary	New or Existing	Entity	Associated IP Section
Ending the HIV Epidemic: California Consortium for CDC PS19-1906 (2020-2025)	An innovative plan to achieve the goal of decreasing new HIV infections 90 percent by 2030. This plan was created by the five Part A Planning Councils (Riverside and San Bernardino are considered one joint Transitional Grant Area), selected staff from each county, and through extensive community input and engagement.	Existing	– California Department of Public Health – Alameda County – Orange County – Riverside County – Sacramento County – San Bernardino County – San Diego County	SCSN
Ending the Epidemics: Collective Strategies for Addressing HIV, Hepatitis C, and Sexually Transmitted Infections in San Francisco	An innovative plan to achieve the goal of decreasing new infections by 75 percent in San Francisco. This plan was created by a broad coalition of city government and community stakeholders in San Francisco.	Existing	– San Francisco Department of Public Health	SCSN
Ending the HIV Epidemic In Los Angeles County (2020-2025)	An innovative plan to achieve the goal of decreasing new infections by 75 percent in Los Angeles. This plan was created by a broad coalition of city government and community stakeholders in Los Angeles.	Existing	– Los Angeles County Department of Public Health	SCSN
ENDING THE EPIDEMICS: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California-	A plan framed around social drivers of health for a statewide collaborative, harm reduction approach to preventing and treating HIV, hepatitis C virus (HCV), and sexually transmitted infections (STIs) in California.	Existing	– California Department of Public Health	SCSN

Integrated Statewide Strategic Plan, 2022-2026				
Ending the Epidemics: Implementation Blueprint	A comprehensive workbook meant to support individual Local Health Jurisdictions further develop their efforts to address the social drivers impacting HIV, HCV and STI health outcomes in California. This workbook was developed through extensive community engagement from all regions in California and by all co-author counties to this Plan.	Existing	- California Department of Public Health	
California HIV Surveillance Report - 2023	The California HIV Surveillance Report is published annually by the California Department of Public Health, Center for Infectious Diseases, Office of AIDS, Sacramento, California.	Existing	- California Department of Public Health Office of AIDS, Surveillance Branch	Epi Snapshot, SCSN
HIV/AIDS Epidemiology in California - 2023	The HIV/AIDS Epidemiology and Health Disparities Report, published by the Office of AIDS (OA), provides detailed information on the HIV/AIDS epidemic in California and examines gaps in health outcomes across various groups. This report highlights differences in HIV burden and health outcomes by sex, race/ethnicity, and transmission category. Data in this report are intended to be used by OA, and community partners to identify needs, gaps, and the status of the HIV/AIDS epidemic in the state to form strategies to continue to address the epidemic and reduce or eliminate gaps in HIV health outcomes.	Existing	- California Department of Public Health Office of AIDS, Surveillance Branch	Epi Snapshot SCSN
HIV and Homelessness in California - 2023	An infographic analyzing continuum of care data for unhoused individuals newly diagnosed with HIV in 2023.	Existing	- California Department of Public Health Office of AIDS, Surveillance Branch	Epi Snapshot, SCSN

California AIDS Drug Assistance Program (ADAP) Annual Report: State Fiscal Year 2023–2024	A report that summarizes the outcomes of the California AIDS Drug Assistance Program (ADAP). ADAP was established in 1987 to help ensure that uninsured and underinsured people living with HIV/AIDS have access to life-saving medications. ADAP receives federal funds from the U.S. Health Resources and Services Administration through grants provided by Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009.	Existing	- California Department of Public Health Office of AIDS, ADAP Branch	SCSN
Epidemiology of HIV in California, 2017–2021	This report, although it reviews the epidemiology trends from 2017-2021, was published in 2022 and was developed in part to analyze the impacts of the major strategies in California to impact HIV health outcomes. One theme of this report is we have made progress, but not enough for all communities.	Existing	- California Department of Public Health Office of AIDS, Surveillance Branch	SCSN
HIV and Women in California - Infographic - 2025	A community-friendly infographic that presents key prevention and care data about women in California. This was a product of the Women's Subcommittee of the Part B advisory body: the California Planning Group.	Existing	- California Planning Group Women's Committee, and the California Department of Public Health Office of AIDS, Prevention Branch	SCSN
Viral Suppression Rates of Medi-Cal Enrollees with HIV, 2023	This analysis calculated the annual HIV viral load suppression indicator for the Medi-Cal population. Viral suppression rates among Medi-Cal enrollees continue to exceed the statewide average for people living with HIV.	Existing	- California Department of Health Care Services in collaboration with the California Department of Public Health, Office of AIDS	SCSN
Master Plan for Aging Initiatives Report 2025	Document summarizing the Master Plan for Aging Initiatives 2025-2026. The Master Plan for Aging (MPA) is a 10-year blueprint that reflects California's future	Existing	- California Health & Human Services Agency, California Department of Aging	Situational Analysis

	vision of and commitment to an age- and ability-forward state. Housing, transportation, and other social drivers of healthy aging are noted as key themes.			

SECTION II: Community Engagement and Planning Process

1. Jurisdiction Planning Process

The community engagement and planning for this Integrated Plan were marked by an especially chaotic policy and funding environment that left a good deal of uncertainty as to what types of work would be allowed. Given this, California and its co-author counties decided to leverage their considerable ongoing community engagement efforts that occurred during the 2022-2026 Integrated Plan implementation cycle. These community engagement efforts included the ongoing community engagement done as a requirement of implementing the Ending the HIV Epidemic Initiative.

California has 8 Ending the HIV Epidemic (EHE) jurisdictions. During the creation of the initial EHE plans in 2020-2025, the COVID-19 pandemic was disruptive to community engagement activities, as in-person community engagement forums became restricted. Despite the challenges, counties throughout California were agile and quickly adapted to use of virtual platforms to proceed in creating their plans. A set of alternative community engagement approaches were developed to ensure that those with limited or no access to the internet or cell phone service could also provide input. Community members provided input by completing surveys, participating in key informant interviews, and through teleconferences with HIV medical and service providers, who continued to provide needed services despite the pandemic. Several engagement activities were conducted using Spanish translation, along with some mono-lingual Spanish events. Although the priority populations varied between counties, members from 10 identified priority communities were successfully engaged in the formation of the EHE plans. After the COVID-19 pandemic subsided, virtual community engagement work has continued to augment in-person strategies through the process of implementing EHE work in California.

Figure 2 Priority Populations

A combined list of priority populations involved in California's community engagement efforts, includes the data-identified groups most impacted by HIV/HCV/STIs:

- People disproportionately impacted
- Young people (15-29)
- Men who have sex with men
- People experiencing homelessness
- People who are incarcerated or justice involved
- Women
- People Aging with HIV, Older Adults with HIV

Beyond the EHE plans and ongoing community engagement efforts that focused on 8 Phase I counties (including San Francisco and Los Angeles), during the 2022-2026 implementation of the Integrated Plan California continued a comprehensive strategic planning process to further develop our statewide approach to ending the HIV, HCV, and STI syndemic through the development of an Implementation Blueprint.

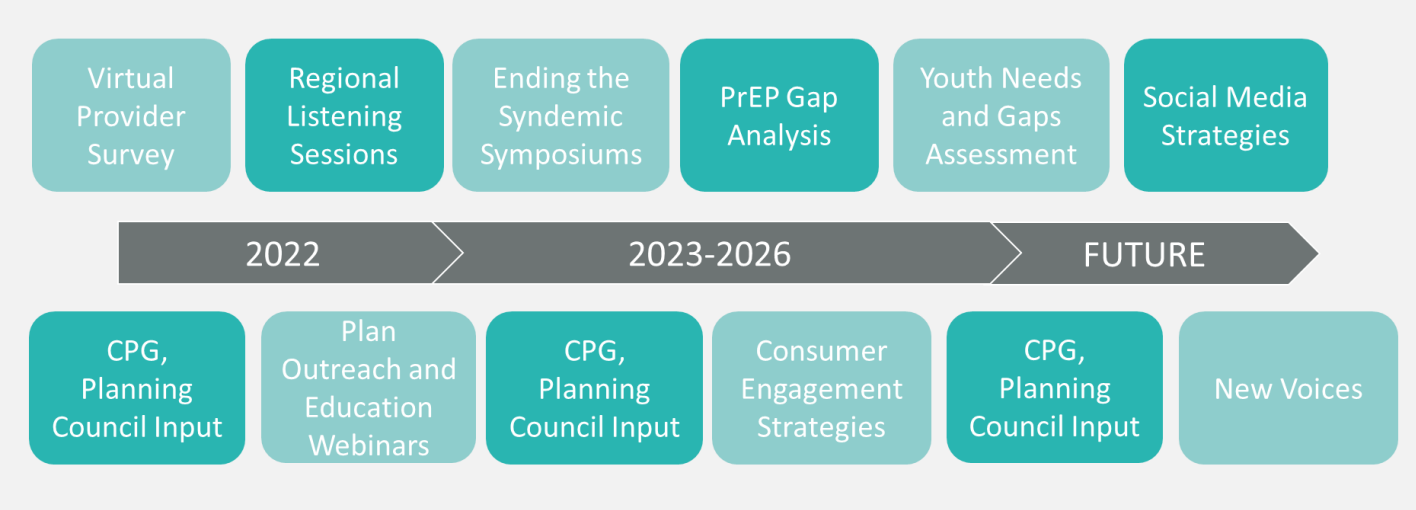
In addition to ongoing EHE community engagement activities, other community engagement efforts were conducted to:

- reach out to a wide range of people across the state to ask for ideas on how California should be responding to the overlapping HIV, HCV, and STI epidemics;

- use those ideas to decide what we can do to make it easier for people to avoid getting HIV, HCV, and STIs, and what activities are most important to support the health of people in California when they have HIV, HCV, and/or STIs; and
- summarize these ideas into a high-level plan with associated strategies.

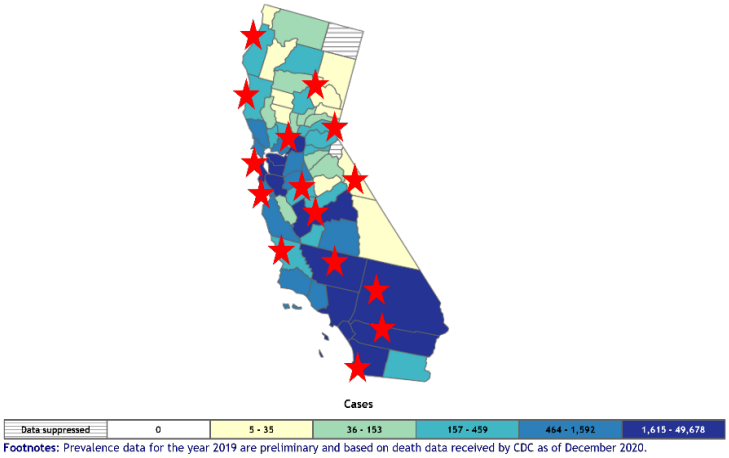
Figure 3 is an overview of selected community engagement strategies used in the development of this Integrated Plan.

Figure 3. Community Engagement Strategies



Regional Listening Sessions. In 2022, CDPH and Facente Consulting partnered with local jurisdictions to develop an implementation blueprint to assist local partners to successfully implement the 30 innovative strategies prioritized in the high-level strategic plan. To do this, we developed a multi-tier approach to community engagement and planning that involved individual meetings with local health jurisdictions, local HIV planning bodies, a virtual townhall held on April 14, 2022, which was attended by over 400 California constituents, 16 regional in-person community listening sessions throughout California planned in partnership with local health jurisdictions (see stars on map to left), and various virtual sessions with key partners throughout the state, including consumers, community-based organizations, pharmaceutical companies, local hospital or clinic staff, medical staff from correctional facilities, and other non-traditional partners, to ensure as many diverse groups and stakeholders as possible. In total more than 300 individuals provided direct input through these listening sessions held in summer of 2022.

Figure 4. Listening Sessions Overlay with HIV Prevalence



Each jurisdiction has involved their planning bodies and individual community engagement groups at each stage of the Integrated Plan development process. Check-in points were built-in throughout the process to ensure consensus from all parties, especially the statewide workgroup, before moving to the next stage of plan development. OA staff presented a summary of the plan prior to seeking concurrence from each of the Part A Transitional Grant Area/Eligible Metropolitan Area (TGA/EMA) planning councils and responded to questions, inquiries, and suggestions throughout the planning period

before final submission. Additionally, Part A and B grantees have been instrumental partners in the development of the blueprint documents that support and guide the implementation of the proposed strategies at the local level.

This Integrated Plan is an active working document, and as such will be reviewed and updated annually, or as needed, to ensure compliance and that key indicators are met throughout the state. The process will include the identification of relevant data, analysis of data on performance measures, a review of activities and strategies, a mechanism to revise goals and objectives as needed based on data, and an evaluation of the planning process by state and local HIV planning bodies. Providing ongoing opportunities for community input will additionally allow the State and its co-authors from local health jurisdictions to provide, monitor, and modify interventions as needed, and to ensure the success of the Integrated Plan.

A. Entities Involved in the Planning Process

California is strongly committed to the involvement of stakeholders and other key partners in the planning and implementation of strategies to prevent HIV transmission, HCV, and STI, as well as care for Californians living with HIV. To that end, we have developed this Integrated Plan through a joint effort between OA, local health jurisdictions, and HIV planning bodies in California, in collaboration with other state programs that serve the residents of California. **Exhibit 1** below is a comprehensive list that identifies the types of entities involved in the planning, engagement, and development process of the California Integrated Plan from 2022 through 2026.

Exhibit 1 also includes a summary of selected community engagement activities that are being put forward as California's and its co-author county partners community engagement activities used to develop this updated Integrated Plan. The Exhibit lists the date of the event, a brief description of the event, and an overview of the participants at each event.

Exhibit 1. **Summary of California selected community engagement activities.**

EVENT	DESCRIPTION	VOICES & PARTNERS
COMPLETED ACTIVITIES		
	All California	
PrEP Gap Analysis Listening Session September 17, 2025	A community forum to share and gather input on persistent gaps of PrEP use by populations most impacted by HIV and California. An initial participant poll indicated representation from each EHE priority county and a third indicated working in other California counties. Among the participants who shared information on communities they serve, a majority documented service across diverse communities. This includes LGBQ, transgender, gender expansive, and intersex individuals, as well as women, youth, and young adults. People who use drugs, experience homelessness and/or those who engage in sex work were also represented in these focal communities.	***Participants:*** *Reaching 145 registrants that included HIV planning body members, PrEP providers, public health staff.*
The Ending the Syndemic Symposium **2023** June 22-23, 29-30 **2024** Sept. 30, Oct. 1-2 **2025** Sept. 23-25	The Ending the Syndemic Symposium is sponsored by CDPH-OA annually offers an opportunity for California Counties and their funded Community Programs and partners to share best practices and innovations in serving the communities most impacted by HIV, HCV, and STIs. This symposium was held annually from 2023-2025. The themes of the Symposium rotated each year to explore key social drivers of health identified in the Integrated Plan: housing, health access, mental health and substance use, economic factors and stigma. Symposium materials are made available to partners to strengthen their syndemic work. Evaluation data of these events show wide participation from every Part A/EHE jurisdiction in California.	***Participants****: Reaching 150-300 participants per year, attendees and presenters include PLWH and others with lived experience, HIV/STI/HCV prevention service providers, public health staff, and harm reduction and housing providers.*
Virtual Provider Survey **2022** April-June	Provider needs assessment (n=130) respondents to the Needs Assessment survey released in 2022, 40% represented the Southern California region, and 60% represented the Central and Northern regions of California.	***Participants:*** *HIV prevention and care service providers; housing and mental health supportive services providers.*

EVENT		
Regional Listening Sessions **2022** **May 9** **May 10** **May 11** **May 12** **May 24** **May 25** **May 26** **May 31** **June 1** **June 2** **June 28** **June 29** **June 30** **July 6** **July 7** **July 8** **July 12** **July 13** **July 14**	California launched a series of 17, regional, 2-3 hour, community meetings to inform the development of a statewide strategy to end the HIV, HCV, and STI epidemics in California. Officials from local health departments, academic institutions, community-based organizations, State Office of AIDS staff, community members and advocacy groups attended to have their voices heard. The goal was to gather community input on what a future comprehensive strategy for the state should include. Recommendations from these meetings were used to help create the states Ending the Epidemics Integrated Statewide Strategic Plan and subsequent Ending the Epidemics: Implementation Blueprint. Together, these documents outline the states response to the epidemic 2022-2026. Additionally, the implementation blueprint offers counties and jurisdiction a roadmap to implementation.	***Participants**: HIV planning councils, local public health department staff, CDPH-OA and OSH, HIV/HCV/STI service providers, PLWH and others with lived experience.*
Social Media Strategies **2022-2025**	Continuous community engagement to link priority populations to integrated testing for HIV, HCV and other STIs as well as and other status neutral services. Implementation of these social media strategies has improved California's use of social media strategies to reach priority population that do not access services through traditional means.	***Participants:** Clients linking to services via social media sites that provide information about their experience. California public health departments that link their services to referral pages for social media campaigns.*

EVENT		
California Planning Group Meetings **2022-2025** Spring and Fall	The California Planning Group (CPG): HIV, STD, Hepatitis C & Harm Reduction is the statewide HIV planning body convened by the California Department of Public Health, Office of AIDS (OA), in collaboration with the Sexually Transmitted Disease Control Branch (STDCB), that enables key partners, communities, and providers to engage in active, ongoing dialogue to advise OA and STDCB on community needs and gaps, and to reach the goals of the Ending the Epidemics Integrated Statewide Strategic Plan.	***Participants:*** *California Planning Group members, HIV planning council representatives, community participants and staff from OA and OSH who regularly attend and support its work.*
CPG Women's Committee Meetings **2025** **Monthly**	The CPG Women's Committee is dedicated to addressing disproportionate impacts in women, especially women of color, in relation to HIV, STIs, HCV. Through education, representation, and advocacy, the committee develops practical tools and resources and provides expert guidance and feedback on issues that impact women living with HIV and who are disproportionately impacted by HIV. Their work is centered on empowering and uplifting the voices of women in their communities.	***Participants:*** *Currently, the committee has 13 CPG members – all who have lived experience and/or professional experience in HIV, STI, HCV, and/or harm reduction. The committee has two co-chairs and is supported by two OA liaisons, one OSH liaison, and the State Co-Chairs.*
CPG HIV and Aging Committee Meetings **2025** **Monthly**	The HIV and Aging Committee supports the California Planning Group (CPG) by identifying best practices, consulting with experts, and sharing emerging knowledge on issues affecting people living with or at risk for HIV. The committee participates in statewide meetings, distributes educational opportunities to CPG members, and addresses the needs of people living with or at risk for HIV over the age of 50, with attention to cultural, social, and health differences. It also reviews statewide planning efforts, identifies gaps in federal guidance, highlights behavioral health needs, and promotes collaboration across HIV, aging, behavioral health, housing, and -community-based systems.	***Participants:*** *California Planning Group members, HIV planning council representatives, community participants and staff from OA and OSH who regularly attend and support its work.*
CPG Youth Committee Meetings **2025** **Monthly**	The CPG Youth Committee is dedicated to addressing the HIV prevention needs of youth through reviewing youth-related data, strategies and services and making recommendations about how to best improve health outcomes for youth.	***Participants:*** *California Planning Group members, HIV planning council representatives, community participants, youth service providers,*

EVENT		
		and staff from OA and OSH who regularly attend and support its work.
California Prevention Priorities Assessment **2026** February	In February and March (2026), prevention partners were solicited for consultation on what the priorities should be for future special funding prevention initiatives released from CDPH OA. This feedback suggested the following: a syndemic approach, whole-person care; focus on non-traditional settings or Street Medicine. Priority population(s): those who have financial barriers to care (uninsured/underinsured), individuals who are unhoused/unsheltered, PWUD, and data-supported underserved PLWH.	***Participants****: Community based organizations, local health department staff, HIV prevention service providers*
Adolescent Sexual Health Workgroup (ASHWG) **Quarterly**	ASHWG is an organized collaborative that aims to bridge the gap between governmental agencies, community-based organizations, and other statewide collaborators to work more effectively in addressing the sexual and reproductive health of California adolescents, which includes HIV and STI prevention practices. ASHWG meets quarterly, sharing program updates as it relates to sexual and reproductive health access and education, legislative updates, and resource sharing across government and non-governmental organizations.	***Participants:*** *Public health staff, community-based organizations focused on youth-focused sexual and reproductive health, youth advocacy groups.*
School-based Youth Prevention Providers Needs Assessment **2025** **July-December**	As part of our state-wide Condom Availability Program, we conducted a needs assessment that included focus groups with youth and interviews with stakeholders. Across the two youth focus groups of California teens, low income and LGBTQ+ youth were identified as key priority populations. The youth highlighted the need to reduce STIs and unplanned pregnancies as well as increase sexual health knowledge amongst young people. We conducted stakeholder interviews with 11 organizations including school district staff, Title X health centers, on campus health clinics, and state-wide organizations. These interviews highlighted the need for staff training on topics around minor consent laws and youth-centered counseling. Additionally, even where condoms are available, there remains a need for non-latex condoms, demonstration tools, and outreach materials. There	***Participants:*** *Low-income youth, 11 organizations, 11 organizations including school district staff, Title X health centers, on campus health clinics, and state-wide organizations.*

EVENT		
	remains a need for discrete, comprehensive condom distribution for young people.	
Cluster Detection Response Community Advisory Board **2025-2026**	Community members serving 2-years terms to advise CDPH-OA, San Francisco, and Los Angeles on cluster detection and response. CAB meets quarterly with 2-4 ad hoc meetings a year. CAB members are provided stipends for participation.	***Participants:*** *16 community members representing broad expertise in HIV work and lived experience.*
California HIV/STI/HCV Partner Call **2022-2026** Monthly	Monthly the CDPH OA and OSH host a joint call with HIV/HCV/STI syndemic partners across the state. The call develops the agenda from suggestions from community partners as well as providing critical updates across programs. Community members that are part of Part A planning councils attend at times to lend critical perspectives to the dialogue. Direct consumer and community input has resulted in changes to programs, like updates to the ADAP formulary.	***Participants:*** *Any partner involved in ending the syndemic work in California, including consumers and other members of Part A planning councils.*
OA Voice **Monthly**	The OA Voice is a monthly newsletter designed to present key outcomes from across the HIV portfolio of Care and Prevention services funded by California. Outcomes are presented to address progress made across the specific activities organized across the six social determinants of health noted in the Integrated Plan. The OA Voice is sent to a Listserv of over 1,500 partners across California.	***Participants:*** *Any partner involved in ending the syndemic work in California, including consumers and other members of Part A planning councils.*
Alameda		
Prevention Navigation Meetings **2025**	An East Bay Getting to Zero collaborative meeting aimed at gathering input and developing strategies aimed at strengthening the prevention network of providers in Alameda County.	***Participants:*** *PrEP Navigators and frontline prevention staff*
HIV Continuum of Care Meetings **2025** October	An East Bay Getting to Zero collaborative meeting series aimed at improving the HIV services continuum of care in Alameda County.	***Participants:*** *HIV service providers, public health staff*

EVENT		
People Living with HIV Committee **2025**	A committee of the Oakland TGA HIV Planning Council aimed at gathering input from People Living with HIV. This committee leads needs assessment activities for the annual Part A Priority Setting and Allocations	***Participants:*** *Oakland TGA Consumers, PLWH*
Inland Empire		
Consumer Empowerment Committee **2025** **January** **March** **May** **July** **September**	The Inland Empire HIV Planning Council hosts several Consumer Caucuses throughout the year, providing a platform for individuals living with HIV to share their experiences and contribute to the planning of services and resources. These events are crucial for ensuring that the needs of the community are met and that the services provided are effective and responsive to the needs of the population.	***Participants:*** *Consumers, PLWH*
Inland Empire Opioid Crisis Coalition	Coordinated work with the Department of Behavioral Health continues to strengthen integrated service delivery, especially as we remain active participants in the Inland Empire Opioid Crisis Coalition. Through this collaboration, we are enhancing harm reduction efforts and expanding access to prevention tools across the county.	***Participants:*** *Substance use providers, Harm Reduction Providers, Public Health**.***
Los Angeles		
HIV Commission Annual Meeting **2026** **April**	The Commission is comprised of volunteers who reflect the diversity of Los Angeles County, including people living with HIV, health care and social service providers, public health professionals, and community-based and AIDS service organizations. Members bring both lived experience and professional expertise to guide the Commission's work.	***Participants:*** *HIV Commission members, community advocates, public health staff, HIV providers and other providers of supportive services, other community-based organizations.*
HIV and Aging Caucus	The Los Angeles County Commission on HIV (COH) is actively involved in addressing the health needs of older adults living with HIV. The Aging Caucus meets	***Participants:*** *HIV Commission members, community advocates, public health staff, HIV providers and other providers of supportive services,*

EVENT		
	virtually to gather community input and shape the work of the Commission.	*other community-based organizations.*
Black Caucus	The Commission on HIV Black Caucus is dedicated to addressing the data defined disproportionate impact of HIV/AIDS in Black communities through advocacy, community engagement, and health initiatives.	***Participants:*** *HIV Commission members, community advocates, public health staff, HIV providers and other providers of supportive services, other community-based organizations.*
Women's Caucus	The Women's Caucus of the Los Angeles Commission on HIV (COH) is a key component of the Commission's efforts to address the unique needs of women living with HIV. The Caucus convenes several subgroups to gather community input and shape the Commission's work around priority setting, resource allocations, service standards, and improving access to services. The Caucus also focuses on strengthening PLWH voices in HIV community planning.	***Participants:*** *HIV Commission members, community advocates, public health staff, HIV providers and other providers of supportive services, other community-based organizations.*
Prevention Advisory Workgroup **2026** **Bi-monthly**	The Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP) formed a Prevention Advisory Workgroup in April 2026, convening key HIV prevention stakeholders to share knowledge and collaboratively shape the strategic direction of HIV/STD prevention planning and resource allocation in Los Angeles County. Participants include representatives from DHSP, prevention-focused provider agencies, the local Ryan White Planning Council (the Los Angeles County Commission on HIV), and Public Health officials from the Cities of Los Angeles and Long Beach. The workgroup convenes on a bimonthly basis to review latest available data for various prevention modalities and services, ensuring that evidence-based practices and emerging innovations inform how prevention services are planned and funded. In the short-term, the workgroup is focused on identifying which services DHSP should prioritize, particularly identifying critical service gaps that no other entity is positioned to support in a resource-constrained environment.	***Participants:*** *HIV Commission members, community advocates, public health staff, prevention stakeholders, governmental officials Cities of Los Angeles and Long Beach.*

EVENT		
	In the long-term, the workgroup's goal is to develop a more holistic approach to shaping the next generation of prevention services, working closely with other County departments including the Substance Abuse Prevention and Control (SAPC), Department of Mental Health (DMH), and Department of Health Services (DHS) to align programming with shared goals to ensure clients accessing services at these entities are better supported across departments.	
Sacramento		
Affected Communities Committee **2025-2026** **Monthly**	Working in collaboration with the Sacramento HIV Health Services Planning Council, this committee amplifies the voices of those priority populations most impacted by HIV in the TGA. In monthly planning meetings this committee plans special community dialogues focusing on improving prevention and care services. These sessions have highlighted the need to continue to focus on those groups that are not experiencing the same benefits from prevention and care services.	***Participants:*** *Consumers, PLWH, community advocates, HIV providers and other providers of supportive services.*
San Francisco		
Community Engagement 2025-2026	• San Francisco Department of Public Health (SFDPH) collaborated with subcontractor Facente Consulting to collect and analyze data from seven complementary sources: Client/community survey (n = 418) • Community engagement events with key populations (n = 161) • Provider survey (n = 62) • Provider reflection groups (n = 11) • Stakeholder engagement (n = 87) • Budget & contract review • Literature review Client/community surveys and community engagement events with key populations were conducted in 7 languages (English, Spanish, Vietnamese, Traditional Chinese, Khmer, Thai, and Tagalog). These surveys and events were promoted and facilitated in partnership with 7 community	***Participants:*** *Client and community members recruited by community agencies with deep roots and connections with the priority populations named in the plan.* ***Providers. Other stakeholders.***

EVENT		
	agencies selected for their deep connections to one of SF's key populations affected by HIV/HCV/STIs including Black/African American people; Latine people; American Indian or Alaska Native people; Asian, Native Hawaiian, or Pacific Islander people; trans, non-binary, and gender-diverse people; gay, bisexual, and queer men, including men who have sex with men; youth and young adults age 18-24; people who are unhoused; and people who use drugs, including both people engaged in SF's publicly-funded HIV/HCV/STI services and those who are living with or have some risk for HIV, HCV, and/or STIs but are not engaged in this service system. Stakeholder engagement was conducted directly with the following groups: The ETE Steering Committee, the ETE Leadership Group, End Hep C SF's Coordinating Committee, San Francisco's Getting to Zero Initiative Steering Committee, San Francisco's HIV Community Planning Council, the HIV/AIDS Providers Network (HAPN), the Frontline Workers Organizing Group (FOG), and the HIV Housing Workgroup. Separate meetings were also scheduled for SFDPH employees: two "town halls" for staff of ARCHES, CHEP, HHS, and the STI/HIV Branch, and one meeting for STI Leadership.	
Santa Clara		
Getting to Zero Initiative **2025-2026** Quarterly Meetings	The Getting to Zero (GTZ) initiative engages the community through a variety of outreach strategies, including hosting events, presentations, and workshops that increase awareness of HIV and STI prevention resources. GTZ also operates a Youth and Young Adult Advisory Board, which provides ongoing input to ensure that activities are responsive to the needs of younger community	***Participants:*** *HIV providers and other providers of supportive services, advocates, public health staff, community members.*

EVENT		
	members. This advisory board plays a key role in shaping efforts aimed at reducing new STIs among youth and young adults.	
Santa Clara HIV Commission Meetings **2025-2026** Monthly	The HIV Commission is the local Ryan White planning body that is established in County of Santa Clara Ordinance Code. The County of Santa Clara Board of Supervisors endeavors to have at least half of the Commission's overall membership consist of persons living with HIV. In 2025, 69% of the HIV Commission membership consisted of people living with or affected by HIV.	***Participants:*** *HIV providers and other supportive services, people living with HIV or lived experiences, community members, public health staff.*

B. Role of the RWHAP Part A Planning Councils/Planning Bodies

California is a vast and diverse state, full of a variety of needs, challenges, and resources. CDPH acknowledges that strategies and solutions must be as unique as the state itself. OA relies heavily on RWHAP Part A planning bodies as the key-informants and gatekeepers to determine the best strategies to address HIV at the local level. California has three Eligible Metropolitan Area (EMAs) and five Transitional Grant Area (TGAs) that are funded by the Ryan White HIV/AIDS Program Part A, as well as two Metropolitan Statistical Areas which receive CDC HIV Prevention funding directly from CDC (San Francisco and Los Angeles). Each EMA and TGA has a local HIV Planning Council, and all Part A planning bodies excepting San Diego and Orange counties co-authored and provided a letter of concurrence to this Integrated Plan.

The respective planning bodies are comprised of stakeholders, including PLWH, that assess the needs of the community and help to inform decisions about what is needed to meet those needs. Their input is critical towards ensuring that strategies developed have met the needs of each respective community. OA participates in the council meetings and provides monthly written updates to the councils and other stakeholders. The updates provided regularly scheduled information to local planning council members about the development of the statewide Needs Assessment and Integrated Plan.

C. Role of Planning Bodies and Other Entities

Part A Planning Bodies. This report would like to highlight the critical work at the planning tables of our HIV Councils, Commission and Groups throughout California. Working in 8 grant areas throughout the state, these bodies are primarily responsible for the priority setting and resource allocation of HRSA Part A dollars that funds critical core medical and support services for low-income people living with HIV. These groups also help to advise HIV prevention work. Their efforts are a critical part of the effectiveness of HIV work and why we are able to aim towards getting to zero HIV deaths, zero HIV stigma, and zero new HIV infections in California.

Six of these groups co-authored California's Integrated Plan and Implementation Blueprint. And all of these groups are partners in addressing HIV as a syndemic with HCV and other STIs through a social drivers of health lens. The role of HIV prevention and care planning bodies, and any other community members or entities who contributed to developing the Integrated Plan, is to ensure that comprehensive and extensive input is provided towards developing strategies that are

reflective of all Californians. **Part F** providers develop training and technical assistance to address the needs identified by this Integrated Plan.

To California readers of this plan, if you are part of the communities represented by the groups below, please consider joining your home planning body or supporting their work by adding your voice, skills and insight to their community events and activities throughout the year. At these meetings you will find amazing and talented individuals: people living with HIV, those whose communities are most impacted by HIV, and their allies and advocates. You will find people grappling directly with how to address social drivers of health barriers to make sure that all communities benefit from the life-saving tools and resources that are available to treat and prevent HIV. The California Department of Public Health, Office of AIDS does our best to help in their important work, and to learn from their communities how the State can partner with their best next steps of getting to zero in California.

- Inland Empire HIV Planning Council - Serving Riverside and San Bernardino Counties
- Los Angeles Commission on HIV
- Oakland TGA HIV Planning Council- Serving Alameda and Contra Costa Counties
- Orange County HIV Planning Council
- San Diego HIV Planning Group
- Sacramento TGA HIV Health Services Planning Council - Serving El Dorado, Placer, Yolo and Sacramento Counties
- Santa Clara HIV Commission
- San Francisco HIV Community Planning Council – Serving Marin, San Francisco, and San Mateo Counties

Noting also that Parts C and D Providers participate as representatives Part A Planning Councils to ensure coordination of services across funding sources.

Part B Advisory Body. One of the primary bodies that informed the development of this plan is the statewide California Planning Group (CPG). This Part B Advisory Body is comprised of 25-35 members who are appointed by OA following both a nomination process conducted by local planning bodies, and an open application process conducted by OA. The CPG membership includes one representative from each of the 8 Part A HIV planning councils who serves as a nominated CPG member, as well as at-large members representative of those involved in the prevention, care and treatment of HIV throughout the state, either as consumers or service providers.

The selection process takes into consideration the knowledge, experience, and expertise of each prospective member and ensures that the CPG reflects the diversity of the HIV epidemic in California, based on HIV status, age, gender identity, race/ethnicity, sexual orientation, and geographic distribution (e.g., urban and rural residence). Currently, all CPG members commit to a three-year term of service, with a new cohort of CPG members appointed every three years; members may apply for a second term if desired. The main function of CPG is to work with OA to develop the most current Integrated Plan; to monitor the implementation of this plan; and to provide timely advice on emergent issues identified by the OA and other key stakeholder parties. CPG is committed to working openly in a group to make decisions and is guided by the principles of fairness, and respectful engagement. The group has had direct input into the development of this Integrated Plan by assisting OA in the development of the Needs Assessment, by providing input on prioritizing HIV services and subpopulations to assess, and by identifying needs assessment questions, in addition to other input noted below.

The CPG has structured subcommittees that are voted in each year. Work in subcommittees allows CPG members to focus on developing a clearer picture on gaps, and needs for priority populations in California. Current subcommittees include HIV and Aging, Women and Youth. Each of the subcommittees is charged with reviewing data about overarching social drivers of health such as substance use.

Other Entities

California Consortium. CDPH-OA has organized the 8 EHE funded local health jurisdictions into a consortium of practice. This group meets quarterly in order to share updates, and innovations from implementation of the EHE Initiative. Community engagement has been critical to achieving the goals of California's EHE plans, and each Phase 1 county has partnered with their Part A planning council/commission/group to serve as the concurrence body for their local EHE plan implementation. In addition, OA requires that at least 25% of the total funds directed to local EHE jurisdictions support the planning and implementation of EHE activities by CBOs. Further, all California Consortium counties are required to conduct community engagement to enhance their EHE interventions and assist with updating their EHE plans annually. Recruitment of new voices and non-traditional partners are prioritized to address social determinants of health in EHE jurisdictions, and OA has contract with Facente Consulting and other TA providers to assist with community engagement as needed.

D. Collaboration with RWHAP Parts

OA continually expands its collaborative network to include more agencies and services that respond to populations we have yet to successfully reach, as shown by disparities in health outcomes. The OA team has worked closely with each of the Part A and B planning bodies throughout the state, briefing them on the goals and requirements at the beginning of all grant periods, soliciting input and advice in the initial stage of plan development, providing progress reports throughout the formative phase, and sharing iterative drafts of any plans and associated updates. CDPH will continue to ensure the OA and OSH teams and contractors work side by side with the LHJs as they initiate and provide the interventions outlined in the plan. OA monitoring will allow for rapid response when barriers, challenges, or gaps occur, as well as avoid duplication and gaps in service delivery systems. Continued listening sessions will be conducted jointly by OA and the OSH , including the Surveillance and Prevention Evaluation and Reporting (SuPER) Branch of OA, to best support statewide efforts to be inclusive, including how to make and effect change using quantitative and qualitative driven strategies. OA and OSH will also develop integrated response models to be presented at conferences for health care providers throughout the state, including conferences and webinars not only for physicians, but also for medical case managers, HIV counselors, outreach workers, nurse practitioners and physician assistants, and other supporting staff.

CDPH has a commitment to conducting efforts that focus on a continuum of care for all, as well as being more inclusive of programs that actively offer care, specifically those rendering services to key priority populations outlined in this plan, to ensure alignment with the strategies proposed. The State of California is also innovative in our efforts to leverage funding streams that may not traditionally support HIV services but supports activities that impact all people who may be living with HIV.

E. Engagement of People Living with HIV

As described above, impacted communities and consumers of HIV-related services were engaged in the development of the Integrated Plan in multiple ways. CPG was one main source of community engagement, because it most adequately represents consumers of HIV services in California. Ten out of the 32 CPG members (43.75 percent) are PLWH. Similar to the profile of Californians who are living with or most at risk for HIV in California, 50 percent of CPG members are male, 37.5 percent are female. Eight of the 15 members are MSM. CPG members are Hispanic/Latino, African American, Native American, Asian, Pacific Islander, Native Hawaiian and White. Twelve are from Northern California, five from Central California, and fourteen from Southern California.

In addition to the conscious efforts by OA to ensure that CPG members reflect the diversity of the HIV epidemic in California, members are also selected by carefully considering the knowledge, experience, and expertise of each prospective CPG member. CPG members are leaders in California's HIV planning processes, and one of their primary responsibilities is to provide critical insight into developing solutions to health problems. All CPG members attended at least one of the virtual or in-person regional community listening sessions for the statewide strategic plan, in addition to other opportunities for review and feedback of the Integrated Plan. Additionally, more than 300 other professionals and community advocates from the field of HIV, many of whom are PLWH, attended each of the community engagement events. During all events, PLWH and other stakeholders were specifically asked to evaluate whether the HIV prevention and care activities in the strategic plan were responsive to their needs, both state-wide and locally. This process helped us to ensure that the strategies and activities reflect all Californians equally.

F. Priorities

The following key values arose out of the planning and community engagement process to address gaps in health outcomes and aims to enhance efforts that address eliminating HIV, HCV, and STIs.

- EVIDENCED BASED, DATA DEFINED FOCUS: Center the voices, experiences, and leadership of the people most affected by this syndemic. We commit to evidenced and data-based policies and programs to improve the health of our communities.
- COMPREHENSIVE, LOW BARRIER PREVENTION: Invest in low barrier prevention and drug treatment for people with substance use disorder.
- COURAGEOUS LEADERSHIP: Value visionary leadership and taking risks needed to change patterns and end this syndemic.
- COLLABORATION: 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.
- PERSON-CENTERED SOLUTIONS: Focus on finding creative solutions. We expect systems to change to meet the needs of people, not the other way around.
- HUMAN DIGNITY: 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.

G. Updates to Other Strategic Plans Used to Meet Requirements

Excerpts of other source documents are included in the text of this plan or are briefly summarized. California and its co-authoring partners, in this revision of the 2022-2026 Integrated Plan, have developed new strategies and objectives to be implemented from 2027 - 2031, as part of this Integrated Plan. Annual needs assessment data will be collected using various data collection methods through ongoing collaborations with the state epidemiological team, as well as through partnerships with local Part A planning bodies, ensuring adequate inclusion of key populations, especially persons living with HIV. The state is also developing a robust monitoring and evaluation approach that will measure deliverables, outcomes, and success throughout the life of the Integrated Plan.

SECTION III: Contributing Data Sets and Assessments

1. Data Sharing and Use

Data and data use are fundamental to our HIV Integrated Plan. The Office of AIDS uses multiple data systems to collect HIV program data from local health jurisdictions, providers, and contractors. These systems are secure and security measures are kept up to date to ensure the confidentiality of the data collected. The data are collected to guide program implementation and improvement, as well as to meet the requirements of funders.

HIV Surveillance. The CDPH OA works with local health jurisdictions to collect, analyze, and disseminate surveillance data on people living and diagnosed with HIV in California. Providers and clinical laboratories provide HIV surveillance data to local health jurisdictions as a routine public health activity required by state law. More information about HIV surveillance in California can be found at the OA website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAsre.aspx. HIV surveillance is conducted through three different activities: HIV case surveillance, the Medical Monitoring Project (MMP) and the National HIV Behavioral Surveillance System (NHBS).

- **Electronic HIV/AIDS Reporting System (eHARS).** The Enhanced HIV/AIDS Reporting System (eHARS) is a browser-based application provided by the Centers for Disease Control and Prevention (CDC). The Office of AIDS uses eHARS to collect, manage, and report California's HIV/AIDS case surveillance data to CDC. HIV/AIDS is a condition that is mandated by state laws and regulations to be reported by local health officers to CDPH.
- **Medical Monitoring Project (MMP).** MMP is a surveillance project designed to produce nationally representative data about the health-related experiences and needs of persons living with HIV (PLWH) in the United States and California. The CA MMP Project Area is one of 23 state or local health departments that conduct MMP nationwide. In California, Los Angeles and San Francisco counties also conduct MMP through the local health departments. While Funding for this project was interrupted, it has recently been reinstated. This project is the basis of the integrated testing and quality of life indicators for the National HIV/AIDS goals for PLWH.
- **National HIV Behavioral Surveillance System.** The NHBS System is a national health survey that collects information on sexual risk, drug use, HIV testing behaviors, and HIV seroprevalence from populations at highest risk for HIV infection—men who have sex with men, people who inject drugs and low-income heterosexual people. NHBS collects data from these populations each year on a rotating basis, in specific jurisdictions. NHBS is designed, coordinated, and funded by the CDC. San Diego County is one of approximately 20 areas across the nation currently participating in NHBS, with data collection conducted by the CDPH OA, with assistance from Family Health Centers of San Diego. In California, Los Angeles and San Francisco counties also conduct NHBS through the local health departments.

Local Evaluation Online (LEO). LEO is an online system for tracking information about OA-funded HIV education and prevention programs, including counseling and testing services. Local Health Jurisdictions and individual contractors are able to enter data and print out reports to review and summarize their progress implementing programs to reach priority populations.

California Health Interview Survey: The California Health Interview Survey (CHIS) is a statewide survey conducted by the University of California, Los Angeles (UCLA) that examines population health and healthcare access issues. Its mixed-mode (web and telephone), population-based design makes CHIS results representative of the state's population. OA funds a series of HIV prevention-related questions on CHIS. Data collected helps OA understand the HIV testing and pre-exposure prophylaxis (PrEP) landscape across the state, both demographically and geographically. Recently, OA identified a need to expand PrEP questions to all respondents, as previously they were not asked of cisgender women or men who have never had sex with men. This change takes effect January 2027 but data will not be available from this change until 2028.

Health Care Access and Information (HCAI) The California Department of Health Care Access and Information produces data sets and products from nearly 9,500 licensed health care facilities in California, including aggregate patient utilization data. California will use these data to analyze health outcomes for people living with HIV and those at risk of HIV.

HIV Care Connect (HCC) (HCC) is a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment, and support providers, and provides comprehensive data for program reporting and monitoring. HCC is used by Ryan White HIV/AIDS Program and Housing Opportunities for Persons Living with AIDS (HOPWA) providers to automate, plan, manage, and report on client data. HCC replaced the AIDS Regional Information and Evaluation System (ARIES). ARIES was taken offline as of September 30, 2025

ADAP Enrollment System (AES). AES is a custom developed web-based solution used by OA staff and enrollment workers at ADAP and Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) sites throughout California. Data collected and processed in the AES includes client-level demographic characteristics, financial eligibility documentation, clinical laboratory test results, and insurance coverage; enrollment site staff information; and medication, premium, and out-of-pocket claims information. Data interfaces exchange eligibility information and claim payment information with separate Pharmacy Benefits Manager (PBM) and Insurance and Medical Benefits Manager (IBM/MBM) systems.

California Reportable Disease Information Exchange (**CalREDIE).** CalREDIE is a secure system that the CDPH has implemented for electronic disease reporting and surveillance. Today, all 61 local health departments in California use CalREDIE in some capacity, but not all local health jurisdictions (LHJs) use the system for surveillance of all notifiable communicable diseases. LHJs and CDPH have access to disease and laboratory reports in near real-time for disease surveillance, public health investigation, and case management activities.

CalCONNECT. California has a salesforce-based platform for patient outreach, engagement and case management for public health. The CalCONNECT STI/HIV Field Investigation (SHFI) record has added functions to increase the efficiency of case investigation and contact tracing for HIV and sexually transmitted infections. By combining surveillance records for HIV, syphilis, gonorrhea, and chlamydia into a single public health follow up record, CalCONNECT improves care coordination across teams and eliminates duplicative data entry for individuals who are coinfected with multiple STIs. The system includes tools in the systems like the integrated softphone, two-way SMS, customizable list views, reports, and dashboards contribute to efficiencies to public health outreach, monitoring, and outbreak response. Additionally, CalCONNECT makes statewide historical laboratory testing, diagnosis, and treatment data for syphilis readily available to local health departments so that cases can be evaluated more easily and prioritized for follow up.

AIDSVu is and interactive online data visualization tool that represents the impact of the HIV epidemic on communities across the United States. AIDSVu is a project developed by Emory University and other partners. CDPH OA uses the PrEP data associated with this tool.

America's HIV Epidemic Analysis Dashboard (AHEAD) is a national data visualization platform developed by the U.S. Department of Health and Human Services to support Ending the HIV Epidemic (EHE) efforts by providing timely, standardized CDC data on key HIV indicators. The tool enables federal, state, and local stakeholders to monitor progress toward 2025 and 2030 goals, identify service gaps, track trends, evaluate interventions, and strengthen planning and grant development. In addition to HIV outcomes, AHEAD incorporates social determinants of health data and allows users to explore demographic and transmission-related factors—such as age, race/ethnicity, sex, and mode of transmission—to better inform coordinated, data-driven responses at the national and local levels.

Los Angeles County

Multiple data sources are utilized in Los Angeles County to monitor the HIV and STD epidemics, track service utilization, better understand service needs and assess progress in achieving county-wide and national HIV-related goals. Similar to California, the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP) obtains HIV and STI data through eHARS, electronic laboratory report (ELR), MMP, NHBS, and Cal Connect. However. HIV programmatic data are captured and managed through RedCap, and e2LA data systems in Los Angeles County. E2LA Los Angeles County's newest state-of-the-art, fully integrated, web-based system which supports data collection, contract management, contractor billing, client insurance eligibility, and grant required data reporting. Currently, within e2LA, the Ryan White Program and Fiscal and Procurement Data Systems are operational, and the final Prevention module will be launched in 2027. Collectively, these data systems will provide DHSP the ability to track the extent of Los Angeles County's HIV epidemic across the full HIV care continuum.

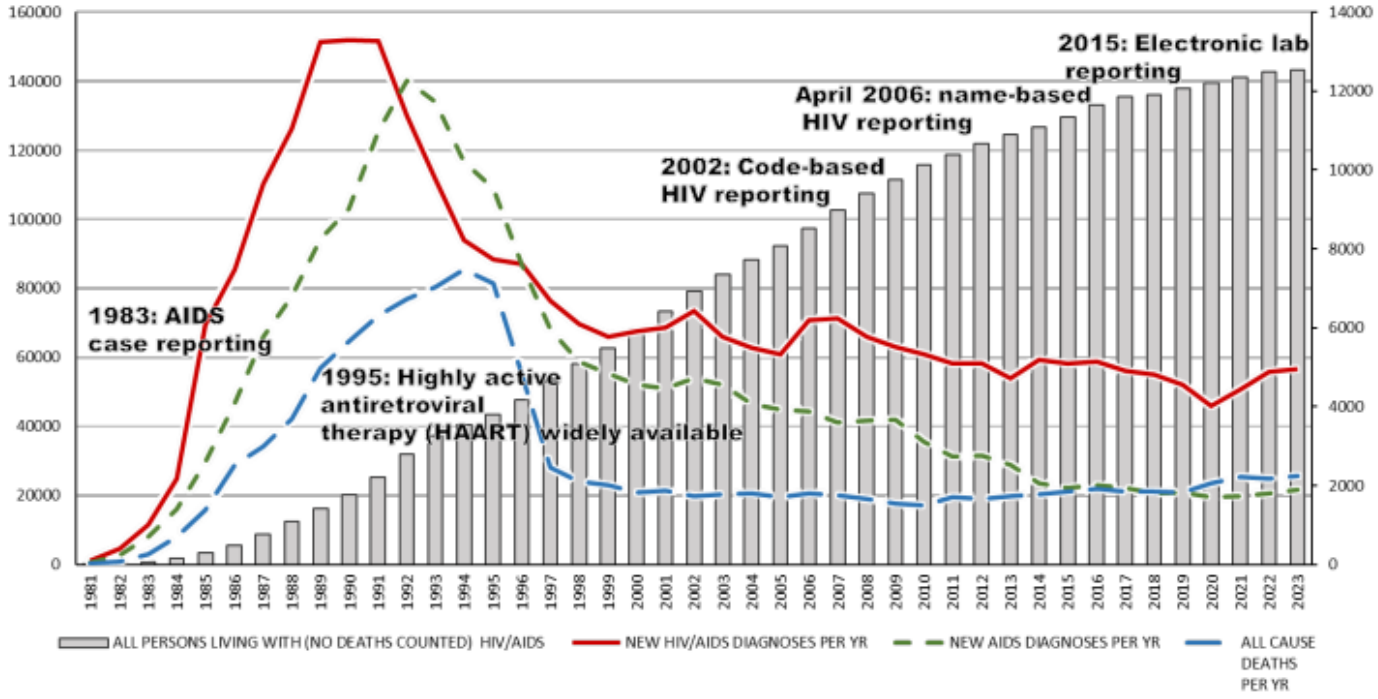
2. Epidemiological Snapshot

This section describes the most recent epidemiological data available describing HIV in California with key indicator trends presented for the years 2019 through 2023. This section was largely derived from excerpts of existing surveillance reports as allowed by the guidance for developing this report. Demographic, geographic, socioeconomic and behavioral characteristics are presented. Selected continuum of care data for the TGA/EMA co-authors are noted in **Tables 5** through **8**. Most recent epidemiological reports for selected co-author counties are also noted in the key documents reviewed. Finally, the most recent epidemiological data is also noted in Section V of this report that highlights differences for health outcomes for HIV, STIs and HCV. Each LHJ will augment these data with updated and regular presentations of data to Part A Planning Councils during their ongoing review of the data necessary for annual priority setting and allocation of Part A funding.

Introduction

In 2023, there were 143,254 people living with diagnosed HIV (PLWDH) in California and 4,948 new diagnoses. While the number of PLWDH has steadily increased over time, the number of new HIV diagnoses has decreased since the peak of the epidemic. Since the HIV epidemic began in 1981, approximately 112,000 Californians diagnosed with HIV have died, with over 2,200 dying in 2023 alone (Figure 5).

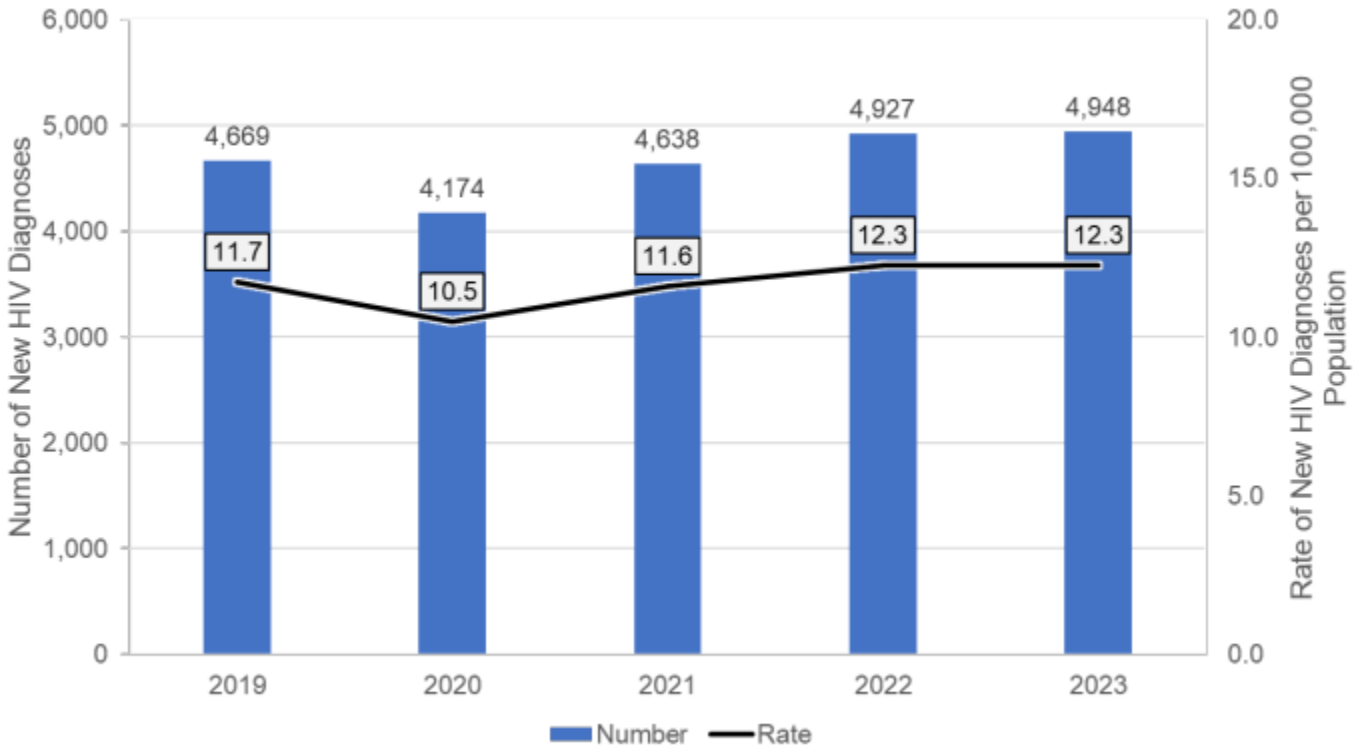
Figure 5. HIV/AIDS Diagnoses, AIDS Diagnoses, Deaths, and Persons Living with HIV or AIDS in California: 1981-2023



Newly Diagnosed HIV Infections in California

From 2019 to 2021, the number and rates of cases declined slightly. Note that both transmission and case reporting were most likely depressed in 2020 as a result of the COVID-19 pandemic and resulting stay-at-home order. Case counts and rates have since rebounded, resulting in case counts and rates similar to 2019 in 2021, and slight increases in counts year over year. Rates rose from 2021 to 2022 as well, but have remained steady at 12.3 per 100,000 population from 2022 to 2023. Overall, the number of new diagnoses increased 6% from 2019 to 2023, and the rate of new diagnoses has increased by 5%, from 11.7 to 12.3, during the same time period (Figure 6).

Figure 6. Number and Rate of New HIV Diagnoses in California, 2019-2023



Disproportionately Impacted Groups

Although there has been progress in addressing California's HIV/AIDS epidemic, HIV continues to disproportionately affect many populations (**Figure 7**). **Figure 7** shows characteristics of new HIV diagnoses in California in 2023.

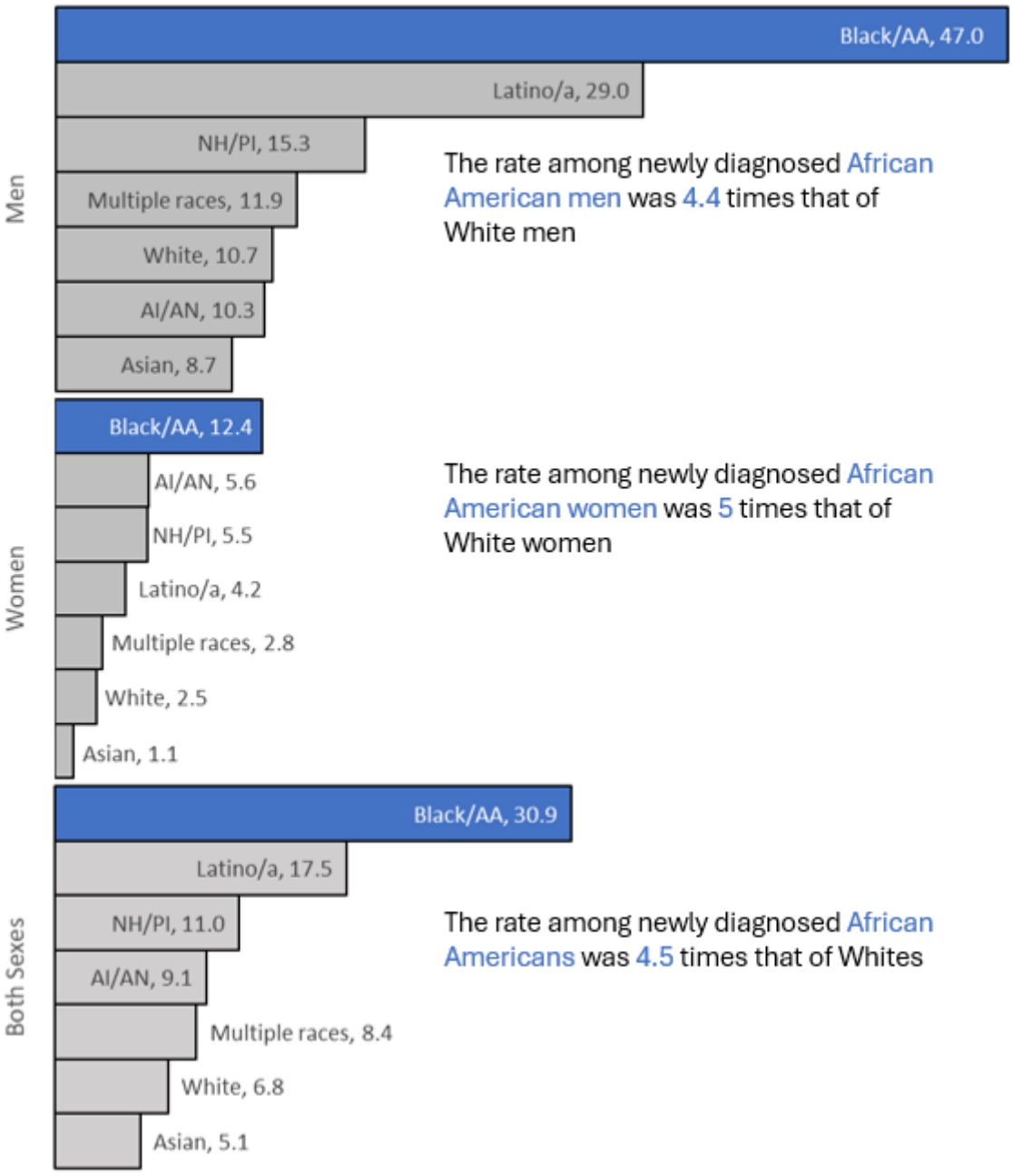
Men continue to be the demographic most disproportionally affected by HIV, accounting for 85% of new HIV diagnoses in 2023 (Figure 7). Male-to-male sexual contact (MMSC), including MMSC-IDU, accounted for 54% of new HIV diagnoses in 2023. Heterosexual contact accounted for 22% of new HIV diagnoses in 2023, 5% of new HIV diagnoses were attributed to injection drug use (IDU) alone, 3% attributed to other sexual contact (OSC), and 16% were attributed to unknown/other risk (Figure 7). Latino/as made up the largest racial/ethnic group among new HIV diagnoses, accounting for 57% of all new HIV diagnoses in 2023 (Figure 7).

Figure 7: New HIV Diagnoses by Selected Demographic Characteristics, California, 2023

	New Diagnoses	
Characteristic	#	% of Total
Male	4,212	85%
Female	736	15%
0 to 12	3	0%
13 to 24	740	15%
25 to 44	3,065	62%
45 to 64	1,018	21%
≥65	122	2%
American Indian/Alaska Native	16	0%
Asian	268	5%
Black/African American	718	15%
Latino/a	2,801	57%
Native Hawaiian/Pacific Islander	16	0%
White	1,032	21%
Multiple Races	97	2%
Unknown	0	0%
Other sexual contact	168	3%
Male-to-male sexual contact (MMSC)	2,521	51%
MMSCIDU	137	3%
Injection drug use (IDU)	233	5%
Heterosexual contact	1,111	22%
Perinatal	5	0%
Unknown risk/other risk	773	16%
TOTAL	4,948	

California has defined several groups as being disproportionately affected by HIV according to surveillance data. Among all racial/ethnic groups, Black/African Americans are the most affected by HIV. The rate of new HIV diagnoses among Black/African Americans is 4.4 times higher than Whites among men, and 5 times higher among women. Latino/as are also disproportionately affected by HIV, with rates of new HIV diagnoses 2.7 times higher than Whites among men and 1.7 times higher among women (Figure 8). While Latino/as and Whites make up the largest percentage of persons newly diagnosed with HIV (Figure 7, above), the rate of HIV among Blacks/African Americans is substantially higher (30.9 per 100,000 population, compared to 6.8 per 100,000 among Whites and 17.5 per 100,000 among Latinos/as).

Figure 8. Rate of New HIV Diagnoses by Race/Ethnicity and Sex, California 2023

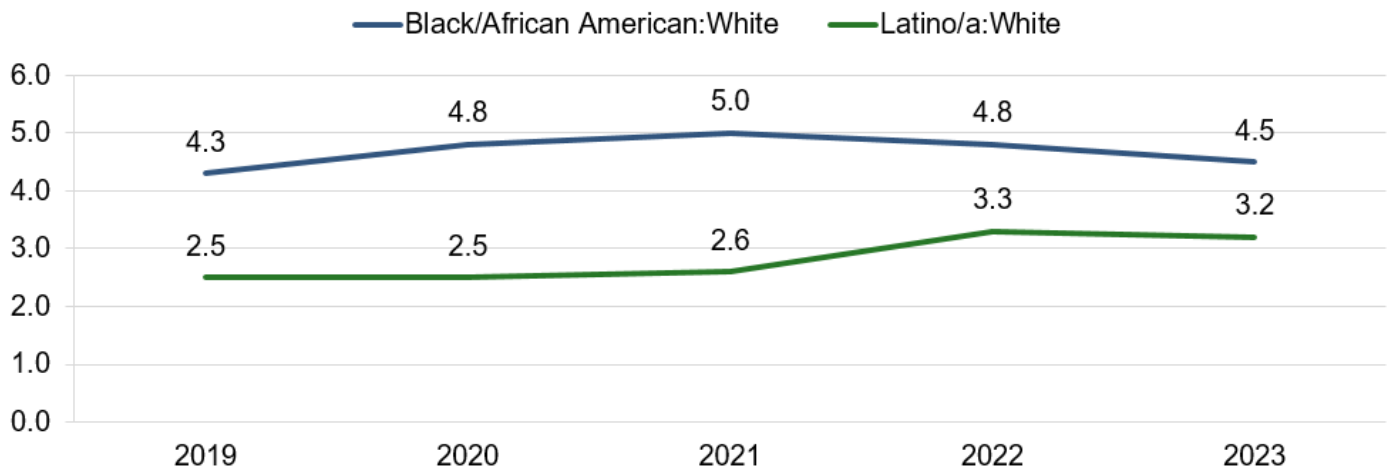


Disproportionate Impacts in Health Outcomes

Disproportionate Impacts among Men who have male-to-male sexual contact (MMSC)

In 2023, the rate of new HIV diagnoses among Black/African American MMSC was 4.5 times higher than White MMSC, and the rate of Latino/a MMSC was 3.2 times higher than White MMSC (Figure 9). From 2019-2023, racial/ethnic disproportionate impacts among MMSC have increased for both Black/African Americans and Latino/a MMSC compared to White MMSC, despite diagnosis rates decreasing for all three races/ethnicities since 2019. However, the diagnosis rate among White MMSC decreased more sharply over the time period, contributing to the disproportionate impacts.

Figure 9. Rate Ratios of New Diagnoses in MMSC by Race/Ethnicity, California, 2019-2023

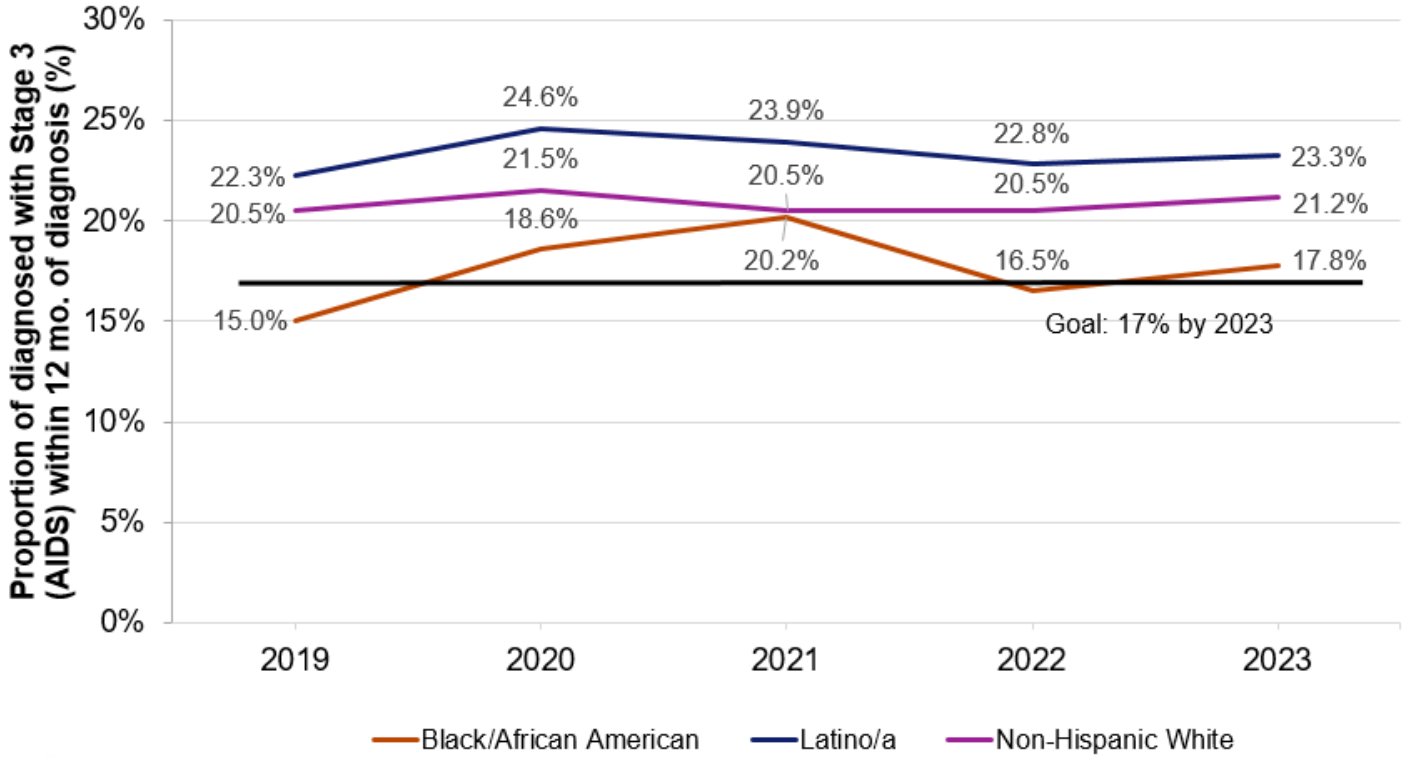


Race/Ethnicity	2019	2020	2021	2022	2023	% Change
Black/African American	34.3	31.1	34.5	29.6	26.8	-45.4%
Latino/a	19.8	16.5	18.1	20.4	19.1	-7.7%
White	7.9	6.5	6.9	6.2	5.9	-55.6%

Late Diagnosis

In 2023, over 22% of new HIV diagnoses were late HIV diagnoses, defined as having Stage 3 (AIDS) at the time of initial HIV diagnosis or within 12 months of the HIV diagnosis date. Latinos/as (23.3%) have a higher proportion of late HIV diagnoses compared to Black/African American (17.8%) and White individuals (21.2%) (Figure 10). Although late diagnoses for Black/African Americans reached the goal of 17% (or below) in 2022, it has since risen, and the percentage of late diagnoses for all three races/ethnicities is on an upward trajectory.

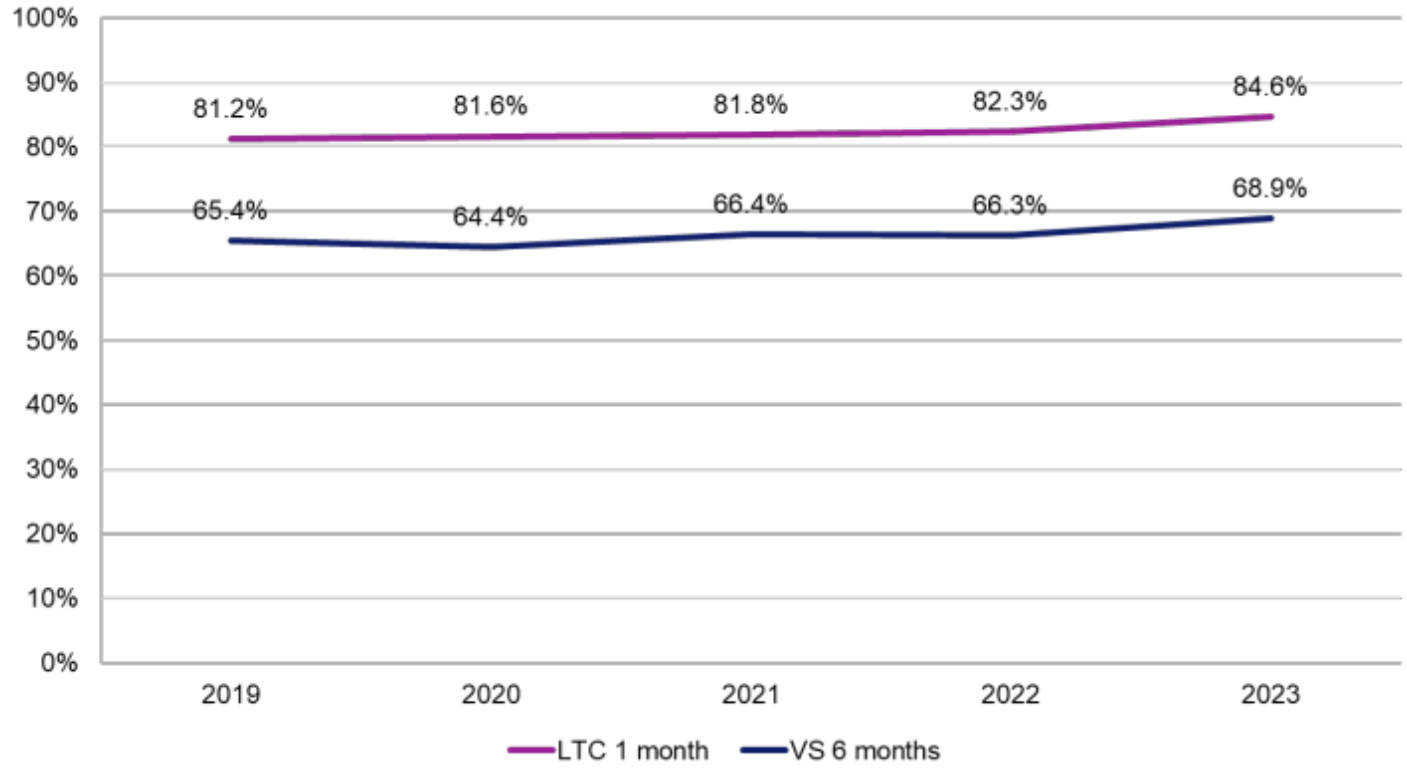
Figure 10. Proportion of Individuals Diagnosed with Stage 3 (AIDS) within 12 Months of HIV Diagnosis by Race/Ethnicity, California, 2019-2023



The Continuum of HIV Care: Persons Newly Diagnosed with HIV

A key pillar of the Ending the HIV Epidemic initiative is to facilitate early linkage to HIV treatment to enable rapid viral suppression. Among the 4,948 individuals newly diagnosed with HIV in 2023, 85% were linked to care (LTC) within one month of diagnosis – a 4% increase since 2019 (Figure X). Viral suppression (VS) is an important factor in enabling persons living with diagnosed HIV to live long, healthy lives and preventing new HIV infections. Among individuals newly diagnosed in 2023, approximately 69% achieved VS within six months of diagnosis, a 5% increase compared to 2019 (Figure 11).

Figure 11. Percent of People Newly Diagnosed with HIV Infection Linked to HIV Medical Care within 1 Month of Diagnosis and Virally Suppressed within 6 Months of Diagnosis – California, 2019-2023



Linkage to Care

The data-defined groups with the lowest percentage of LTC within one month of diagnosis were Black/African Americans (80% overall, and 79%, and 84% for men and women, respectively), American Indian/Alaska Natives (81% overall, and 90% and 60% for men and women, respectively), and both Asian and White women (80%) (Tables 1, 2). The groups with the lowest rates of VS within six months of diagnosis were American Indian/Alaska Natives (44% overall), Black/African American and Multirace men (60% and 66%, respectively), White and Black/African American women (61% and 78%, respectively), , and persons who inject drugs (IDU) (49%), including MMSC & IDU (59%) (Tables 2, 3).

Table 2. Linkage to HIV Care within 1 Month of Diagnosis by Birth Sex, Race/Ethnicity, Age Group, and Risk/Exposure Group, 2023

New HIV Diagnoses, 2023						
		Diagnosed	Linked to Care in 1 Month		Achieved Viral Suppression in 6 Months	
Characteristic		N	N	%	N	%
Birth Sex	Men	4,212	3,573	85%	2,783	66%
	Women	736	611	83%	476	65%
Race/Ethnicity	American Indian/Alaska Native	16	13	81%	7	44%
	Asian	268	235	88%	203	76%
	Black/African American	718	576	80%	446	62%
	Latino/a	2,801	2,410	86%	2,009	72%
	Native Hawaiian/Other Pacific Islander	16	13	81%	10	63%
	White	1,032	852	83%	670	65%
	Multiple Races	97	85	88%	64	66%
Age	0 to 12	3	-		-	
	13 to 24	740	706	95%	525	71%
	25 to 44	3,065	2,880	94%	2,132	70%
	45 to 64	1,018	956	94%	669	66%
	≥65	122	109	89%	80	66%
Risk/Exposure Group	Other Sexual Contact	168	164	98%	120	71%
	MMSC	2,521	2,420	96%	1,881	75%
	IDU	233	211	91%	115	49%
	MMSC & IDU	137	132	96%	81	59%
	High-Risk Heterosexual Contact (HRH)	305	297	97%	220	72%
	Perinatal	5	-		-	
	Heterosexual Contact (Non-HRH)	806	744	92%	551	68%
	Unknown risk	773	681	88%	436	56%

Table 3. Linkage to HIV Care within 1 Month of HIV Diagnosis by Sex and Race/Ethnicity, 2023

New HIV Diagnoses, 2023			
Birth Sex	**Race/Ethnicity**	**Linked to Care in 1 Month**	**Achieved Viral Suppression in 6 Months**
Men	American Indian/Alaska Native	90%	-
	Asian	89%	76%
	Black/African American	79%	60%
	Latino/a	86%	72%
	Native Hawaiian/Other Pacific Islander	83%	67%
	White	83%	67%
	Multiple Races	88%	66%
Women	American Indian/Alaska Native	60%	-
	Asian	80%	89%
	Black/African American	84%	78%
	Latino/a	85%	93%
	Native Hawaiian/Other Pacific Islander	-	-
	White	80%	61%
	Multiple Races	88%	94%

Note: Some numbers were suppressed to ensure the confidentiality of personally identifiable information.

Social Drivers of Health

California HIV surveillance data continues to show that HIV disproportionately impacts specific subpopulations. To eliminate disproportionate health impacts, the California OA has developed a five-year strategic plan – Ending the HIV Epidemic – incorporating social drivers of health (SDH) in its elimination strategy. SDH are non-medical factors, such as communal, economic, and environmental conditions that can impact a person's health. Examples of SDH include a region's access to education, income, housing, and transportation. At the national level, the Office of Disease Prevention and Health Promotion recognizes that promoting good healthcare and lifestyle choices alone will not eliminate disproportionate health impacts; therefore, they have incorporated SDH across their five overarching goals for promoting health and well-being for all ages in the Healthy People's 2030 initiative. Given the significance of SDH as contributing factors to disproportionate health impacts, it is important to understand their relationship with the health outcomes of HIV infection, LTC, and VS.

Table 4 below depicts HIV-related outcomes (i.e., the rate of new HIV diagnoses, percent linked to care within one month of diagnosis, and percent virally suppressed within six months of diagnosis) by SDH (i.e. education level, health care coverage, and median household income). Each SDH is divided into quartiles that delineate the percentage of households/residents that meet the definition of the given SDH. For example, the first row under the heading "Less than a high school diploma" is labeled "<5" and depicts HIV cases living in census tracts in which less than 5% of adult residents do not have a high school diploma (i.e., more than 95% of adult residents DO have a high school diploma).

Table 4. Persons Newly Diagnosed with HIV Infection by Census Tract, Characterized by Continuum of Care, by Selected Social Drivers of Health, 2023 – California

	Total diagnoses		Linked to Care in 1 Month		Virally Suppressed in 6 Months	
	N	Rate	N	%	N	%
Below federal poverty level (%)[1]						
<5.95	608	7.8	444	73.0	526	86.5
5.95-9.57	926	11.6	658	71.1	788	85.1
9.58-15.11	1,255	16.4	893	71.2	1,073	85.5
≥ 15.12	1,742	25.0	1,178	67.6	1,452	83.4
CA Overall	**4,531**	**14.9**	**3,173**	**70.0**	**3,839**	**84.7**
Less than high school diploma (%)[2]						
<5.28	555	7.4	423	76.2	475	85.6
5.28-11.22	865	11.0	617	71.3	745	86.1
11.23-22.44	1,255	16.0	849	67.6	1,048	83.5
≥ 22.45	1,877	25.7	1,303	69.4	1,592	84.8
CA Overall	**4,552**	**14.9**	**3,192**	**70.1**	**3,860**	**84.8**
Without health insurance (%)[3]						
<3.21	611	8.2	439	71.8	522	85.4
3.22-6.45	929	11.7	669	72.0	779	83.9
6.46-11.42	1,200	15.4	824	68.7	1,008	84.0
≥ 11.43	1,791	24.7	1,241	69.3	1,530	85.4
CA Overall	**4,531**	**14.9**	**3,173**	**70.0**	**3,839**	**84.7**
Gini index (%)[4]						
<37.85	1,084	13.7	743	68.5	911	84.0
37.86-41.95	1,138	14.5	808	71.0	976	85.8
41.96-46.42	1,164	15.3	802	68.9	999	85.8
≥ 46.43	1,126	16.1	801	71.1	934	82.9
CA Overall	**4,512**	**14.8**	**3,154**	**69.9**	**3,820**	**84.7**
Median household income (U.S. $)						
≥ 127,431	552	6.9	435	78.8	489	88.6
94,917-127,430	947	12.1	658	69.5	805	85.0
70,336-94,916	1,273	16.6	882	69.3	1,086	85.3
<70,336	1,721	25.3	1,169	67.9	1,424	82.7
CA Overall	**4,493**	**14.8**	**3,144**	**70.0**	**3,804**	**84.7**
Cost-burdened households (%)[5]						
<32.43	653	8.6	471	72.1	556	85.1
32.44-39.47	971	12.3	689	71.0	827	85.2
39.48-47.57	1,206	15.5	842	69.8	1,018	84.4
≥ 47.58	1,701	23.6	1,171	68.8	1,438	84.5
CA Overall	**4,531**	**14.9**	**3,173**	**70.0**	**3,839**	**84.7**
Geographic Mobility (%)[6]						
<6.06	1,110	15.0	738	66.5	926	83.4
6.07-9.58	1,112	14.3	776	69.8	935	84.1
9.59-14.28	1,034	13.4	734	71.0	881	85.2
≥ 14.29	1,296	17.1	944	72.8	1,118	86.3
CA Overall	**4,552**	**14.9**	**3,192**	**70.1**	**3,860**	**84.8**

[1]The federal poverty level of a household consisting of one individual in 2023 is $14,580/year, while for a household of four persons it is $30,000.

[2]Percentage of adult residents in a region having received less than a high school diploma.

[3]Percentage of residents within a region who possess some form of health insurance coverage for a given year.

[4]Measure of a region's income inequality. 0% corresponds to perfect equality; 100% corresponds to perfect inequality.

[5]Percentage of households that spend 30% or more of their income on rent, mortgage, or other housing needs.

[6]Percentage of residents who have moved to the region within the previous year.

A markedly consistent pattern emerged among each of the depicted SDH factors such that, for geographic areas of residence at time of HIV diagnosis, increased levels of environmental barriers (e.g., lower income, education, health insurance coverage, etc.) were associated with increased rates of infection, and oftentimes worse health outcomes. This suggests that effective approaches to reducing disproportionate impacts in HIV infection rates and outcomes continue to require consideration of these social drivers of health.

Federal Poverty Level
Adults living in census tracts with the highest poverty rates (≥15.12% of residents) were newly diagnosed at a rate 3.2 times (321%) higher than those in areas with the lowest poverty rates (< $70,336 per year) were newly diagnosed at a rate 3.7 times (367%) higher than those in areas with highest median household incomes (≥ $127,431 per year). Additionally, this group consisted of 10.9% fewer individuals linked to care and 5.9% fewer achieving viral suppression compared to those in highest median household income areas.

Education Level
Adults living in census tracts with the lowest levels of education (≥ 22.45% of residents without a high school diploma) were newly diagnosed at a rate 3.5 times (347%) higher than those in areas with the highest education levels (<5.28% without a high school diploma). This group consisted of 6.8% fewer individuals linked to care and 0.8% fewer achieving viral suppression compared to those in highest education areas.

Health Care Coverage
Adults who lived in census tracts with the lowest levels of health care coverage (≥ 11.43% of residents without health insurance coverage) were newly diagnosed at a rate 3.0 times (301%) higher than those in areas with the highest coverage levels (<3.21% without coverage). Additionally, this group consisted of 2.5% fewer individuals linked to care and 0.0% fewer achieving viral suppression compared to those in highest health care coverage areas.

Income Inequality (Gini Index)
Adults who lived in census tracts with the highest levels of income inequality (Gini index ≥ 46.43%) were newly diagnosed at a rate 1.2 times (118%) higher than those in areas with the lowest inequality levels (Gini index <37.85%). Additionally, this group consisted of 2.6% greater individuals linked to care and 1.1% fewer achieving viral suppression compared to those in lowest inequality areas.

Median Household Income
Adults who lived in census tracts with the lowest median household incomes (< $70,336 per year) were newly diagnosed at a rate 3.7 times (367%) higher than those in areas with highest median household incomes (≥ $127,431 per year). Additionally, this group consisted of 10.9% fewer individuals linked to care and 5.9% fewer achieving viral suppression compared to those in highest median household income areas.

Cost-Burdened Households
Adults who lived in census tracts with the highest percentages of cost-burdened households (≥47.58%) were newly diagnosed at a rate 2.7 times (274%) higher than those in areas with the lowest percentages of cost-burdened households (< 32.43%). Additionally, this group consisted of 3.3% fewer individuals linked to care and 0.6% fewer achieving viral suppression compared to those in areas with the lowest rates of cost-burdened households.

Geographic Mobility
Adults who lived in census tracts with the highest rates of geographic mobility (≥ 14.29%) were newly diagnosed at a rate 1.1 times (114%) higher than those in areas with the lowest geographic mobility (< 6.06%). Additionally, this group consisted of 6.3% greater individuals linked to care and 2.9% greater achieving viral suppression compared to those in the lowest geographic mobility areas.

Co-Author Epidemiological Summaries

The tables below show epidemiological data along the continuum of care or HIV for those counties that are part of the Part A EMAs and TGAs that are co-authors to this Integrated Pan: new diagnoses, people living with diagnosed HIV, people living with diagnosed HIV that are in care and virally suppressed. In addition, deaths among those that are living with diagnosed HIV are also reported.

Table 5 presents trends of persons newly diagnosed for HIV infections across selected California counties from 2019 through 2023. For these counties, the numbers and rates per 100,000 population fluctuate slightly year to year, but overall, the data shows relatively flat trends for new diagnoses. Note that city-specific health jurisdictions like Berkeley (Alameda), Long Beach (Los Angeles), and Pasadena (Los Angeles) are included within their respective county totals.

Table 6 From 2019 to 2023 in California, the numbers of persons living with diagnosed HIV infection generally show a gradual increase year over year. This upward trend is consistent across most jurisdictions, reflecting ongoing advancements in HIV diagnosis, treatment, and reporting, as well as population growth.

Table 7 below shows that for 2023 in California, the continuum of HIV care for people living with diagnosed HIV infection. The proportion of individuals "in care" and "virally suppressed" in these counties did not reach the target goal of 95 percent. These figures indicate that although many counties are making progress, significant gaps remain in achieving the 95 percent target for both in care and virally suppressed populations. Continued efforts are needed to improve access to care and support viral suppression among people living with HIV in California.

Table 8 below show that between 2019 and 2023, California exhibited a stable number deaths among persons with diagnosed HIV infection, as reflected in the provided rates and counts per 100,000 population reflecting its longstanding public health interventions.

Table 5 Persons newly diagnosed with HIV infection, by year of diagnosis and local health jurisdiction, 2019–2023 — California

	2019			2020			2021			2022			2023		
County of residence at diagnosis	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**
Alameda	225	4.8%	13.5	165	4.0%	9.9	195	4.2%	11.6	212	4.3%	12.5	196	4.0%	11.5
Contra Costa	98	2.1%	8.5	74	1.8%	6.4	109	2.4%	9.4	120	2.4%	10.3	126	2.5%	10.7
El Dorado	7	0.1%	3.7	6	0.1%	3.1	8	0.2%	4.2	6	0.1%	3.2	6	0.1%	3.1
Los Angeles	1,641	35.1%	16.1	1,465	35.1%	14.4	1,568	33.8%	15.4	1,640	33.3%	16.1	1,631	33.0%	16.0
Marin	13	0.3%	5.0	14	0.3%	5.4	11	0.2%	4.3	15	0.3%	5.8	24	0.5%	9.3
Orange	245	5.2%	7.7	264	6.3%	8.3	269	5.8%	8.4	258	5.2%	8.0	262	5.3%	8.1
Placer	13	0.3%	3.3	17	0.4%	4.3	14	0.3%	3.5	9	0.2%	2.2	8	0.2%	2.0
Riverside	271	5.8%	11.2	244	5.8%	10.0	274	5.9%	11.1	324	6.6%	12.9	300	6.1%	11.8
Sacramento	168	3.6%	10.8	157	3.8%	10.0	182	3.9%	11.7	191	3.9%	12.2	186	3.8%	11.7
San Bernardino	303	6.5%	13.9	270	6.5%	12.4	304	6.6%	13.8	293	5.9%	13.2	296	6.0%	13.2
San Diego	431	9.2%	12.9	347	8.3%	10.4	418	9.0%	12.5	416	8.4%	12.4	393	7.9%	11.7
San Francisco	209	4.5%	23.3	157	3.8%	17.4	190	4.1%	21.3	211	4.3%	23.5	187	3.8%	20.7
San Mateo	55	1.2%	7.1	47	1.1%	6.1	50	1.1%	6.5	62	1.3%	8.0	77	1.6%	9.9
Santa Clara	166	3.6%	8.5	116	2.8%	5.9	131	2.8%	6.6	162	3.3%	8.1	166	3.4%	8.3
Yolo	21	0.4%	9.5	13	0.3%	5.9	15	0.3%	6.6	16	0.3%	7.0	22	0.4%	9.5
California	**4,669**		**11.7**	**4,174**		**10.5**	**4,638**		**11.6**	**4,927**		**12.3**	**4,948**		**12.3**

Note: Rates are per 100,000 population. Numbers for the city health jurisdictions of Berkeley, Long Beach and Pasadena are subsets of the numbers for the counties in which they are located (numbers on Alameda, and Los Angeles counties (above) include the respective city LHJ numbers).

Table 6. Persons living with diagnosed HIV infection, by year and current local health jurisdiction, 2019–2023 — California

	2019			2020			2021			2022			2023		
County of current residence	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**
Alameda	6,311	4.6%	378.1	6,238	4.5%	373.1	6,214	4.4%	370.2	6,217	4.4%	368.0	6,250	4.4%	367.4
Contra Costa	2,768	2.0%	241.3	2,806	2.0%	244.0	2,814	2.0%	242.7	2,861	2.0%	244.9	2,875	2.0%	244.1
El Dorado	228	0.2%	120.8	223	0.2%	116.1	237	0.2%	125.3	235	0.2%	123.7	237	0.2%	124.0
Los Angeles	52,604	38.2%	515.2	52,917	38.0%	520.2	53,000	37.6%	519.7	52,871	37.1%	517.9	52,247	36.5%	511.1
Marin	828	0.6%	317.3	808	0.6%	312.0	798	0.6%	309.1	784	0.5%	304.1	760	0.5%	295.0
Orange	7,256	5.3%	227.1	7,400	5.3%	231.9	7,543	5.4%	235.0	7,656	5.4%	237.9	7,780	5.4%	241.0
Placer	378	0.3%	95.8	387	0.3%	97.4	421	0.3%	106.2	427	0.3%	106.6	424	0.3%	104.7
Riverside	9,728	7.1%	400.6	10,152	7.3%	414.5	10,555	7.5%	426.0	10,997	7.7%	438.8	11,263	7.9%	444.2
Sacramento	4,543	3.3%	293.3	4,670	3.4%	298.9	4,747	3.4%	304.6	4,777	3.4%	303.9	4,869	3.4%	307.0
San Bernardino	4,898	3.6%	225.1	5,022	3.6%	229.9	5,241	3.7%	238.2	5,435	3.8%	245.2	5,550	3.9%	248.4
San Diego	13,793	10.0%	412.1	13,897	10.0%	414.6	14,110	10.0%	422.0	14,314	10.0%	426.5	14,406	10.1%	427.5
San Francisco	12,530	9.1%	1396.7	12,210	8.8%	1356.8	11,919	8.5%	1335.6	11,845	8.3%	1319.9	11,621	8.1%	1287.5
San Mateo	1,657	1.2%	213.5	1,643	1.2%	212.0	1,626	1.2%	209.8	1,648	1.2%	211.9	1,661	1.2%	212.8
Santa Clara	3,648	2.6%	186.0	3,716	2.7%	189.4	3,770	2.7%	190.9	3,929	2.8%	197.6	4,064	2.8%	203.1
Yolo	321	0.2%	145.4	328	0.2%	147.9	340	0.2%	150.5	365	0.3%	159.8	387	0.3%	167.7
California	**137,777**		**346.5**	**139,317**		**350.2**	**140,842**		**352.5**	**142,589**		**355.2**	**143,254**		**355.0**

Note: Rates are per 100,000 population. Numbers for the city health jurisdictions of Berkeley, Long Beach and Pasadena are subsets of the numbers for the counties in which they are located (numbers on Alameda, and Los Angeles counties (above) include the respective city LHJ numbers).

Table 7. Continuum of HIV care for persons living with diagnosed HIV infection, 2023 — California

	No. people living and diagnosed with HIV	In care		Virally suppressed	
Jurisdiction of residence (by name)		N	%	N	%
2025 National EHE Goals			95.0%		95.0%
California	143,254	107,606	75.1%	95,199	66.5%
Alameda	6,250	4,940	79.0%	4,490	71.8%
Contra Costa	2,875	2,299	80.0%	2,077	72.2%
El Dorado	237	197	83.1%	176	74.3%
Los Angeles	52,247	38,182	73.1%	33,749	64.6%
Marin	760	566	74.5%	535	70.4%
Orange	7,780	5,445	70.0%	4,889	62.8%
Placer	424	336	79.2%	302	71.2%
Riverside	11,263	9,261	82.2%	8,554	75.9%
Sacramento	4,869	3,865	79.4%	3,464	71.1%
San Bernardino	5,550	3,821	68.8%	3,344	60.3%
San Diego	14,406	10,216	70.9%	8,553	59.4%
San Francisco	11,621	9,279	79.8%	8,644	74.4%
San Mateo	1,661	1,255	75.6%	919	55.3%
Santa Clara	4,064	3,108	76.5%	2,756	67.8%
Yolo	387	306	79.1%	271	70.0%

Note: Data from city local health jurisdictions Berkeley, Pasadena, and Long Beach are reported as a subset of their respective counties. Persons who had at least one CD4, viral load, or HIV-1 genotype test during the calendar year were considered to be in care. Persons whose most recent HIV viral load test result during the calendar year was ≤ 200 copies/ml were considered to be virally suppressed. Small numbers were suppressed to ensure the confidentiality of personally identifiable information.

Table 8. Deaths among persons with diagnosed HIV infection, by year and local health jurisdiction, 2019–2023 — California

	2019			2020			2021			2022			2023		
County of residence at death	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**	**N**	**%**	**Rate**
Alameda	78	4.2%	4.7	103	4.9%	6.2	101	4.4%	6.0	104	4.7%	6.2	120	5.3%	7.1
Contra Costa	45	2.4%	3.9	28	1.3%	2.4	46	2.0%	4.0	33	1.5%	2.8	40	1.8%	3.4
El Dorado	2	0.1%	1.1	5	0.2%	2.6	2	0.1%	1.1	5	0.2%	2.6	5	0.2%	2.6
Los Angeles	572	30.9%	5.6	779	36.8%	7.7	774	33.8%	7.6	770	34.8%	7.6	708	31.4%	6.9
Marin	10	0.5%	3.8	12	0.6%	4.6	12	0.5%	4.6	12	0.5%	4.6	11	0.5%	4.3
Orange	94	5.1%	2.9	79	3.7%	2.5	103	4.5%	3.2	97	4.4%	3.0	91	4.0%	2.8
Placer	9	0.5%	2.3	7	0.3%	1.8	7	0.3%	1.8	9	0.4%	2.3	10	0.4%	2.5
Riverside	188	10.1%	7.7	213	10.1%	8.7	240	10.5%	9.7	192	8.7%	7.7	208	9.2%	8.2
Sacramento	79	4.3%	5.1	72	3.4%	4.6	80	3.5%	5.1	93	4.2%	6.0	105	4.7%	6.6
San Bernardino	70	3.8%	3.2	96	4.5%	4.4	106	4.6%	4.8	105	4.8%	4.8	97	4.3%	4.3
San Diego	162	8.7%	4.8	133	6.3%	4.0	192	8.4%	5.7	188	8.5%	5.6	199	8.8%	5.9
San Francisco	193	10.4%	21.5	223	10.5%	24.8	202	8.8%	22.6	214	9.7%	24.0	190	8.4%	21.0
San Mateo	20	1.1%	2.6	14	0.7%	1.8	20	0.9%	2.6	25	1.1%	3.2	24	1.1%	3.1
Santa Clara	27	1.5%	1.4	39	1.8%	2.0	31	1.4%	1.6	41	1.9%	2.1	46	2.0%	2.3
Yolo	4	0.2%	1.8	1	0.0%	0.5	6	0.3%	2.7	5	0.2%	2.2	6	0.3%	2.6
California	**1,854**		**4.7**	**2,114**		**5.3**	**2,292**		**5.7**	**2,210**		**5.5**	**2,252**		**5.6**

Note: Rates are per 100,000 population. Numbers for the city health jurisdictions of Berkeley, Long Beach and Pasadena are subsets of the numbers for the counties in which they are located (numbers on Alameda, and Los Angeles counties (above) include the respective city LHJ numbers).

3. HIV Prevention, Care and Treatment Resource Inventory

The template provided by HRSA/CDC to document resources throughout California was used and completed. All federal HRSA and CDC HIV and STI contracts managed by OA and Oare included, with detail as to the distribution of federal funds throughout the 61 local health jurisdictions. Funding from HOPWA, SAMHSA, and other funding sources are listed to the best of our ability. Private grants to community-based organizations are not included in this resource inventory. We are pleased with the tabulation of resources and plan to utilize the information to increase awareness of funding in each health jurisdiction, especially when funding went directly to community-based organizations that the health department may not have been aware of previously. The resource inventory is summarized in **Appendices C-F.** Funded approaches and partnerships are included in the resource tables.

4. Needs Assessment

This California Statewide Needs Assessment for HIV was a collaborative activity conducted by CDPH OA and its partnering co-authors as identified in Section I of this document, in partnership with Facente Consulting and UCLA, for inclusion in this Integrated Plan. The California Statewide Needs Assessment uses both quantitative and qualitative data to support data-driven decision making for the development and implementation of California's Integrated Plan, as well as to meet federal requirements. It reflects the community's vision to address and deliver HIV prevention and care services. It outlines the needs and barriers to adequate and equitable services of people at greatest risk for and living with HIV infection - examining the service needs of California's current status neutral approach for HIV prevention and treatment services. It identifies resources available to meet those needs, and determines what gaps and barriers in testing, prevention, care, and treatment services currently exist throughout California. The Needs Assessment is further designed to provide information needed to eliminate HIV, HCV, and STIs, especially among those from communities who are disproportionately impacted and at higher-risk of these infections– supporting the states need and approach to address social drivers of health.

This Needs Assessment addresses four required components: (1) a summary of findings for needs, barriers, gaps; (2) key priority areas identified; (3) action taken to address needs and barriers; and (4) the methods used to complete the needs assessment, including a demographic profile of participants. The primary scope of this document is the entire state of California; therefore, the most detailed information is provided at the state level. Some sections include suggestions for addressing HIV prevention and care within the context of the proposed strategy. When callout boxes are used, they highlight details and themes that emerged over the course of the research, including reaching populations at high-risk for HIV, improving access to HIV care and prevention using non-traditional services, addressing the needs of aging and long-term survivors of HIV, and the importance of housing. Key insights and recommendations are also noted.

CDPH OA intends to review and update this California Statewide Needs Assessment periodically to identify ongoing and evolving needs of program planning and development, and to assess additional HIV, HCV, and STI integrated services and activities based on input from stakeholders throughout the state. In addition, each local health jurisdiction will augment this needs assessment, as needed, with additional, locally focused assessment activities that will aid in the implementation of this Integrated Plan.

All Ryan White Part A and CDC Prevention grant recipients in California were invited to participate in the California Statewide Needs Assessment process as part of the Integrated Plan process. Two Part A grant recipients in California (San Diego and, and Orange) elected to develop their own local needs assessments and integrated plans but also provided input into the California Statewide Needs Assessment and the broader Integrated Plan. Continuous coordination among all Part A jurisdictions in California continues to be a hallmark of this Integrated Plan's collective action strategy.

A. Needs, Barriers, and Gaps Summary

Through the EHE initiative, California's goal is to reduce HIV infections by 90 percent by 2030. The four pillars of the EHE initiative (i.e., Diagnose, Treat, Prevent, and Respond) highlight the need to coordinate HIV testing, rapid linkage to medical care, PrEP and social support services to effectively fight the HIV epidemic. Results from this Needs Assessment support the key indicators and strategies proposed by CDPH to address reaching the national and EHE goals, integrating activities that address the complex needs of California using a social drivers of health framework to align with the four EHE pillars.

Barriers: Although specific behaviors may increase individual risk for HIV, social drivers of health create barriers to service access and restrict available options. Substance use, economic and housing challenges, and stigma are embedded within the social landscape and complicate the process of achieving good health. The California Statewide Needs Assessment tool is organized to use social drivers of health as an analytical framework to highlight service areas that may present barriers to optimal healthcare and access for people at highest risk for HIV and for PLWH.

Needs Assessment: Provider Survey

The first method of this Needs Assessment was a virtual provider survey. Among the 130 respondents to the last statewide Needs Assessment survey (2022), 40% represented the Southern California region, and 60% represented the Central and Northern regions of California. The main issues identified were the following:

I. Needs

1. **People at Higher Risk for HIV and Other Sexual Health Concerns**
   a. **HIV Testing Access**- Needs Assessment data indicate that only 19/130 (15%) of respondents' service facilities offer weekend or evening services. 33/130 (25%) estimated their average client/patient's household income was less than $35,000, meaning the average client/patient served by these programs in California is a person experiencing poverty, who likely has fewer options to utilize services during regular business hours, due to limited or no paid time off. Changes are needed to improve the experience of low-income people having to choose between health and employment.

   b. **Maintaining an HIV-negative Status**- When asked to respond to a list of experience that providers may have had during the past year, the number one response was an increase in clients seeking STI services other than HIV testing. However, this indicator combined clients who are both HIV negative and living with HIV. The second most popular response was an increase in services *from* clients living with HIV. The third most frequently selected was clients seeking at home self-testing options. These results suggest that, while people continue to seek services in traditional HIV/STI testing sites, others are interested in nontraditional HIV/STI testing services as well.

      Nontraditional HIV/STI testing options, such as self-testing programs, have been shown to increase Black/African American engagement with testing services. This is important in California, since providers responding to the Needs Assessment estimated that Blacks/African Americans used their services less than half as much as Latino/a or White Californians, despite Blacks/African Americans carrying a disproportionate burden of HIV diagnoses compared to their population in the State.

Although African Americans carry a disproportionate burden of HIV diagnosis in the state, providers estimate African Americans use their services less than half as much as Latino or White Californians

50 percent of respondents provide medical care and treatment within 3 days of an HIV diagnosis and about half of those link clients within 24 hours.

c. **Rapid Linkage to HIV Medical Care, Treatment, and Support Services**- Fifty percent of respondents (65/130) provide medical care and treatment within 3 days of an HIV diagnosis and about half of those link clients within 24 hours. 125/130 (96%) facilitate linking people to HIV medical care and support services outside of their agency after diagnosis. Only 25/130 respondents (19%) provide internal linkage services for persons newly diagnosed with HIV, and 31/130 respondents (24%) provide transportation assistance or services, with 23/130 (18%) accompanying clients to services. However, limited staff time was identified as the number one barrier to facilitating linkage services. Staff lack of knowledge and experience a close second, selected by 24 (18%) and 21 (16%) respondents, respectively.

2. **People Living with HIV**

Homelessness and substance use were the top two barriers to support services for PLWH, followed by, stigma & transportation.

a. **Barriers to support services that PLWH need in order to achieve viral suppression**- Homelessness and substance use were named as the number one barriers to retention in support services for PLWH, with 16/130 (12%) of service providers selecting each of those options. These were followed by avoiding HIV status, stigma, and lack of transportation, with approximately 8% of respondents identifying each of these as key barriers for their typical clients.

b. **Necessary services for elder and long-term survivors to achieve optimal health and wellness**- A CDPH surveillance report published in 2020 states over 55.2% of PLWH in California are fifty years old or older. Although people are living longer with HIV, this wonderful news adds the challenge that PLWH over age 50 have more comorbidities than the general population.

Needs Assessment respondents identified difficulty navigating the healthcare system, housing instability, and mental health challenges as the most common reasons that PLWH did not access HIV-related medical care. Responding to these needs can increase providers ability to retain PLWH in care, including PLWH who are age fifty and over, who need to manage multiple providers to treat more medical needs associated with aging.

II. Barriers/Challenges:

1. **Accessibility**- 56/130 respondents (43%) do not directly offer medical care for PLWH; however, 125/130 (96%) facilitate linkage services for newly-diagnosed clients, with the most common services including referrals to specific providers and case management. Case management services tend to focus primarily on addressing housing and employment needs, as 40/130 respondents (31%) said that maintaining stable housing is the most common barrier to clients' engagement in medical care, and 32/130 (25%) said unstable employment was a common challenge faced by their clients.

25 percent of respondents report their client's household income was less than $35,000 annually

2. **Barriers to necessary support services**- Lack of transportation, unstable housing, and mental health disorders were all more commonly cited as social or structural barriers to care impacting their clients.

Forty-six of the 130 respondents answered the question estimating the average household income of their clients; of those, 33/46 (72%) indicated an average client household income of less than $35,000 annually. Yet despite this, less than half of the respondents reported providing transportation to HIV care services after diagnosis. This may be especially problematic in suburban or rural areas of the state, where low-income clients newly

diagnosed with HIV may find lack of transportation to be a major barrier to linkage in or retention in HIV-related care.

3. **Health department barriers**- California law states health department staff are obligated to perform as disaster service workers during an emergency, if requested. During the COVID-19 pandemic, many health department staff previously dedicated to HIV-related services were "activated" and moved to COVID-19 response teams as part or all of their daily work. As COVID restrictions have lifted, HIV-related staff capacity has been slow to return to pre-2020 levels as other pressures have weakened public health infrastructure.

   These staffing challenges have profound effects on PLWH. Nearly 25% of respondents identified limited staff time as a barrier to facilitating linkage to HIV care for newly-diagnosed clients, and 20% of respondents identified lack of staff knowledge or experience as barriers to facilitating linkage to HIV care in their organization.

4. **Partner services**- Only 75% of providers (98/130) reported they offer partner services after a client is diagnosed with HIV; the other 25% either do not offer partner services or were unsure.

III. Gaps:

1. **Better integration of services**- For people who are unhoused or living in remote rural areas, especially if also using substances, mobile outreach services that provide integrated care are a critical need. One respondent especially highlighted this need for people who are pregnant, noting, "Mobile medical outreach to specifically target unhoused substance-using women would help test, treat, and prevent the spread of HIV, HCV, STIs to unborn children as well as partner(s)."

   However, integration of services must be done thoughtfully, especially in small communities where everyone knows everyone else. Reorganizing and centralizing services under one roof can impose additional barriers due to perceived stigma. As an example, one service provider shared, "Individuals are not seeking our STI/HIV screening since moving to a consolidated office building with every other department in the county including: probation, sheriff, employment and eligibility, Child Protective Services (CPS), APS, WIC. Clients who do come to access our service often express concern of confidentiality being seen in the building. We now provide one fifth of the reproductive health services we use to provide before moving to the building."

"I think we need to take into consideration that clients need nontraditional entry points to care."

2. **Limited entry points to care**- Respondents of the Needs Assessment identified several areas where gaps in care and prevention services existed as a result of bottlenecks in service provision and few entry points to care. Excessive bureaucracy related to pharmacy and medical dispensing was one often-cited example of this, as well as a lack of primary care providers with HIV and STI expertise, and an insufficient number of nurses to provide case management in clinical settings. Particularly for people who are unhoused or use substances, and are disproportionately impacted for other reasons, traumatic experiences with the traditional healthcare system may serve as barriers to care in the future. As one respondent said, "I think we need to take into consideration that clients need nontraditional entry points to care." Examining and changing policies or barriers that limit clients' ability to access care through non-traditional settings will be a key strategy to improve care provision to these priority populations.

3. **Resources needed to serve PLWH better** – Respondents identified a number of gaps in existing resources for serving PLWH in their jurisdictions. The top three resources named as gaps were: (1) funds for capacity-building, (2) qualified staff to provide services, and (3) timely wrap-around navigation services, including housing, transportation, food assistance, and job search assistance.

Needs Assessment: PrEP Gaps

The second method of the Needs Assessment was a PrEP gap analysis that is currently still in process. Preliminary results are presented here. In July 2025, CDPH began a PrEP gap analysis in collaboration with UCLA to increase California's understanding of needs and challenges related to PrEP uptake. This work is to be completed in phases. The approach of this work completed so far are described here and made part of the SCSN in this Integrated Plan.

Summary Overview

Informed from the completed phases of the PrEP gap analysis are the following insights and recommendations for future PrEP work in California:

1) **Expand Relevance and Reach**
   Insight: Traditional PrEP outreach has been effective but limited in scope; engagement grows when rooted in community norms, spaces, and stories (e.g., barber shops, beauty salons, other community venues).

   Recommendation: Fund and co-create **tailored media campaigns** with trusted community voices and influencers to normalize PrEP across all populations.

2) **Normalize PrEP Access Through Everyday Healthcare**
   Insight: "One-stop shop" and mobile models for PrEP access reduce patient/provider friction but remain unevenly available.

   Recommendation: Scale low-barrier, community-based models (street medicine, drive-throughs, telehealth) and embed PrEP into routine and specialty care (OB-GYN, primary care, outreach sites).

3) **Invest in Provider Capacity and Systems Support**
   Insight: Some providers are willing to prescribe PrEP but constrained by limited training and administrative burden.

   Recommendation: Implement continuing education pathways for MDs, nurses, and pharmacists on PrEP, PEP, and DoxyPEP; streamline documentation through integrated EHR templates and simplified prescribing protocols.

4) **Address Gaps for Women, Rural Populations**
   Insight: Persistent provider bias and stigma deter women and rural communities from accessing PrEP.

   Recommendation: Develop population-specific educational materials, trusted care networks, and collaborative partnerships between public health agencies and rural entities to build trust.

5) **Strengthen Data and Feedback Mechanisms**
   Insight: PrEP program gaps are identified informally, hindering systematic improvement.

   Recommendation: Establish statewide data dashboards to track uptake, adherence, and population-specific access; integrate community feedback loops to ensure data informs ongoing interventions.

6) **Align Policy, Funding, and Implementation**

Insight: Fragmented funding and inconsistent messaging about PrEP dilute impact.

Recommendation: Advocate for coordinated policy frameworks that align funding, communications, and data systems around shared prevention goals.

Needs Assessment: ADAP Gap Analysis

The third method of the Needs Assessment was an ADAP gap analysis that is currently still in process. A noted strength of California's family of HIV/ADS programs is the AIDS Drug Assistance Program. Beginning as a program to distribute AZT in 1987, the program has grown to serve over 28,835 low-income people living with HIV in California in fiscal year 2023-2024. It is critical that this program remains funded and effective at levels that continue to support viral suppression rates that approach 95% for program participants. California, in collaboration with Facente Consulting, undertook an assessment of the program and what could continue to improve ADAP's effectiveness and its long-term viability. This effort is made part of this Needs Assessment. A summary of findings and recommendations are below. A final report of this gap analysis will be published as a separate report later in the calendar year 2027.

Key Findings

1. Enrollment workers and clients see ADAP-funded services as valuable

Enrollment workers and clients perceive ADAP services as crucial to maintaining people in HIV care. Clients are overwhelmingly satisfied with ADAP, describing services as timely and straightforward, and expressing gratitude for their relationships with enrollment workers.

2. The uncompensated labor of enrollment workers drives ADAP's impact

ADAP enrollment workers go above and beyond to help applicants enroll successfully by providing informal case management, outreach and follow-up support, and troubleshooting with providers and pharmacies, among other roles. However, they are not adequately compensated for this work, creating risks for burnout, capacity, and program sustainability.

3. Clients do not want to transition away from ADAP-funded services

ADAP clients are hesitant to transition away from ADAP because they do not want to disrupt their care. Clients fear that care will become unaffordable, and they are concerned that they will lose access to their known network of care providers.

4. ADAP is more accessible to certain populations compared to Medi-Cal

Transitioning to Medi-Cal, California's Medicaid program, is logistically complex for certain applicants, such as those who may struggle to obtain required documentation (e.g., people experiencing homelessness), those who may be fearful of sharing personal information with Medi-Cal (e.g., people who are needing case management to successfully complete applications).

5. ADAP's insurance assistance programs are not reaching their full potential

Clients appear to under-enroll in ADAP's insurance assistance programs, in part due to knowledge gaps at enrollment sites. For the Employer-Based Health Insurance Premium Payment program specifically, stigma and fear about submitting paperwork through one's employer is a notable barrier.

6. California's ADAP resources are not fully reaching their audiences

Many enrollment workers and ADAP clients are unfamiliar with existing OA ADAP resources, suggesting a gap in communication between OA, enrollment sites, and clients.

Recommendations

1. Align funding with the true scope of ADAP enrollment work
Covering the full cost of enrollment and retention in ADAP is needed for program sustainability. This could be achieved by increasing the base fees and fees per application that enrollment sites receive, adjusting fees per application to be larger for more complex enrollment cases, and supporting reimbursement of client transportation to enrollment sites.

2. Expand outreach, education, and navigation services for clients
Formalizing outreach and navigation support roles for ADAP, premium payment ADAP's insurance assistance programs, and coverage transitions are needed to acknowledge the true scope of enrollment worker labor. In addition, investing in support for outreach, education, and navigation can yield client-facing materials that reduce program confusion, such as clearer eligibility and documentation criteria.

3. Minimize the burden of transitioning between coverage types
At the client level, transitions between coverage can be improved with better informational materials about different coverage paths within and beyond ADAP. At the enrollment worker level, guidance around complex enrollment cases, such as clients experiencing homelessness and those with immigration-related concerns, would be beneficial. At the systems level, there are opportunities to destigmatize the Employer-based Health Insurance Premium Payment programs, as well as coordinate with other coverage providers to minimize care disruption across coverage types.

4. Strengthen the reach and impact of centralized systems
Existing state-level resources and processes can be better communicated to enrollment workers and clients. In addition, programs may be strengthened by new centralized resources, such as self-enrollment paths and clear protocols for reassigning applicants between enrollment sites.

5. Expand training opportunities for ADAP enrollment workers
Enrollment workers seek improved training on ADAP's insurance assistance programs. They may also benefit from state- and peer-led training on common pain points, such as interpersonal aspects of the enrollment work and using technology to streamline enrollment.

To maximize ADAP's value, impact, and sustainability, while ensuring that ADAP remains the payor of last resort, additional recommendations are being developed from the above key insights. These were not all available at the time of this report drafting.

B. Key Priority Areas

In addition to the Needs Assessment survey, OA and Facente Consulting held individual conversations with numerous health department staff and each of the TGA/EMA planning councils to discuss needs and identify priority service areas for work over the next 5 years. Participants broadly identified the need to develop specific goals to addressing the HIV/HCV/STI as one syndemic, and the need to unify a statewide movement to end these epidemics. Participants expressed that public health professionals from different disciplines can play an active role in this work, and that stigma must be addressed to break down barriers and begin fruitful conversations. Funding was a frequent topic, with respondents asking for flexible funding that covers not only clinical services but also costs related to addressing social drivers of health (e.g. housing, food) to avoid medical costs in the future. To this end, respondents identified siloed systems of care as problematic, as they are not set up to deliver holistic care, and called for greater communication between healthcare providers in primary care, behavioral health, and HIV/viral hepatitis specialty care. They noted that limitations on data sharing – while in place to protect privacy – also made it difficult to treat the whole person, rather than one symptom at a time.

Respondents also discussed the need to carve out more space for community health workers with lived experience, and requested more opportunities for training to ensure staff without lived experience are competent and empathetic to serve the community effectively and to address mistrust, and support to empower priority population led efforts. Some noted the historical context where the majority of advocates addressing HIV in California were individuals of greater economic means, which continues to overshadow opportunities to foster more varied leadership within advocacy groups.

Overall, the priority areas identified by respondents through the Needs Assessment were grouped into 6 categories, which we have defined as “impact areas”:

Figure 12--List of Priority Areas Identified for Inclusion in the 2027-2031 California Statewide Strategies:

1. Data defined, priority population focus
2. Housing
3. Health access for all: Access to quality of HIV prevention and medical care including testing, PrEP/PEP, attaining viral suppression, use of appropriate anti-retroviral therapy, and implementation of recommended sexually transmitted infection (STI) testing practices, as well as retention in and/or re-engagement in care through case management (including medical case management, non-medical case management, benefits counseling, patient navigation, and other similar patient support activities)
4. Mental health and substance use care and treatment
5. Economic factors
6. Stigma

C. Actions Taken

Key activities undertaken by the State to address needs and barriers identified during the California Statewide Needs Assessment are outlined in Section IV of this document (Situational Analysis) found below. Testing, Treatment, Prevention and Respond program expansions are described in Exhibits X and Y in section IV. All co-author jurisdictions have concurred with the need to address HIV as a syndemic with STIs and HCV and by addressing, where possible, the social drivers of health listed in **Figure 12**. Epidemiological data, community needs assessment data, and California community engagement efforts have suggested these actions.

D. Approach

Method 1: Provider Survey Approach. An electronic questionnaire was developed and prepared by Facente Consulting using Qualtrics and disseminated across the state. HIV service providers working in California were asked: (1) what services are needed to maximize access to HIV-related and sexual health services in the next five years, (2) what barriers there may be to accessing services, (3) what healthcare challenges currently exist for their clients, and (4) what gaps still exist in optimal services and care for HIV in California.

Key questions were developed with input from OA subject matter experts, the State CPG, and the Part A co-authors. Questions were prioritized based on the existing gaps in data, and the importance of addressing the question to understand the scope of HIV-related need. Questions that were tangential, specifically related to implementation or program evaluation, or deemed to be research were excluded.

Information was collected from April 2022 through June 2022, and yielded 130 responses from 22 local health departments, 9 community-based organizations, 6 HIV/AIDS Service Organizations, 7 federally qualified health centers (FQHCs), 5 hospitals, 4 local public health clinics, 4 private medical offices, and 4 community health centers that were not FQHCs. Participants were recruited from across the state. The list below shows the cities and counties where participants reside or work from each region:

- **Northern California:** Mendocino (Ukiah, Willits, Lake Port, Fort Bragg)**,** Butte (Chico)**,** Nevada (Grass Valley)**,** Humboldt (Eureka)**,** Yuba (Marysville)
- **Bay Area:** Alameda**,** San Francisco San Jose, Sonoma, Solano, Napa, Vallejo, Santa Clara
- **Greater Sacramento:** Sacramento, Stanislaus (Modesto)
- **Central/San Joaquin Valley:** Fresno, San Joaquin, Kern (Bakersfield), San Luis Obispo, Merced, Monterey, Inyo (Bishop), Madera Tulare
- **Southern California:** Los Angeles (Venice Beach, Long Beach), San Diego, Bakersfield, Orange (Irvine, Newport Beach, Santa Ana), Riverside (Palm Springs), Imperial (Calexico), San Bernardino

Participants identified their service facilities were in Southern California (40%), the Bay Area (9%) and Northern California (22%). The Central/San Joaquin Valley represented 15% percent and Greater Sacramento represented 4% percent.

Of all respondents, 1.3% percent identified as American Indian/Alaskan Native, 0.3% as Native American, 4.0% as Asian, Native Hawaiian or Pacific Islander, 5.3% as Black or African American, 19.2% percent as Latinx or Hispanic, and 19.9% as White. 40.0% percent of respondents were female and 20.0% percent were male. Respondents most often identified as program managers, followed by medical physicians, physician assistants or nurses.

Method 2: PrEP Gap Analysis Approach. The approach and components of the PrEP gap analysis included the following:

1) PrEP Gaps Listening Session (Virtual). On September 17, 2025, UCLA facilitated a listening session with 60 PrEP providers from regions across California, including co-author counties. Information from this listening session was augmented with a pre-session survey and posted chat comments during the session in response to key questions posed. Questions included how organizations and local health jurisdictions were capturing information about gaps in PrEP uptake.

2) Focus Groups (In Person). On October 15, 2026, five focus groups were held in person in conjunction with the fall California Planning Group meeting. Current membership of the CPG (n=32) is representative of every Part A TGA/EMA in California. Attendees were split into groups focused on PrEP priority populations, including women, youth and older adults, and asked to identify key strategies for PrEP navigation, PrEP patient education and outreach, and PrEP provider education.

3) Literature Review. UCLA conducted a review of 116 published articles with PrEP data from parts of CA. A majority of these articles included data from Los Angeles and San Francisco. Three articles included data from Alameda, twelve from San Deigo, eleven from Southern California and eight are for the state as a whole.

Method 3: ADAP Gap Analysis Approach. The approach and components of the PrEP gap analysis included the following:

From May 2025 – June 2026, OA collaborated with an external consultant (Facente Consulting) to explore barriers and facilitators of ADAP enrollment, with a focus on the following questions:

1. What are the main facilitators of and barriers to ADAP enrollment?
2. Why are some ADAP applicants not enrolled in health insurance or Medi-Cal coverage despite eligibility?
3. Why are some ADAP clients not enrolled in ADAP's insurance assistance programs that supplement ADAP coverage despite eligibility?

Stakeholders for this assessment included ADAP enrollment sites from all parts of California (including San Francisco and Los Angeles) and multiple types of enrollment sites (hospital, urban county run clinic, rural clinic, community-based organization, federally qualified health center). ADAP enrollment site workers and service providers (n=19) included both direct service workers and program advisory staff. Six listening sessions (n=23) and three key informant interviews were with people on or eligible for ADAP or ADAP assistance programs.

Strengths and Limitations

This Needs Assessment **Provider Survey** was intended to identify salient issues affecting service providers' ability to reach PLWH and individuals at risk for HIV, to explore the various dimensions of these issues, and in general to gather a detailed picture of provider opinions, client needs, and resources available for PLWH and people at elevated risk of HIV infection across the state. The provider survey was augmented by the **PrEP Gap Analysis** and **ADAP Gap Analysis** listening sessions and key informant interviews. This included information directly from PLWH and those at risk for HIV. Notably, due to the extensive efforts already being made through the EHE initiative and strategic planning outreach and engagement, the Needs Assessment was designed to leverage ongoing community engagement in Part A and EHE jurisdictions. This Needs Assessment provided an updated picture of how HIV-related programs and policies are perceived by the people providing these services to clients living with or at risk for HIV.

Summary of the Needs Assessment

The Needs Assessment process was developed by OA in collaboration with the co-authoring TGAs and partners to support data-driven decision making for the development and implementation of California's Integrated Plan, as well as to meet federal requirements. The Needs Assessment built upon work already done as part of EHE planning, and further included an electronic survey that was disseminated throughout the state using RWAHP Part A provider networks, all state HIV community planning bodies, the California STD/HIV Controllers Association, and the California Primary Care Association, in addition to being shared with all participants of our regional community engagement meetings as part of our statewide strategic planning. The Needs Assessment was designed to identify the needs, gaps and challenges in sexual health promotion, disease prevention and care services throughout the state, especially HIV, HCV, and STIs, with the goal of improving existing services and helping to create new ones as needed. Throughout the gathering of community input for this plan, participants consistently described the social determinants of health that contribute to the challenges of people living with and at risk for HIV, creating a strong rationale for responding to the syndemic using the approach and framework outlined throughout this plan.

The data show that some groups in California experience higher rates of illness and death across a wide range of health conditions. California's data-defined priority populations are disproportionately impacted by HIV, HCV, and STIs in California, in a similar pattern to the rest of the United States. This is not simply a matter of individual behaviors, education, or attitudes; research consistently finds that social drivers of health weaken the quality of services received by disproportionately impacted groups in the US. Challenges due to limited access to jobs, education, housing, and other growth opportunities for priority populations 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.

SECTION IV: Situational Analysis

1. Situational Analysis

This Situational Analysis provides a high-level overview of the strengths, needs, gaps, and barriers related to ending the syndemic in California and its co-author counties. It synthesizes information from the epidemiological profile, community engagement efforts, planning conversations, and consultations with key partners and stakeholders.

The Situational Analysis is organized into the following three sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps and has sections that address the four pillars of the Ending the Epidemic Initiative: Diagnose, Treat, Prevent and Respond as required by the Integrated Plan Guidance.

Methods

To ascertain the needs of the priority populations, as well as resources to meet those needs and gaps in services, a needs assessment was conducted. The needs assessment consisted of data gathered through a provider survey, a PrEP Gap Analysis, an ADAP Gap Analysis, community engagement efforts, assembly of a list of current HIV-related services and the agencies that provide them, and identification of gaps based on the current epidemiologic profile and current needs.

Exhibit 2: Methods and sources used for California's situational analysis

Method	Description
Needs assessment to ascertain needs, resources, and service gaps	• Virtual Provider Survey • Community engagement efforts • Information on existing services • California Directory of Syringe Services Programs
Review of secondary data and reports	• AIDSVu local PrEP estimates • California Epi Profile 2023 • CA Opioid Surveillance Dashboard • Ryan White HIV/AIDS Program Part A applications (co-author counties) • CA HIV Surveillance Report 2023 • U.S. Census Population Estimates for California
Community engagement and consultation	• HIV Planning Councils • Service providers • Community members representing the priority populations disproportionately impacted by HIV
Review of relevant County and State plans	• Ending the HIV Epidemic: California Consortium for CDC PS19-1906 (2020-2025) • Ending the Epidemics: Collective Strategies for Addressing HIV, Hepatitis C, and Sexually Transmitted Infections in San Francisco • Ending the HIV Epidemic In Los Angeles County (2020-2025) • ENDING THE EPIDEMICS: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California-Integrated Statewide Strategic Plan, 2027-2031 • Ending the Epidemics: Implementation Blueprint
Consultation with key stakeholders	• Local public health department staff • Regional and State: CDPH; Federal Ryan White Program Staff, TA Providers

Situational Analysis Snapshot

Situational Analysis Summary

Since 2013, CDPH and its jurisdictional partners have released three statewide Integrated Plans for California. All the plans have articulated strategies to eliminate new HIV infections and AIDS-related deaths, as well as reach zero stigma and discrimination against people living with HIV in California. After the completion of the first Integrated Plan (2017-2021) California made progress, but not enough progress and not fast enough for all population. So, with the plan released to cover the period 2022-2026, and with this 2027-2031 update, California proposed to not only address the better integration of HIV prevention, care and surveillance, but to address HIV as a syndemic with other STIs and HCV through a social drivers of health lens.

The plan, 2022-2026, had 4 strategic goals and the current plan you are reviewing recommits to these goals as a long-term investment and strategy:

1. Preventing new HIV infections by identifying all individuals potentially living with HIV;
2. Improving HIV-related health outcomes for all Californians;
3. Using a syndemic approach to achieve integrated, coordinated efforts that address the HIV, HCV, and STI epidemics synergistically;
4. Addressing social drivers of health that impact health outcomes.

CDPH and its community partners have made substantial progress in implementing many of the plan's recommendations. Throughout the state there have been thousands of people doing incredible work towards ending the HIV, HCV, and STI epidemics in California, from the implementation of integrated PrEP/PEP services and PrEP-AP sites throughout the state, to signing on to the Undetectable Equals Untransmittable (U=U) campaign, to routinized opt-out (ROOT) HIV testing in state prisons, to meaningfully integrating the expertise of people with lived experience to ensure programs are the best they can be. EHE funding is awarded to 8 California jurisdictions that together comprise 85% of the state's HIV cases. These jurisdictions now have plans that are being implemented, aimed at accelerating the end of the HIV epidemic in their communities. These EHE counties meet regularly and network to share best practices in collaboration with CDPH.

Some examples of California's progress in addressing HIV over the past 5 years include:

- From 2017 through 2023, both the annual number and rate of new HIV diagnoses declined slightly in California.
- Of all PLWH in 2023, 75.1% were retained in HIV care and 67.0% achieved viral suppression.
- From 2017 to 2023, the percentage of newly diagnosed people in California linked to HIV medical care within 1 month of their HIV diagnosis increased from 69% to 80.1%.
- An estimated 86.1% of PLWH in California are thought to know their status. To help diagnose infection among the remaining 13.9%, CDPH partnered with Building Healthy Online Communities (BHOC) to expand self-testing programs to those who have not recently tested for HIV or STIs.
- Exceeded the goal of increasing the number of Californians at high risk for HIV infection who are on PrEP to 60,000 (79,648 on PrEP as of 2024, excluding Kaiser data).
- In recent years, OA developed statewide data fact sheets specifically about HIV among key priority populations in California to help service providers better understand how to engage these communities and focus resources on reducing disproportionate health impacts.

Although California continues to make progress towards addressing HIV, HCV, and STIs, it's clear that the benefits of these advances have not been experienced proportionately. Too many people with HIV, HCV, and STIs still do not know they are infected. People who are Black or African American, White, and American Indian or Alaska Native experience a much greater burden of hepatitis C infection than should be predicted given their population size in the state. There are sex-

based disproportionate outcomes in STI diagnoses, and for syphilis, gonorrhea, and chlamydia, people who are Black or African American have more cases per 100,000 Californians than any other group.

For those who are aware of their infection, access to care remains difficult, particularly for individuals who are low-income or uninsured. Many health professionals in remote areas still lack experience testing and screening their patients, interpreting laboratory results, or treating these infections. Access to infectious disease specialists is limited throughout the state, and not enough primary care providers are equipped to handle the magnitude of cases. Organizations have limited resources and must balance competing priorities in a rapidly changing healthcare landscape.

To address these complex issues, CDPH convened a diverse group of over 50 individuals from state and local health departments, service providers, community leaders, and individuals living with or affected by HIV, HCV, and STIs to make recommendations for a coordinated and integrated approach to eliminate the HIV, HCV, and STI epidemics. Their input, along with the needs assessment results and countless community feedback hours obtained throughout 2022-2026, was used to update this plan and further inform the development of the six key impact areas described further in **Section V.**

Now this Situational Analysis will turn to presenting selected topics that were viewed as significant resources and gaps that were noted in the various methods listed in **Exhibit 2**. This list is not exhaustive and will expand during the implementation of this plan.

Summary of Resources and Assets

Resources and Assets

Exhibit 3 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance Integrated Plan planning and implementation.

Exhibit 3: Selected Resources and Assets	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Testing expansion initiatives. California will continue to implement and evaluate an array of HIV testing methods, including but not limited to, ROOT in healthcare settings, focused (rapid) testing in community settings, self-testing and testing in correctional facilities and/or jails. California will continue to fund jurisdictions to implement HIV testing services that are bundled with screening for other conditions relevant to OA's priority populations (such as STIs, mpox and HCV testing). California will also implement a new test counselor training program that will increase and expand its ability to train test counselors across the state to provide rapid HIV, HCV and syphilis testing.	●			

Integrated HIV, STI, HCV self-testing program. California is continuing to work closely with Building Healthy Online Communities (BHOC) to provide self-testing options for HIV, HCV, and STIs statewide. To date, BHOC's Take Me Home initiative has resulted in a substantial increase in HIV testing for some priority populations. California has taken steps to expand this service beyond EHE Phase I counties, purchasing 21,000 additional self-tests through BHOC to distribute to individuals at high risk for HIV throughout the state.	●			
Treatment expansion initiatives. California has designed programs and services to increase early linkage to medical care, syndemic approaches, and refer to or provide prevention and essential support services (e.g., health benefits navigation/enrollment, behavioral health services, social services, etc.) to support improved quality of life. Additionally, California continues to fund activities aimed at increasing medication adherence, reengagement in care and viral suppression.		●		
Prevention expansion initiatives. California continues its collaboration of funded jurisdictions, stakeholders, medical providers, pharmacists, and capacity building partners, etc. to increase awareness and expand access to PrEP and PEP for priority populations. California monitors PrEP data indicators to evaluate PrEP referral, linkage and initiation. Long-Acting Injectable (LAI) PrEP represents a unique opportunity, especially for those populations that may find it a barrier to take a daily dose of PrEP medication. An ongoing PrEP gap analysis scheduled to be completed and published in early 2028, will offer recommendations to accelerate progress on implementing PrEP in California.			●	
PrEP-Assistance Program. To ensure clients of the PrEP Assistance Program (PrEP-AP) maintain access to their medications during COVID-19, PrEP-AP now allows up to a 90-day supply of medications, unless the client is previously enrolled in a program that limits medication dispensing. PrEP-AP also added coverage for the OraQuick In-Home HIV test, to allow people taking PrEP to conveniently test at home.			●	
HIV surveillance. California continues to collect and report surveillance data with a focus on identifying areas for improvement in timeliness, completeness, and accuracy. California continues to produce and disseminate reports to facilitate program planning and program action, as well as working towards the development of tools to facilitate more rapid and effective dissemination, such as dashboards and other data pipelines, and in continued collaboration with other groups focused on mpox, STIs and HCV. California will maintain data security and confidentiality in accordance with CDC guidelines.				●
ADAP modernization. As of January 13, 2026, California transitioned ADAP to an open formulary model. This means that all FDA-approved medications are now included in the formulary except for selected medications that have been excluded due to safety concerns or cost. The expanded formulary will align ADAP more closely with Medi-Cal's broad medication coverage and will reduce treatment interruptions, especially for clients whose insurance changes between ADAP and Medi-Cal. California has also maintained eligibility for ADAP at 600% of the federal poverty rate. Through an ongoing ADAP gap analysis scheduled to be		●		

completed in calendar year 2026, other recommendations will be forthcoming to further modernize the ADAP program. HRSA Part B, the primary source of ADAP funding, has been trending as a stable source of income, and currently, California sees no need to shrink the program's services or eligibility.				
Respond expansion initiatives. All California counties coordinate with CDPH for HIV transmission cluster detection and response. CDPH provides technical resources and coordinates HIV molecular cluster detection efforts across California, using the secure HIV Trace program. CDPH uses routine molecular sequences from drug-resistance screenings of PLWH to detect groups of individuals who represent geographically and temporally connected HIV transmission events. California counties utilize these resources to support outreach to populations with notably active or increasing HIV transmission, in order to enhance prevention, testing, and linkage to care. Along with conventional HIV surveillance and epidemiology, this also helps define the leading edge of the local epidemic. California counties use HIV Data-to-Care processes and the Local Evaluation Online (LEO) database to track outreach and linkage efforts and outcomes. Contractors who case manage or serve PLWH identified through cluster detection efforts use CDPH's HIV Care Connect (HCC) database to track retention and health outcomes.				●
Viral suppression rates among Medi-Cal enrollees continue to exceed the statewide average for people living with HIV. A similar pattern is observed among people enrolled in ADAP, who consistently achieve a 95% viral suppression rate, which is again much higher than the statewide average for people living with HIV.				●
Data to Care. The Enhanced Data-to-Care Initiative trains Disease Intervention Specialists (DIS) and special community response workers to utilize surveillance data to not only respond to local outbreaks and clusters, but offer social support and address additional community needs, placing more relatable community individuals in roles to support response efforts.				●
Cluster Detection Response. CDPH-OA analyzes HIV transmission data monthly looking for abnormal increases, known as time space clusters, in counties and among priority populations within counties. HIV molecular sequence data is incorporated to identify related infections and networks of rapid transmission. National priority clusters have 5 or more related infections in the previous twelve months. In 2025, CDPH-OA detected 36 county and 8 regional time space alerts and detected 12 new priority molecular clusters and monitored 28 molecular clusters. At the time of detection, the most common risk factor for all the 12 new molecular clusters was male to male sexual contact.				●
Cross-Pillar				
Project Cornerstone. An innovative, evidence-based approach to improve the health and well-being of people living with HIV who are fifty years of age and older, has been planned and initiated. This project addresses the increasingly complex needs of this expanding population through the integration of clinical and non-clinical care, as well as coordination of comprehensive support services.				

Mobile/Street Medicine and other wholistic models for provision of status-neutral health services. A robust Street Medicine program has been implemented through a partnership with the USC Keck School of Medicine. This program addresses the needs of unsheltered/unhoused individuals throughout California, offering ongoing training opportunities focused on street medicine models of care. Currently, California's six EHE-funded counties are piloting services and integrating this model of care into their existing HIV prevention services.
Strategic partners outside of HIV/STI/HCV work and public health. Through the activities outlined in this Integrated Plan, OA is focused on engaging non-traditional partners (e.g., HOPWA housing providers, mental health providers, workforce development teams, jail health clinicians) as full partners in our work to plan and implement HIV, HCV, and STI-related prevention and care services.
Community Engagement. California will continue to conduct regular strategic community engagement activities with the California Planning Group (CPG), Prevention Partners Monthly Webinars, and mpox and Vaccine event teams in collaboration with the Office of STIs and Hepatitis C (OSH). California will continue maintaining the CPG planning body through ongoing membership activities and will collaborate with the CPG to implement the statewide strategic plan. California will also continue enhanced community engagement to recruit new voices and non-traditional partners to the HIV, STI and HCV planning table and to continuously improve EHE and core interventions.

Summary of Gaps and Challenges

Gaps and Challenges

Exhibit 4 highlights selected gaps and challenges identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance Integrated Plan planning and implementation.

Exhibit 4: Selected Gaps and Challenges	1:Diagnose	2:Treat	3:Prevent	4:Respond
Pillar-Specific				
Routine opt out testing (ROOT) is not universal. Risk-based screening may fail to identify some people with HIV**.** In health care setting where ROOT is implemented, patients are informed on intake that an HIV test will be included in the standard preventative screening tests. Patients can decline (or opt out) of the test if they would like. ROOT has been shown to be effective because it can reduce the stigma associated with HIV testing. ROOT can also be effective as a syndemic strategy: implementing STI and HCV testing at the same time. Providers have shared that implementing ROOT, particularly for syndemic testing, is a heavy lift. Increasing investment in ROOT start-up costs for health care systems that lack ROOT could lower barriers to initiation.	●			

Insufficient extended service hours and nontraditional models to better meet the needs of priority populations. Many of our priority populations are simply not well served by traditional 4-wall clinics or service organizations with hours from 9 – 5 on Monday through Friday, a structure that inhibits HIV testing and screening rates and is a barrier to care linkage for people testing positive.	●			
Insufficient education and community knowledge regarding HIV and its treatments. While there have been incredible advancements in HIV treatment, many people in California continue to hold outdated perceptions about the options available to them if they do become infected with HIV. Also, internalized stigma still impacts the ability for communities to acknowledge their risk for HIV.		●		
Lack of programs to support HIV retention in care for formerly incarcerated persons. A great area of need is for recently released PLWH who were able to access treatment while incarcerated, but for whom there is insufficient re-entry support.		●		
Insurance gaps and health outcomes. Individuals who are not enrolled in insurance or benefits programs are more likely to be out of care and therefore contribute to lower statewide viral suppression rates. These findings underscore the importance of proactively navigating all people living with HIV to comprehensive insurance and benefits programs.		●		
Ongoing opioid and methamphetamine epidemics. Increasing epidemics of opioid and methamphetamine use make it difficult to prevent both primary and secondary HIV infections.			●	
Data to Care. Funding uncertainty has begun to limit the capacity for epidemiological analyses and HIV surveillance activities including Data to Care prevent from ideal targeting of resources and programs to best address HIV.				●
Cross-Pillar				
Medical mistrust. Failure by health and research institutions to rebuild trust among the populations most highly affected by HIV, STIs and HCV has impacted their access to and use of health- and HIV-related services.				
Insufficient institutional support to nurture community and public health leadership among communities most impacted. Public health departments partially hold the responsibility to cultivate and support development of new leaders in HIV, STI and HCV public health locally, among those communities most impacted by the syndemic.				
Lack of accessible, culturally competent mental health and substance use services. For those struggling with problematic substance use and/or mental health concerns, there are insufficient options for behavioral health services that will meet their needs in a culturally appropriate way.				
Incarceration. Incarceration greatly increases the risk of fatal overdose — the death rate from drug overdose in California prisons is 3 times higher than the national average and continues to rise.				
Service deserts. There are increasing economic pressures and a resulting substantially increased migration to less expensive outlying areas of California, causing challenges for retention in HIV care and other challenges to HIV treatment.				
Disproportionate impact of the syndemic. Data defined disproportionately impacted groups are disproportionately impacted by HIV, HCV, and STIs in the United States and in California. Challenges due to limited access to jobs, education, housing, and other growth opportunities for priority				

populations 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.
Housing. People who are unhoused or marginally housed are at higher risk for HIV, HCV, and STIs. 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.
Health Access. 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. 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 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. Other barriers include, long wait times for appointments, providers are too far, people cannot afford to take time off, lack transportation or afford childcare, and in some instances, the provider does not speak their language or understand their culture. For people who do access care, they may have a negative experience that makes them not want to seek care again except in emergencies.
Mental Health and Substance Use Prevention. For the estimated eight percent of Californians with a Substance Use Disorder (SUD), the California Health Care Foundation (CHCF) estimates only 10 percent receive treatment. CHCF also estimates that 1 out of 6 Californians have a mental health concern, and 1 out of 24 have 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. For those struggling with problematic substance use and/or mental health concerns, there are insufficient options for behavioral health services that will meet their needs.
Economic barriers. 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. 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.
Stigma. 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 stigma and their guesses about whether a provider will be supportive. A review 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 determined 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.

2. Priority Populations

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

- People disproportionately impacted as defined by data
- Young people (ages 15-29 years)
- Men who have sex with men
- People experiencing homelessness
- People who are incarcerated or justice involved
- Women
- People who are aging with HIV, older adults with HIV

These groups are not mutually exclusive, nor do they experience negative health outcomes independently. Many people identify with more than one of the groups in this list and are disproportionately impacted by a number of factors. These intersecting identities can often mean people experience multiple compounding barriers, making it harder for them to thrive, thus causing negative health outcomes.

Table 9 shows high-level factors across the syndemic for each priority population are noted below.

Table 9. High-level factors across the syndemic for each priority population

Population	HIV	HCV	STIs
Data defined disproportionately impacted groups	Californians who are Latino/a account for more than half of all new HIV diagnoses, with rates increasing over the past five years.	American Indian/Alaska Native individuals represent 1% of newly reported chronic HCV cases but less than 0.5% of California's population.	Black/African American Californians bear the most disproportionate burden for syphilis, gonorrhea, chlamydia and HIV.
Young people (aged 15-29 years)	One-third of all new HIV diagnoses in CA are among people aged 15-29 years.	The proportion of newly reported HCV cases among young people, especially males 20-29 years, has increased over the past decade.	The highest STI rates in CA occur among young people aged 15-24 years.
Men who have sex with men (MSM)	Over three-quarters of men living with diagnosed HIV in CA acquired HIV through male-to-male sexual contact (MMSC).	MSM in the U.S. are at higher risk of acquiring HCV due to injection drug use and HIV infection (which increases the risk of sexual transmission of HCV).	Gay and bisexual men and other MSM account for more than half of gonorrhea and early syphilis cases in CA.

People experiencing homelessness (PEH)	PEH experience higher rates of HIV, are more likely to engage in activities associated with increased HIV risk and face greater barriers to HIV care and treatment.	Due to overlap with injection drug use, PEH are at higher risk for HCV.	PEH, especially youth, have high rates of STIs like chlamydia, gonorrhea, and syphilis.
Recently or formerly incarcerated or justice involved people	Approximately 1% of people incarcerated in the U.S. are living with HIV.	The rate of newly reported HCV diagnoses in state prisons is more than 30 times that of the general population.	Incarceration in the previous 12 months is a risk factor for congenital syphilis among pregnant people.
Women	New HIV diagnoses among this population have remained steady between 2018-2022.	In state prisons, newly reported HCV cases among women are increasing more rapidly than among men.	Syphilis rates have risen much more dramatically among cisgender women in CA.
People who are aging with HIV, older adults with HIV	People who are 50 years and older are the largest population of people with HIV whose needs are still emerging.	Almost half of all HCV infections in California are in the 50+ age group.	Syphilis remains a concern for those over age 50, while gonorrhea and chlamydia rates decrease with age.

Priority Population Notes

Community engagement efforts have augmented the "population notes" that are part of the Implementation Blueprint. However, in the last Integrated Plan, ***people who are aging with HIV*** were not listed as a priority population. ***PLWH who 50+*** are the largest population of PLWH in the state, and their needs are still emerging. California intends to update the population notes for all priority populations as noted in our workplan to aid local health jurisdictions in implementing the strategies and activities noted in our Integrated Plan and Implementation Blueprint. During the development of this plan, a number of key stakeholders provided feedback about how to approach strengthening California's syndemic response for people who are aging with HIV. The insights and suggestions and developed from these conversations are below.

Priority Population Notes Focus: People who are aging with HIV, older adults with HIV

Noted Needs and Gaps

Fragmentation between HIV and aging service systems. There is limited coordination between HIV care providers and aging services can result in missed referrals, delayed access to supportive services, and gaps in continuity of care.

Data limitations and visibility. There is a lack of integrated data systems that capture HIV status within aging services limits planning, accountability, and the ability to target resources effectively.

Workforce capacity gaps. Many providers across both HIV and aging systems lack training to address the intersecting needs of older adults living with HIV, particularly in behavioral health, long-term care, and social support settings.

Social isolation and loneliness. Social isolation causes acceleration of cognitive decline and higher rates of depression and both of those issues can cause people to spiral quickly. How can public health and the community more broadly help people to stay socially engaged as they age.

Economic stability. Financial insecurity directly impacts health outcomes. Over the life-course, the resources available for self-support will vary widely and should be assessed: employment history, discrimination, share of cost for medications and care, et cetera.

Trauma and Long-Term Survivorship. Many older adults with HIV are long-term survivors who lived through the early epidemic. Culturally responsive care must address chronic trauma, grief and survivors' guilt, as well as medical mistrust rooted in historical experiences.

Polypharmacy. With accelerated aging comes more medical diagnoses and people are soon taking 10+ meds (5+ is how polypharmacy is defined) and that causes drug-drug interactions and drug adverse reactions and often confusion about what each medication is treating.

Stigma. Late life stigma as living situations change – as people more dependent on care and health with activities of daily living from home health or assisted living there may be new stigma that people experience related to sexuality or other issues. The term "going back into the closet" because your experience with "aging" services does not feel safe with regards to sexuality.

Noted Strategies

Prevention Assessments. Conduct regular health screenings to include assessments for sexual, drug user, mental and physical health. These screenings may need to be more frequent among people aging with HIV and should occur earlier, as they may experience a more rapid aging of the life-course due to the effects of HIV medications and psycho-social stressors that are often cofactors of being diagnosed with HIV as outlined in the Strategic Plan: priority population focus, health access, mental health and substance use, economic factors, and stigma.

Wellness. Provide prevention education to focus on wellness to managing aging in the best and most healthy way possible.

End of life planning and palliative care. This is especially important because of stigma and chosen-family structures that are part of the support network of people aging with HIV. This should include ongoing assessments to create a plan and regularly update advance care plans. Palliative care access and access plans for culturally competent hospice services should be part of this planning.

Priority population sensitive counseling. Develop and use counseling specifically tailored to people who are aging with HIV with attention to intersectional communities that may increase challenges and strengths in a syndemic fashion and may even accelerate aging.

Benefits and services education. Benefits and services education and support to help individuals negotiate a complex services structure, with particular attention to those in transition on to MediCare.

Detail aging services. Ensuring the broader systems of aging care and support understand the HIV and aging population and are addressing their unique needs.

Support Caregivers. Recognizing the importance of supporting caregivers, including those accessed through In Home Support Services (IHSS), is essential, as they provide daily physical, emotional, and logistical support that helps individuals maintain independence, dignity, and stability in their communities.

Cross-sector integration. Promote formal partnerships between HIV care systems and aging services, including shared care models, referral pathways, and coordinated service delivery.

Workforce training across systems. Expand training to ensure that aging services providers understand HIV-related needs and that HIV providers are equipped to address aging-related conditions and services.

Enhanced navigation and care coordination. Strengthen support for individuals navigating complex and often siloed systems, particularly during key transitions such as enrollment in Medicare or entry into long-term services and supports.

Alignment with existing policy frameworks. Ensure that HIV and aging strategies are aligned with state and federal aging policy, including implementation of the Older Californians Act as amended by SB 258 (California HIV and Aging Act), as well as broader aging initiatives, to support consistency and accountability across systems.

Summary of the Situational Analysis

This situational analysis has presented an overview of topics derived from a number of data sources that show that California has made progress but needs to continue its efforts to address HIV not on its own, but as part of a broader set of factors. This strategy is derived from the facts that

1) Not everyone experiences the same benefits from prevention and care services; We need to focus work on those priority populations that the data tell us are disproportionately impacted;
2) HIV, STIs and HCV impact our priority populations in a syndemic way and need to be addressed in an integrated fashion; and,
3) Addressing the syndemic must be done by addressing social drivers of health factors like health access for all, housing, mental health and substance use prevention, economic barriers and stigma free services.

In addition to our SMART objectives presented in **Section V**, we reassert that 30 strategies organized across 6 social drivers of health, derived from wide community consultation and input, are the activities that best inform our work over the next 5 years. The following pages present these strategies, relate them to the EHE pillars (Test, Treat, Prevent, Respond) and will be the touchstone of our work over the next 5 years.

SECTION V: 2027-2031 Goals and Objectives

1. Introduction and Overview of Workplan

This Integrated Plan responds to the needs identified in the Needs Assessment (see Section III), and aligns closely with the goals of the NHAS to address the national HIV goal of reducing the number of new HIV infections by at least 90 percent by 2030. **Section V** is split into sections that address the requirements of the Integrated Plan Guidance to develop a workplan. This section also discusses a strategy to make that workplan more effective by addressing social drivers of health more directly. As this plan has discussed above, the core work located in the pillars needs to go on: test, treat, prevent, respond. **Section 2** below describes the core activities goals and objectives of the Integrated Plan. These are described in a narrative summary and through objectives that are organized across the pillars. This core work has allowed California to make progress, but not enough progress, and not for all priority populations. Thus, **Section 3** below also describes 30 strategies organized across 6 social drivers of health. These high-level strategies were developed through extensive subject matter expert consultation and community engagement. These strategies are not mandates but the best suggestions that California has at this time to address the social drivers of health that are impacting the health outcomes of our priority populations. They are not presented as SMART objectives, because each jurisdiction that adopts these strategies along with their core work, will adapt them differently into an implementation blueprint. Funding for these strategies will be through a combination of sources as resources become available. Each jurisdiction's implementation blueprint will have activities and metrics that will vary depending on the community, and its resources. CDPH OA is making resources available to develop or update an implementation blueprint to accompany this Integrated Plan for all jurisdictions that chose to use this Plan. Finally, an initial workplan is included as **Appendix G: California Integrated HIV and Prevention and Care Plan Work Plan and Monitoring Table, 2027-2031.**

2. Description Core/Baseline Work

Pillar 1 Activities: Diagnose

Activities include targeted testing of priority populations, distributing self-collection tests, increasing testing through Partner Services referrals, expanding Routine Opt-Out Testing (ROOT), and bundling HIV testing with STI screening and Hepatitis C testing. Linkage to HIV Care and Rapid ART for those who receive an HIV diagnosis is a critical element to transition from Diagnosis to Treat. Likewise, linkage to PrEP services for those who test negative for HIV but are PrEP eligible is an important link between Diagnosis and Prevention. Maintaining core testing interventions can be made more effective by addressing social drivers of health.

Pillar 2 Activities: Treat

Rapid Linkage to Care and ART is a critical activity. Each jurisdiction, assisted by CDPH, will use surveillance data to follow up on individuals identified as out of care. Non-Ryan White providers will be offered assistance with retention and reengagement of clients, as well as services for non-virally suppressed individuals. Community education about Rapid ART, viral suppression, and Undetectable equals Untransmittable will assist in realizing the value of ongoing HIV medical care. The ongoing improvement and modernization of the ADAP Program, through the recommendations of an ADAP Gap Analysis scheduled for completion in June 2027, will improve client access to treatment. Addressing social drivers of health is critical to ensuring that treatment and supportive services for PLWH are effective and client-centered.

Pillar 3 Activities: Prevent

Expansion of PrEP, especially among priority populations, will be aided by additional provider sites and promotion of the OA PrEP Assistance Program (PrEP AP) that will remove a fiscal barrier for many. Agencies will collaborate with pharmacies dispensing PrEP and PEP to ensure individuals are linked to a provider for ongoing PrEP services. Coordinating PrEP initiatives will reduce redundancy while expanding PrEP access.

Technology solutions, like social media outreach and expansion of PrEP through tele-health are also being explored through a PrEP Gap Analysis and recommendations scheduled to be completed in June 2027. Effective behavioral interventions are offered for those not choosing PrEP. Core SMART objectives for the Prevent Pillar are located below. Addressing social drivers of health is critical to ensure that prevention efforts accelerate the end of the HIV, STI, HCV syndemic in California.

Pillar 4 Activities: Respond

California will continue to enhance partner services through the implementation of the partner-services data-to-care tool, CalCONNECT, and CDPH OA will lead Molecular Cluster identification. CDPH OA will collaborate with the county(ies) in outbreak response. If counties identify or suspect a cluster, they will work with OA to verify and develop the response plan. If cluster investigation exceeds the capacity of the county, the OA Disease Outbreak Intervention and Field Investigation Unit will assist. For significant outbreaks, the CDPH Office of Emergency Preparedness will activate its emergency response protocol. Addressing social drivers of health is critical to ensuring that respond efforts are effective and respectful of individuals.

Core Goals and Objectives by Pillar

Pillar 1 Activities: Diagnose

Goal 1: Diagnose all people as early as possible

Objective 1.1. By December 31, 2031, increase the estimated percentage of Californians living with HIV who know their serostatus to at least 95 percent.

Objective 1.2. By December 31, 2031, implement a testing program including ROOT and focused testing strategies administering 1 million HIV tests with at least 70 percent being from priority populations in California.

Objective 1.3. By December 31, 2031, implement an integrated self-testing program conducting at least 10,800 tests reaching at least 70 percent individuals from listed priority populations in California.

Pillar 2 Activities: Treat

Goal 2: Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Objective 2.1. By December 31, 2031, increase the percentage of newly diagnosed persons in California linked to HIV medical care within 1 month of their HIV diagnosis to at least 85 percent.

Objective 2.2. By December 31, 2031, increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75 percent.

Objective 2.3. By December 31, 2031, increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 80 percent.

Pillar 3 Activities: Prevent

Goal 3: Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP).

Objective 3.1. By December 31, 2031, reduce the number of new HIV diagnoses in California by at least 50 percent, to fewer than 2,500 per year.

Objective 3.2. By December 31, 2031, increase the number of Californians at high risk for HIV infection who are on PrEP to 120,000 from a baseline of 79,648 (2024).

Objective 3.3. By December, 2031, maintain a condom distribution program, distributing at least 5 million condoms to priority populations in California.

Pillar 4 Activities: Respond

Goal 4: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them.

Objective 4.1. By December 31, 2031, all identified HIV clusters will be actively managed with a response plan implemented.

Objective 4.2. By December 31, 2031 assist with 100% of all requests for assistance from local health departments to help manage clusters and outbreaks of HIV.

Objective 4.3. By December 31, 2031, maintain a state-wide Cluster Detection Response Community Advisory Board with recruited members comprised of people living with HIV and with lived experience and other subject matter experts from all regions of California in collaboration with San Francisco and Los Angeles, holding at least 4 quarterly meetings per year to help advise and improve the efficacy of California's response to HIV clusters.

3. Description Social Drivers of Health Impact Areas and Strategies

The Integrated Plan expands and enhances existing HIV, HCV, and STI programming to address the comprehensive and complex needs of all communities. Each coauthor local health jurisdiction's baseline, core objectives will be informed and address their work through the following impact areas and strategies.

Our California-specific goals include 6 key impact areas and 30 associated strategies, as follows:

Impact Area 1. ***Priority Population Focus:*** Improve health outcomes for all Californians, especially highly impacted communities.

- *Strategy 1a. Leadership and Workforce Development:* Expand pathways and workforce development initiatives to increase the proportion of priority population public health staff, leadership, and administrators, including at CDPH.
- *Strategy 1b. 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 all communities, to inform resource allocation and identify community-based strategies and solutions.
- *Strategy 1c. Distribution of Funding and Resources:* Review all CDPH OA and STD Control Branch contracts, budgets, guiding service formulas, policies, and program decisions to advance delivery of resources and opportunities to highly impacted communities.
- *Strategy 1d. Community Engagement:* Forge strategic partnerships to ensure more priority population outreach, involvement, and engagement processes to reframe the structure, funding, and policies of HIV, HCV, and/or STI services and messaging to all Californians.
- *Strategy 1e. 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 greater effectiveness in our prevention, testing, treatment, and care services.

Impact Area 2. ***Housing:*** Create systems that promote stable housing access with minimal-to-no barriers using evidence-based models for all.

- *Strategy 2a. 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.
- *Strategy 2b. 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.
- *Strategy 2c. 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 Homekey, for people living with HIV and pregnant people who are unhoused and/or living with HCV or syphilis.
- *Strategy 2d. 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.
- *Strategy 2e. 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 comprehensive and low barrier approaches to substance use, are available to families and couples, and/or allow people to bring their pets.

Impact Area 3. ***Health Access for All:*** Increase access to comprehensive, high-quality health care services for all.

- *Strategy 3a.* 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.
- *Strategy 3b. Comprehensive 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.

- *Strategy 3c. 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 special circumstances or housing status.
- *Strategy 3d. Effective and Relevant Services:* Improve capacity of public health and health care providers to offer HIV, HCV, and STI services that are responsive to all Californians regardless of factors like health literacy, and other communication needs.
- *Strategy 3e. 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.

Impact Area 4. *Mental Health and Substance Use Prevention:* Increase the proportion of people with a mental health or substance use disorder who receive adequate and appropriate treatment; reduce unmet need.

- *Strategy 4a.* Life-saving strategies *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.
- *Strategy 4b. 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.
- *Strategy 4c. Build Comprehensive and Low Barrier Prevention Infrastructure:* Expand comprehensive prevention services in federally qualified health centers, hospitals, and SUD treatment facilities; build up staffing, brick and mortar locations, and other vital (health, legal, housing, benefits, employment) support services in existing prevention programs.
- *Strategy 4d. Expand Low-Threshold SUD Treatment Options*: Expand options for low barrier comprehensive prevention-based treatment, and easier access to buprenorphine and methadone, including in street medicine programs.
- *Strategy 4e. Cross-Sector Collaboration*: Encourage collaboration between local and statewide mental health programs, substance use programs, comprehensive low barrier prevention and HIV/HCV/STI programs.

Impact Area 5. *Economic Barriers*: Increase the proportion of programs and opportunities that promote jobs, equitable income, sustainability, and growth for all.

- *Strategy 5a. 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.
- *Strategy 5b. 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 people reflective of those most impacted by HIV, HCV and STIs serving in meaningful leadership positions.
- *Strategy 5c. Hiring Practices and Fair Pay*: Examine state and local health jurisdiction hiring practices to promote hiring those most impacted by HIV, HCV and STIs; look to remove barriers such as college and advanced degree requirements; offer extra pay to people who have lived experience with HIV, HCV, STDs, substance use, mental health challenges, or homelessness.
- *Strategy 5d. 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.
- *Strategy 5e. 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.

Impact Area 6. *Stigma Free*: Increase the proportion of people who seek treatment for HIV, HCV, and STIs without fear of stigma.

- *Strategy 6a.* 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.
- *Strategy 6b.* 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.
- *Strategy 6c.* Positive, Accurate Information: Ensure images and language used in communications show accurate and diverse depictions of communities
- *Strategy 6d.* Acknowledge Medical Mistrust: Recognize medical mistrust; work to build trust and correct misperceptions by example.
- *Strategy 6e.* Ongoing Partnerships: Use of paid peer engagement by people from the communities being served to educate, support, advocate, and link to care people who have not been as well-served by public health services and the health care system.

These 30 strategies were developed as part of our statewide integrated strategic planning process to address eliminating HIV, HCV, and STIs using a cross-cutting and innovative framework. This plan was released first in January 2022 and updated for this 2027-2031 planning cycle and will continue to guide California's work for the next five years. All co-author Part A Planning Councils and the CPG concurred with this plan (**Appendix B**). An Implementation Blueprint for these strategies will be updated, using feedback gathered in community engagement activities across all co-author counties. It will be available statewide by December 31, 2027. The blueprint will outline updated strategic activities for implementing these strategies, along with recommendations, action steps, potential partners, and updated evaluation measures for achieving the goals of this plan. Each local health jurisdiction will adapt or update a local version of this Implementation Blueprint.

The table on the following page demonstrates the way that these 30 strategies align closely with the 4 pillars of the Ending the HIV Epidemic (Diagnose, Treat, Prevent, and Respond). The activities are the best recommendations suggested by community and subject matter experts about how to more effectively address the syndemic. They are note mandated activities and they may be applied in each jurisdiction differently. They are meant to accelerate the core work described above on page 69.

Table 10. Prioritized Impact Areas and Associated Strategies Organized by the Pillars of the Ending the HIV Epidemic Initiative

Impact Area	Strategy	Diagnose	Treat	Prevent	Respond
1. Priority Population Focus	**1a. Leadership and Workforce Development**: Expand pathways and workforce development initiatives to increase the proportion of priority population public health staff, leadership, and administrators, including at CDPH.		x	x	x
	1b. Data Collection and Stratification: Expand pathways and workforce development initiatives to increase the proportion of priority population public health staff, leadership, and administrators, including at CDPH.	x	x	x	x
	1c. Distribution of Funding and Resources: Review all CDPH OA and OSH contracts, budgets, guiding service formulas, policies, and program decisions to advance delivery of resources and opportunities to the most highly impacted communities.	x	x	x	x
	1d. Community Engagement: Forge strategic partnerships to ensure priority population outreach, involvement, and engagement processes to reframe the structure, funding, and policies of HIV, HCV, and/or STI services and messaging to all Californians.	x	x	x	x
	1e. 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 greater effectiveness in our prevention, testing, treatment, and care services.	x	x	x	x
2. Housing	**2a. Data Collection and Stratification**: 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.	x		x	x
	2b. Infrastructure Changes: 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.		x	x	x
	2c. 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 Homekey, for people living with HIV and pregnant people who are unhoused and/or living with HCV or syphilis.		x		x
	2d. 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.	x	x	x	
	2e. Low-barrier Housing Options: Collaborate with housing partners to expand low barrier housing options available in both urban and rural areas, including	x	x	x	

Impact Area	Strategy	Diagnose	Treat	Prevent	Respond
	those that offer comprehensive and low barrier approaches to substance use, are available to families and couples, and/or allow people to bring their pets.				
3. Health Access for All	**3a. 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.	x	x	x	x
	3b. Comprehensive and Responsive Services: Train medical and public health service providers in comprehensive approaches to create responsive care to better serve patients, clients, and providers.	x	x	x	x
	3c. 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 special circumstances or housing status.	x	x	x	
	3d. Effective Relevant Services: Improve capacity of public health and health care providers to offer HIV, HCV, and STI services that are responsive to health literacy, and other communication needs.	x	x	x	
	3e. 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.	x	x	x	
4. Mental Health and Substance Use	**4a. Life-Saving Strategies in Correctional Settings:** Promote medication for opioid use disorder during incarceration in prison and jails and naloxone distribution and continuity of substance use disorder (SUD) and medical care upon release.	x	x	x	
	4b. 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.	x	x	x	
	4c. Build Comprehensive and Low Barrier Prevention Infrastructure: Expand prevention 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 low barrier prevention programs.	x	x	x	
	4d. Expand Low-Threshold SUD Treatment Options: Expand options for low barrier treatment, including easier access to buprenorphine and methadone, including in street medicine programs.	x	x	x	
	4e. Cross-Sector Collaboration: Encourage collaboration between local and statewide mental health programs, substance use programs, comprehensive and low barrier prevention programs and HIV/HCV/STI programs.	x	x	x	x

Impact Area	Strategy	Diagnose	Treat	Prevent	Respond
5. Economic Barriers	**5a. 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.	x	x	x	
	5b. 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 people reflective of those most impacted by HIV, HCV and STIs serving in meaningful leadership positions.	x	x	x	
	5c. Hiring Practices and Pay: Examine state and local health jurisdiction hiring practices to promote hiring those most impacted by HIV, HCV and STIs; remove barriers such as college and advanced degree requirements; offer extra pay to people who have lived experience with HIV, HCV, STDs, substance use, mental health challenges, or homelessness.	x	x	x	
	5d. 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.	x	x	x	
	5e. 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.	x	x	x	
6. Stigma	**6a. 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.	x	x	x	x
	6b. 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.	x	x	x	x
	6c. Positive, Accurate Information: Ensure images and language used in communications show accurate depictions of communities.	x	x	x	x
	6d. Acknowledge Medical Mistrust: Recognize medical mistrust; work to build trust and correct misperceptions by example.	x	x		
	6e. Ongoing Partnerships: Use 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.	x	x	x	x

SECTION VI: 2027-2031 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

1. 2027-2031 Integrated Planning Implementation Approach

Implementation and Monitoring

This section describes the general implementation plan and key personnel and structures that will be responsible for implementing the plan. The California HIV Planning Group, and the Part A Planning Councils from Alameda, Los Angeles, Santa Clara, Sacramento San Franciso, and San Bernardino/Riverside with the support of OA will be responsible for monitoring the implementation of this plan in their respective health jurisdictions.

In addition, the Office of AIDS will use its organizational senior leadership group to focus on the implementation of the Integrated Plan: **Office of AIDS Steering Committee (OASC)**. This group is headed by Dr. Marisa Ramos and is responsible for strategic decision-making, communications, and resource development related to the Strategic Plan and all CDPH-OA organizational-wide activities. This group meets monthly and the Integrated Plan is a standing agenda item.

Further, California has hired an **Integrated Plan Implementation Program Manager**, who will oversee development of a monitoring and implementation plan for the Integrated Plan, which include developing an internal tracking system for monitoring progress made on Integrated Plan metrics. This tracking system will be updated at least every 12 months and summary data will be shared with OA, Part A grantee leadership, HRSA and CDC, and stakeholders. California will also integrate relevant Integrated Plan objectives and metrics into contracts with local health jurisdictions and other entities, and will require annual reports from contractors on progress made in meeting these objectives. In the spirit of Continuous Quality Improvement, California will make available resources to assist any co-author jurisdictions who are not meeting objectives outlined in this plan.

Section III of this plan details the various data sources CDPH-OA uses as part of its monitoring activities. California will continue to review 5-year trends for infection rates which are updated annually, stratified by age, race/ethnicity, sex and other key factors across the continuum of care for each local health jurisdiction.

One of the overall goals of this plan is to decrease disproportionate impacts on any one particular group by addressing more directly the social drivers of health. California's community engagement activities have suggested 30 strategies organized across six social determinants of health recommendations for this work. These are not mandates, as the resources and context to address social drivers of health will vary from community to community. Each jurisdiction will be offered resources to conduct an optional next step to this plan: developing a local implementation blueprint with the help of the consulting group, Facente Consulting, to better link social drivers of health strategies with their core work. Additional local metrics and objectives will likely be developed in this step. They will be included in the overall evaluation and monitoring plan.

There are 12 indicators that will be used to monitor progress. These indicators were used in the last plan. These indicators were chosen in part because of the ready sources of data available to use for evaluation purposes. These indicators are noted below.

1. Increase the estimated percentage of Californians living with HIV who know their serostatus to 95%.
2. Reduce the number of new HIV diagnoses in California by at least 50%, to fewer than 2,500/year.
3. Increase the number of Californians at high risk for HIV infection who are on PrEP to 120,000.
4. Decrease the percentage of persons with new HIV diagnoses in California that are diagnosed with Stage 3 (AIDS) within twelve months of diagnosis (i.e., late diagnosis) to less than 20%.

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%.
6. Increase the percentage of newly diagnosed persons in California linked to HIV medical care within 1 month of their HIV diagnosis to at least 85%.
7. Increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75%.
8. Increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 85%.
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 85%.
10. Increase the percentage of California AIDS Drug Assistance Program clients with public or private health insurance to at least 71%.
11. Reduce the percentage of Californians with newly diagnosed HIV infection who are experiencing homelessness to less than 5%.
12. Reduce the age-adjusted death rate among Californians with diagnosed HIV infection to less than 650 per 100,000 per year.

Some of these indicators were developed into objectives in our workplan. In addition, the AHEAD Dashboard will be used to monitor progress on the EHE initiative and includes some data sources that overlap with our social drivers of health outcomes measures. Finally, California expects that it will be necessary to develop new indicators and new data sources that might be more attuned to the social drivers of health strategies optionally adopted by each jurisdiction. Refining and finalizing our monitoring and evaluation plan will happen in Year One. A combined workplan and monitoring table are included as **Appendix G**.

Evaluation and Improvement

California will use HIV surveillance data to develop annual reports on the HIV care continuum for the entire state, for each LHJ, and for the Ryan White Part A grant recipients. Evaluation summaries will be created annually. California will work with LHJs to review data and determine areas that need improvement, as well as strategies to improve metrics not meeting the goals.

This plan will require a year for further refinement of the monitoring plan. This will include leveraging existing relationships and activities already aligned with the plan to determine the feasibility of expanding collaboration in strategic ways. In Year One, each local health jurisdiction will create an expanded custom plan and implementation blueprint based on this Integrated Plan. California will make available planning resources to help further customize these local plans.

Reporting and Dissemination

OA will release data annually summarizing statewide and local health jurisdiction progress on each objective and sub-objective in the Integrated Plan. These reports will provide demographic and service summaries of persons accessing the programs and will report on relevant Integrated Plan metrics and objectives. OA is developing a Continuum of HIV Care report in HCC, the data system used by Ryan White providers, so that continuums can be run on demand and used to guide local program planning as needed.

These data will be released publicly and posted on OA's website. Data tables on the HIV care continuum will also be posted on the California Health and Human Services Open Data Portal (https://chhs.data. ca.gov/) These data will be shared with CPG and with all local HIV planning councils during regularly scheduled meetings. At these meetings, OA and Part A grantee representatives will present and discuss the findings and solicit feedback to identify ways the Integrated Plan efforts should be modified or improved. This data will also be shared with other stakeholder groups, and feedback received will be reviewed and discussed with statewide and local planning councils for consideration.

Updates to Other Strategic Plans Used to Meet Requirements

This Integrated plan is being submitted to HRSA and CDC as the fulfillment of our requirement as a Ryan White and CDC prevention funds recipient to have an integrated plan. California and its co-author jurisdictions to this report ensured the plan is in harmony with the other state and local HIV Surveillance, Prevention and Care Integrated Plans, Getting to Zero and Ending the HIV Epidemic plans and other California and county documents that guide the delivery of HIV prevention and care services. Great care was also used to ensure the suggested goals and objectives of this plan were also responsive to all existing federal orders and guidelines at the time of the drafting of this plan.

APPENDICES

A. CY 2027 – 2031 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	New Material and/or Existing Material	Title/File Name of Materials	Page(s) for this Section
Section I: Introduction of Integrated Plan and SCSN			
1. Introduction	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 7-8
a. Approach	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 7-8
b. Documents submitted to meet requirements	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 9-11
Section II: Community Engagement and Planning Process			
1. Jurisdiction Planning Process	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 12-14
a. Entities involved in the process	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 14-24
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 24
c. Role of Planning Bodies and other entities	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 24-26
d. Collaboration with RWHAP Parts – SCSN requirement	New and Existing Material	California Integrated HIV Prevention and Care Plan	Page 26
e. Engagement of People with HIV – SCSN requirement	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 26-27
f. Priorities	New and Existing Material	California Integrated HIV Prevention and Care Plan	Page 27
g. Updates to other strategic plans used to meet requirements	New and Existing Material	California Integrated HIV Prevention and Care Plan	Page 27
Section III: Contributing Data Sets and Assessments			
1. Data Sharing and Use	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 28-30
2. Epidemiologic Snapshot	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 31-46

3. HIV Prevention Care and Treatment Resource Inventory	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 47, 60-65, 98-116
a. Strengths and gaps	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 47, 60-65, 98-116
b. Approaches and partnerships	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 47, 98-116
4. Needs Assessment	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 47-57
a. Priorities	New and Existing Material	California Integrated HIV Prevention and Care Plan	Page 54
b. Actions taken	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 55
c. Approach	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 55-57
Section IV: Situational Analysis			
1. Situational Analysis	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 58-70
a. People and communities disproportionately impacted by HIV	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 33-42, 66-69
Section V: 2027-2031 Goals and Objectives			
1. Goals and Objectives Description	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 71-79, 117-123
a. Updates to other strategic plans used to meet requirements	New and Existing Material	California Integrated HIV Prevention and Care Plan	Page 82
Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up			
1. 2027-2031 Integrated Planning Implementation Approach	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 80-82, 117-122
a. Implementation	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 80-82, 117-122
b. Monitoring	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 80-82, 117-122
c. Evaluation	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 80-82, 117-122

d. Improvement	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 80-82, 117-122
e. Reporting and dissemination	New and Existing Material	California Integrated HIV Prevention and Care Plan	Pages 80-82, 117-122
f. Updates to other strategic plans used to meet requirements	New and Existing Material	California Integrated HIV Prevention and Care Plan	Page 82
Section VII: Letters of Concurrence			
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	New Material	Letter of Concurrence CPG	Pages 87-97
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	New Material	Letters of Concurrence Part A Planning Councils of Co-Author Jurisdictions	Pages 87-97
3. RWHAP Part B Planning Body Chair or Representative	New Material	Letter of Concurrence CPG	Pages 87-97
4. Integrated Planning Body	New Material	Letter of Concurrence CPG	Pages 87-97
5. EHE Planning Body	New Material	Letters of Concurrence, Part A Planning Councils and CPG	Pages 87-97

B. Communities, Partners and Letters of Concurrence

Communities and Stakeholders Outline

1. RWHAP Part B Planning Council/Planning Body and CDC Prevention Program Planning Body Chair(s) or Representative(s)

California Planning Group

- Vivian Gallardo, Community Co-Chair
- John Paul Soto, Community Co-Chair
- Tiffany Woods, State Co-Chair
- Matthew Willis, State Co-Chair

2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)

Inland Empire HIV Planning Council

- Fred Maypark, Community Co-Chair
- Dr. Sharon Wang, San Bernardino County Public Health Officer, Co-Chair

Oakland/Alameda Transitional Grant Area Community Collaborative Planning Council

- Shelley Stinson, Co-Chair
- Damon Powell, Co-Chair

Sacramento Transitional Grant Area HIV Health Services Planning Council

- Richard Benavidez, Council Chair
- Stephan Thomas, Council Vice-Chair

San Francisco EMA HIV Community Planning Council

- Irma Parada, Co-Chair
- Thomas Knoble, Co-Chair

Santa Clara HIV Commission

- Mannye Mensima Clerk, Chair
- Gordon Bowman, Vice Chair

Los Angeles County Commission on HIV

- Alvaro Ballesteros, Co-Chair
- Katja Nelson, Co-Chair

3. California HIV, HCV, and STI Strategic Plan Workgroup

California Department of Public Health

- Alessandra Ross – Office of AIDS (OA)
- Artnecia Ramirez – OA
- Ashley Dockter – Congenital Syphilis Program Coordinator, Program Development Section, Office of STIs and HCV (OSH)

- Edwin Lopez – Chief, Disease Intervention Section, OSH
- Eric Tang, MD – Chief, Medical and Scientific Affairs Section, OSH
- Jessica Frasure – Chief, Program Development Section, OSH
- Kathleen Jacobson, MD – Chief, OSH
- Marisa Ramos – Chief, OA
- Melissa Marston – Branch Chief Executive Assistant, OSH
- Phil Peters, MD – Medical Officer, OA
- Rachel McLean – Chief, Policy and Viral Hepatitis Prevention Section, OSH
- Tiffany Woods –Sexual Health and Community Engagement Specialist, Capacity Building and Program Development, OA

Community Stakeholders

- Anne Donnelly – San Francisco AIDS Foundation (SFAF)
- 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

4. **Ongoing Ending the HIV Epidemic California Consortium Membership**

- CDPH-OA (Coordinating)
- Alameda
- Orange County
- Riverside County
- Sacramento County
- San Bernardino County
- Los Angeles (Ad Hoc Member)
- San Francisco (Ad Hoc Member)

5. Letters of Concurrence

- California Planning Group (Page 89), Oakland/Alameda TGA Planning Council (Pages 90-91), Inland Empire HIV Planning Council (To be submitted separately), Sacramento HIV Health Services Planning Council (Page 94), San Francisco HIV Community Planning Council (Pages 96-97), Santa Clara HIV Commission (Page 95), Los Angeles County Commission on HIV (Pages 92-93)

CALIFORNIA planning group
california department of public health, office of AIDS

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 California HIV/STI/HCV Planning Group (CPG) is in concurrence with the revised integrated plan entitled ***Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California 2027-2031.*** We enthusiastically join the California Department of Public Health (CDPH) Office of AIDS (OA) and the Office of Sexually Transmitted Infections and Hepatitis C (OSH) in co-authoring this plan that will continue to 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 drivers of health.

The CPG also notes the strong community engagement efforts in this planning and implementation process that our planning group undertook in partnership with CDPH-OA/OSH from 2022 through 2026. We received an overview of the draft plan at a presentation to the CPG and were allowed to ask questions and make suggestions about ways to improve the draft. In our core work, we are continually engaging with our HIV community voices and priority populations, and we are proud to leverage our ongoing efforts for input into the plan.

The process above resulted in the final plan being submitted to HRSA and CDC as the fulfillment of our requirement as a Part B 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 CDPH-OA.

The selected integrated strategies organized to impact selected social drivers of health will expand our reach to populations in California underserved to date and impact HIV/HCV/STIs as a syndemic across the continuum of care for these priority 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*** **2027-2031** 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 CPG Co-Chairs on behalf of the entire Part B Planning Body,

Vivian Gallardo, Community Co-Chair

John Paul Soto, Community Co-Chair

Public Health Department
Alameda County Health

Kimi Watkins-Tartt
Director

Dear Dr. Ramos,

This letter confirms that the (Noted TGA/EMA HIV Planning Council) HIV Planning Council agrees with the revised plan called *Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California 2027–2031*. We are proud to support the California Department of Public Health (CDPH) Office of AIDS (OA) and the Office of Sexually Transmitted Infections and Hepatitis C (OSH) in this work. The plan will help guide efforts to prevent and treat HIV, HCV, and STIs across California.

The (Planning Council) also recognizes the strong community involvement during the planning process with CDPH OA/OSH from 2022 through 2026. We received information about the draft plan, asked questions, and shared ideas to improve it. Through our regular Planning Council work, we continue to hear from people living with HIV and other priority communities. Their voices helped shape this plan.

This work led to the final plan being submitted to HRSA and CDC to meet federal requirements for an integrated plan. The plan also matches other HIV prevention, care, and surveillance efforts across the state and local counties.

The strategies in this plan focus on important social and health needs. They will help reach people and communities in California who have not always had equal access to care and services. The plan will help more people get tested, receive treatment, and connect to prevention and care services for HIV, HCV, and STIs.

Our planning body will continue to watch the progress of *Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California 2027–2031* and its activities. We will also continue to work with the community and listen to feedback to make sure these services meet the needs of the people they are meant to help.

Sincerely,

Public Health Department
Alameda County Health

Signed by:
Damon Powell
Damon Powell, PhD
Co – Chair
Oakland TGA Planning Council

DocuSigned by:
Shelley Stinson
Shelley Stinson, MPA
Co - Chair
Oakland TGA Planning Council

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

May 26, 2026

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

Subject: Concurrence with the revised Integrated Statewide Strategic Plan, 2027-2031

Dr. Ramos,

On behalf of the Los Angeles County Commission on HIV (Commission), serving as the Los Angeles County Eligible Metropolitan Area (EMA) Ryan White Program Part A Planning Council, this letter documents the Commission's concurrence with *Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California, Integrated Statewide Strategic Plan, 2027-2031 (Plan)*.

The draft Plan was shared with the Commission on May 7, 2026, for review and feedback. At the Commission's May 14, 2026 meeting, the California Department of Public Health, Office of AIDS (CDPH-OA), presented the draft Plan, including its syndemic approach, social determinants of health framework, priority populations, implementation considerations, and the role of planning councils in review, concurrence, community communication, and ongoing monitoring. **Following the presentation and discussion, the Commission voted unanimously to approve concurrence.**

The Commission's concurrence is grounded in support for the Plan's overall direction and our responsibility to elevate community voice, local implementation needs, and the realities of communities most impacted by the syndemic of HIV, HCV, and STIs. During the review and discussion, members raised the following recommendations for CDPH-OA's consideration as the Plan is finalized and implemented:

- Develop an **Executive Summary**, plain-language FAQs, and other community-facing tools to make the Plan more accessible to community members, consumers, providers, and local planning bodies.
- **Strengthen alignment** with Ryan White Part A planning and funding priorities, including the **Commission's priority-setting and resource allocation (PSRA) process.**

- More clearly acknowledge the work already completed and currently underway across local jurisdictions and planning bodies, including efforts that support or complement statewide implementation.
- Incorporate behavioral health integration as a key component of HIV, HCV, and STI prevention, care, treatment, and supportive services.
- Include homelessness prevention, in collaboration with Housing First partners, as an important intervention strategy connected to housing stability, health access, retention in care, and viral suppression.

The Commission also wants to be clear that the communities most impacted by HIV, HCV, and STIs must remain visible throughout this work. We understand that the Plan must comply with current executive orders released by the federal administration, and that this compliance impacts the language used in the final document. Even with these constraints, the Commission strongly objects to the negative impacts of executive orders on our community; prohibiting certain language makes the disproportionate impact of HIV on our communities less visible. Clear, meaningful naming is essential to understanding need, directing resources appropriately, measuring progress, and ensuring implementation remains grounded in the lived experiences of all priority populations.

The Commission offers these recommendations in the spirit of partnership and shared accountability. We understand that the Plan provides a high-level statewide framework while allowing room for local implementation, adaptation, innovation, and community engagement. As implementation moves forward, the Commission will continue to engage community members, consumers, providers, public health partners, and other impacted communities; review progress and share updates; and offer recommendations to help ensure the Plan remains responsive to the people and communities it is intended to serve.

We appreciate the opportunity to participate in this statewide effort and look forward to continuing to work with CDPH Office of AIDS and our local partners to advance a coordinated, community-centered response to HIV, HCV, and STIs in California.

In community,

Alvaro Ballesteros, MBA
Co-Chair
Los Angeles County Commission on HIV

Katja Nelson, MPP
Co-Chair
Los Angeles County Commission on HIV

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 TGA's HIV Planning Council is in concurrence with the revised integrated plan entitled ***Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California 2027-2031.*** We enthusiastically join the California Department of Public Health (CDPH) Office of AIDS (OA) and the Office of Sexually Transmitted Infections and Hepatitis C (OSH) in co-authoring this plan that will continue to 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 drivers of health.

The Sacramento TGA's HIV Planning Council also notes the strong community engagement efforts in this planning and implementation process that our TGA undertook in partnership with CDPH-OA/OSH from 2022 through 2026. We received an overview of the draft plan at a presentation to the Sacramento TGA's HIV Planning Council and were allowed to ask questions and make suggestions about ways to improve the draft. In our core Planning Council work, we are continually engaging with our HIV community voices and priority populations, and we are proud to leverage our ongoing efforts for input into the plan.

The process above resulted in the final plan being submitted to HRSA and CDC as the fulfillment of our requirement as a 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 CDPH-OA.

The selected integrated strategies organized to impact selected social drivers of health will expand our reach to populations in California underserved to date and impact HIV/HCV/STIs as a syndemic across the continuum of care for these priority 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*** **2027-2031** 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 Chair and Vice Chair on behalf of the entire Part A Planning Body.

Richard Benavidez, Chair 5/21/2026 *Stephen Thomas, Vice Chair*

Santa Clara County
HIV Commission

Maŋnyɛ Mensima Clerk, Chair
Gordon Bowman, Vice Chair
976 Lenzen Avenue
San Jose, CA 95126

May 12, 2026

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 County of Santa Clara HIV Commission (HIV Planning Body for the San Jose TGA) is in concurrence with the revised integrated plan entitled *Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California 2027-2031*. We enthusiastically join the California Department of Public Health (CDPH) Office of AIDS (OA) and the Office of Sexually Transmitted Infections and Hepatitis C (OSH) in co-authoring this plan that will continue to 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 drivers of health.

The HIV Commission also notes the strong community engagement efforts in this planning and implementation process that our TGA undertook in partnership with CDPH-OA/OSH from 2022 through 2026. We received an overview of the draft plan at a presentation to the HIV Commission and were allowed to ask questions and make suggestions about ways to improve the draft. In our core planning body work, we are continually engaging with our HIV community voices and priority populations, and we are proud to leverage our ongoing efforts for input into the plan.

The process above resulted in the final plan being submitted to HRSA and CDC as the fulfillment of our requirement as a 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 CDPH-OA.

The selected integrated strategies organized to impact selected social drivers of health will expand our reach to populations in California underserved to date and impact HIV/HCV/STIs as a syndemic across the continuum of care for these priority 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* 2027-2031 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 HIV Commission leadership on behalf of the entire Part A Planning Body,

Signed by:
02F254BE8AED4A0...
Maŋnyɛ Mensima Clerk, Chair

Signed by:
Gordon Bowman
DFF6C61A03B5402...
Gordon Bowman, Vice Chair

San Francisco HIV Community Planning Council
San Francisco Eligible Metropolitan Area
San Francisco, San Mateo, and Marin Counties

June 8, 2026

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 San Fracisco HIV Community Planning Council is in concurrence with the revised integrated plan entitled ***Ending the Epidemics: Addressing Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) in California 2027-2031***. We enthusiastically join the California Department of Public Health (CDPH) Office of AIDS (OA) and the Office of Sexually Transmitted Infections and Hepatitis C (OSH) in co-authoring this plan that will continue to 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 drivers of health.

The Planning Council also notes the strong community engagement efforts in this planning and implementation process that our EMA undertook in partnership with CDPH-OA/OSH from 2022 through 2026. We received an overview of the draft plan at a presentation to the Planning Council and were allowed to ask questions and make suggestions about ways to improve the draft. In our core Planning Council work, we are continually engaging with our HIV community voices and priority populations, and we are proud to leverage our ongoing efforts for input into the plan.

The process above resulted in the final plan being submitted to HRSA and CDC as the fulfillment of our requirement as a 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 CDPH-OA.

(415) 674-4751 27 Maiden Lane, 4th Floor, San Francisco CA 94108 (415) 674-0373 fax
www.sfhivplanningcouncil.org

The selected integrated strategies organized to impact selected social drivers of health will expand our reach to populations in the San Francisco EMA underserved to date and impact HIV/HCV/STIs as a syndemic across the continuum of care for these priority 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 Council 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*** 2027-2031 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.

Sincerely,

Derrick Mapp (Jun 8, 2026 22:40:29 PDT)	Irma Parada (Jun 8, 2026 18:59:14 PDT)	Thomas Knoble (Jun 8, 2026 19:18:42 PDT)
Derrick Mapp	Irma Parada	Thomas Knoble
HCPC Co-Chair	HCPC Co-Chair	HCPC Co-Chair

(415) 674-4751 27 Maiden Lane, 4th Floor, San Francisco CA 94108 (415) 674-0373 fax
www.sfhivplanningcouncil.org

C. California Statewide HIV Prevention Care and Treatment Resource Inventory by Continuum of Care

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression
CDC	PS24-0047 (Core Prevention)	California Department of Public Health, Office of AIDS	$39,828,904.00	City & County of San Francisco, County of Alameda, County of Contra Costa, County of Fresno, County of Kern, County of Los Angeles, County of Marin, County of Merced, County of Monterey, County of Orange, County of Riverside, County of San Bernardino, County of San Diego, County of San Joaquin, County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Santa Cruz, County of Solano, County of Sonoma, County of Stanislaus, County of Tulare, County of Ventura, County of Sacramento	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔	✔
CDC	PS24-0047 (EHE)	California Department of Public Health, Office of AIDS	$14,488,876.00	City & County of San Francisco, County of Alameda, County of Orange, County of Riverside, County of San Bernardino, County of San Diego, County of Sacramento, County of Los Angeles	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔	✔
CDC	PS24-0047 (Surveillance)	California Department of Public Health, Office of AIDS	$3,033,867.00	N/A	Capacity building/technical assistance, Surveillance		✔	✔		✔
CDC	PS22-2201	California Department of Public Health, Office of AIDS	$470,000.00	Family Health Centers of San Diego, Inc	Capacity building/technical assistance, HIV transmission cluster and outbreak identification and response, Surveillance		✔	✔		✔
CDC	PS25-0008	California Department of Public Health, Office of AIDS	$955,472.00	N/A	Capacity building/technical assistance, Surveillance		✔	✔		
HOPWA	HOPWA (Office of AIDS Care Branch)	California Department of Public Health, Office of AIDS	$5,132,250.00	Access Support Network, Ampla Health, Change And New Beginnings, Community Care Management Corp, Community Impact Central Valley, County of Humboldt, County of Imperial, County of Kings, County of Madera, County of Nevada, County of Plumas, County of San Joaquin, County of Santa Cruz, County of Ventura, Family Services of Tulare County, Housing Authority of the County of Marin , Merced County Community Action Agency, Queen of the Valley Medical Center, Sierra Hope	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection			✔		✔

HOPWA	HOPWA Direct Funding (Formula)	Funds distributed directly to subrecipients listed	$56,355,771.00	City of Anaheim, City of Bakersfield, City of Fresno, City of Los Angeles, City of Oakland, City of Riverside, County of San Diego, City of San Francisco, City of San Jose, City of Santa Rosa, City of Sacramento	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection		✔		✔
HRSA	Ryan White Part A HIV Emergency Relief Grant Program	Funds distributed directly to subrecipients listed	$102,089,900.00	City & County Of San Francisco, County Of Alameda, County Of Los Angeles, County Of San Diego, County Of Santa Clara, Orange County Health Care Agency, San Bernardino Public Health, County Of Sacramento	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔	✔
HRSA	Ryan White Part C (EIS)	Funds distributed directly to subrecipients listed	$16,923,991.00	Cares Community Health, Aids Healthcare Foundation, Altamed Health Services Corporation, Ampla Health, Bartz-Altadonna Community Health Center, Bay Area Community Health, Centro De Salud De La Comunidad De San Ysidro, Inc., Charles R. Drew University Of Medicine And Science, City & County Of San Francisco, Clinica Sierra Vista, Community Medical Centers, Inc., County Of Monterey, County Of Plumas, County Of Santa Barbara, County Of Santa Clara, County Of Santa Cruz, County Of Ventura, Dap Health, Inc., Dignity Health, El Proyecto Del Barrio, Inc., Family Health Centers Of San Diego Inc, Fresno Community Hospital & Medical Center, Jwch Institute, Inc., Los Angeles Lgbt Center, Mendocino Community Health Clinic Inc, Northeast Valley Health Corporation, Open Door Community Health Centers, Orange County Health Care Agency, San Bernardino Public Health, San Francisco Community Clinic Consortium, Santa Rosa Community Health Centers, Shasta Community Health Center, Solano County Health & Social Services Department, Tarzana Treatment Centers, Inc., The Clinic, Inc., University Of California, San Diego, University Of Southern California, Venice Family Clinic, Watts Healthcare Corp, West County Health Centers, Inc	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services	✔	✔	✔	✔

HRSA	Ending the HIV Epidemic: A Plan for America Ryan White HIV/AIDS Program Parts A and B	Funds distributed directly to subrecipients listed	$21,189,234.00	City & County of San Francisco, County of Alameda, County of Los Angeles, County of San Diego, Orange County Health Agency, San Bernardino Public Health, County of Sacramento	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection		✔	✔	✔	✔
HRSA	Ryan White Part D	Funds distributed directly to subrecipients listed	$5,985,229.00	Altamed Health Services Corporation, Cares Community Health, Children'S Hospital & Research Center At Oakland, Clinica Sierra Vista, Fresno Community Hospital & Medical Center, Regents Of The University Of California, San Francisco, The, Santa Rosa Community Health Centers, University Of California, Los Angeles, University Of California, San Diego, University Of Southern California	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔	✔	✔	✔
HRSA	Ryan White Part B Supplemental X08	California Department of Public Health, Office of AIDS	$3,616,421.00	Magellan Rx Management (Pharmacy Benefits Manager); Pool Administrators, Inc. (Medical and Insurance Benefits Manager); HIV resources for clients awarded through contracts for reimbursable services - please refer to narrative portion for complete listing.	Medications, Insurance Premium Payment/Co-pays	✔	✔	✔	✔	✔
HRSA	Ryan White Part B HIV Care Grant Program (X07 OA Care Branch)	California Department of Public Health, Office of AIDS	$26,391,814.00	Access Support Network, Community Care Management Corp, Community Medical Center (Fresno), County of Alameda, County of Sacramento, Ampla Health, County of Butte, County of Contra Costa, County of Humboldt, County of Imperial, County of Kern, County of Kings, County of Marin, County of Merced, County of Monterey, County of Nevada, County of Orange, County of Plumas, County of Riverside, County of San Bernardino, County of San Diego, County of San Francisco, County of San Joaquin, County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Santa Cruz, County of Solano, County of Stanislaus, County of Tulare, County of Ventura, John C. Fremont, City of Long Beach, County of Los Angeles, County of Madera, Santa Rosa Community Health, Shasta Community Health Center, Sierra HOPE	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔		✔
HRSA	Ryan White Part B HIV Care Grant Program (X07 ADAP Allocation)	California Department of Public Health, Office of AIDS	$102,403,026.00	HIV resources for clients awarded through contracts for reimbursable services - please refer to narrative portion for complete listing.	Medications, Insurance Premium Payment/Co-pays	✔	✔	✔	✔	✔
HRSA	HIV Care Formula Grants (X09 ADAP Allocation)	California Department of Public Health, Office of AIDS	$4,652,262.00	N/A - this award is only for provision of medications in emergency circumstances					✔	

HRSA	Ryan White Part F Dental Reimbursement	Funds distributed directly to subrecipients listed	$2,529,312.00	Regents of the University of California san Francisco, University of California Los Angeles, University of Pacific, University of Southern California, Western University of Health Services	Oral Health Care			✔		
HRSA	Ryan White Part F (Community Based Dental Partnership Program)	Funds distributed directly to subrecipients listed	$315,215.00	Loma Lina University	Oral Health Care			✔		
HRSA	Ryan White Part C (HIV Capacity Development and Planning)	Funds distributed directly to subrecipients listed	$1,925,000.00	Fresno Community Hospital & Medical Center, Los Angeles LGBT Center, Northeast Valley Health Corporation, St. John's Community Health, The Clinic Inc, University of Southern California, Via Care Community Health Center, Young scholar for Academic Empowerment, La Maestra Family Clinic Inc, North County Health Project Incorporated, Wellness and Equity Foundation Inc, West County Health Centers Inc, Ampla Health	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔	✔	✔	✔
HRSA	Ryan White Part F SPNS	Funds distributed directly to subrecipients listed	$1,235,296.00	County of Sacramento, County of Alameda, JWCH Institute Inc, St. John's Community Health	Early Intervention Services (EIS) , Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Substance Abuse Services (residential), Capacity building/technical assistance, Community engagement, Prevention for persons living with diagnosed HIV infection, Testing	✔		✔	✔	✔
HRSA	Ryan White Part F SPNS (MAI U1S)	Funds distributed directly to subrecipients listed	$500,000.00	County of San Diego	Mental Health Services, Substance Abuse Outpatient Care, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔		
HRSA	Ending the HIV Epidemic - Primary Care HIV Prevention (H8H)	Funds distributed directly to subrecipients listed	$3,003,759.00	ALL FOR HEALTH, HEALTH FOR ALL, INC, CLINICA MSR. OSCAR A ROMERO, Gracelight Community Health, SOUTHLAND INTEGRATED SERVICES INC, TRI-STATE COMMUNITY HEALTHCARE CENTER, UNIVERSITY OF CALIFORNIA IRVINE, THE DAVIS STREET COMMUNITY CENTER INCORPORATED	AIDS Drug Assistance Program Treatments, Outpatient/Ambulatory Health Services, Health Education/Risk Reduction, Condom distribution, PrEP delivery, Testing		✔	✔	✔	✔
IHS	Ending the HIV/HCV/Syphilis Epidemics in Indian Country	Funds distributed directly to subrecipients listed	$193,843.00	Viejas Band of Kumeyaay Indians	Early Intervention Services (EIS) , Mental Health Services, Substance Abuse Outpatient Care, Health Education/Risk Reduction, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔		

SAMHSA	TI-22-004 Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Funds distributed directly to subrecipients listed	$7,499,765.00	JWCH Institute Inc., Westcare California Inc., Bienestar Human Services Inc., Children's Hospital of Los Angeles, Special Service For Groups Inc., Via Care Community Health Center Inc., California Prevention/Education Project, East Bay Community Recovery Project, Public Health Institute, Family Health Centers of San Diego Inc., Baker Places Inc., Friendship House Assn/American Indians, University of California San Francisco, University of California San Francisco, Center Point Inc.	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔	✔
SAMHSA	SP-22-002 Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities Cooperative Agreement	Funds distributed directly to subrecipients listed	$1,250,000.00	Children's Hospital of Los Angeles, Special Service for Groups Inc, St. John's Well Child Center Inc, Sunrise Community Counseling Center, Women Organized to Respond to Lige-Threatening Diseases	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services	✔	✔	✔
SAMHSA	TI-23-008 Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Funds distributed directly to subrecipients listed	$2,000,000.00	Center for Health Justice Inc, San Ysidro Health Center inc, Asian and Pacific Islander Wellness Center, Clare Foundation	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔	✔
SAMHSA	TI-23-024 Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project	Funds distributed directly to subrecipients listed	$1,330,871.00	University of California San Francisco, City of Vernon	Mental Health Services, Referral for Health Care and Support Services , Community mobilization, Prevention for persons living with diagnosed HIV infection		✔	✔

SAMHSA	SP-20-001 Capacity Building Initiative for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Funds distributed directly to subrecipients listed	$1,400,000.00	CENTRAL CITY NEIGHBORHOOD PARTNERS, NATIVE AMERICAN HEALTH CENTER INC., LA MAESTRA FAMILY CLINIC INC., SAN YSIDRO HEALTH CENTER INC., THE SAN DIEGO LESBIAN, GAY, BISEXUAL AND TRANSGENDER COMMUNITY CENTER, FRIENDSHIP HOUSE ASSN/AMERICAN INDIANS, HEALTH INITIATIVES FOR YOUTH INC.	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔	✔		
State General Fund	Opioid Settlement Fund	California Department of Public Health, Office of AIDS	$8,166,694.44	Sierra Health Foundation	Health Education/Risk Reduction, Prevention for persons living with diagnosed HIV infection, Syringe services programs		✔	✔		
State General Fund	Project Empowerment	California Department of Public Health, Office of AIDS	$4,298,700.00	AIDS Healthcare Foundation, AIDS Project Los Angeles Health, AltaMed, CAL-PEP, Christie's Place, East LA Women's Center, Golden Rules Services, LA LGBT Center, Lifelong Medical Care, Lyon-Martin Community Health Services, REACH LA, Roots Community Health, Sacramento LGBT Community, Siskiyou County HHS, St. John's Community Health, Suburst Project, Young Scholars for Academic Empowerment	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation	✔	✔	✔		✔
State General Fund	PrEP & PEP Initiation & Retention	California Department of Public Health, Office of AIDS	$5,018,734.98	AltaMed Health Services Corporation, Altura Centers for Health, Asian Health Services, California State University - East Bay Foundation, Inc., Central Neighborhood Health Foundation, Centro de Salud de la Comunidad de San Ysidro Inc, Charles R Drew University of Medicine and Science, Clinicas de Salud del Pueblo Inc., Community Medical Centers Inc., County of Butte, County of Sacramento, County of San Diego, County of Santa Cruz - Health Services Agency, County of Yolo, Fresno Community Hospital and Medical Center, San Bernardino County, San Francisco AIDS Foundation, Sunburst Projects, Sutter Bay Hospitals, The Source LGBT+ Center Inc., The Wall - Las Memorias, University of Southern California	Health Education/Risk Reduction, PrEP delivery			✔	✔	✔
State General Fund	PrEP & PEP Navigator Funding	California Department of Public Health, Office of AIDS	$1,740,000.00	AltaMed Health Services, Asian American Drug Abuse Prg Inc, Central Valley Gender Health & wellness, Mercy Health, St. John's Community Health, WestCare California Inc	Health Education/Risk Reduction, PrEP delivery, Testing, PrEP Navigation, Rapid ART		✔	✔	✔	✔

State General Fund	PrEP & PEP Initiation & Retention	California Department of Public Health, Office of AIDS	$5,018,734.98	AltaMed Health Services Corporation, Altura Centers for Health, Asian Health Services, California State University - East Bay Foundation, Inc., Central Neighborhood Health Foundation, Centro de Salud de la Comunidad de San Ysidro Inc, Charles R Drew University of Medicine and Science, Clinicas de Salud del Pueblo Inc., Community Medical Centers Inc., County of Butte, County of Sacramento, County of San Diego, County of Santa Cruz - Health Services Agency, County of Yolo, Fresno Community Hospital and Medical Center, San Bernardino County, San Francisco AIDS Foundation, Sunburst Projects, Sutter Bay Hospitals, The Source LGBT+ Center Inc., The Wall - Las Memorias, University of Southern California	Health Education/Risk Reduction, PrEP delivery			✔	✔	✔
State General Fund	PrEP & PEP Navigator Funding	California Department of Public Health, Office of AIDS	$1,740,000.00	AltaMed Health Services, Asian American Drug Abuse Prg Inc, Central Valley Gender Health & wellness, Mercy Health, St. John's Community Health, WestCare California Inc	Health Education/Risk Reduction, PrEP delivery, Testing, PrEP Navigation, Rapid ART		✔	✔	✔	✔
State General Fund	Strategic Rapid ART	California Department of Public Health, Office of AIDS	$2,000,000.00	County of Stanislaus, DAP Health, City of Long Beach, TruEvolution	Testing, Rapid ART, Linkage to Care	✔	✔		✔	✔
State General Fund	Surveillance General Fund Awards	California Department of Public Health, Office of AIDS	$6,664,872.00	County of Alameda, County of Amador, Berkeley LHJ, County of Butte, County of Calaveras, County of Colusa, County of Contra Costa, County of Del Norte, County of El Dorado, County of Fresno, County of Glenn, County of Humboldt, County of Imperial, County of Inyo, County of Kern, County of Kings, County of Lake, County of Lassen, City of Long Beach, County of Los Angeles, County of Madera, County of Marin, County of Mariposa, County of Mendocino, County of Merced, County of Modoc, County of Mono, County of Monterey, County of Napa, County of Nevada, County of Orange, Pasadena LHJ, County of Placer, County of Plumas, County of Riverside, County of Sacramento, County of San Benito, County of San Bernardino, County of San Diego, County of San Francisco, County of San Joaquin, County of San Luis Obispo, County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Santa Cruz, County of Shasta, County of Sierra, County of Siskiyou, County of Solano, County of Sonoma, County of Stanislaus, County of Sutter, County of Tehama, County of Trinity, County of Tulare, County of Tuolumne, County of Ventura, County of Yolo, County of Yuba	Capacity building/technical assistance, HIV transmission cluster and outbreak identification and response, Surveillance		✔	✔		✔

D. California Statewide HIV Prevention Care and Treatment Resource Inventory by EHE Pillar

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	Diagnose	Treat	Prevent	Respond
CDC	PS24-0047 (Core Prevention)	California Department of Public Health, Office of AIDS	$20,863,136.00	County of Alameda, County of Contra Costa, County of Fresno, County of Kern, County of Marin, County of Merced, County of Monterey, County of Orange, County of Riverside, County of San Bernardino, County of San Diego, County of San Joaquin, County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Santa Cruz, County of Solano, County of Sonoma, County of Stanislaus, County of Tulare, County of Ventura, County of Sacramento	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔
CDC	PS24-0047 (EHE)	California Department of Public Health, Office of AIDS	$8,977,024.00	County of Alameda, County of Orange, County of Riverside, County of San Bernardino, County of San Diego, County of Sacramento	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔
CDC	PS22-2201	California Department of Public Health, Office of AIDS	$470,000.00	Family Health Centers of San Diego, Inc	Capacity building/technical assistance, HIV transmission cluster and outbreak identification and response, Surveillance	✔	✔		✔
CDC	PS25-0008	California Department of Public Health, Office of AIDS	$955,472.00	N/A	Capacity building/technical assistance, Surveillance				✔
HOPWA	HOPWA Direct Funding (Formula)	Funds distributed directly to subrecipients listed	$56,355,771.00	City of Anaheim, City of Bakersfield, City of Fresno, City of Los Angeles, City of Oakland, City of Riverside, County of San Diego, City of San Francisco, City of San Jose, City of Santa Rosa, City of Sacramento	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection		✔	✔	

HRSA	Ryan White Part A HIV Emergency Relief Grant Program	Funds distributed directly to subrecipients listed	$102,089,900.00	City & County Of San Francisco, County Of Alameda, County Of Los Angeles, County Of San Diego, County Of Santa Clara, Orange County Health Care Agency, San Bernardino Public Health, County Of Sacramento	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔	✔
HRSA	Ryan White Part C (EIS)	Funds distributed directly to subrecipients listed	$16,923,991.00	Cares Community Health, Aids Healthcare Foundation, Altamed Health Services Corporation, Ampla Health, Bartz-Altadonna Community Health Center, Bay Area Community Health, Centro De Salud De La Comunidad De San Ysidro, Inc., Charles R. Drew University Of Medicine And Science, City & County Of San Francisco, Clinica Sierra Vista, Community Medical Centers, Inc., County Of Monterey, County Of Plumas, County Of Santa Barbara, County Of Santa Clara, County Of Santa Cruz, County Of Ventura, Dap Health, Inc., Dignity Health, El Proyecto Del Barrio, Inc., Family Health Centers Of San Diego Inc, Fresno Community Hospital & Medical Center, Jwch Institute, Inc., Los Angeles Lgbt Center, Mendocino Community Health Clinic Inc, Northeast Valley Health Corporation, Open Door Community Health Centers, Orange County Health Care Agency, San Bernardino Public Health, San Francisco Community Clinic Consortium, Santa Rosa Community Health Centers, Shasta Community Health Center, Solano County Health & Social Services Department, Tarzana Treatment Centers, Inc., The Clinic, Inc., University Of California, San Diego, University Of Southern California, Venice Family Clinic, Watts Healthcare Corp, West County Health Centers, Inc	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services	✔	✔	✔	
HRSA	Ending the HIV Epidemic: A Plan for America Ryan White HIV/AIDS Program Parts A and B	Funds distributed directly to subrecipients listed	$21,189,234.00	City & County of San Francisco, County of Alameda, County of Los Angeles, County of San Diego, Orange County Health Agency, San Bernardino Public Health, County of sacramento	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔	

HRSA	Ryan White Part D	Funds distributed directly to subrecipients listed	$5,985,229.00	Altamed Health Services Corporation, Cares Community Health, Children'S Hospital & Research Center At Oakland, Clinica Sierra Vista, Fresno Community Hospital & Medical Center, Regents Of The University Of California, San Francisco, The, Santa Rosa Community Health Centers, University Of California, Los Angeles, University Of California, San Diego, University Of Southern California	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services	✔	✔	✔	
HRSA	Ryan White Part B Supplemental	California Department of Public Health, Office of AIDS	$3,616,421.00	Magellan Rx Management (Pharmacy Benefits Manager); Pool Administrators, Inc. (Medical and Insurance Benefits Manager); HIV resources for clients awarded through contracts for reimbursable services - please refer to narrative portion for complete listing.	Medications, Insurance Premium Payment/Co-pays	✔	✔	✔	✔
HRSA	Ryan White Part B HIV Care Grant Program (OA Care Branch)	California Department of Public Health, Office of AIDS	$26,391,814.00	Access Support Network, Community Care Management Corp, Community Medical Center (Fresno), County of Alameda, County of Sacramento, Ampla Health, County of Butte, County of Contra Costa, County of Humboldt, County of Imperial, County of Kern, County of Kings, County of Marin, County of Merced, County of Monterey, County of Nevada, County of Orange, County of Plumas, County of Riverside, County of San Bernardino, County of San Diego, County of San Francisco, County of San Joaquin, County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Santa Cruz, County of Solano, County of Stanislaus, County of Tulare, County of Ventura, John C. Fremont, City of Long Beach, County of Los Angeles, County of Madera, Santa Rosa Community Health, Shasta Community Health Center, Sierra HOPE	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔	
HRSA	Ryan White Part B HIV Care Grant Program (X07 ADAP Allocation)	California Department of Public Health, Office of AIDS	$102,403,026.00	HIV resources for clients awarded through contracts for reimbursable services - please refer to narrative portion for complete listing.	Medications, Insurance Premium Payment/Co-pays	✔	✔	✔	✔
HRSA	HIV Care Formula Grants (X09 ADAP Allocation)	California Department of Public Health, Office of AIDS	$4,652,262.00	N/A - this award is only for provision of medications in emergency circumstances			✔		
HRSA	AIDS Education and Training Centers Program	Funds distributed directly to subrecipients listed	$2,527,777.00	Regents of the University of California, San Francisco	Health Education/Risk Reduction			✔	

SAMHSA	TI-22-004 Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Funds distributed directly to subrecipients listed	$7,499,765.00	JWCH Institute Inc., Westcare California Inc., Bienestar Human Services Inc., Children's Hospital of Los Angeles, Special Service For Groups Inc., Via Care Community Health Center Inc., California Prevention/Education Project, East Bay Community Recovery Project, Public Health Institute, Family Health Centers of San Diego Inc., Baker Places Inc., Friendship House Assn/American Indians, University of California San Francisco, University of California San Francisco, Center Point Inc.	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔
SAMHSA	TI-22-004 Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Funds distributed directly to subrecipients listed	$1,250,000.00	Children's Hospital of Los Angeles, Special Service for Groups Inc, St. John's Well Child Center Inc, Sunrise Community Counseling Center, Women Organized to Respond to Lige-Threatening Diseases	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services	✔	✔
SAMHSA	SP-22-002 Substance Abuse and HIV Prevention Navigator Program for Racial/Ethnic Minorities Cooperative Agreement	Funds distributed directly to subrecipients listed	$2,000,000.00	Center for Health Justice Inc, San Ysidro Health Center inc, Asian and Pacific Islander Wellness Center, Clare Foundation	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔
SAMHSA	TI-23-024 Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project	Funds distributed directly to subrecipients listed	$1,330,871.00	University of California San Francisco, City of Vernon	Mental Health Services, Referral for Health Care and Support Services , Community mobilization, Prevention for persons living with diagnosed HIV infection	✔	✔
SAMHSA	SP-20-001 Capacity Building Initiative for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Funds distributed directly to subrecipients listed	$1,400,000.00	CENTRAL CITY NEIGHBORHOOD PARTNERS, NATIVE AMERICAN HEALTH CENTER INC., LA MAESTRA FAMILY CLINIC INC., SAN YSIDRO HEALTH CENTER INC., THE SAN DIEGO LESBIAN, GAY, BISEXUAL AND TRANSGENDER COMMUNITY CENTER, FRIENDSHIP HOUSE ASSN/AMERICAN INDIANS, HEALTH INITIATIVES FOR YOUTH INC.	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔

HRSA	Ryan White Part C HIV Capacity Building and Planning	Funds distributed directly to subrecipients listed	$1,925,000.00	Fresno Community Hospital & Medical Center, Los Angeles LGBT Center, Northeast Valley Health Corporation, St. John's Community Health, The Clinic Inc, University of Southern California, Via Care Community Health Center, Young scholar for Academic Empowerment, La Maestra Family Clinic Inc, North County Health Project Incorporated, Wellness and Equity Foundation Inc, West County Health Centers Inc, Ampla Health	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔		
HRSA	Ryan White Part F SPNS	Funds distributed directly to subrecipients listed	$1,235,296.00	County of Sacramento, County of Alameda, JWCH Institute Inc, St. John's Community Health	Early Intervention Services (EIS) , Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Substance Abuse Services (residential), Capacity building/technical assistance, Community engagement, Prevention for persons living with diagnosed HIV infection, Testing	✔	✔	✔	
HRSA	Ryan White Part F SPNS	Funds distributed directly to subrecipients listed	$500,000.00	County of San Diego	Mental Health Services, Substance Abuse Outpatient Care, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔		✔	
HRSA	Ending the HIV Epidemic - Primary Care HIV Prevention (H8H)	Funds distributed directly to subrecipients listed	$3,003,759.00	ALL FOR HEALTH, HEALTH FOR ALL, INC, CLINICA MSR. OSCAR A ROMERO, Gracelight Community Health, SOUTHLAND INTEGRATED SERVICES INC, TRI-STATE COMMUNITY HEALTHCARE CENTER, UNIVERSITY OF CALIFORNIA IRVINE, THE DAVIS STREET COMMUNITY CENTER INCORPORATED	AIDS Drug Assistance Program Treatments, Outpatient/Ambulatory Health Services, Health Education/Risk Reduction, Condom distribution, PrEP delivery, Testing	✔	✔	✔	✔
IHS	Ending the HIV/HCV/Syphilis Epidemics in Indian Country	Funds distributed directly to subrecipients listed	$193,843.00	Viejas Band of Kumeyaay Indians	Early Intervention Services (EIS) , Mental Health Services, Substance Abuse Outpatient Care, Health Education/Risk Reduction, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔	

State General Fund	Opioid Settlement Fund	California Department of Public Health, Office of AIDS	$8,166,694.44	Sierra Health Foundation	Health Education/Risk Reduction, Prevention for persons living with diagnosed HIV infection, Syringe services programs			✔	
State General Fund	Project Empowerment	California Department of Public Health, Office of AIDS	$4,298,700.00	AIDS Healthcare Foundation, AIDS Project Los Angeles Health, AltaMed, CAL-PEP, Christie's Place, East LA Women's Center, Golden Rules Services, LA LGBT Center, Lifelong Medical Care, Lyon-Martin Community Health Services, REACH LA, Roots Community Health, Sacramento LGBT Community, Siskiyou County HHS, St. John's Community Health, Suburst Project, Young Scholars for Academic Empowerment	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation	✔		✔	
State General Fund	PrEP & PEP Initiation & Retention	California Department of Public Health, Office of AIDS	$5,018,734.98	AltaMed Health Services Corporation, Altura Centers for Health, Asian Health Services, California State University - East Bay Foundation, Inc., Central Neighborhood Health Foundation, Centro de Salud de la Comunidad de San Ysidro Inc, Charles R Drew University of Medicine and Science, Clinicas de Salud del Pueblo Inc., Community Medical Centers Inc., County of Butte, County of Sacramento, County of San Diego, County of Santa Cruz - Health Services Agency, County of Yolo, Fresno Community Hospital and Medical Center, San Bernardino County, San Francisco AIDS Foundation, Sunburst Projects, Sutter Bay Hospitals, The Source LGBT+ Center Inc., The Wall - Las Memorias, University of Southern California	Health Education/Risk Reduction, PrEP delivery		✔	✔	
State General Fund	PrEP & PEP Navigator Funding	California Department of Public Health, Office of AIDS	$1,740,000.00	AltaMed Health Services, Asian American Drug Abuse Prg Inc, Central Valley Gender Health & wellness, Mercy Health, St. John's Community Health, WestCare California Inc	Health Education/Risk Reduction, PrEP delivery, Testing, PrEP Navigation, Rapid ART		✔	✔	
State General Fund	Strategic Rapid ART	California Department of Public Health, Office of AIDS	$2,000,000.00	County of Stanislaus, DAP Health, City of Long Beach, TruEvolution	Testing, Rapid ART, Linkage to Care	✔	✔	✔	
State General Fund	Surveillance General Fund Awards	California Department of Public Health, Office of AIDS	$6,664,872.00	County of Alameda, County of Amador, Berkeley LHJ, County of Butte, County of Calaveras, County of Colusa, County of Contra Costa, County of Del Norte, County of El Dorado, County of Fresno, County of Glenn, County of Humboldt, County of Imperial, County of Inyo, County of Kern, County of Kings, County of Lake, County of Lassen, City of Long Beach, County of Los Angeles, County of Madera, County of Marin, County of Mariposa, County of Mendocino, County of Merced, County of Modoc, County of Mono, County of Monterey, County of Napa, County of Nevada, County of Orange, Pasadena LHJ, County of Placer, County of Plumas, County of Riverside, County of Sacramento, County of San Benito, County of San Bernardino, County of San Diego, County of San Francisco, County of San Joaquin, County of San Luis Obispo, County of San Mateo, County of Santa Barbara, County of Santa Clara, County of Santa Cruz, County of Shasta, County of Sierra, County of Siskiyou, County of Solano, County of Sonoma, County of Stanislaus, County of Sutter, County of Tehama, County of Trinity, County of Tulare, County of Tuolumne, County of Ventura, County of Yolo, County of Yuba	Capacity building/technical assistance, HIV transmission cluster and outbreak identification and response, Surveillance	✔	✔		✔

E. Resources in the County of San Francisco

						HIV Care Continuum					EHE Pillar			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
CDC	PS24-0047 (Core Prevention)	City & County of San Francisco	$4,668,504.00	City & County of San Francisco, Shanti	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔	✔	✔	✔	✔	✔
CDC	PS24-0047 (EHE)	City & County of San Francisco	$2,386,651.00	City & County of San Francisco, Facente Consulting LLC	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔	✔	✔	✔	✔	✔
HOPWA	HOPWA Direct Funding (Formula)	City of San Francisco	$7,259,242.00	N/A	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection			✔		✔		✔	✔	
HRSA	Ending the HIV Epidemic: A Plan for America Ryan White HIV/AIDS Program Parts A and B	City & County of San Francisco	$2,710,822.00	N/A	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection		✔	✔	✔	✔	✔	✔	✔	
HRSA	Ryan White Part A HIV Emergency Relief Grant Program	City & County of San Francisco	$14,841,000.00	N/A	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection		✔	✔	✔	✔	✔	✔	✔	✔

HRSA	Ryan White Part B HIV Care Grant Program (OA Care Branch)	California Department of Public Health, Office of AIDS	$3,149,750.00	County of San Francisco	Early Intervention Services, Medical Case Management, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistics Services, Medical Transportation, Non-medical Case Management, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection	✔	✔	✔		✔	✔	✔	✔
HRSA	AIDS Education and Training Centers Program	Funds directly distributed to subrecipients	$2,527,777.00	Regents of the University of California, San Francisco	Health Education/Risk Reduction								✔
HRSA	Ryan White Part C (EIS)	Funds directly distributed to subrecipients	$971,239.00	City & County of San Francisco, San Francisco Community Clinic Consortium	Early Intervention Services, Outpatient/Ambulatory Health Services		✔	✔	✔	✔	✔	✔	✔
HRSA	Ryan White Part D	Funds directly distributed to subrecipients	$693,114.00	Regents of the University of California, San Francisco	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔	✔	✔	✔	✔	✔	✔
HRSA	Ryan White Part F Dental Reimbursement	Funds directly distributed to subrecipients	$173,413.00	Regents of the University of California, San Francisco	Oral Health Care			✔					
SAMHSA	SP-20-001 Capacity Building Initiative for Substance Abuse (SA) and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Funds directly distributed to subrecipients	$400,000.00	Friendship House Association of American Indians, Health Initiatives for Youth, Inc.	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔	✔			✔		✔
SAMHSA	TI-22-004 Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Funds directly distributed to subrecipients	$2,499,821.00	Baker Places, Inc., California Prevention and Education Project, Friendship House Association of American Indians, University of California, San Francisco	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔	✔			✔		✔

SAMHSA	TI-23-024 Minority HIV/AIDS Fund: Integrated Behavioral Health and HIV Care for Unsheltered Populations Pilot Project	Funds directly distributed to subrecipients	$664,571.00	University of California, San Francisco	Mental Health Services, Referral for Health Care and Support Services , Community mobilization, Prevention for persons living with diagnosed HIV infection		✔	✔				✔	✔	
SAMHSA	TI-23-008 Minority AIDS Initiative: Substance Use Disorder Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Funds directly distributed to subrecipients	$500,000.00	Asian and Pacific Islander Wellness Center,	Substance Abuse Outpatient Care, Substance Abuse Services (residential)	✔	✔	✔			✔		✔	
State General Fund	Surveillance General Fund Awards	California Department of Public Health, Office of AIDS	$672,178.00	City & County of San Francisco	Capacity building/technical assistance, HIV transmission cluster and outbreak identification and response, Surveillance		✔	✔		✔	✔	✔		✔
State General Fund	PrEP & PEP Initiation & Retention	California Department of Public Health, Office of AIDS	$347,635.00	San Francisco AIDS Foundation	Health Education/Risk Reduction, PrEP delivery			✔	✔	✔		✔	✔	
State General Fund	Project Empowerment	California Department of Public Health, Office of AIDS	$125,000.00	Lyon-Martin Community Health Services	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation	✔	✔	✔		✔	✔		✔	

F. Resources in the County of Los Angeles

						HIV Care Continuum					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
CDC	PS24-0047 (Core Prevention)	County of Los Angeles	$14,297,264.00	Various	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔	✔	✔	✔	✔	✔
CDC	PS24-0047 (EHE)	County of Los Angeles	$3,125,201.00	Various	Early Intervention Services (EIS) , Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation, Rapid ART	✔	✔	✔	✔	✔	✔	✔	✔	✔
HOPWA	HOPWA Direct Funding (Formula)	Funds directly distributed to subrecipient	$24,183,591.00	City of Los Angeles	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection			✔		✔		✔	✔	
HRSA	Ending the HIV Epidemic: A Plan for America Ryan White HIV/AIDS Program Parts A and B (UT8)	County of Los Angeles	$7,541,999.00	Various	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection		✔	✔	✔	✔	✔	✔	✔	
HRSA	Ryan White Part A HIV Emergency Relief Grant Program	County of Los Angeles	$46,295,740.00	Various	Early Intervention Services (EIS) , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Child Care Services, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Substance Abuse Services (residential), Prevention for persons living with diagnosed HIV infection		✔	✔	✔	✔	✔	✔	✔	✔
HRSA	Ryan White Part B HIV Care Grant Program (OA Care Branch)	County of Los Angeles	$7,705,173.00	Various	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection			✔		✔				

HRSA	Ending the HIV Epidemic - Primary Care HIV Prevention (H8H)	Funds directly distributed to subrecipient	$1,287,342.00	All For Health, Health For All, Inc., Clinica Msr. Oscar A Romero, Gracelight Community Health	AIDS Drug Assistance Program Treatments, Outpatient/Ambulatory Health Services, Health Education/Risk Reduction, Condom distribution, PrEP delivery, Testing		✔	✔	✔	✔	✔	✔	✔	✔
HRSA	Ryan White Part B HIV Care Grant Program (OA Care Branch)	Funds directly distributed to subrecipient	$1,114,281.00	City of Long Beach	Housing, Non-Medical Case Management Services, Prevention for persons living with diagnosed HIV infection			✔		✔				
HRSA	Ryan White Part C (EIS)	Funds directly distributed to subrecipient	$5,355,190.00	Altamed Health Services Corporation, Bartz-Altadonna Community Health, Charles R. Drew University of Medicine and Science, Dignity Health (Long Beach), El Proyecto Del Barrio, Inc., JWCH institute, Inc., Los Angeles LGBT Center, Northeast Valley Health Corporation, Tarzana Treatment Centers, Inc., The Clinic, Inc., Univeristy of Southern California, Venice Family Clinic, Watts Healthcare Corp	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔	✔	✔	✔	✔	✔	✔	
HRSA	Ryan White Part C: HIV Capacity Development and Planning Grants	Funds directly distributed to subrecipient	$900,000.00	Los Angeles LGBT Center, Northeast Valley Health Corporation, St. John's Community Health, The Clinic, Inc., University of Souther California, Via Care Communtiy Health Center	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔	✔	✔	✔		✔		
HRSA	Ryan White Part D	Funds directly distributed to subrecipient	$1,633,218.00	Altamed Health Services Corporation, Univeristy of California Los Angeles, University of Southern California	Early Intervention Services (EIS) , Outpatient/Ambulatory Health Services		✔	✔	✔	✔	✔	✔	✔	
HRSA	Ryan White Part F Dental Reimbursement	Funds directly distributed to subrecipient	$2,058,798.00	Univeristy of California Los Angeles, University of Southern California, Western University of Health Sciences	Oral Health Care			✔						
HRSA	Ryan White Part F SPNS	Funds directly distributed to subrecipient	$617,648.00	JWCH Institute, Inc., St. John's Community Health	Early Intervention Services (EIS) , Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Substance Abuse Services (residential), Capacity building/technical assistance, Community engagement, Prevention for persons living with diagnosed HIV infection, Testing	✔		✔	✔	✔	✔	✔	✔	

State General Fund	PrEP & PEP Navigator Funding	Funds directly distributed to subrecipient	$870,000.00	Altamed Health Services Corporation, Asian American Drug Abuse Program, St. John's Community Health	Health Education/Risk Reduction, PrEP delivery, Testing, PrEP Navigation, Rapid ART		✔	✔	✔	✔		✔	✔	
State General Fund	Project Empowerment	Funds directly distributed to subrecipient	$1,800,000.00	AIDS Project Los Angeles Health, Altamed Health Services Corporation, East LA Women's Center, Los Angeles LGBT Center, Reach LA, St. John's Community Health	Health Education/Risk Reduction, Outreach Services, Referral for Health Care and Support Services , Condom distribution, Prevention for persons living with diagnosed HIV infection, Testing, PrEP Navigation	✔	✔	✔		✔	✔		✔	
State General Fund	Strategic Rapid ART	Funds directly distributed to subrecipient	$500,000.00	City of Long Beach	Testing, Rapid ART, Linkage to Care	✔	✔		✔	✔	✔	✔	✔	
State General Fund	Surveillance General Fund Awards	Funds directly distributed to subrecipient	$2,344,398.00	City of Long Beach, City of Pasadena, County of Los Angeles	Capacity building/technical assistance, HIV transmission cluster and outbreak identification and response, Surveillance		✔	✔		✔	✔	✔		✔

G. California Integrated HIV and Prevention Care Plan Work Plan and Monitoring Table, 2027-2031

California Integrated HIV and Prevention and Care Plan Work Plan and Monitoring Table, 2027-2031

Goal 1: Diagnose all people as early as possible											
Objective / Strategy #	**Objective / Strategy**	**EHE Strategy**	**Performance Measure**	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Timeline**	**Data Source**	**Responsible Parties**	**Responsible Data Staff**	**Responsible Program Staff**
Objective 1.1	By December 31, 2031, increase the estimated percentage of Californians living with HIV who know their serostatus to at least 95 percent.	Diagnose	Percent of Californians living with HIV who know their serostatus	Percent is based on a calculated estimate of those of unknown status using a CDC formula	2024	86.1	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	Surveillance	HIV Prevention
Strategy 1.1.a	Fund routine opt-out (ROOT) HIV screenings in health care and other institutional settings	Diagnose	Number of routine opt-out HIV screenings	Number of routine opt-out screenings at funded sites	2026	TBD	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.1.b	Fund sites offering focused HIV testing in health care and non-health care settings, including distributed HIV self-testing kits	Diagnose	Number of sites offering HIV testing in health care and non-health care settings, including distributed HIV self-testing kits	Number of tests done using a focused testing strategy at funded sites	2026	TBD	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.1.c	Fund integrated screening of HIV with other STIs, TB, viral hepatitis and mpox	Diagnose	Number of integrated screenings of HIV with other STIs, TB, viral hepatitis, and mpox	Number of integrated screenings done at funded sites	2026	TBD	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Objective 1.2	By December 31, 2031, implement a testing program including ROOT and focused testing strategies administering 1 million HIV tests with at least 70 percent being from priority populations in California.	Diagnose	Percent of HIV tests reaching priority populations	Percent of HIV tests reaching named priority populations at funded test sites	2025	1 million	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.2.a	Develop revised prevention guidance to include comprehensive, low barrier testing strategies to be implemented in all funded jurisdictions	Diagnose	Completed prevention guidance being implemented in funded jurisdictions	Percent of funded jurisdictions implementing completed prevention guidance	2026	Draft Guidance	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.2.b	Fund organizations with connections to priority populations	Diagnose	Completed subcontracts to organizations able to reach named priority populations	Number of funded subcontractors	2026	TBD	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention

Strategy 1.2.c	Plan and apply relevant social drivers of health strategies to improve the effectiveness of testing strategies to reach priority populations and remove barriers to testing.	Diagnose	Completed implementation blueprint applying relevant social drivers of health strategies	Number of jurisdictions completing a plan to address social drivers of health	2026	TBD	12/31/2031	Local Evaluation Online	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Objective 1.3	By June 30, 2031, implement an integrated self-testing program conducting at least 10,800 tests reaching at least 70 percent individuals from listed priority populations in California.	Diagnose	Number of self-tests	Number of self-tests completed by the funded California self testing program	2026	TBD	12/31/2031	Self-testing Subcontractor Data	California Department of Public Health and Local Health Departments, Self-Testing Subcontractor	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.3.a	Fund integrated self-testing in all EHE jurisdictions in California	Diagnose	Number of EHE jurisdictions implementing integrated self-testing	Percent of EHE jurisdictions implementing integrated self-testing	2026	TBD	12/31/2031	Contract data	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.3.b	Maintain at least HIV self-testing in all regions of California	Diagnose	Percent of counties in California implementing at least HIV self-testing	Number of jurisdictions maintaining at least HIV self-testing	2026	100%	12/31/2031	Building Healthy Online Communities, Take Me Home data	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Strategy 1.3.c	Develop social media outreach focused on priority populations that link them to self-testing and other supportive services	Diagnose	Social media plan completed and implemented	Reported social media interactions with campaigns	2026	TBD	12/31/2031	Social Media Data	California Department of Public Health and Local Health Departments	Prevention, Evaluation and Monitoring Sections California Department of Public Health and Local Health Departments	HIV Prevention
Goal 2: Treat people with HIV rapidly and effectively to reach sustained viral suppression.											
Objective / Strategy #	**Objective / Strategy**	**EHE Strategy**	**Performance Measure**	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Timeline**	**Data Source**	**Responsible Parties**	**Responsible Data Staff**	**Responsible Program Staff**
Objective 2.1	By December 31, 2031, increase the percentage of newly diagnosed persons in California linked to HIV medical care within 1 month of their HIV diagnosis to at least 85 percent.	Treat	Percent of people linked to HIV medical care within 1 month	Percent of people linked to HIV medical care within 1 month: all California and by local health jurisdiction	2024	80%	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	Surveillance	HIV Care
Strategy 2.1.a	Implement community engagement listening sessions across all co-author counties to better understand priority populations and how to improve core and social drivers of health strategies for them; beginning with older adults, people aging with HIV.	Treat, Diagnose, Prevent, Respond	Number of people with lived experience at risk for HIV and/or PLWH reached in listening sessions	Number of people with lived experience at risk for HIV and/or PLWH reached in listening sessions reported by co-author counties and other regions of California	2026	TBD	12/31/2031	Community Engagement Process Data	California Department of Public Health and Local Health Departments	HIV Care	HIV Care
Strategy 2.1.b	Complete an ADAP Gap Analysis to better understand how to improve the ADAP program for low income PLWH in California.	Treat	Completed ADAP Gap Analysis with Recommendations	Completed ADAP Gap Analysis with Recommendations will address the needs of all regions of California, including co-author counties	2026	Preliminary findings, in process	12/31/2031	Community Engagement Process Data	California Department of Public Health and Local Health Departments	HIV Care	HIV Care

Strategy 2.1.c	Plan and apply relevant social drivers of health strategies to improve the effectiveness of linkage to care strategies to reach priority populations and remove barriers to care.	Treat	Number of competed plans in each local health jurisdiction	Number of completed plans in each co-author jurisdiction	2026	TBD	12/31/2031	Community Engagement Process Data	California Department of Public Health and Local Health Departments	HIV Care	HIV Care
Objective 2.2	By December 31, 2031, increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75 percent.	Treat	Percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis	Percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis reported for all California and by local health jurisdiction	2024	64%	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	Surveillance	HIV Care
Strategy 2.2.a	Maintain and improve program utilization reporting data system	Treat	Number of HIV care providers reporting satisfaction with the HIV Care Connect data system	Number of HIV care providers reporting satisfaction with the HIV Care Connect data system	2026	TBD	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Care	HIV Care
Strategy 2.2.b	Increase utilization of surveillance-based partner services activities	Treat	Percent of newly diagnosed individuals who are offered partner services	Percent of newly diagnosed individuals who are offered partner services reported for all California and by local health jurisdiction	2026	TBD	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	HIV Care, Surveillance	HIV Care, Surveillance
Strategy 2.2.c	Plan and apply relevant social drivers of health strategies to improve the effectiveness of linkage to care strategies to reach priority populations and remove barriers to care.	Treat	Number of competed plans in each local health jurisdiction	Number of completed plans in each co-author jurisdiction	2026	TBD	12/31/2031	Community Engagement Process Data	California Department of Public Health and Local Health Departments	HIV Care	HIV Care
Objective 2.3	By December 31, 2031, increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 80 percent.	Treat	Percentage of Californians with diagnosed HIV infection who are virally suppressed	Percentage of Californians with diagnosed HIV infection who are virally suppressed reported for all California and by local health jurisdiction	2024	68%	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	Surveillance	HIV Care
Strategy 2.3.a	Increase the percentage of Californians with diagnosed HIV infection who are in HIV medical care (at least 1 visit per year).	Treat	Percentage of Californians with diagnosed HIV infection who are in HIV medical care (at least 1 visit per year)	Percentage of Californians with diagnosed HIV infection who are in HIV medical care (at least 1 visit per year) reported for all California and by local health jurisdiction	2024	76%	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	HIV Care, HIV Prevention	HIV Care
Strategy 2.3.b	Increase the percentage of California ADAP clients with public or private health insurance to at least 71 percent	Treat	Percentage of California ADAP clients with public or private health insurance	Percentage of California ADAP clients with public or private health insurance who have had at least one medication dispensed during the year reported for all California and by local health jurisdiction.	2024	66%	12/31/2031	ADAP Data	California Department of Public Health and Local Health Departments	ADAP	HIV Care, AIDS Drug Assistance Program
Strategy 2.3.c	Reduce the percentage of Californians newly diagnosed with HIV infection who are experiencing homelessness at time of diagnosis to less than 5 percent.	Treat	Percentage of Californians newly diagnosed with HIV infection who are experiencing homelessness at time of diagnosis	Percentage of Californians newly diagnosed with HIV infection who are experiencing homelessness at time of diagnosis reported for all California and by local health jurisdiction	2023	5.9%	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	Surveillance	HIV Care

Goal 3: Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis.											
Objective / Strategy #	**Objective / Strategy**	**EHE Strategy**	**Performance Measure**	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Timeline**	**Data Source**	**Responsible Parties**	**Responsible Data Staff**	**Responsible Program Staff**
Objective 3.1	By December 31, 2031, reduce the number of new HIV diagnoses in California by at least 50 percent, to fewer than 2,500 per year from a baseline of 4,538.	Prevent	Number of new HIV diagnoses in California	Number of new HIV diagnoses reported for all California and by local health jurisdiction and proportionally for each local health jurisdiction	2024	4,538	12/31/2031	Surveillance Data	California Department of Public Health and Local Health Departments	Surveillance	HIV Prevention
Strategy 3.1.a	Fund low-barrier, community-based, status-neutral models (street medicine, drive-throughs, telehealth) and embed PrEP into routine and specialty care (OB-GYN, primary care, outreach sites).	Prevent	Number of funded low-barrier, community-based, status-neutral interventions (street medicine, drive-throughs, telehealth) with embed PrEP into routine and specialty care (OB-GYN, primary care, outreach sites)	Number of funded low-barrier, community-based, status-neutral interventions (street medicine, drive-throughs, telehealth) with embed PrEP into routine and specialty care (OB-GYN, primary care, outreach sites) for all California and by local health jurisdiction and proportionally for each local health jurisdiction	2026	TBD	12/31/2031	Contract data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Strategy 3.1.b	Maintain a hybrid virtual HIV test counselor training program	Prevent	Number of HIV test counselors certified and recertified	Number of HIV test counselors certified and recertified reported for all California and by local health jurisdiction and proportionally for each local health jurisdiction	2026	TBD	12/31/2031	HIV Certification Data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Strategy 3.1.c	Implement integrated rapid testing training for HIV, syphilis and HCV	Prevent	Percent of HIV test counselors also trained to administer point of care rapid testing for syphilis and HCV	Percent of HIV test counselors also trained to administer point of care rapid testing for syphilis and HCV reported for all California and by local health jurisdiction and proportionally for each local health jurisdiction	2026	TBD	12/31/2031	Integrated HV/Syphilis/HCV training Data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Objective 3.2	By December 31, 2031, increase the number of Californians at high risk for HIV infection who are on PrEP to 120,000 from a baseline of 79,648.	Prevent	Increase the number of Californians at high risk for HIV infection who are on PrEP	Number of people on PrEP reported for all California and by local health jurisdiction	2024	79,648	12/31/2031	AIDSVu	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Strategy 3.2.a	Complete PrEP gap analysis	Prevent	Completed gap analysis	Completed PrEP Gap Analysis with recommendations will address the needs and gaps of all regions of California, including co-author counties	2026	preliminary findings, in process	6/30/2027	Focus Groups, Key Informant Interviews, California Health Information Survey, Health Information and Access system	California Department of Public Health	California Department of Public Health, Office of AIDS, Division	California Department of Public Health, Office of AIDS, Division
Strategy 3.2.b	Leverage continuing education pathways for MDs, nurses, and pharmacists on PrEP, PEP, and DoxyPEP	Prevent	Number of MDs, nurses, and pharmacists that have been trained on how to better offer PrEP, PEP, and DoxyPEP to priority populations	Number of MDs, nurses, and pharmacists that have been trained on how to better offer PrEP, PEP, and DoxyPEP to priority populations reported for all California and by local health jurisdiction	2026	TBD	12/31/2031	Training process data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention

Strategy 3.2.c	Fund tailored media campaigns with trusted community voices and influencers to normalize PrEP across all priority populations.	Prevent	Number of media campaigns completed	Number of media campaigns implemented and documented interactions with media campaigns	2026	TBD	12/31/2031	Media campaign process data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Objective 3.3	By December 31, 2031, maintain a condom distribution program, distributing at least 5 million condoms to priority populations in California.	Prevent	Number of condoms distributed	Number of condoms distributed reported for all California and by local health jurisdiction	2026	TBD	12/31/2031	Condom process data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Strategy 3.3.a	Maintain a centralized clearinghouse for condom distribution to community-based organizations implementing HIV prevention interventions	Prevent	Number of community based organizations registered at the clearing house	Number of community based organizations registered at the clearing house reported for all California and by local health jurisdiction	2026	TBD	12/31/2031	Clearing house program enrollment data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Strategy 3.3.b	Complete a condom gap analysis for selected priority populations in California and augment the workplan with the findings	Prevent	Completed condom gap analysis for selected priority populations in California and augment the workplan with the findings	Completed condom gap analysis for selected priority populations in California and augment the workplan with the findings reported for all California and by local health jurisdiction	2026	TBD	12/31/2031	Gap analysis process data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Strategy 3.3.c	Measure unmet need for condoms	Prevent	Reported numbers of orders unable to be filled	Reported numbers of orders unable to be filled reported for all California and by local health jurisdiction	2026	TBD	12/31/2031	Unmet order data	California Department of Public Health and Local Health Departments	HIV Prevention	HIV Prevention
Goal 4: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them.											
Objective / Strategy #	**Objective / Strategy**	**EHE Strategy**	**Performance Measure**	**Measure Definition**	**Baseline Year**	**Baseline Value**	**Timeline**	**Data Source**	**Responsible Parties**	**Responsible Data Staff**	**Responsible Program Staff**
Objective 4.1	By December 31, 2031, all identified HIV clusters will be actively managed with a response plan implemented.	Respond	Percent of HIV clusters with a response plan implemented	Percent of HIV clusters with a response plan implemented	2026	TBD	12/31/2031	Cluster report form data	California Department of Public Health and Local Health Departments	HIV Surveillance	HIV Surveillance
Strategy 4.1.a	By December 31, 2031, 100 percent of clusters that meet CDC's criteria for an annual or closeout cluster report form will have had an annual or closeout cluster report form submitted to CDC by the submission deadline.	Respond	Number clusters that meet CDC's cluster report form criteria detected during the evaluation period will have had an initial cluster report form submitted to CDC by the submission deadline.	Number clusters that meet CDC's cluster report form criteria detected during the evaluation period will have had an initial cluster report form submitted to CDC by the submission deadline reported for all California and by local health jurisdiction.	2026	TBD	12/31/2031	Surveillance and Cluster report form data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.1.b	By December 31, 2031, 100 percent of clusters that meet CDC's cluster report form criteria detected during the evaluation period will have had an initial cluster report form submitted to CDC by the submission deadline.	Respond	Percent of clusters that meet CDC's cluster report form criteria detected during the evaluation period will have had an initial cluster report form submitted to CDC by the submission deadline.	Percent of clusters that meet CDC's cluster report form criteria detected during the evaluation period will have had an initial cluster report form submitted to CDC by the submission deadline reported for all California and by local health jurisdiction.	2026	TBD	12/31/2031	Surveillance and Cluster report form data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.1.c	By December 31, 2031, 100 percent of people with HIV in clusters for which a cluster report form was submitted during the evaluation period will have had cluster variables entered into eHARS.	Respond	Percent of people with HIV in clusters for which a cluster report form was submitted during the evaluation period will have had cluster variables entered into eHARS.	Percent of people with HIV in clusters for which a cluster report form was submitted during the evaluation period will have had cluster variables entered into eHARS.	2026	TBD	12/31/2031	Surveillance and Cluster report form data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section

Objective 4.2	By December 31, 2031 assist with 100% of all requests for assistance from local health departments to help manage clusters and outbreaks of HIV.	Respond	Percent of all requests for assistance from local health departments to help manage clusters and outbreaks of HIV	Percent of all requests for assistance from local health departments to help manage clusters and outbreaks of HIV	2026	TBD	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.2.a	Maintain and update a CDR outbreak manual for use by public health departments.	Respond	Manual is current and submitted to the CDC	Manual is current and submitted to the CDC	2026	TBD	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.2.b	Monitor genetic and time space related HIV clusters across California	Respond	Number of HIV clusters detected	Number of HIV clusters detected	2026	TBD	12/31/2031	Surveillance	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.2.c	Improve the response to clusters by applying evaluation methods to each incident and improve future outcomes	Respond	Number of clusters evaluated	Number of clusters evaluated	2026	TBD	12/31/2031	Cluster report form data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Objective 4.3	By December 31, 2031, maintain a state-wide Cluster Detection Response Community Advisory Board with recruited members comprised of people living with HIV and with lived experience and other subject matter experts from all regions of California in collaboration with San Francisco and Los Angeles, holding at least 4 quarterly meetings per year to help advise and improve the efficacy of California's response to HIV clusters.	Respond	Number of CDR Community Advisory Board Meetings	Number of CDR Community Advisory Board Meetings	2026	TBD	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.3.a	Maintain a CDR CAB with people with lived experience and other subject matter experts in collaboration with Los Angeles and San Francisco.	Respond	CDR CAB is active	CDR CAB is active	2026	Active	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.3.b	Conduct anti-stigma education that includes information about CDR efforts.	Respond	Number of anti-stigma campaigns or events including information about CDR	Number of anti-stigma campaigns or events including information about CDR	2026	TBD	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section
Strategy 4.3.c	Conduct statewide partner calls that will address a wide range of topics including concerns and questions about CDR	Respond	Number of partner calls	Number of partner calls where CDR questions were raised and documented responses	2026	TBD	12/31/2031	Process Data	California Department of Public Health and Local Health Departments	HIV Surveillance, CDR Section	HIV Surveillance, CDR Section

California Department of Public Health
Office of AIDS
MS 7700
P.O. Box 997426
Sacramento, CA 95899-7426

HIV/AIDS Program Homepage (ca.gov)