

Climate Change and Continuity of Care

Maintaining Access to Prevention and Care Services During Climate-Related Events in California



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Executive Summary

In California, natural disasters related to climate change have increased in both frequency and severity in recent years. The impacts of climate-related events on healthcare delivery and client engagement in care are not yet well understood. We conducted a rapid assessment to: 1) better understand the impact of climate change (e.g., wildfires, floods) on HIV, STI, and harm reduction services; 2) document adaptive strategies that address these disruptions and facilitate retention in care; 3) identify which opportunities and gaps remain; and 4) summarize policy implications and recommendations to address service gaps.

From October 2021 through April 2022, we interviewed 18 key informants providing services across nine California counties and two Indian Reservations. All reported severe climate-related events in their service catchment areas, most commonly wildfires, floods, and increasingly extreme seasonal weather patterns. Providers described critical barriers impacting access to and continued engagement in HIV prevention and care services. We found that these barriers came in two waves: *immediate impacts* of climate-related events, and *aftermath*.

Immediate impacts: infrastructure disruption; displacement; and an abrupt shift in priority hierarchy of needs.

Aftermath: trauma and isolation; client perception of service inaccessibility; loss of essential documentation; and disrupted access to harm reduction services.

Participants further described effective facilitators that supported critical adaptations during climate events: expanded reimbursement and capacity for virtual services; reliance on backup infrastructure and resource sharing; community trust and relationships; robust client data; and developing creative mobile service delivery methods.

Our findings support policy that equips staff and agencies with the support they need to be adaptive, flexible, and resilient in the face of climate-related events, and addresses barriers that clients face in the acquisition of services.

Background

In the last decade, California has seen rapid changes to the frequency and scale of natural disasters related to climate change. Twelve of the 20 largest wildfires in the state's history have occurred in the last 5 years alone.¹ According to California's Fourth Climate Change

Assessment (CCA),² California continues to experience rapidly increasing temperatures and durations of heat waves, increasingly heavy precipitation events, increased incidence and severity of drought, rising sea levels, declining snowpack, and increasing yearly acreage burned by wildfires.

Findings

OVERVIEW

We initially sought to understand ways in which direct HIV services are disrupted during and in the wake of climate-related events. While some service delivery was interrupted, we found that in many cases—particularly with clinical, case management, and community support—direct services were **disrupted but not interrupted**. Service providers adapted to the needs of the moment, going above and beyond their usual operations to make sure their clients’ essential needs were met and that they had access to continuity of care. The adaptive strategies taken immediately following events were often difficult and not well supported (underfunded/understaffed), but ultimately ensured continuity of service provision. Despite continued availability of services, informants reported that clients still struggled to access those services due to internal (psychological/emotional) and structural barriers caused by climate-related events.

Our findings point broadly to two critical needs:

- 1) Equipping ground-level staff and agencies with the support they need to be adaptive, flexible, and resilient in the face of climate-related events;
- 2) Addressing structural and individual barriers that clients face in the acquisition of services following climate-related events, even when provision of those services has been maintained.

Below, we present barriers impacting access to and continued engagement in care following climate-related

events, facilitators to mitigating or overcoming these barriers, and policy recommendations.

It is important to note that these findings represent participant reports of client experiences, not client reports of their own experiences.

TYPES OF CLIMATE-RELATED EVENTS

Participants reported the most common types of climate-related events in their service catchment areas to be wildfires, flooding, intensifying seasonal weather patterns (i.e., storm surges), drought, and excessive heat for prolonged periods.

BARRIERS

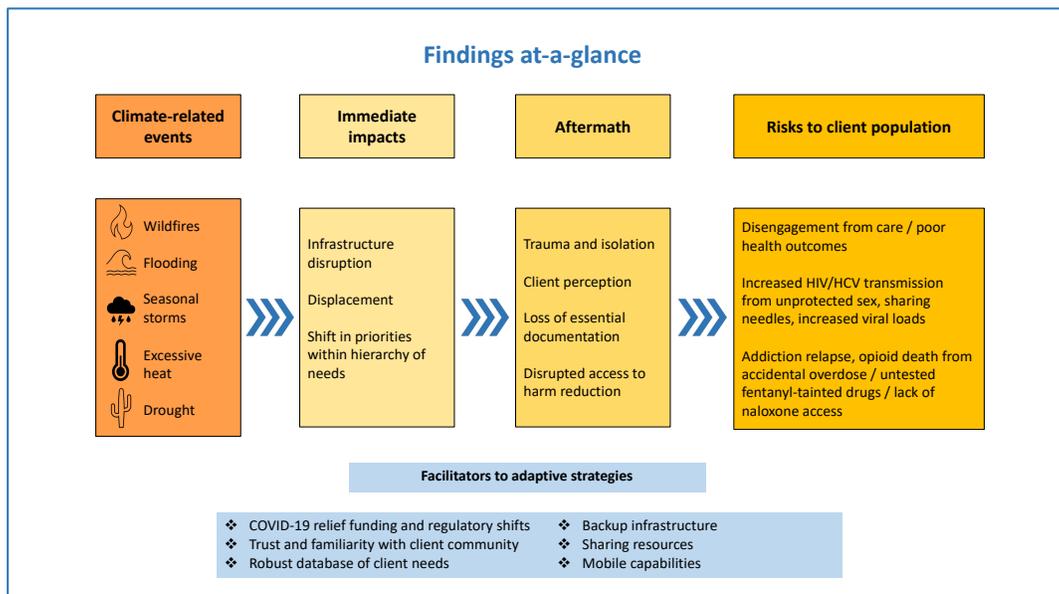
We found that barriers came in two waves: *immediate impacts* of climate-related events, and *aftermath*.

Immediate impacts represent barriers to services immediately following a climate-related event, while *aftermath* represents impacts that result from or follow immediate impacts.

Immediate impacts

Infrastructure disruption. Loss of essential infrastructure—electricity, phone lines, cellular service, internet connectivity, structures, open roadways—disrupted every aspect of care interactions. Informants most heavily stressed:

- loss of power (preventative brownouts or blackouts, sometimes for periods of hours, sometimes for longer periods up to weeks);



- disruptions to physical movement (clients' ability to get to care, providers' ability to get to clients, safe transport of essential medical supplies);
- internet / network disconnection (providers unable to access client records, pharmacies unable to receive remote prescriptions or process co-pays);
- loss of / damage to physical structures (clinic buildings, homes, businesses);
- loss of communication (providers unable to reach clients, clients unable to reach providers, instructions / contingency plans cannot be communicated leaving clients unaware of new service locations, other points of service distribution, plans related to medication, etc.).

The impact infrastructure disruptions had on services were immediate. Informants gave multiple examples of structure inaccessibility, inability of clients and providers to connect, and services rendered inoperable.

To try to locate [clients and staff after the fire], to contact them, was like you just couldn't. There was no way to do that. So, you couldn't go door to door, because they were evacuated from their area. You couldn't go to the clinic because the clinic didn't exist.
[Client Services 03 – drought/fires/flooding]

Pharmacies may be inaccessible to clients if their physical structure is compromised, if power or internet are down, if the transportation clients rely on to get to the pharmacy are unavailable, or if the pharmacy's supply of medications is interrupted.

But the fires did burn out all the fiber optic lines underneath the ground, so we had no Internet for days. It was very difficult to provide services. Everything is online. You know, all their notes are online, check-ins are online, everything is online. ... The pharmacy wasn't able to distribute services because they can't look up the copays. They can't process it.
[Harm reduction/prevention services 17 – fires/storms/flooding]

Mobile services—often relied on more heavily during events in which people were displaced (like evacuations) or their movement constrained (like excessive heat or toxic smoke levels)—lost operability

when roads were closed from landslides, floods, wildfires, and storm conditions.

Displacement. Clients and staff may be displaced in multiple climate-related situations. Individuals can lose their homes outright, or be evacuated from where they are living, be it a home or encampment. Informants told stories of staff and clients losing their homes to fire or being severely damaged due to floods, as well as unhoused clients being rained, flooded, or evacuated out of an encampment site, which had been serving as the base for contact with many of the services on which they relied (e.g., mobile outreach to provide HIV testing, syringe access, clothing and food services).

The burden of displacement was not experienced equally. Reports from providers suggest that the more resources a client had (shelter, insurance, home ownership, savings), the more straightforward the process was of recovering from displacement and staying connected—or resuming connection—to care. Clients living in economic precarity had a more difficult time.

I've had a bunch of patients, some who have moved out of the area. It's just like, "I can't ever do this again." It's too scary to know you have to leave, know you have to take everything with you, and you're going to be on a bus taking you to the state fairgrounds or something. So, that's where the economic difference really plays out. People that have a car and can afford a motel and can go somewhere else, it's different than somebody who doesn't, who's in subsidized housing or in marginal housing.
[HIV Clinical Provider 08 – drought/fires/flooding]

Informants in multiple roles talked about how clients who are unhoused and clients who rely on harm reduction services to stay well often suffer the most profound and unrecoverable losses from displacement.

When it starts raining heavily, a lot of [unhoused] people fall off the map. ... It is really common to not have people come back.
[Harm reduction/prevention services 12 – fires/storms/flooding/drought]

Shift in position on hierarchy of needs. Overwhelmingly, informants reported that their clients experienced a shift in the relative priority of their needs in the wake of a climate-related event. Nearly every participant, either directly or indirectly, identified this issue as a key barrier to clients maintaining engagement in care. When basic elements of survival were threatened—shelter, access to food and clean water, physical safety—higher order needs, like those associated with longer-term health and well-being, were deprioritized.

[During a disaster], folks are more on their survival mode. They're not on a like, "Oh, let me take care of my health," mode because they're just trying to figure out where their next meal is going to come from, how they're going to feed their kids.
[Client Services 03 – drought/fires/flooding]

In this way, even when services themselves were not technically interrupted, **disruption to clients' foundations of survival and wellbeing constituted a disruption in their ability to stay connected to care.**

Aftermath

Trauma and isolation. While not as immediately identifiable or easily measured as structure loss or individual displacement, the trauma and isolation seen in clients and service staff were a major concern and “main worry” of many informants.

Informants talked about the tendency for clients to isolate or be triggered following disasters. Some turned to substance use and unsafe practices as comfort and coping. Informants were particularly concerned about how isolation can exacerbate mental health issues and may result in clients falling out of routine with medications or falling out of care.

In terms of being an HIV provider, the biggest risk I see to people's health going forward is isolation. The people that are the most isolated are the people that are going to be the most vulnerable to not being able to navigate these stresses.
[HIV Clinical Provider 08 – drought/fires/flooding]

The importance of **staff and providers' experiences and mental health**, too, cannot be overstated. Staff faced

evacuations and home loss, as well as other personal emergencies common in disaster situations. Operationally, this impacted overall staff availability as well as specialty care in areas reliant on singular providers for an entire cadre of care (e.g., HIV primary care). At the community level, the mental health and structural wellbeing of those providing essential care during a traumatic event was a significant concern.

The agency itself did not burn down, but my home burned down, and I had to relocate my animals to our actual agency, where they had to live for 15 months. ... We also, a year later, had another staff member whose home burned down. Again, that was very disruptive, very traumatic. Then in the last two months, we've had another staff member's home burned down, and it disrupted to the degree that this person has had to go out on disability. She was homeless for a while living in a motel. There are waves. There's just waves of grief if you will, and waves of inability to do one's job.
[HIV program leadership 07 – fires/drought]

Client perception of service availability. Participants in this study described several circumstances in which, during or in the wake of a climate-related event, providers managed to adapt their services to prevent interruption, but clients were not accessing them. The barrier here was a client not *perceiving* the service to be available, or that a client perceived the barrier to receiving services as too high under current conditions. We saw this perception described in our data as being related to safety, logistics, and mental health.

- **Safety:** in conditions like smoky air or seasonal weather changes like high heat, some clients refrained from traveling to medical/support services because the exposure was too dangerous.
- **Logistics or Geography:** often a clinic relocated services a distance away that a client found prohibitive, or a client wasn't made aware of service adaptations in the wake of climate-related events.
- **Mental health:** several informants talked about how they worry most about their clients withdrawing, struggling with trauma, depression, and anxiety. This presented as an internal barrier to care, when in the wake of displacement, fear, or trauma, clients isolated, and were unable to access the services they needed.

Loss of essential documentation. Displacement could lead to loss of essential documentation needed for enrollment or re-enrollment in ADAP, Medicaid and other services, particularly if displacement meant moving to another area and needing to set up new care. This was true for people whose homes were destroyed or damaged in floods or fires, those leaving homes due to evacuation, and those whose encampments were washed out, disrupted, or swept up by officials during emergencies or heavy weather.

Disrupted access to harm reduction services. Harm reduction services include community education about safer sex and injection practices, HIV/STI testing, MAT, syringe access services, naloxone distribution, and distribution of fentanyl testing strips. Harm reduction as a package of services can be disrupted along multiple axes, and were often the first to fall away in a disaster (e.g., not being included in Red Cross emergency relief packages). As with direct HIV care and treatment services, harm reduction services were disrupted by:

- closed roads limiting physical access to material exchanges;
- downed communications preventing clients from getting updates about alternative program meeting places or times;
- displacement into areas with different local regulations around provision of harm reduction services;
- lack of staff to provide services due to their own evacuation or crisis, or because they have been redirected to provide emergency services deemed higher priority.

A lot of times folks will go into withdrawal because they're not able to get what they need to stay well. Or they'll seek out stuff that's really from an unreliable source that might have more fentanyl in it or something like that. They do whatever they need to do to get by. And I think that a lot of times in a— if they're in a spot because they're also displaced, so they're in a spot where they don't have their normal sources to be able to get things, they might do things that they normally don't.

[Harm reduction/prevention services 05 – fires/flooding/storms]

Informants explained that this can kick off a cascade that potentially increases risk of community transmission of HIV or HCV, increases risk of death as an outcome, and shifts the locus on the hierarchy of needs such that preventing withdrawal becomes the priority, and adhering to safer use practices is deprioritized.

FACILITATORS

Facilitators represent existing dynamics or resources that participants reported aided in continuing services during a disaster, or strategies or resources applied in response.

COVID-19 relief funding and regulatory shifts. Prior to the pandemic, most insurers paid for in-person visits only, or if reimbursement for phone visits existed, the rate was considerably less. As a result, phone and video visits were not feasible for most agencies. The state of emergency triggered by COVID-19 allowed Medicaid and Medicare to **reimburse equally for in-person, phone, and video visits**. This made it possible for many agencies to remain in business while seeing clients remotely. COVID-19 relief funding through the CARES Act also allowed for **capacity building for virtual care**.

*I'd say that it saved our butts in our behavioral health program, that we were able to do telehealth and be able to bill for it because the state was more lenient about [reimbursing] face-to-face visits versus doing telephone and Zoom visits with clients.
[HIV program leadership 07 – fires/drought]*

Many informants spoke of how critical remote services, often only implemented via COVID-related funding, had been in their ability to adapt quickly during wildfires and heavy storms, and their hope that they can retain this capability. The shift to telehealth allowed for:

- continuation of standard clinical care;
- lower reliance on brick-and-mortar facilities and client mobility;
- connection to clients who were isolated and experiencing poor mental health;
- provider engagement in multiple roles when staffing was challenged;
- access to specialty services (e.g., HIV primary care, MAT consultation) regardless of physical distance.

I think we're actually going to be able to help more patients during the next flood and fire than we were in the last flood and fire because [staff] can go to their homes and answer the phone for the health center. They can have a computer at home and do Zoom visits, and it's not only relying on the brick and mortar building that's there.

[HIV Program Leadership 02 – fires/floods]

Agencies were also able to utilize COVID-19 relief funding to address client needs holistically, through providing internet and computer access, food cards, gas cards, and medical supplies. Agencies provided housing or hotel vouchers for individuals who were displaced due to fires or floods.

Backup infrastructure. When essentials, such as electricity and internet, were unavailable due to climate-related events, agencies with backup infrastructure were able to maintain their services. Backup power generators not only kept services functioning, but in certain counties, having access to a backup generator made an agency the destination for displaced people from neighboring towns and counties. In the case of patients with acute medical needs, access to, for example, supplementary oxygen, was crucial.

Since we're public health, we have a generator. You know, for our immunizations and stuff. So, we opened up a shelter here at public health for oxygen patients here in [town], that didn't have power and that needed oxygen.

[Client services 15 – fires/storms]

Backup infrastructure could restore network access to administer health care when internet was down. In some rural areas, internet infrastructure was already weak, and intensifying storms were regularly knocking out connection, with no backup. In one area, underground fiberoptic cables were burned and local agencies and pharmacies were unable to access patient records for care and insurance purposes. One agency paid for installation of a backup satellite to reboot network connectivity, and still had to wait for the roads to be clear of fires for installation. This satellite will continue to serve as a backup for future disasters for this agency.

Trust and familiarity with client community. Many informants stressed the importance of knowing their communities in times of disaster. Providers leveraged word-of-mouth networks when communication mechanisms were unavailable due to power outages, fires, or flooding. These networks were accessed through awareness of community spaces and needs.

Word of mouth was a big one. One person would [see our signs], and spread the word to other community members. And then it would spread. It was a slow start, but then it ramped up quickly. Within a week, it was back-to-back.

[Client Services 03 – drought/fires/flooding]

Service providers utilized networks to 1) locate clients, 2) spread information about service provision, and 3) check in on clients who were difficult to reach. Often, providers would informally drive around their service areas to check in on clients in disaster aftermath.

I do know where people live. I do know where people squat. I do know encampments and I have always been welcomed. Well, I usually bring stuff, too, so that sweetens the deal.

[Harm reduction/prevention services 11 - fires]

One informant spoke directly to an element of community care that others had illustrated but not named: clients, in time of emergency or crisis, turn first to providers and agencies they trust—even if the support they need is outside the scope of what the agency provides. This made local service provision agencies the ‘front line’ for many services. As a result, community understanding and strong connections to community members served as a facilitator of adequate health care during emergencies.

Well, the thing of it is, who are the frontline people? Those are your community-based organizations. ... People are going to come to where they know first. And I'm going to tell you something, a lot of people, during COVID, they didn't have HIV and we still helped them. Because people just needed help.... We [should] have what we need for the community because we're on the front lines.

[HIV program leadership 16 – heat/drought/fires]

Robust database of client needs. Amidst climate related-events, those with existing vulnerabilities become increasingly vulnerable. To prioritize these populations, agencies employed various database strategies, highlighting client information and concurrent health concerns. These databases were utilized to locate vulnerable clients, specifically those with health concerns exacerbated by climate-related events (COPD, asthma, etc.), in order to provide them with appropriate services. Agencies adopted various forms of this model, from mapping tools where locations of patients with risk indicators could be overlaid with fire, flood, and evacuation maps, to manual documents listing high priority clients who needed to be proactively tracked and reached out to in emergency situations.

Sharing resources through relationships. The majority of informants gave examples of ways that communities shared resources to maintain services during climate-related disruptions. In cases of limited capacity and communication access, agencies shared mobile vans for outreach and mobile health service technology. Power outages prompted sharing of power generators and refrigerators to preserve food and maintain cold chain availability.

*Like when the Tubbs fire hit, we actually, one of our staff members, her partner works for [a major food bank], and he actually came with a semi, and we moved a bunch of frozen food over [there]. They happened to have [freezer] space for us, which was just wonderful.
[Client services 06 – fires/flooding/drought]*

Providers from various agencies worked together to share funding and material support for clients. Many called upon their own networks to access services such as food and water, clothing, harm reduction, and housing for their clients, indicating the role of community support and sharing as critical to disaster response.

Mobile capabilities. Adapting to client displacement and inaccessible service locations, many providers turned to mobile capabilities such as service vans, private

vehicles, and ambulatory teams. Mobile strategies were used to:

- locate clients through physical outreach;
- bring services to people displaced or without independent mobility;
- pick-up and deliver prescriptions;
- shift all services to a combination of remote and mobile when their brick-and-mortar location closed;
- transport clients to care (alternate service locations when a primary location was closed, or along alternate routes when the primary route was inaccessible).

*One of our providers went to a local CVS and just stood by the pharmacy with a prescription pad and just offered to – I mean, not like, "Hey, get your Norco here," but, "you need your Metformin or your Lisinopril?" Just helping people just trying to be helpful because it was a – you know, it's a scary time.
[HIV clinical provider 10 – drought/fires/flooding]*

Some agencies had vehicles that were used for specific purposes, which they then repurposed for broader use in disaster aftermath. Other mobile services were made possible through clinic partnerships with testing and harm reduction organizations that had established mobile routes and community contact. Often, it was providers using their own vehicles to get to clients in their homes or new locations, to locate clients, and to give clients transportation to care. When vehicles were unavailable or when terrain was not passable by vehicle, some informants reported accomplishing whatever they could on foot.

*We sometimes call it "backpack outreach" or "wagon outreach." Just knowing that there's probably people around the corner if we just walk out there. ... And sometimes, they're not, but doing that more and more, just to make sure people know that we're still doing services even though everywhere else is closed.
[Harm reduction/prevention services 12 – fires/storms/flooding/drought]*

Policy implications

PLANNING

Centralize best practices and resources.

Agencies tailoring their disaster protocols based on unique community needs and resources was a strength, but few benefited from broader sharing of best practices and standards, which represents an opportunity for change.

- ✓ Collaboration of adaptive strategies – convene a conference focused on sharing adaptive strategies across stakeholders involved in this research as well as their counterparts in other areas of California and nationally. Share learnings from experience (e.g., having a social media presence and using it to communicate in emergencies) and share creative approaches to stubborn challenges. Look to the VA and FEMA models, which have processes for disasters at a broader level, and represent a centralized standard baseline response.
- ✓ Scale-up of standard data systems – implement cross-county tracking systems for clients to mitigate communication barriers and disconnection from services caused by displacement. Collaborate on best data practices for ready responses during wildfires, floods, and other emergencies.

Build telehealth capacity.

- ✓ Maintain (or reinstate) full insurance and Medicaid reimbursement for remote services, including video and phone. Mobile services are key to being adaptive and flexible during climate-related events.

Install backup infrastructure.

- ✓ Power generators and backup satellites already in place will minimize service interruption during a spectrum of climate-related events, from power outages due to seasonal storms to catastrophic wildfires. This can mitigate multiple primary barriers to continued engagement in care.

Loosen restrictions on harm reduction operations.

- ✓ Clients engaged in harm reduction and prevention services rely on regular, predictable engagement with these services in order to stay well (e.g., out of withdrawal), and safer from HIV/HCV transmission, opioid overdose, and death from overdose. Multi-level jurisdictional regulations, from shelter policy to city ordinance to county restrictions, make displacement of these services extremely dangerous.

Formalize planning between providers and clients.

- ✓ At the clinic level, providers can work with clients during calm, non-crisis moments to prepare materially (*what items and information do I need to have ready to grab and go*), logistically (*what are contingency plans for accessing medication and services in disaster situations*), and mentally (*traumatic events can lead to isolating behaviors and be psychological triggers for mental health difficulties*). We have created a toolkit, published alongside this policy brief, as an example.

RESPONSE

Expand and facilitate access to discretionary relief funding.

- ✓ Our data show that ground-level service providers know best how to address the urgent, unpredictable, and rapidly changing needs of their client population; what they lack is the funding and resources necessary to execute adaptive strategies optimally or to scale up relief efforts. Relief funding that can be used at providers' discretion, as was available in the early days of the COVID-19 pandemic response, will allow providers to meet the needs in front of them in response to climate disasters. These funds should be accessible with minimal administrative requirements, and as an allowance rather than reimbursement, as many small agencies do not have the resources to spend first and recoup later.

Support capacity-building for mental health and mobile services.

- ✓ Mental health support was found to be a crucial gap across service areas, particularly as it applies to the aftermath of a climate disaster and the risks it poses to provider well-being as well as clients' continued engagement in care and adherence to medication. Mobile services were found to be a key facilitator to continuing or immediately resuming the provision of services during displacements and downed infrastructure. Building capacity in both of these areas are strongly indicated.

Provide direct financial relief to individuals impacted by climate disasters.

- ✓ Similar to the \$400 direct payments that the state of California is proposing to send to all residents to offset the rising gas prices,⁶ California can ease the sudden financial crisis of surviving a climate-related event. Those with the fewest baseline economic resources are often hit the hardest in these events (more likely to live in flood plains, less likely to be able to replace lost necessities), and care should be taken to ensure those without residential addresses, employers, or cell phones are included in this benefit.

Expand declaration of emergency.

- ✓ Climate-related events that do not rise to the current definition of a “natural disaster” (such as storm surges, toxic smoke, and excessive heat) can still profoundly disrupt infrastructure and individuals’ ability to get the care that they need. Expanding what is considered an “emergency” at the local policy level will open up funding and local discretion for public health operations.

BETTER BASELINE CONDITIONS

Focus on foundational support.

- ✓ Fundamental needs, like housing and economic stability, are the predeterminants of resilience during an emergency. Our findings support universal basic income⁷ and housing first⁸ policies.

A Note About Data from Indian Reservations

We interviewed two informants providing services to Indigenous peoples on tribal lands. The data gathered from these interviews added depth and dimension to our main themes, and are reflected in our findings.

It was important that we include perspectives from providers serving clients on Indian Reservations because, while tribal sovereignty technically exempts these areas from state policy, that distinction shapes but does not erase the impact of state policy on Indigenous communities. Many Indigenous residents of tribal land seek public health services in neighboring towns, some non-profit and county-affiliated agencies bring services onto reservations, and broader state and federal policies regarding land and water management impact life on reservations not least when water is scarce, land is on fire, and seasonal weather patterns are in upheaval.

Further, any measure of isolation, be it geographic, economic, or political, can exacerbate the impacts of climate-related disaster. It was the reports of those serving Indian Reservations more so than those of any other informants that reflected the most dire results of fires, drought, and storm surges on client health. Outside service providers that stopped coming for extended periods of time. Power outages that lasted for days or weeks during extreme temperatures. A reliance on and special significance of food and herbs grown seasonally that were disrupted and salmon populations decimated. Clinics that closed and stay closed, and clients who went without care.

Our data are not sufficient to draw generalizable conclusions about the impact of climate-related events on HIV, STI, and harm reduction care within Indian Reservations, but they do highlight tensions between federal and state level policies, tribal sovereignty, and the complexities of how they play out among Indigenous populations in need of care while suffering the same, and often worse, impacts of climate change as the rest of California. These dynamics should be investigated more broadly.

Table 1. Key Informants by Role and Areas Served

Role	N =	Areas Served*
HIV clinical providers	4	San Francisco Sonoma Fresno Alameda
Harm reduction and HIV/STI prevention services <i>(Testing, education, and outreach / syringe access, naloxone and fentanyl testing strip distribution, MAT)</i>	5	Plumas Lake Humboldt Lassen Modoc Sierra
HIV program leadership <i>(Clinical programs within hospital systems and independent non-clinical programs providing multidimensional care)</i>	6	Sonoma Plumas Mendocino Lake Riverside San Bernadino Siskiyou Modoc Sierra
Client services <i>(Case management, care coordination, food/housing support)</i>	3	Sonoma Lassen

* The names of the Indian Reservations included in our sample area are not included here in order to protect informant confidentiality. The teams providing specialized services in these areas are small, and naming Reservations could identify informants in certain roles.

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