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

Meeting Agenda

June 28, 2023, 10:00 AM – 12:00 PM

Meeting Location –
4600 Broadway, Sacramento, CA 95820
2nd Floor Conference/Community Room 2020

Facilitator: Richard Benavidez, Council Chair
Scribe: Angelina Olweny, Council Staff
Meeting Invitees:

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

Public Comment: This provides opportunities for the public to address the Council as a whole in order to listen to opinions regarding matters within the jurisdiction of the Council during Regular meetings and regarding items on the Agenda at all other meetings. Public Comment time limit is three (3) minutes.

*Action Items

Topic	Presenter	Start Time and Length
Welcome, Introductions, & Housekeeping	Benavidez	10:00 am
Announcements	All	As Needed
Public Comments-Agenda Items 3 Minute Time Limit	All	
May 2023 Agenda*	Benavidez	
Minutes of April 2023*	Benavidez	
State Office of AIDS May 2023 Update	Pulupa	
Presentation: LGBT Center Update	Christi Gray	

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CPG/HIV/STI Prevention Updates	All	As Needed
Recipient Report: ➢ FY23 March Part A Monthly Fiscal Report* ➢ FY23 March Part B Monthly Fiscal Report ➢ SOA Ending the HIV Epidemic Update ➢ HRSA Part A Ending the Epidemic Update ➢ FY22 Year-End Report	Caravella	
Committee/Work Group Updates ➢ Administrative Assessment Committee ➢ FY22 AdAC Year-End Review Results ➢ Next Meeting 11/16/23 ➢ AdAC Overview* ➢ Affected Communities Committee ➢ Community Presentations ➢ Reflectiveness ➢ Priorities and Allocations ➢ FY24 Priorities* ➢ FY23 PAC Overview* ➢ Executive Committee ➢ Quality Advisory Committee ➢ FY22 Post Card Survey Report Findings ➢ FY22 Client Satisfaction Survey Findings ➢ Needs Assessment Committee ➢ FY22 Needs Assessment Report ➢ AdHoc WorkGroup ➢ Governance ➢ GOV-01 Committee Development* ➢ GOV-10 Officer Elections*	Willett Zach B. Bradley-Rowe Benavidez Benavidez Miranda Zach B. Ungeheuer	
Binder Updates	Caravella	
Public Comments-Non-Agenda Items	All	
Technical Assistance	Benavidez	
Adjournment	Benavidez	12:00 pm

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Attachments:

- Minutes of May 2023*
- June 2023 OA Voice Update
- FY23 March Part A Monthly Fiscal Report*
- FY23 March Part B Monthly Fiscal Report
- FY22 Year-End Report
- FY22 AdAC Year-End Review Results
- AdAC Overview*
- FY24 Priorities*
- FY23 PAC Overview*
- FY22 Post Card Survey Report Findings
- FY22 Client Satisfaction Survey Findings
- FY22 Final Needs Assessment Report
- GOV -01 Committee Development*
- GOV-10 Officer Elections*

NEXT MEETING: **August 23, 2023**
September 27, 2023
October 25, 2023
December 13, 2023
January 24, 2024
February 28, 2024

HIV HEALTH SERVICES PLANNING COUNCIL

Meeting Minutes

May 24, 2023, 10:00 a.m. to 12:00 p.m.

Facilitator: Zach B, ACC Chair
Scribe: Angelina Olweny, Council Staff

Committee Member Attendees:

Chelle Gossett, Dennis Poupart, Christopher Kendrick-Stafford, David Contreras, Jake Bradley-Rowe, Kane Ortega, Kaye Pulupa, Kristina Kendricks-Clark, Lenore Gotelli, Melissa Willett, Melody Law, Richard Benavidez, Ronnie Miranda, Shy Brown, Steve Austin, Yingjia Huang, and Zach B.

Members Excused: Minerva Reid

Members Absent: Tami Emslie

Guests: Troy Stermer, Michael Gloria, Michelle Monroe, Jessica Lara, Staci Syas, Dr. Demisha Burns

County Staff: Paula Gammell and Danielle Caravella

Topic	Minutes
Welcome, Introductions and Announcements	Meeting began at 10:05 a.m. Lenore Gotelli stated that the Office of Aids has approved a five-county expansion in the Central Valley that includes Stanislaus, San Joaquin, Kern and Merced Counties for the Rx Healthcare Medi-Cal Waiver Program. Richard Benavidez stated that the NorCal AIDS Cycle raised $150,000 to benefit various community organizations. The Sacramento LGBT Center is hosting a Black sexual health event followed by a mixer on May 25th and 26th. LGBTQ Center is distributing Sac Pride tickets to consumers who get tested.
Public Comments	None
Agenda and Minutes*	The May Agenda was presented for review and approval. The CPG prevention updates were changed to include the CPG representative nomination. Kane Ortega motioned to approve the agenda with the changes made with a second by Jake Bradley-Rowe. The motion passed with a majority. April 2023 Minutes was presented. Kristina Kendricks Clark motioned to accept the minutes as presented and Kane Ortega seconded the motion. Discussion ensued and Christopher Kendrick-Stafford motioned to remove a phrasing in a sentence of the minutes that read "essentially shutting down a member" Kristina Kendricks-Clark amended her motion to approve the Minutes with the changes discussed and Kane Ortega seconded the amended motion. The motion was passed by majority.

Topic	Minutes
State Office of AIDs May 2023 Update	Kaye Pulupa highlighted issues reported in the May newsletter, which was included in the meeting packet. The May issue highlighted a new Clinical Quality Management Specialist Nicholas Wong at Office of AIDS. May 18th is National HIV Vaccine Awareness Day to recognize scientists, health professionals, community members, and volunteers to are working to develop a vaccine to prevent HIV. May 19th is National Asian & Pacific Islander HIV/AIDS Awareness Day. OA is reinitiating integration discussions on integrating HIV, STI, and HCV programs to a new single Division. California Planning Group hosted a Strategic Plan and Implementation Blueprint in the May in-person meeting that focused on how to provide stigma free services. Strategy A- There are 203 PreEP-AP enrollment sites covering 189 clinics. Strategy B- OA has expanded it Building Healthy Online Communities to allow for rapid OraQuick test orders in all jurisdictions in California Strategy C – California Prevention Training Center in collaboration with CDPH, OA and Sexually Transmitted Disease Control branch is holding a Virtual DIS Summit on June 5th, 7th and 9th. Strategy G- OA HIV Care Branch is looking for a new Housing Opportunities for Persons with AIDS (HOPWA) Program Provider in Santa Cruz County. The closing date for RFA is May 19, 2023 Strategy J- No updates Strategy K- California Department of Health Care Services in partnership with The Center at Sierra Health Foundation Released to RFAs for projects to fund drug education and

	prevention. Submissions are due by May 8th Strategy N- CPG and OA hosted a meeting on May 1-May 3rd at the Hyatt Regency in Long Beach CA.
Presentation: Inclusivity	Dr. Demisha Burns gave a presentation on Diversity and Inclusion that highlighted embracing and tolerating diversity and the importance of transparency and inclusivity; the presentation also recognized the importance of acknowledging implicit biases. Dr. Burns led the members through exercises about self-awareness; discussed structural and systemic racism, and shared specific tools and suggestions for promoting diversity, equity, inclusion, and belonging. The training was made possible by the AETC.
CPG/STI Prevention Update	There was a discussion regarding nominations for a representative from the Planning Council to serve as a member on the CPG. Richard Benavidez has been the current member representing the Planning Council. Kane Ortega motioned to nominate Richard Benavidez for an additional one-year term. Zach Basler seconded the motion. The motion passed with a majority. There has been a renewed focus on HIV and aging among the CPG.
➢ FY22 Year End Part A Monthly Fiscal Report* ➢ FY22 Year End Part B Monthly Fiscal Report ➢ SOA Ending the HIV Epidemic Update	The FY22 Part A Year-end report was presented for review and approval. The report reflected the recipients' final changes to get the funds spent. The unobligated balance remaining for Part A was under 5%. Jake Bradley-Rowe moved to accept the FY22 Year End Part A Monthly Fiscal Report with a second by Ronnie Miranda. The motion passed by a majority. Part A Award has been notified and recipient is finalizing its documentation. Provider contracting will take place next. The FY22 Part B Year End report was presented for informational only. It was mentioned that some of the line items in the Part B Fiscal Report had negative numbers. Paula Gammell explained that it showed that more funds were used than was budgeted and that the recipient is working with Part B to true-up and finalize those numbers. An error in the formatting was also identified: Food Bank does not have a balance remaining. The Sexual Health Clinic now has 70 HIV clients and is looking internally for more space to increase its capacity. The clinic has also onboarded a new mental health therapist. The

	Mobile Van is providing services 3 days a week.
Committee /Workgroup Updates ➢ Administrative Assessment Committee FY22 AdAC Year-End Review 6/15/23	There will be an Administrative Assessment Committee meeting on Zoom in June. Members must attend a training before the meeting and sign a confidentiality agreement form before attending the meeting on June 15th.
➢ Affected Communities Committee ➢ Community Presentations ➢ Reflectiveness	There was a community conservation event on HIV that focused on youth. It was highlighted that children are not receiving sexual health education in school. It was reported that more youth are thinking about their gender identity before their sexuality. Some of them are not sure about their pronouns. There will be a presentation in June on PrEP. Gustavo Trejo from One Community Health will be the presenter. Reflectiveness is at 28%. The committee is looking for Native Americans and previously incarcerated to fill the position.
➢ Priorities and Allocations	PAC met in May and approved a change to their meeting schedule to be in June instead of July, the next meeting will be on June 8th. The meeting on June 8th will discuss priorities for funding for FY24. The September meeting will be on the FY24 allocation of funding.
➢ Executive Committee	The committee agreed that there would be a schedule change to the executive meetings, to meet in June instead of July to align with the PAC meeting in June. The governance documents will be discussed.
➢ Quality Advisory Committee	The QAC committee will be meeting on June 6th.
➢ Needs Assessment Committee	The NAC committee will be meeting on June 6th and there will be a discussion of the Needs Assessment Survey.

➢ AdHoc Workgroup ➢ Governance	The AdHoc committee had its first meeting via zoom on May 16th. Members chose to be part of smaller groups that would focus on ideas around having a stronger presence on social media, website design and function, and the attendance policy. If anyone is interested in joining the AdHoc working group, reach out to Richard Benavidez.
FY23 Gov Overview* ➢ GOV-01 Committee Development* GOV-10 Officer Elections* Acronyms and Roberts Rules of Order Chart*	The FY23 GOV Overview was presented for review and approval. Changes were made to the Governance overview document to reflect Angelina Olweny as the new support staff member. Jake Bradley-Rowe motioned to approve the document as presented with a second by Kristina Kendricks-Clark. Motion passed with a majority. Michael Ungeheuer wasn't present at the last Executive Committee meeting. It was agreed that the governance documents presented for review and approval should be tabled until the next meeting. Jake Bradley-Rowe motioned to table the discussion on GOV-01 with a second by Zach B. Motion passed with a majority. Michael Ungeheuer's changes were highlighted in blue on GOV-10. It was proposed that the discussion should be tabled till the next council meeting. Jake Bradley-Rowe motioned to table the discussion with a second by Melissa Willett. Motion passed with a majority. The Acronyms and Robert's Rules of Order Chart was presented for review and approval. Changes made to the acronyms are striped in red in the Planning Council Member Binders. Contact information has been removed. Ronnie Miranda motioned to approve the changes with a second by Jake Bradley-Rowe. Motion passed with a majority.
Council July Meeting Discussion	It was discussed and stated that there are no other committees scheduled to meet in July and thus little business to conduct. Zach B motioned to cancel the July Planning Council meeting, with a second by Ronnie Miranda. Motion passed with a majority.
Binder Updates	Danielle Caravella announced that binder updates will be forthcoming.
Public Comments-Non-Agenda Items	N/A
Technical Assistance	If in need of technical assistance, members can reach out to the Council Chair, Richard Benavidez, Zach B.
Adjournment	11:51 a.m.

the OA Voice
Issue: June 2023

This newsletter is organized to align the updates with Strategies from the ***Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan*** (Integrated Plan). The Integrated Plan is available on the Office of AIDS' (OA) website.

INSIDE:

STAFF HIGHLIGHT

OA congratulates **Leslie Knight** on her promotion to Health Program Specialist I in the newly formed "Business Implementation and Program Collaboration Unit" of the HIV Prevention Branch. This is the second time in her OA career Leslie has helped launch a new unit. She was the first staff hired in the Harm Reduction Unit, and she helped design the innovative Harm Reduction Supply Clearinghouse, which provides a baseline level of supplies to the 68 Syringe Services Programs (SSPs) in the state and was one of the first programs of its kind in the United States. Leslie has overseen the program for the past 7 years and has been key to the program's success. She worked closely with our contractor, Dave Purchase Project, to develop standards and protocols for it, honoring the expertise that our partner brings to the collaboration while meeting stiff state requirements. She helped design the evaluation instrument for the project and leads the process of developing the survey we send out to programs to check our progress each year. She has helped steer the inclusion of new products into the Clearinghouse that are critically useful to protect the health of people who use SSPs but are often perceived as controversial, such as smoking supplies. She recently helped design a mini grant program that allowed SSPs to apply for a small amount of funds to help them deliver services to their program participants. Her guidance in setting up the program was critical, and the program has helped people experiencing homelessness in several rounds of funding since its inception.

Leslie is a published author, and before coming to OA spent many hours coaching other authors in how to do the same. She keeps up the creative work by crafting, although a good deal of her time is now spent chasing after her very enthusiastic dogs. She also keeps up with her three adult kiddos and whenever she and her husband James can hang out on the water with friends, that's where you'll find them.

Congratulations to **Juanita Moses** on her promotion as the newest Quality Assurance and Training Coordinator/Associate Governmental Program Analyst (AGPA) within the AIDS Drug Assistance Program (ADAP) Branch's Quality Assurance and Training (QAT) Unit. Juanita has been a Staff Services Analyst working as an ADAP Advisor for the Eligibly Operations Section for almost two years. In that time, she reviewed and analyzed supporting documentation, verified client eligibility, and evaluated insurance assistance program applications for accuracy and payment requests. She is also a member of the ADAP Team Building Workgroup where she helps to plan and facilitate ADAP team building events. Prior to that, she was a Supervising Program Technician II for the Client Services Unit within ADAP for over three years. During that time, she had a staff of six direct reports, and was responsible for overseeing their work, and ensuring adequate phone coverage and timely processing of eligibility documents for the unit. She performed quality assurance reviews of phone calls and work items that were processed by the call center, facilitated team and one on one meetings, and oversaw onboarding and training for new staff. Prior to joining ADAP, she worked as a Program Technician II for both the California Department of Social Services and Covered California, where she gained experience answering inquires related to all IHSS pay-roll issues and on-exchange healthcare coverage. Juanita has a bachelor's degree in Psychology and completed her senior thesis on the rise of HIV/AIDS in the African American Communities, during which time she interned with the Palmetto AIDS Life Support Services in Columbia, South Carolina.

In her free time, Juanita enjoys spending time with her son, wine tasting, reading, and being the social butterfly that she is.

OA would also like to congratulate **Patrice Lewis** on her promotion to AGPA in the Client Services Unit (CSU). Patrice has spent the last five plus years as the CSU Technical Lead/Staff Services Analyst in the CSU. During that time, she was instrumental in standing up the new unit, helping to create various processes and procedures, and conducting user acceptance testing for the ADAP Enrollment System (AES).

Patrice has also quickly become a subject matter expert in the ADAP and PrEP-AP programs. In her role as an SSA, she gained valuable experience working alongside our developers for the AES and assisting with AES access issues for multifactor authentication (MFA) to internal staff as well as Enrollment Workers, which will serve her well in her new position. Patrice began her state service career as a Key Data Operator at the Franchise Tax Board before joining CDPH. In the private sector, Patrice worked as a Geographic Information Systems Analyst for SMUD where she reviewed, converted, and edited maps before going into production, and as an Eligibility Worker for Healthy Families where she would enter new applications for Medi-Cal into the Medi-Cal Eligibility Data System (MEDS) before being assigned to a caseworker. In addition, she worked in various call centers for over 20 years assisting callers from commercials to collections in Virginia before moving to California. In her spare time, she enjoys making candles and diamond art paintings. She also enjoys spending time with her 8 grandchildren and looking forward to the birth of the 9th in a couple of months.

Lastly, congratulations to **Joseph Lagrama** on his promotion to Branch Chief of the ADAP Branch. Joseph has been with the state for more than 13 years, with about 3 of those years being with OA. In July 2020, he joined OA as the Unit Chief of the Pre-Exposure Prophylaxis Assistance Program, where he oversaw the planning, development, and implementation of various health program policies and initiatives aimed at advancing health equity by expanding pre-exposure prophylaxis access. In January 2022, he became the Section Chief of the Business Operations and Compliance Section, where he managed and provided strategic direction related to OA's administrative, personnel, and federal grant compliance functions. He centralized and streamlined access to OA's most commonly needed resources through the development of the OA Support Branch SharePoint site. He's developed federal grant budgets and has created tools to automate

salary expenditure forecasting methodologies. Prior to OA, he provided fiscal oversight over a multi-million-dollar program, led re-designs of competency-based training curricula for multiple government programs, implemented automated claims research processes, oversaw contracts and invoices, ensured internal and external compliance to contractual and legal requirements, and more.

In his spare time, Joseph likes to cook, travel, scuba dive, and spend time with his partner and their two new puppies!

HIV AWARENESS

June is Pride Month! Pride month is a tribute to honor those who took part in the Stonewall Uprising and is celebrated to continue advocating for equity and inclusivity for the Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) community. On June 28,1969 the Stonewall Uprising was a six-day occurrence where members of the LGBTQ+ community and

clientele of the Stonewall Inn, fought back and stood up against injustice and discrimination. This was not the first altercation between the police and the LGBTQ+ community; however, this uprising changed the discourse surrounding LGBTQ+ activism in the United States. A year later, the first Pride march and protest was held in New York City. Since 1970, the LGBTQ+ community and allies continue to celebrate and advocate for equity, justice, and inclusion. Now, 54 years later, the Stonewall Uprising continues to inspire us to fight for our hard-fought equality currently being rolled back by anti-trans/Anti-LGBTQ legislation.

June 27, 2023 is National HIV Testing Day. The theme this year is "Take the Test & Take the Next Step." National HIV Testing Day is meant to encourage individuals to get tested and learn their HIV status. Knowing your HIV status helps you choose options to keep yourself and others healthy or linked to care and treatment. This day also focuses on education, care and prevention. More than 1.1 million people in the U.S. are living with HIV, 1 in 7 are unaware. We encourage you to take the test and take the next step!

GENERAL UPDATES

COVID-19

OA is committed to providing updated information related to COVID-19. We have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to our OA website to stay informed.

Mpox

OA is committed to providing updated information related to mpox. We have partnered with the Division of Communicable Disease Control (DCDC), a program within the Center of Infectious Diseases and have disseminated a number of documents in an effort to keep our clients and stakeholders informed. Please refer to the DCDC website to stay informed.

Spanish mpox digital assets are now available for LHJs and CBOs.

Racial Justice and Health Equity

The Racial & Health Equity (RHE) workgroup aims to gain insight and understanding of racial and health equity efforts throughout the California Department of Public Health (CDPH) and take next steps towards advancing RHE in our work. The workgroup has formed subcommittees to address community stakeholder engagement challenges, improve OA policy and practices to support RHE and increasing OA knowledge and attitude on RHE among leadership and staff.

HIV/STD/HCV Integration

Now that the Emergency Declaration has ended and the COVID-19 response is winding down, we are reinitiating our integration discussions and moving forward with the necessary steps to integrate our HIV, STI, and HCV programs into a single new Division. We will continue to keep you apprised on our journey!

Ending the HIV Epidemic

Free Virtual Ending the Syndemic Symposium June 22nd, 23rd, 29th and 30th, 9-1 PM. Sponsored by CDPH, OA, the Ending the Syndemic Symposium will offer an opportunity for all California counties and the community programs that they fund to share best practices and innovations in serving the communities most impacted by HIV, HCV and STIs.

This symposium also aims to support the 8 federally funded California-based counties participating in the Ending the HIV Epidemics in America (EHE) initiative: Alameda, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, and Los Angeles.

Workshops will include best practices for integrated HIV/STI/HCV work with cisgender women, transgender people, older adults living with HIV, people experiencing homelessness,

and young Black, Indigenous, and people of color. Special sessions will also be held on effective partner services, self-testing and how to leverage our Strategic Plan and Implementation Blueprint. The conference is free and open to all interested in ending the syndemic.

Register for the Syndemic Symposium at https://us06web.zoom.us/webinar/register/WN_zVQvJ84WTCWwwoEMPjSnXw

ENDING THE EPIDEMICS STRATEGIC PLAN OA/STD

Special thanks to the San Diego HIV Planning Group, Strategies & Standards Committee for hosting a discussion about the *Strategic Plan* and *Implementation Blueprint* on June 6th. The San Diego HIV Planning Group, along with the Part A Planning Councils of Alameda, Sacramento, San Bernardino/ Riverside, San Francisco, Santa Clara and the California Planning Group were all partners in reviewing and improving the Strategic Plan and Implementation Blueprint. The work that is done at California's planning councils is what makes it possible to talk about Ending the Epidemics today. We stand on the shoulders of so many and we are grateful for their work and advocacy. Please look for ways to amplify the work of the HIV/STI/HCV planning council in your community!

STRATEGY A

Improve Pre-Exposure Prophylaxis (PrEP) Utilization:

> PrEP-Assistance Program (AP)

As of May 24, 2023, there are 204 PrEP-AP enrollment sites covering 189 clinics that currently make up the PrEP-AP Provider network.

A comprehensive list of the PrEP-AP Provider Network can be found at https://cdphdata.maps.arcgis.com/apps/webappviewer/index.html?id=6878d3a1c9724418aebfea96878cd5b2.

Data on active PrEP-AP clients can be found in the three tables displayed on page 6 of this newsletter.

STRATEGY B

Increase and Improve HIV Testing:

OA continues to implement its Building Healthy Online Communities (BHOC) self-testing program to allow for rapid OraQuick test orders in all jurisdictions in California.

TAKEMEHOME

The program, **TakeMeHome**, (https://takemehome.org/) is advertised on gay dating apps, where users see an ad for home testing and are offered a free HIV-home test kit. In April, 153 individuals in 35 counties ordered self-test kits, with 131 individuals ordering 2 tests. Additionally, OA's existing TakeMeHome Program continues in the six California Consortium Phase I Ending the HIV Epidemic in America counties. In the first 32 months, between September 1, 2020, and April 30, 2023, 5732 tests have been distributed. This month, mail-in lab tests (including dried blood spot tests for HIV, syphilis, and Hepatitis C, as well as 3-site tests for gonorrhea and chlamydia) accounted for 309 (73.2%) of the 422 total tests distributed in EHE counties.

Additional key characteristics of individuals ordering TakeMeHome kits are outlined in the chart on page 7.

(continued on page 7)

Active PrEP-AP Clients by Age and Insurance Coverage:

Current Age	PrEP-AP Only		PrEP-AP With Medi-Cal		PrEP-AP With Medicare		PrEP-AP With Private Insurance		TOTAL	
	N	%	N	%	N	%	N	%	N	%
18 - 24	285	8%	---	---	---	---	29	1%	314	9%
25 - 34	1,146	32%	1	0%	1	0%	245	7%	1,393	39%
35 - 44	897	25%	---	---	2	0%	164	5%	1,063	30%
45 - 64	484	13%	1	0%	20	1%	99	3%	604	17%
65+	22	1%	---	---	193	5%	8	0%	223	6%
TOTAL	**2,834**	**79%**	**2**	**0%**	**216**	**6%**	**545**	**15%**	**3,597**	**100%**

Active PrEP-AP Clients by Age and Race/Ethnicity:

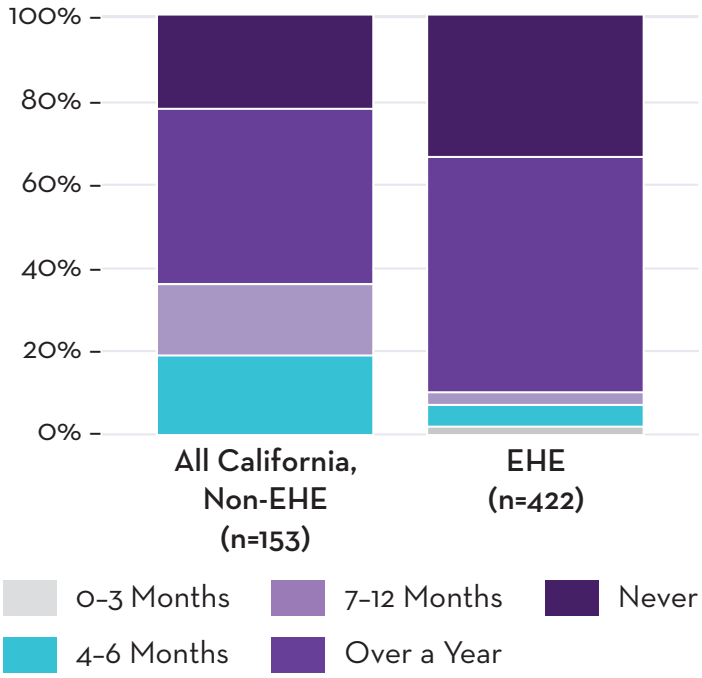
Current Age	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
18 - 24	181	5%	---	---	36	1%	12	0%	1	0%	56	2%	2	0%	26	1%	314	9%
25 - 34	834	23%	2	0%	121	3%	82	2%	3	0%	270	8%	9	0%	72	2%	1,393	39%
35 - 44	695	19%	3	0%	83	2%	39	1%	2	0%	195	5%	5	0%	41	1%	1,063	30%
45 - 64	394	11%	2	0%	37	1%	17	0%	1	0%	132	4%	2	0%	19	1%	604	17%
65+	22	1%	1	0%	3	0%	3	0%	---	---	187	5%	---	---	7	0%	223	6%
TOTAL	**2,126**	**59%**	**8**	**0%**	**280**	**8%**	**153**	**4%**	**7**	**0%**	**840**	**23%**	**18**	**1%**	**165**	**5%**	**3,597**	**100%**

Active PrEP-AP Clients by Gender and Race/Ethnicity:

Gender	Latinx		American Indian or Alaskan Native		Asian		Black or African American		Native Hawaiian/ Pacific Islander		White		More Than One Race Reported		Decline to Provide		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Female	177	5%	---	---	4	0%	8	0%	1	0%	13	0%	---	---	5	0%	208	6%
Male	1,749	49%	8	0%	256	7%	141	4%	6	0%	803	22%	18	1%	142	4%	3,123	87%
Trans	180	5%	---	---	17	0%	4	0%	---	---	14	0%	---	---	6	0%	221	6%
Unknown	20	1%	---	---	3	0%	---	---	---	---	10	0%	---	---	12	0%	45	1%
TOTAL	**2,126**	**59%**	**8**	**0%**	**280**	**8%**	**153**	**4%**	**7**	**0%**	**840**	**23%**	**18**	**1%**	**165**	**5%**	**3,597**	**100%**

All PrEP-AP charts prepared by: ADAP Fiscal Forecasting Evaluation and Monitoring (AFFEM) Section, ADAP and Care Evaluation and Informatics Branch, Office of AIDS. Client was eligible for PrEP-AP as of run date: 05/31/2023 at 12:01:12 AM Data source: ADAP Enrollment System. Site assignments are based on the site that submitted the most recent application.

HIV Test History Among Individuals Ordering TakeMeHome Kits, April 2023



Since September 2020, 626 test kit recipients have completed the anonymous follow up survey from EHE counties; there have been 101 responses from the California expansion since January 2023. Highlights from the survey results include:

	EHE	All California, Non-EHE
Of those sharing their gender, were cisgender men	66.3%	67.3%
Of those sharing their race or ethnicity, identify as Hispanic or Latinx	34.4%	39.4%
Were 17-29 years old	48.1%	45.8%
Of those sharing their number of sex partners, reported 3 or more in the past year	51.0%	43.4%
Would recommend TakeMeHome to a friend	94.3%	94.1%
Identify as a man who has sex with other men	69.7%	73.3%
Reported having been diagnosed with an STI in the past year	9.1%	7.9%

STRATEGY J

Increase Rates of Insurance/ Benefits Coverage for PLWH or on PrEP:

As of May 24, 2023, the number of ADAP clients enrolled in each respective ADAP Insurance Assistance Program are shown in the chart at the top of page 8.

STRATEGY K

Increase and Improve HIV Prevention and Support Services for People Who Use Drugs:

> Overdose Among Top Causes of Death for People Experiencing Homelessness in Los Angeles County

The Los Angeles (LA) County Department of Public Health released its comprehensive report on mortality rates and causes of death among people experiencing homelessness (PEH) in LA County. People experiencing homelessness died from different causes at rates greater than the general population in LA County.

ADAP Insurance Assistance Program	Number of Clients Enrolled	Percentage Change from April
Employer Based Health Insurance Premium Payment (EB-HIPP) Program	500	+ 2.25%
Office of AIDS Health Insurance Premium Payment (OA-HIPP) Program	5,662	- 1.29%
Medicare Part D Premium Payment (MDPP) Program	901	- 13.28%
Total	**7,063**	**- 2.76%**

Source: ADAP Enrollment System

The crude mortality rate among LA County PEH increased by 55% from 2019 to 2021. Drug overdose was the primary driver of the increaorganization.

An infographic can be found at http://publichealth.lacounty.gov/chie/docs/PEH_infographic2023.pdf

> WEBINAR: Opioid Settlements in CA

It is estimated that California will receive approximately $2.05 billion from the California opioid settlement agreements over the next 18 years. The California Department of Health Care Services and Aurrera Health Group will facilitate a webinar to provide an overview of how settlement funds are being distributed across the state, guidelines for their use on high-impact interventions, and ways you can connect with leaders in your community on local investment of funds.

Register for June 27th webinar at https://nopn.org/webinars/opioid-settlements-in-ca

> SELF-PACED TRAINING: Building Successful Overdose Prevention and Response Programs in Community Corrections

The National Council for Mental Wellbeing, with support from the Centers for Disease Control and Prevention, has created a series of free, self-paced courses with essential information to help people successfully implement overdose prevention and response practices within their work.

For more information, register for their webinar.

STRATEGY M

Improve Usability of Collected Data:

The *California HIV Surveillance Report - 2021* and the *Supplemental Tables to the California HIV Surveillance Report - 2021* are now available on the OA Case Surveillance Reports page. The report includes statewide summary tables and summary tables by local health jurisdiction of new diagnoses of HIV infection, persons living with HIV infection, and deaths among persons with diagnosed HIV infection for years 2017-2021. Statewide summary tables also include data by selected demographics and transmission category.

For questions regarding this issue of *The OA Voice*, please send an e-mail to angelique.skinner@cdph.ca.gov.

Sacramento TGA

Recipient
FY22 Annual Progress Report
March 1, 2022 – February 28, 2023

FY22 ANNUAL RECIPIENT REPORT

EXECUTIVE SUMMARY

By February 28, 2023, the Sacramento Ryan White Program served 2,315 unduplicated clients; compared to 2,405 in FY21. In FY22, the largest age group at 36.07% are clients between the ages of 25-44. The majority of individuals (84.75%) reside in Sacramento County.

Most notably, the TGA assisted 258 **new (never been served in the Sacramento Ryan White Program) clients**. These are new clients in the TGA, which are the counties of Placer, El Dorado, and Sacramento as well as Part B funded Yolo. During the same period last year, the TGA served 206 new clients.

There is a disproportionate impact of HIV/AIDS among African Americans in the TGA. Although they make up only 7.5% of the TGA's general population, African Americans represent 22.7% of the TGA's HIV/AIDS Prevalence (people living with HIV/AIDS) and their representation in the Ryan White system of care is currently 26%, 3.3% higher than their HIV/AIDS prevalence as of December 31, 2021. Also of note is the representation of the Hispanic caseload in the Ryan White system of care. As of February 28, 2023, Hispanics accounted for 26.31% of the caseload or 5.61% higher than their HIV/AIDS prevalence of 20.7%. Thus, these two populations continue to be a priority target for outreach in the TGA, and current caseloads indicate the TGA has been successful in bringing and keeping their population in care.

By the end of FY22, 70.89% (1,641 clients) of the Ryan White clients in the Sacramento Ryan White Program had income ranges between 0 to 138% of the Federal Poverty Level. This is a slight increase over the prior year of 68.36%.

Of the Ryan White clients served in FY22, males are the primary gender group (78.06%) living with HIV/AIDS. Likewise, Men Having Sex with Men (MSM) is the most reported mode of transmission at 57.49%.

The Recipient continues to meet the various reporting requirements and deadlines set forth by the United States Health and Human Resources Administration. The Recipient maintains a delicate balance meeting the federal and state reporting requirements, assisting and contracting with providers, staffing the Planning Council, and responding to inquiries from consumers.

Extensive efforts have been made to correct the data on Viral Suppression. The County has been working to correct many of the data integrity issues. However, the Recipient anticipates possible data integrity issues as the State Office of AIDS is switching from the ARIES system to a new data reporting system, HIV Care Connect (HCC).

The TGA experienced an increase in clients seeking housing and food bank services in FY21 which were augmented with CARES Act COVID Response funding. Since the termination of the CARES Act funding, the Ryan White Program has seen a decrease in the number of clients receiving housing and food bank services, despite the ongoing need.

County Executive
Ann Edwards

Deputy County Executive
Chevon Kothari
Social Services

County of Sacramento

Department of Health Services
Timothy W. Lutz, Director

Divisions
Behavioral Health Services
Primary Health
Public Health
Departmental Administration

SACRAMENTO TRANSITIONAL GRANT AREA
FY22 ANNUAL PROGRESS REPORT

I. Programmatic Narrative

Utilization and Trends In Care:

Utilization and trend data were compiled for March 2022 through February 2023. Overall, the Sacramento Ryan White Program which includes the Part A Transitional Grant Area (TGA) of Sacramento, Placer, and El Dorado Counties and Part B-funded services in Sacramento and Yolo Counties, served 2,315 unduplicated clients. This represents a 3.7% decrease (90 clients) over the prior year's ***total*** clients of 2,405 in 2021.

During Fiscal Year 2022, the Sacramento Ryan White Program including Yolo County, served a total of 258 ***new*** unduplicated clients, or clients who have never been served by the Ryan White system of care in any previous year. Whereas in Fiscal Year 2021, the Sacramento Ryan White Program served a total of 206 new unduplicated clients. This data reflects a 25.2% increase in new clients over the previous year in the three-county TGA and the Part B funded Yolo County area.

While Yolo County is not part of the Part A Sacramento Transitional Grant Area, the County of Sacramento is the Recipient for the Part B funds from the State of California. These clients may also obtain services in Sacramento. Therefore, the clients are included for reference. It should be noted that any increases in clients in Yolo County also creates a strain on services with the one Ryan White funded provider, CommuniCare Health Center, in that county.

Of the 241 new clients (in the TGA) in 2022, 213 resided in Sacramento, 17 in Placer, and 11 in El Dorado County. In comparison, of the 191 new unduplicated clients in the TGA itself during FY21, 161 resided in Sacramento, 20 in Placer, and 10 in El Dorado County.

Additionally, 17 new clients were reported from Yolo County, a non-TGA Part B-funded county. In the prior year (FY21), there were 15 new unduplicated clients in Yolo County.

Comparisons of year-to-date FY 2022 client demographics and FY 2021 data reveal the following trends:

Total Clients:
In 2022, the Sacramento County Ryan White CARE Program served 2,315 total clients compared to 2,405 in FY21 representing a 3.7% decrease in total clients overall.

Of the total (2,315) Sacramento County Ryan White CARE Program clients above, 114 clients lived in Yolo County, a non-TGA county which is the same number of clients the prior year (FY21).

New Clients:
As mentioned in the Utilization and Trends in Care above, the TGA has served a total of 241 new unduplicated clients who had never been seen in the Ryan White system of care before this year. This represents a 26.2% increase over the prior year, FY21 in which the three-county TGA served 191 new clients.

Clients by CD4:
Based on a comparison between fiscal years 2021 and 2022, clients' CD4 counts showed a slight increase in CD4 counts below 200. There was also a decrease in the number and percent of unknown CD4 counts. Below is a breakdown of the HIV+ client's CD4 counts.

	2021			2022	
CD4 Range	# of HIV+ Clients	% of HIV+ Clients		# of HIV+ Clients	% of HIV+ Clients
Below 200	198	8.23%		198	8.55%
200 - 499	671	27.90%		671	28.98%
500 - 749	707	29.40%		655	28.29%
750 - 1,499	784	32.60%		745	32.18%
Greater than 1,500	43	1.79%		45	1.94%
Unknown/Unreported	2	0.08%		1	0.04%
Total Clients	2405	100%		2315	99.88%*

*Percentages may be off due to rounding

Clients by Viral Load:
A review of clients by viral load for fiscal year 2022 in comparison with fiscal year 2021, noted a slight decrease (FY21: 85.94% vs FY22: 83.85%) in clients who are virally suppressed (VL <= 200), including undetectable. Of the clients with undetectable viral loads, there was slight decrease from 64.53% (1552 clients) in FY21 to 62.94% (1457 clients) in FY22.

	2021			2022	
Viral Load	# of HIV+ Clients	% of HIV+ Clients		# of HIV+ Clients	% of HIV+ Clients
Unknown/Unreported	2	0.08%		2	0.09%
<= 20 (Undetectable)	1552	64.53%		1457	62.94%
21 - 200 (Virally Suppressed <=200)	515	21.41%		484	20.91%
201 - 999	66	2.74%		64	2.76%
1,000 - 4,999	59	2.45%		51	2.20%
5,000 - 9,999	22	0.91%		24	1.04%
10,000 - 24,999	40	1.66%		58	2.515
25,000 - 74,999	56	2.33%		59	2.55%
75,000 or Higher	93	3.87%		116	5.01%
Total Clients	2405			2315	

Clients by County:

During fiscal year 2022, 84.75% of the clients (1,962) resided in Sacramento County. Placer County was home to 5.96% (138 clients), El Dorado 4.36% (101 clients), and Yolo County 4.92% (114 clients).

In comparison, during fiscal year 2021, 84.91% of the clients (2,042) resided in Sacramento County. Placer County was home to 6.15% (148 clients), El Dorado 4.20% (101 clients), and Yolo County 4.74% (114 clients).

While Yolo County is not part of the Part A Sacramento Transitional Grant Area, the County of Sacramento is the Recipient for the Part B funds from the State of California. These clients may also obtain services in Sacramento. Therefore, the clients are included for reference. It should be noted that any increases in clients in Yolo County also creates a strain on services with the one Ryan White funded provider, CommuniCare Health Center, in that county.

Clients by Age:

In this reporting period, the Sacramento County Ryan White CARE Program observed a 2.3% increase in HIV+ clients between the ages of 0-44 (887 clients in FY 2022 compared to 867 in 2021).

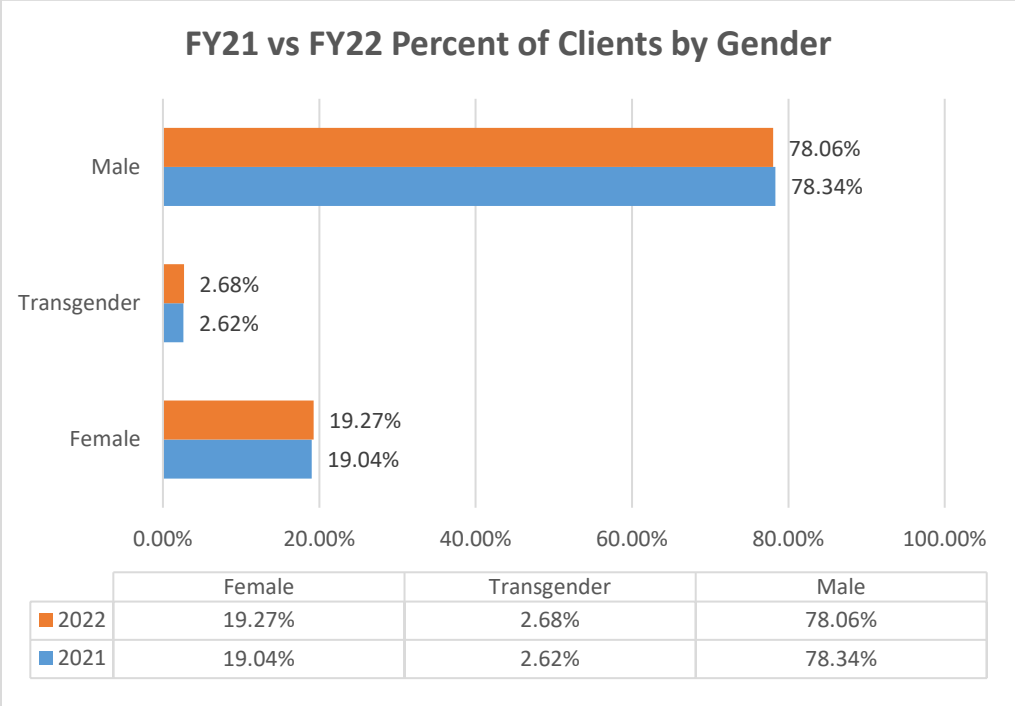
For those 45 years of age and over, there was a 12.5% increase in clients served in 2022 (1,728 clients) compared to 2021 (1,538 clients).

Age Category	**2021** # of HIV+ Clients	**2021** % of HIV+ Clients		**2022** # of HIV+ Clients	**2022** % of HIV+ Clients
Infants 0 - 2 years	1	0.04%		1	0.04%
Children 3 - 12 years	1	0.04%		1	0.04%
Youth 13 - 19 years	8	0.33%		7	0.30%
Youth 20 - 24 years	37	1.54%		43	1.86%
Adults 25 - 44 years	820	34.10%		835	36.07%
Adults 45 - 59 years	794	33.01%		768	33.17%
Adults 60+	744	30.94%		660	28.51%
Total Clients	2405			2315	

Clients by Gender:

In FY22, males represented 78.06% of the clients; transgender represented 2.68% of the clients; and females 19.27%. With a decrease in the total clients served in FY22 (2,315) compared to FY21 (2,405), there was also a slight decrease in the percentage of clients for male clients compared to fiscal year 2021. In fiscal year FY21, 78.34% of the clients were male; transgender represented 2.62% of the clients; and females 19.04%.

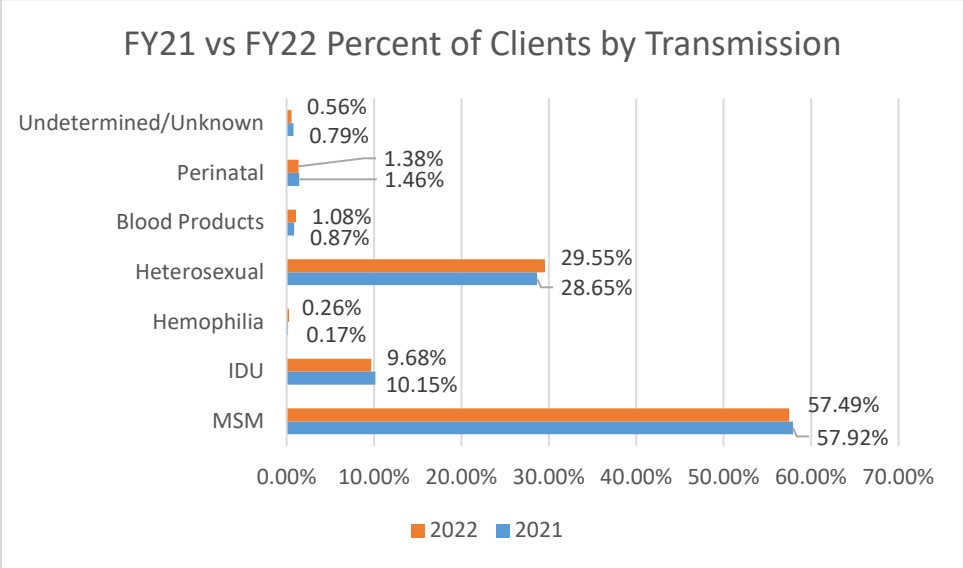
II.



Our final WICY (Women, Infants, Children, and Youth) expenditures show that Sacramento is responding to the needs of women by allocating and expending funds targeted to women in an amount that exceeds their current representation in the epidemic. Total expenditures for WICY must meet a minimum of 18.37% of the total Part A and Part A MAI direct service grant award. At year-end, WICY expenditures ($789,786) represented 26.98% (Part A and Part A MAI) of the grant award total service expenditures. See **Attachment C**.

Clients by Transmission:

There has been no significant change in the transmission methods of the clients in the TGA. Men Having Sex with Men (MSMs) continues to represent the highest transmission level at 57.49%, followed by heterosexual transmission (29.55%). As documented in our FY22 grant application, Heterosexuals experienced an increase in the percentage of people living with HIV (PLWH) transmission between 1995 and 2020 (7% vs 15.8%). Heterosexual transmission is the second largest percentage of PLWH in the TGA.



Clients by Income:

Although there was a decrease in the total clients in FY22 compared to FY21, there was an increase in the percentage of clients with an income of *138% or less* of the federal poverty level. In FY22, clients with an income of *138% or less* accounted for 70.89% of individuals (1,641) receiving Ryan White services. In FY21, they accounted for 68.36% (1,644 clients).

Clients by Income	2021		2022	
	Count	Percent	Count	Percent*
No Income	607	25.24%	623	26.91%
100% of Poverty	676	28.11%	681	29.42%
101- 138% of Poverty	361	15.01%	337	14.56%
139-250% of Poverty	306	12.72%	288	12.44%
251-300% of Poverty	265	11.02%	228	9.85%
Over 300% of Poverty	190	7.90%	158	6.83%
Totals	2405	100%	2315	100%

* Percentage may be off due to rounding

Clients by Ethnicity:

There has been no significant change to client ethnicity in the Sacramento TGA. See **Attachment D** "Client Demographic Reports." Compared to their percentage in the general population, Black/African-American and Hispanic/Latinx clients are the most significantly over-represented in the epidemic.

I.a.i.1. Program Successes addressing the National HIV/AIDS Strategy Goals

- Accomplishments in reducing new infections:

On behalf of the Sacramento Community, Sacramento County Public Health (SCPH) continues to host an STD/HIV Stakeholder group, the Sacramento Workgroup to Improve Sexual Health (SacWISH) with a goal of intensifying HIV and STD prevention, testing, and treatment efforts in the community to reduce new infections and increase the percentage of persons who know their sero-status and are linked to and receive care. The Coalition is comprised of more than 100 sexual health stakeholders throughout Sacramento (medical clinics, testing agencies, school districts, local and state public health representatives, and non-profit agencies that work closely with high-risk populations).

Objective 1: Health Education and Outreach was conducted in many regions and methods across Sacramento. Outcomes are listed below.

- To date, 2000 Sacramento County Sexual Health Clinic (SHC) referral cards and branded materials have been disseminated to patients, community agencies, and at testing/outreach events.
    - 600 SHC referral cards have been distributed to Wind Youth Services.
    - 400 have been given out to Sexual Health Clinic patients.
    - 800 clinic branded handouts were given away during community outreach/education and testing events.
- To date, digital advertising of Undetectable=Untransmittable, HCV, and Monkeypox campaigns on social media and dating applications, have gained 11,481 click-throughs to our Sacramento County Sexual Health Clinic's website www.SacSexualHealth.com

- Eight Sexual Health Clinic Billboards were posted in high morbidity Zip codes from May-July 2022 - on El Camino Ave, Florin Rd, Florin Perkins, Fruitridge Rd, Gerber Rd, Rio Linda, and Auburn Blvd.
    - These billboards yielded 570,310 weekly impressions with a total of 2,281,241 impressions.
- Nine SHC Bus Transit Shelter advertisements were posted May-July 2022 on Florin Rd, Exposition Blvd, Mack Rd, Natomas Park Dr, Franklin Blvd, Calvine Rd, Stockton Blvd and Power Inn Rd.
    - These shelter advertisements yielded 645,444 weekly impressions with a total of 2,581,778 impressions.
- Four digital advertisements were placed on dating applications targeting priority populations in Sacramento County (Skout, MeetMe, Tagged, Grindr, Si.com, and etonline.com).
    - These displays ran in March of 2022 and generated 4,164 clicks through to www.SacSexualHealth.com.
- During the reporting period (January-December 2022) we distributed a total of 35,640 condoms, 640 dental dams, and 17,420 packets of lube to various community-based organizations, school clinics, high schools, and community events such as Pride and National HIV Testing Day

Objective 2: Referrals for Testing

In 2022, Harm Reduction Services (HRS) and Golden Rule Services (GRS) were funded to provide community-based data-driven testing among priority populations including people who are African American/Black, LGBTQ+, and those who can become pregnant. Our CBO's report combined CT/GC testing & results.

	Number	Percentage
Tested for CT/GC	1,262	
Positive for CT/GC	143	11%
Treated for CT/GC	142	99%

In 2022 Sacramento County SHPU conducted STI screening among people experiencing homelessness utilizing our W3 Mobile van, which launched in September of 2022.

	Number	Percentage
Tested for CT/GC	23	
Positive for CT/GC	0	0%
Treated for CT/GC	0	0%

Tested for Syphilis	35	
Reactive Syphilis Test	2	6%
Treated for Syphilis	2	100%

HCV Data

	Number	Percentage
Clients tested for HCV antibody	436	
Clients with a reactive HCV antibody result	39	9%
Clients who received follow up HCV RNA testing	9	23%
Clients tested for HCV RNA	9	100%
Clients who test HCV RNA positive among clients tested for HCV RNA	3	33%

Through funding from the California Department of Public Health, Office of AIDS (OA), HIV Prevention Branch, provided by the Centers for Disease Control and Prevention (CDC), the Sacramento County Sexual Health Promotion Unit (SHPU) integrates HIV prevention and surveillance activities and goals to utilize surveillance data to inform prevention activities.

The approved activities outlined within the LHJ's Work Plans are informed by the HIV Prevention Branch's guidanceto LHJs, ***Enhanced Integration: 2020 Guide to HIV Prevention and Surveillance***. OA's guidance outlines three core required HIV prevention activities, six recommended activities, and program requirements for each strategy. These include:

Funding Requirements

1. Strengthen Disease Investigation Infrastructure
2. Expand and Provide Navigation Services
3. Expand Access to Syringe Services for People Who Inject Drugs

Recommended Activities

1. Health Care Provider Engagement
2. Conduct HIV Testing
3. Linkage to Care Coordinator
4. Condom Distribution
5. Strengthen Community Engagement
6. Strengthen Structural/System-Level Interventions

Overall successes include:

Strengthen Disease Investigation Infrastructure:

During 2022, Sacramento County hired additional personnel to assist with disease investigation. Four (4) new Communicable Disease Investigators (CDIs) were hired with Spanish and Hmong language skills, representing Latinx, Black, and Asian as well as non-binary

identities. They are being fully trained to assist with surveillance investigations and prevention efforts.

In efforts to expand HIV, STI, and HCV testing services for high-risk populations, SHPU has collaborated with Sacramento County Primary Care to launch a new mobile health clinic. The mobile testing unit (Wellness Without Walls-W3) launched in September 2022 and provides services that include HIV, sexual health, and broader services (e.g., wound care, assistance with prescription refills, mental health, and substance counseling)-to unhoused communities and transitional aged youth.

Lastly, eight (8) of our staff that are Certified Phlebotomy Technicians (CPT) began rotating through the Sexual Health Clinic (SHC) to assist with HIV testing and venipuncture.

I.a.i.2. Program Challenges addressing the National HIV/AIDS Strategy Goals

Due to its large three-county area of over 4,000 square miles, the TGA has unique characteristics that create challenges to the efficient and effective delivery of HIV/AIDS services. Most specialized services for HIV/AIDS medical care are centrally located in the City of Sacramento. PLWH in the rural counties of El Dorado and Placer Counties must travel, sometimes up to 90 miles in each direction, to access HIV/AIDS care. Increasing HIV/AIDS cases throughout the TGA have increased the need for HIV related services in all three counties.

In addition to geographic challenges in the TGA, another impact over the last several years has been the implementation of the Affordable Care Act (ACA). Due to the limited availability of HIV specialists in the health care plans under the ACA, additional PLWH are continuing to turn to the RW Program for specialized HIV care and treatment. In addition, increases in poverty throughout the TGA, combined with significant increases in the cost of living, including housing and transportation, continue to have a significant impact on PLWH throughout the TGA.

Staff turnover has continued to plague subrecipients in the Sacramento TGA. Hiring and retaining trained staff has been an ongoing struggle. Ryan White program staff continues to provide technical assistance as needed however ongoing technical assistance creates strains on Ryan White staff as well.

Transportation and housing are not only challenges for people living with HIV, but they create challenges for addressing the goals of the HIV Care Continuum. People living with HIV are more concerned about where they're going to sleep each night than their next medical appointment. Then, once the medical appointment is approaching, transportation to and from the appointment creates another problem.

I.a.ii. FACTORS IMPACTING HIV CARE CONTINUUM OUTCOMES

I.a.ii.1. Expanded/reduced resources

Expand and Provide Navigation Services:

In 2021 Sacramento County began expanding access to quality HIV care and treatment services for People Living with HIV/AIDS (PLWH) at the SHC. This year (2022), Sacramento County expanded the SHC to add physical space specifically for HIV treatment and care services.

To ensure patients receive well-rounded quality care, Sacramento County has hired six (6) new healthcare staff. The SHC now houses a full team that includes three (3) new Nurse Practitioners (NP), one (1) new RN Case-Manager, one (1) MD, and one (1) Master of Social Work (MSW) Social Worker. Our clinic services expansion includes the addition of onsite HPV and Hepatitis B vaccination; 24/7 web access to PrEP AP enrollment via the MedAssist Client Portal; 24/7 web access to Gilead Enrollment and the continued offering of our expanded home-testing program including the following tests: HIV oral swab test, HIV finger stick test, Hepatitis C finger stick test, Syphilis finger stick test, multisite (rectal/throat/urine) gonorrhea and chlamydia testing, and creatinine (for PrEP Panels). Additionally, the SHC has begun offering same-day access to PrEP via prescribing patients a 10-day supply of PrEP after a clinical assessment while waiting for their lab results and submission of a longer prescription, as well as language interpretation assistance for medical services. Medication delivery is now available via participating pharmacies and public health staff, in a limited capacity.

Sacramento County has expanded access to quality HIV care and treatment services for PLWH at our SHC. We are currently providing services for 38 HIV + clients.

- 19 Male, 4 Female, 15 Unknown/Declined
- Race/Ethnicity
  - 13 White
  - 2 Latinx
  - 7 Black/AA
  - 1 Asian
  - 15 Unknown/Declined

- Age
  - 10 Under 35 years of age
  - 12 ages 35-40
  - 16 over age 45

Clients are provided incentives such as juice boxes, snacks, masks, transportation vouchers (including cab rides with Yellow Cab), and gift cards. The SHC is continuing to work to adopt and implement youth friendly practices.

Furthermore, in our efforts to guide HIV negative clients to PrEP, in 2022 the Sacramento County SHC received 110 PrEP referrals and provided PrEP care to 75 patients. This total brings us to an initiation rate of 68%; **19** of the referrals came from Golden Rule Services, **33** from the SHC, **9** from The Sacramento LGBT Center, **5** from our SAMHSA Navigator Program, **2** from Wind Youth Services, **2** from Sacramento County CDIs, **3** from Harm Reduction Services, **1** from WellSpace, **1** from One Community Health, **1** from Kaiser, **1** from Loaves and Fishes, **25** from Sunburst Projects, **7** were referred from friends/family and **2** were from Other Sources.

Furthermore, in partnership with a popular LGBT bar, we conducted PrEP outreach at a weekly drag competition, the Maxx Drag Show on 9/27/22, 11/1/22, 11/8/22. At the show we distributed items that included SHC cards, PrEP materials and branded items, condoms, lube, STI information, partner services cards, PrEP AP information, confidential service cards, youth rights

brochures, in-home HIV tests and CA sexual health rights information. Overall, our tabling at the drag show resulted in 321 encounters with local community members (135 at show one, 82 at show two, and 104 at show three).

In partnership with a local marketing firm, Runyon Saltzman Incorporated, we created four digital media PrEP advertisements to run on dating applications targeting those disproportionately impacted by HIV in the greater Sacramento area. The goal of the ads is to inform users about HIV prevention strategies, decrease stigma, and promote PrEP uptake. This activity was completed with private foundation funding. These ads ran through July 2022 and garnered 2,041,837 impressions and 4,164 clicks.

Sacramento County has also focused on building new partnerships and strengthening current partnerships with agencies in the HIV/STD field. These efforts have led to a partnership with Pucci's Pharmacy. Pucci's is a locally owned pharmacy that has offered extensive care and resources related to HIV and PrEP in Sacramento County. This partnership will allow the Sacramento County SHC to offer Injectable PrEP for our new and current PrEP patients.

Lastly, Sacramento County continues to expand options for in home testing for members of the Sacramento County community. We expand this through www.TakeMeHome.org, implementing an at home testing program through Building Health Online Communities (BHOC). This at home testing option increases access to PrEP panels (includes dried Blood Spot (DBS), HIV and creatinine level (kidney function), and STI multisite (Gonorrhea, Chlamydia, Syphilis, Hepatitis C) for harder to reach populations. In 2022 we saw a total of 2,042 TakeMeHome.org website hits, resulting in 185 test kits ordered; with 17 people testing positive for STIs (4 syphilis, 8 CT, and 7 GC) and 1 HIV+ result.

I.a.ii.1.b. <u>Expand Access to Syringes for People Who Inject Drugs:</u>

During 2022, Sacramento County SHPU funded Harm Reduction Services (HRS), a local SSP to provide integrated HIV/HCV/STI testing services with their SSP services to unhoused folks and people who inject drugs. HRS also provides Narcan on demand and training on how to administer it to prevent overdose. HRS presented at our SacWISH meeting, highlighting the current work they are doing in Sacramento County and laminating how we as a collective can better support folks who are affected by drug use.

Additionally, Sacramento County established a new MOU with SANE (Safer Alternatives through Networking and Education). SANE is an additional syringe exchange program located in the Del Paso area of Sacramento. Their services include a needs-based Syringe Exchange Program, distribution of safer sex supplies, HIV & HCV education and referral, overdose prevention education, outreach to people experiencing homelessness, and a low barrier Medication Assisted Treatment (MAT) program. We have worked with SANE to integrate testing activities into their existing SSP activities. SANE is set to begin HIV/STD testing in 2023 after hiring an experienced HIV/STD counselor with more than 20 years of experience in the field.

I.a.ii.2. Unmet need

- Increasing access to care:

The Ryan White CARE Program continued its funding support for Non-Medical Case Management for Benefit and Enrollment Counselors to ensure clients receive assistance in enrolling in any public benefits for which they may be eligible, including Medi-Cal (Medicaid), Covered California (ACA) health plans, California's ADAP program, and the State Health Insurance Premium Payment programs. There were 1097 clients receiving Benefits and Enrollment Services in FY22, a slight increase of 0.9% over FY21 when 1087 clients received those same services.

Enrollment Counselors are co-located at the same site as the Ryan White ambulatory/outpatient clinic and new clients are immediately scheduled for a Benefits Counseling appointment to ensure they obtain immediate enrollment assistance in various programs available here in California. All of the Enrollment Counselors are certified in the aforementioned programs and have the ability to provide electronic applications on behalf of the client. This service has significantly improved clients' access to care within the region.

- Reducing Health-Related Disparities:

The TGA has employed a Continuous Quality Management program that utilizes a significant number of field based Medical Case Managers who provide services to clients at various sites that are more comfortable and convenient to the clients, often meeting them in their homes or in homeless camps to ensure their access to care. Quality Indicators for the TGA require that all Ryan White subrecipients, regardless of the service they provide, document, and track a client's retention in care and viral load status. Clients who receive their care from the Ryan White system are provided high quality care that strives to meet all PHS Guidelines for the treatment of persons with HIV/AIDS. The TGA's outpatient FQHC clinic, which sees the largest population of HIV clients, also offers a one-stop shop for clients where they can fill their medications at the on-site pharmacy, obtain Mental Health and Substance Abuse counseling, Medical Case Management, Benefits Counseling, Nutritional Counseling, Oral Health Care, and support services such as transportation, insurance and medical co-payment assistance, and Emergency Financial Assistance. By adding the Insurance Premium Assistance category of services funded by Ryan White since the implementation of the ACA, the Planning Council has taken a step to reduce health disparities of our HIV+ population by ensuring eligible clients have assistance when needed to pay for their medication and medical visit co-payments, ensuring a seamless system of access to care. While all eligible clients are enrolled in the State's Health Insurance Premium Assistance program, Ryan White funds may still be needed for the first month's premiums while program eligibility approval is being processed by the State. A process is in place to recover those payments once the State pays those premiums retroactively, and those recoveries become program income. The TGA added another option for outpatient Ambulatory Care services through the county's Sexual Health Clinic. The clinic is located in another part of Sacramento from the larger clinic allowing residents the option of having more than one choice for Ambulatory Care Services. The clinic is primarily funded by the HRSA Ending the Epidemic grant.

I.a.ii.3. Public health emergencies (e.g., COVID-19, mpox) and/or natural disasters

The COVID-19 Pandemic brought many changes to people's personal and professional lives. Businesses, community-based organizations, social service providers, professional services, government services, and alike, all initiated social distancing practices and purchased personal protective equipment and plastic barriers for their organizations. Whether it be for a medical appointment, counseling appointment, business meeting, collaborative meeting, or staff meeting, teleconferencing became the norm. Everyone experienced a learning curve utilizing technology-based services and not everyone was happy or adjusted easily to virtual meetings, conferences, appointments, etc. For some, technology is a financial burden that some simply cannot afford. For others, keeping appointments was easier with the use of telehealth.

As the pandemic and various restrictions continued through FY21 and into FY22, there was a continued increase in the need for mental health services, food vouchers, and housing to keep clients safe. The 2020 Coronavirus Aid, Relief and Economic Security Act (CARES Act) funding supplemented these services at five agencies in the Sacramento TGA. CalFresh, the California Food Assistance Program, also supplemented qualifying individuals with additional funds during the COVID-19 pandemic. However, those additional funding sources related to COVID-19, have been terminated despite the need.

During 2022, the Monkeypox (Mpox) outcome became another public health emergency to address. Utilizing relationships and lessons learned during COVID-19, the Sacramento TGA was able to mobilize Mpox vaccines in a timely manner at several community-based organizations.

I.a.ii.4. Evolving healthcare landscape (e.g., changes in healthcare coverage options)

- <u>Impact on Planning and Allocations:</u>

The Sacramento TGA's HIV Health Services Planning Council's Priorities and Allocations Committee (PAC) is tasked with recommendations for priority setting and allocations. With Fiscal Year 2013 marking the implementation of the Affordable Care Act (ACA), the Committee, in addition to considering historical utilization data, Needs Assessments, and year-end reports also accounted for potential cost-savings from clients who had enrolled in ACA insurance plans. The primary cost savings have been in viral load and CD4 lab tests. The Planning Council did fund the Health Insurance Premium and Cost-Sharing Assistance Program service category in an attempt to ensure clients could meet their deductibles and co-pays. In both FY22 there were 11 clients receiving Health Insurance Premium and Cost-Sharing Assistance. Whereas in FY21, nine clients received Health Insurance Premium and Cost-Sharing Assistance.

- <u>Enrollment</u>

Of the 2,051 clients indicating an insurance source, 90.4% of the clients in the Ryan White system of care had a third-party payer: 8.44% had employer-based private insurance and 81.96% had some form of public insurance through Medicare, Medicaid, or local other governmental programs. However, 9.4% had no insurance.

At the end of FY 2021, 91.96% of the clients in the Ryan White system of care had a third-party payer: 9.62% had employer-based private insurance and 82.35% had some form of public insurance through Medicare, Medicaid, or local other governmental programs. However, 8.04% had no insurance.

I.a.iii. Sharing HIV care continuum outcome information with community stakeholders

The Sacramento HIV Care Continuum is disseminated to the subrecipients, Ryan White Planning Council, and community stakeholders, including the Sacramento Work Group to Improve Sexual Health (SacWISH). Additionally, the HIV Care Continuum was used in coordination/conjunction with a presentation from the AIDS Education and Training Center at a community based organization in January 2023.

I.b. Planning Council Activities

I.b.i. Planning Council Accomplishments

Allocations and Reallocations:

The FY22 Allocations were approved by the Sacramento HIV Health Services Planning Council (HHSPC) in June of 2021, during the Priorities and Allocations Committee Part A Grant Application Planning meeting. In May of 2022, PAC and HHSPC approved a General Directive, which provides direction to the Recipient on how to allocate funds should the award come in at various percentages higher or lower than projected.

In September of 2022, PAC and HHSPC approved the reallocation of $110,569 in funds based on services categories and client utilization needs.

At the time of Reallocation, funds were reallocated to Ambulatory Care, Medical Case Management, Mental Health, Medical Transportation, and Non-Medical Case Management as the categories were over-spending.

The HIV Health Services Planning Council's ability to reallocate funds timely helps eliminate waiting lists and improve access to much needed services. These core and support services are important in maintaining the health of the people living with HIV in the Sacramento TGA.

Reflectiveness:

At the end of FY21, the Council's reflectiveness was 41.7%. However, at the end of FY22, the Council's reflectiveness was 39.1%. Nine out of the 23 seated Council members were non-aligned consumers. Additionally, there are two aligned consumers on the Council. Several providers and consumers reached out to people living with HIV and encouraged participation. While the COVID pandemic limited outreach/recruitment opportunities, our existing members stepped up and found active participants.

California Planning Group:

The California Planning Group (CPG) is the statewide HIV planning body that enables key stakeholders, communities, and providers to engage in active and ongoing dialogue with the

Office of AIDS (OA) to reach the goals of the National HIV/AIDS Strategy and the statewide Integrated Plan. The main functions of this group are to work collaboratively with OA to develop a comprehensive HIV/AIDS surveillance, prevention, care, and treatment plan; to monitor the implementation of this plan; and to provide timely advice on emergent issues identified by OA and/or other key stakeholder parties.

The Sacramento TGA has two members, Richard Benavidez and Clarmundo Sullivan, appointed to the CPG. In addition to being the Chair of the Planning Council, Richard Benavidez has been a volunteer and advocate for those living with HIV and also sits on the Board of Directors for the Sierra Foothills AIDS Foundation. Both members provide valuable feedback to the State Office of AIDS on the needs of the people living with HIV and high-risk populations in the Sacramento TGA.

Richard Benavidez is able to provide regular updates to the Sacramento HIV Health Services Planning Council on the activities and achievements made by the CPG.

Clarmundo Sullivan is the Executive Director of Golden Rule Services and a subrecipient of the Sacramento County's HIV Prevention Program and Ryan White CARE Program. He regularly participates in the Ryan White Providers Caucus and HIV Prevention Program's Sacramento Workgroup to Improve Sexual Health (SacWISH) where he provides updates from CPG.

Member Education and Training:

Through Fiscal Year 2022, the Sacramento HIV Health Services Planning Council received training on various topics related to the Ryan White system of care. The trainings were a mixture of both guest presenters and staff/member-lead presentations. Member trainings and presentations included training on the *Mechanics of the Planning Council* and presentations on services provided by Ryan White subrecipients and non-Ryan White funded community based organizations. These trainings provide programmatic updates, as well as an overview and update of services available from both Ryan White funded subrecipients and other community based organizations.

In FY22, these **trainings** included:

- Mechanics of the Planning Council
- Brown Act Overview
- Priority Setting and Resource Allocation Overview
- Administrative Assessment Overview
- Understanding Reallocation

In FY22, the **presentations** included:

- County of Sacramento PrEP & Linkage to Care
- Sacramento LGBT Center

- Cultural Humility
- Diversity and Equity

I.b.ii. Planning Council Challenges

Needs Assessment:

In FY22, the Ryan White (RW) HIV Health Services Planning Council (HHSPC) conducted its tri-annual assessment of people living with HIV/AIDS (PLWH/A) as part of its RW Part A funding for the Sacramento Transitional Grant Area (TGA), which includes Sacramento, El Dorado, and Placer Counties. The goal of the Needs Assessment is to collect and analyze data on Service Needs; Service Gaps; and Barriers to Care for PLWH/A to assist the Council with effective planning for service funding and service delivery. RW Program staff, subrecipient staff, and volunteers conducted surveys in one-on-one sessions.

In 2022, the Council initiated its Needs Assessment with a target of surveying 200 people living with HIV in the Sacramento region. Council Staff reached out to subrecipients for assistance in conducting the surveys. Twenty-two of the participating clients were from the rural counties of either Placer, Yolo, or El Dorado County. The 169 remaining participants were from Sacramento County. Despite an incentive of a $20 gift card, clients are reluctant to take the time to complete the survey. The Council may wish to consider increasing the incentive due to the amount of information gathered.

Substance Abuse Epidemic:

The Sacramento TGA has experienced an increase in its substance abuse issues in recent years. In an article published by the Sacramento Bee on August 17, 2015, (http://www.sacbee.com/site-services/databases/article31324532.html), opioid overdoses in Sacramento, El Dorado, and Placer Counties were higher than the statewide average. On March 29, 2016, the Sacramento Bee (http://www.sacbee.com/opinion/editorials/article68896827.html) published an article in which Sacramento County's Public Health Officer, Dr. Olivia Kasirye, called a public health emergency when 28 people had overdosed on Fentanyl since the prior Thursday (March 24, 2016). A review of the California Department of Public Health's California Opioid Overdose Surveillance Dashboard (https://skylab.cdph.ca.gov/ODdash/) indicated that 159 people died in 2019, in the three-county TGA of Sacramento, El Dorado, and Placer Counties.

In 2016, Sacramento County created an Opioid Coalition committed to saving lives by preventing overdoses through expanding treatment access, promoting safe disposal, encouraging early intervention, treatment and recovery, enhancing opioid surveillance, and expanding public education and media outreach.

In March of 2017, the California Department of Public Health (CDPH) established a Naloxone Grant Program with the goal of reducing the number of fatal overdoses in California from opioid drugs. The funding was available to local health departments to conduct Naloxone Distribution Projects, providing *Narcan* to local programs, agencies, and community-based organizations. Sacramento County Public Health Division obtained funding from this grant

program and is providing local law enforcement supplies of Naloxone and providing them with training on its administration.

In 2019, the California Department of Public Health released a Request for Applications to create California Opioid Safety Coalitions throughout the State. 23 coalitions were awarded, including the Sierra Sacramento Valley Medical Society. Coalitions are using a data-informed approach to implement multiple objectives and prevention strategies at the local level. These approaches include: expand access to medication assisted treatment; develop/adopt local policies and procedures; promote public education and awareness, safe prescribing practices, and harm reduction services; increase access to naloxone and care/services for high-risk populations; and collaborate with local law enforcement to promote primary prevention best practices. Also in 2019, the Sacramento County Division of Behavioral Health Services, Substance Use Prevention and Treatment Services launched the Methamphetamine Coalition, which continues to meet quarterly.

Harm Reduction Services (HRS), a Ryan White funded provider, has utilized other funding sources to offer Overdose Recognition and Response Training since 2014. As of 12/31/20, this training by HRS resulted in 1900 opiate overdose reversals. 781 of these reversals were in 2020. In December of 2021, the Sacramento County Sexual Health Promotion Unit participated in the training as well.

In November 2021, the Sacramento County Department of Health Services partnered with the Sacramento County District Attorney's Office to sponsor a Fentanyl Safety Awareness Fair. The safety fair featured demonstrations on how to use on Narcan, as well as distribution of free Narcan kits, gift card giveaways, food trucks and resource information from more than 25 community-based organizations.

According to Sacramento County, Sacramento County had 116 Fentanyl-involved deaths in 2021 and 50 died during the first seven months of 2022[1]. Fentanyl continues to be a serious problem in our TGA. The County has invested an additional $11.2 million in programs/services including Medication Assisted Treatment and residential treatment services.

Despite the CDPH's Naloxone Grant Program, and HRS' Overdose Recognition and Response Training classes, the TGA has insufficient capacity and funding sources to meet the need of individuals seeking substance abuse treatment. While Naloxone programs do save lives, it is not the solution to addiction. The TGA needs additional substance abuse treatment providers/facilities, especially providers who understand the complexity of substance use and HIV.

Housing and Homelessness:

Housing is a particular struggle for individuals with low or no income, past evictions, mental health issues, criminal records, and current or past drug use. In fact, in an April 14, 2021, Fox40 online article, it was reported that "the median sales price in the Sacramento region, which

[1] https://www.saccounty.gov/news/latest-news/Pages/Overdose-Is-On-The-Rise-In-Sacramento-County.aspx#:~:text=Fentanyl%20poisoning%20impacts%20Sacramento%20residents,first%207%20months%20of%202022.

encompasses Sacramento, Placer, El Dorado and Yolo counties, has gone up over 20% between March 2020 and March 2021. Since January of 2021, the market has shot up 9% and is on track to keep rising". (https://fox40.com/news/local-news/experts-say-influx-of-buyers-from-san-francisco-creating-major-challenges-for-sacramentos-housing-market/). The article further states that "out of the 30 largest metro areas in the U.S., Sacramento is ranked number one in terms of net move-ins, which are mostly from San Francisco".

Finding affordable rentals in the region is a challenge as well. In a Sacramento Bee article, dated July 1, 2019, (https://www.sacbee.com/news/local/article232162102.html) Sacramento was ranked the 26th most expensive city in the United States. In 2019, the average rent on a one-bedroom apartment in Sacramento was $1,260. In an online article by Sage Singleton, (https://www.apartmentguide.com/blog/average-rent-in-sacramento/) dated February 4, 2021, it is noted that the cost of living in Sacramento is 23.4% more expensive than the national average and that the average rent for a one bedroom is apartment is now $2,064.

Both the City Council and the County Board of Supervisors in Sacramento, as well as Placer County have initiated projects aimed at assisting homeless and low-income individuals, but their efforts are still in the planning stages. With approximately 70.89% of the TGA's Ryan White clients served in FY2022 living at or below 138% of poverty, coupled with housing shortages and rent increases, the TGA anticipates these efforts to be insufficient to meet the needs in the region.

The California State University in Sacramento (CSUS) in coordination with Sacramento Steps Forwards conducted a *Point in Time* (PIT) homeless study in February 2022. Findings (https://sacramentostepsforward.org/continuum-of-care-point-in-time-pit-count/2022-pit-count/) indicated that there has been an estimated 67% increase, since 2019, of individuals experiencing homelessness on any given night in Sacramento.

Capacity Issues:

The TGA continues to experience an increased demand for Mental Health services. The demand stretches the capacity of the providers. Finding qualified Mental Health providers who understand the intricacies of HIV and mental health continues to be a challenge. Having a serious health issue, such as HIV, can lend itself to a source of major stress, and the mere diagnosis can negatively impact one's well-being, cause depression, and/or complicate any existing mental health conditions. With the lack of qualified mental health practitioners, people living with HIV who are experiencing increased mental health issues may be left untreated. Untreated mental health conditions can lead to increased medical problems, not to mention negative interactions with others, which may affect employment, housing, and negative interactions with law enforcement. One Ryan White funded agency expanded services and opened a mental health program in FY2021, which helped address the need.

The TGA experienced an increase in clients seeking housing and food bank services in FY21 which were augmented with CARES Act COVID Response funding. Sine the termination of the CARES Act funding, the TGA has seen a decrease in the number of clients receiving housing and food bank services, despite the ongoing need.

Below is an indicator of the service categories which experienced an increase in clients in FY22 compared to FY21.

Service Category	2022 Number of Total Clients	2021 Number of Total Clients	Percent Different	Decrease or Increase
Substance Abuse Residential (Detox)	19	9	111.1%	Increase
Health Education/Risk Reduction	235	191	23.0%	Increase
Health Insurance Premium Payment and Co-Pay Assistance	11	9	22.2%	Increase
Mental Health	501	433	15.7%	Increase
Medical Transportation	525	467	12.4%	Increase
Non-Medical Case Management	1158	1104	4.9%	Increase
Oral Health	634	613	3.4%	Increase
Medical Case Management	1592	1547	2.9%	Increase
Emergency Financial Assistance	147	143	2.8%	Increase
Outpatient Ambulatory Care	1794	1750	2.5%	Increase
Outreach Services	388	379	2.4%	Increase

I.b.iii. Challenges related to compliance with planning council/body legislative requirements and steps taken to address the challenges.

Reflectiveness and Representation

The Sacramento TGA continues to strive for reflectiveness. One limitation is the mandate that the participants must be recipients of Part A funds. The Sacramento TGA has a combined Part A and Part B Planning Council. Many applicants are unaware of how their services are funded. It can be disheartening to a person living with HIV who wishes to volunteer only to realize that do not meet the mandated funding source requirement. It is not the client's decision whether a provider invoices Part A or Part B services. The Planning Council continues to recruit, and appointment members as needed.

I.c. Early Identification of Individuals with HIV/AIDS (EIIHA) Update

I.c. Outline the activities of the TGA's EIIHA Plan Implemented during FY22:

I.c.i.1. <u>Achieving successful outcomes</u>:

With years of community collaboration and coordination, the TGA has a solid framework for the implementation of its EIIHA Plan by targeting demographic characteristics, specific needs, and barriers to HIV testing and care for the TGA's most at risk populations.

The following EIIHA Activities were successfully implemented in 2022:

Activity	Outcome
Provide HIV testing to high-risk populations to make them aware of their HIV status.	• During CY 2022, the Sacramento County Sexual Health Clinic and affiliated community-based testing sites successfully tested 2,453 high-risk individuals to make them aware of their HIV status and identified 19 newly diagnosed individuals.
Provide prevention and harm reduction education information, including PrEP information and referrals, to individuals at testing.	• In addition to providing PrEP education to the 1,800 individuals who received testing services, more than 2,000 PrEP educational materials were distributed during CY2022. • In 2022 the Sacramento County Sexual Health Clinic received 110 PrEP referrals and provided PrEP care to 75 patients. • More than 35,600 condoms, 640 dental dams, and 17,400 packets of lubricant were distributed during CY 2022 • Additionally in 2022, advertising included 8 Sexual Health Clinic billboards (2,281,241 impressions), 9 Sexual Health Clinic bus shelter advertisements (2,581,778 impressions), and 4 digital advertisements on dating apps (4,164 clicks through to www.SacSexualHealth.com)
Increase percent of newly diagnosed HIV+ people linked to medical care within one month of diagnosis.	• 100% of the community-based testing program's newly identified HIV+ clients (10), were linked to medical care within one month of diagnosis on CY 2022. Nine of these were linked within 7 days of specimen collection date.
Make testing sites accessible to targeted populations through venues associated with their culture, geography, and lifestyles. Once tested, ensure that individuals are made aware of their HIV status.	• As traditional testing venues began to open up in CY2021 we saw a rise in testing partners reported testing numbers. Our testing partners began allowing limited onsite testing, and resumed canvassing of high-risk areas, such as encampments. Many partners also continued limited at-home testing and follow up to increase access. • Although not a traditional testing site, the TakeMeHome.org program saw 2,042 website

	visits resulting in 185 test kits ordered with 17 people testing positive for STIs and 1 HIV+ result. • Sacramento County established contracts with two CBOs and a community pharmacy to provide educational materials related to MPOX and collectively administered more than 8,000 doses of JYNNEOS vaccinates to the LGBTQ+ community.
Expand testing venues with additional trained testers, who reach more of the targeted populations by increasing the number of individuals who know their HIV status.	• In CY2022, two new sites were established in Sacramento, and one site was "re-launched". Both SANE and Sunburst Projects became new testing sites and the Sacramento County Probation Department Drug Court re-launched testing services. • This resulted in 13 new test counselors being certified in CY 2022
Increase the number of TGA residents at high risk for HIV infection who are on PrEP by 500 individuals in CY21 to achieve a total goal of 3,100 persons by 2021.	• In CY 2022, the Sacramento County Sexual Health Clinic successfully initiated PrEP with 75 clients. Countywide PrEP data indicates, as of 2021 there were 1054 PrEP users in Sacramento County (this is the most recent data available: https://aidsvu.org/local-data/united-states/west/california/sacramento-county/#prep). In addition, we partnered with a local marketing firm, Runyon Saltzman Incorporated to create four digital media PrEP advertisements to run on dating applications targeting those disproportionately impacted by HIV in the greater Sacramento area. The goal of the ads was to inform users about HIV prevention strategies, decrease stigma, and promote PrEP uptake.

Integration of the HIV/STD Prevention, Surveillance, and Ryan White Care programs – to create the Sacramento County Sexual Health Promotion Unit (SHPU) - within the Sacramento County Division of Public Health has enhanced the TGA's efforts to identify HIV+ individuals and to provide risk reduction counseling. The Sacramento County SHPU relies on the expertise of the Sacramento Workgroup to Improve Sexual Health (SacWISH) to support HIV/STD prevention, testing, and treatment efforts in the TGA.

In the rural counties that make up the TGA, the Sierra Foothills AIDS Foundation (SFAF) has encouraged community clinics in both El Dorado and Placer County to continue HIV testing at their sites. Preliminary figures from the State Office of AIDS for calendar year 2022, indicates

that there were 11 newly diagnosed individuals in Placer County and 3 in El Dorado County. SFAF also conducts HIV testing at their Placer County offices using test kits provided by One Community Health in Sacramento. These test sites inform rural county residents of the availability of treatment and services at One Community Health as well as other providers in the TGA.

I.c.i.2. Resources and Partnerships:

The Sacramento TGA Partners with the following agencies to identify individuals with HIV/AIDS:

- One Community Health,
- Golden Rule Services,
- Safer Alternatives through Networking and Education (SANE),
- Harm Reduction Services (HRS),
- Gender Health Services (GHS),
- Sacramento LGBTQ Community Center,
- Wind Youth Services (Wind),
- Community Against Sexual Harm (CASH),
- Sacramento Native American Health Center,
- Sacramento County Department of Health Services (DHS) Sexual Health Promotion Unit (SHPU),
- El Dorado County Department of Public Health,
- Placer County Department of Public Health,
- Planned Parenthood,
- WellSpace Health, and
- Sierra Foothills AIDS Foundation (SFAF)

Many organizations throughout the TGA are currently funded by public sources and are responsible for ensuring that activities to inform, refer and link individuals are implemented. Sacramento County opened a Sexual Health Clinic in May 2019, which provides sexual health services to high-risk individuals and their partners who come for low/no-cost STD testing and treatment. HRS conducts free HIV and hepatitis C testing and a syringe exchange program and targets the IDU and substance using community members, offering clients' case management services, food, clean syringes, overdose prevention medications, and transportation. Golden Rule Services targets Black/African American and Latinx MSM, offering free HIV testing, case management, and social support services. SANE provides IDUs with clean syringes, risk reduction counseling, referrals to partner services, and medication assisted substance abuse treatment.

The Sacramento County SHPU targets youth and other high-risk populations, by providing testing at venues such as drop-in centers for homeless and runaway youth, and communitywide health fairs. In response to COVID and MPOX, the SHPU staff have made strides to implement innovative testing practices including utilizing home HIV test kits for PrEP patients and developing a "door to door" testing program using technology (Zoom and DocuSign) for counseling and consent paperwork.

All of these organizations work closely with County Public Health to coordinate efforts to target the high-risk populations in the TGA. During 2020, the SHPU staff convened an HIV Test Counselor / PREP Navigator workgroup to coordinate efforts across the county and support one another's programming. This workgroup meets monthly which has continued in 2023.

The Sacramento TGA has used all the available resources, both internal and external, in its efforts to produce favorable outcomes in its effort to achieve the Early Identification of Individuals with HIV/AIDS.

I.c.i.3. Barriers and/or Challenges to Achieving Successful Outcomes:

The Sacramento TGA's EIIHA Plan has numerous approaches to address barriers for its target populations, three of which address barriers to accessing testing and treatment as follows:

1. Promote testing at Safer Alternatives thru Networking and Education (SANE) and Harm Reduction Services (HRS), two agencies that serve as needle-exchange sites targeting substance-using individuals. SANE and HRS have developed and sustained strong trust relationships with the IDU and substance using communities; provide mobile testing on street corners and homeless camps in neighborhoods where IDUs congregate; and provide incentives (food vouchers, etc.) to promote testing for their target populations.

2. Sacramento County testing agencies, including Golden Rule Services, Harm Reduction Services, Gender Health Center, the Sacramento LGBT Community Center, and other County-affiliated testing sites throughout the TGA, provide Finger Stick HIV testing to targeted populations to provide immediate results of HIV status, and to remove barriers that may prevent people from returning for results. These providers make testing sites accessible to populations at risk for HIV through providing services directly through community-centered venues.

3. All TGA testing sites distribute HIV+ Care Packets to newly diagnosed clients; and provide HIV/AIDS resources and referral information. All testing sites inform newly diagnosed clients of services in the TGA and provide linkage to care.

I.c.i.4. EIIHA Plan's Contribution to the National Goals to End the HIV Epidemic

Reduce New HIV Infections

NHAS Action Steps*:*

- *"Intensify HIV prevention and testing efforts in the communities where HIV is most heavily concentrated."*
- *"Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches."*
- *"Educate all Americans with easily accessible, scientifically accurate information and HIV risks, prevention and transmission".*

The TGA's efforts target youth, in particular young gay men, to get tested. In CY21, 14.5% of tests administered through the TGA's community based EIIHA providers were for clients ages 24 years and younger, exceeding their 2.4% representation in the TGA's HIV epidemic as of 12/31/20. Further, 23% of positive tests in CY21 were for those under age 25. The TGA offers a wide range of testing sites accessible to target populations through venues associated with their culture, geography, identity, and sexual orientations. Once tested, individuals are made aware of their HIV status. In addition to young adults, the TGA targets the United States' most at risk and disproportionately impacted populations, for transmission of HIV: MSM, people who use drugs, transgender individuals, Black/Latinx populations, and individuals with a previous STI diagnosis.

Increase Access to Care and Improving Health Outcomes For People Living with HIV

NHAS Action Steps:

"Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV."

During 2021, Sacramento County hired additional personnel to assist with disease investigation. Four (4) new Communicable Disease Investigators (CDIs) were hired and fully trained to assist with surveillance investigations and prevention efforts. One (1) of these CDIs serves in the unique role of Linkage to Care Coordinator working directly with both our Prevention and Surveillance teams. She works to ensure linkage to medical care and support services both internally and for our community based testing sites. One (1) CDI was promoted to the newly established position of Senior CDI. This new position assists with training efforts for staff; triage of cases, and coordination of case assignments. In efforts to expand HIV testing services for high-risk populations, 13 of our staff completed training to become Certified Phlebotomy Technician I. These staff include CDIs, Health Educators, Health Education Assistants, and a certified HIV/HCV test counselor from one of our community based testing sites. This training will help our program provide field-based confirmatory testing (specimen collection) options for HIV, HCV, and Syphilis.

Reduce HIV-Related Health Disparities and Health Inequities

Sacramento County continues to foster relationships with our local community HIV testing partners. Harm Reduction Services (HRS) is a funded partner of Sacramento County. HRS provides a free and anonymous needle exchange program, HIV/HCV/STI testing, condom distribution, and Ryan White case management services.

Golden Rule Services (GRS) is a funded partner of Sacramento County. GRS proudly serves People of Color, the lesbian, gay, bisexual, and transgender (LGBT) community, with a focus on Black and Latinx Men who Have Sex with Men (MSM), ex-offenders, youth, and people living with HIV/AIDS. Most of their clients are uninsured and underinsured.

The Sacramento LGBT Community Center (The Center) currently has a testing partner MOU with the County of Sacramento. The Center works to create a region where LGBTQ+

people thrive. They support the health and wellness of the most marginalized, advocate for equality and justice, and work to build a culturally rich LGBTQ+ community.

Gender Health Center (GHC) is a nonprofit organization and community clinic focusing on transgender health. GHC centers Queer and Trans People of Color (QTPOC) in their services, discussions, goals, and visions. In previous years, GHC served as a subcontractor of one of our contracted testing sites. In 2021, Sacramento County reengaged GHC and they have signed a testing partner MOU with the County of Sacramento. They began HIV testing in early 2022.

Achieve a More Coordinated National Response to the HIV Epidemic

NHAS Action Steps:

- *"Increase the coordination of HIV programs across the Federal government and between Federal agencies and state, territorial, tribal and local governments."*
- *"Develop improved mechanisms to monitor and report on progress toward achieving national goals."*

The TGA's EIIHA efforts clearly aim to increase the number of persons who know their sero-status, refer negative clients to PrEP and risk reduction counseling, and immediately link HIV+ clients into care. In an effort to coordinate services, Sacramento County has convened the HIV Test Counselor/ PrEP Navigator Work Group at the local level. This work group provides a space for collaboration and support for our local HIV programs. In addition, Sacramento County participates in the larger Statewide CA PrEP Navigators group in order to stay abreast of what is happening at the State level around HIV prevention and early intervention. Finally, the Sacramento County Sexual Health Promotion Unit leadership works extremely closely to coordinate the various federal funding streams that have been awarded through the Ending the HIV Epidemic (ETHE) Initiative – collaborating on all activities that make up Sacramento's ETHE plan. This plan includes funding from HRSA, CDC, and SAMHSA.

I.c.ii.1. The following EIIHA Activities were unsuccessful in 2022:

Activity	Barriers and Challenges
Educate medical providers on HIV testing and referral resources to increase routine testing of population at large.	• Unfortunately, due to COVID restrictions and staff reassignments in 2021, Sacramento County was unable to complete Provider Detailing activities

I.c.ii.2. Different Approaches:

As a result of the COVID-19 Pandemic, much of the way we do business was completely disrupted. However, this led to innovation and troubleshooting on the part of Sacramento County and affiliated testing sites. Moving forward our programming will continue to utilize innovative practices, including the use of Home HIV Test kits, telemedicine, virtual risk reduction counseling via Zoom, and DocuSign for obtaining required patient consent forms. These

approaches will allow us to continue streamlining our work and reduce barrier to early intervention for HIV patients.

I.c.iii. Efforts Undertaken to Remove Legal Barriers to routine HIV Testing:

None.

The Sacramento TGA follows the lead of the State Office of AIDS in terms of identifying legislation that would remove legal barriers to increasing access to care. The Recipient's Ryan White Program Coordinator, who is also the AIDS Director for Sacramento County Public Health, participates in monthly calls of the California HIV/STD Controllers Association (CHSCA). CHSCA analyzes all HIV related legislation introduced in the California Legislature each year and provides letters of support or opposition when necessary to bills that could improve or harm HIV+ individuals or the provision of high quality medical care to this population. Legislation following activities related to prevention is also monitored by CHSCA.

I.c.iv. Presentations/Dissemination of the EIIHA Plan

Results of the EIIHA Plan and Outcomes were disseminated to publicly funded testing agencies and private testers through updates at various collaborative meetings. All active EIIHA Plan participants received these results and evaluated them to finalize the 2021 EIIHA Plan. The RW Council and the Sacramento Work Group to Improve Sexual Health (SacWISH) received results of the EIIHA Plan and outcomes The Sacramento County Public Health Department's STD/HIV programs participated in the development of the Plan's goals and objectives and disseminated this information to its community partners. These annual updates allow community partners to remain involved in new directions that are continually evaluated to reach the TGA's targeted populations.

I.d: Subpopulations of Focus – Minority AIDS Initiative (MAI)
Id.i. MAI Viral Load Suppression Rates:
(HAB Core Measure: HIV Viral Load Suppression: Number/Percent of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral Load test during the measurement year. 85% of clients will be virally suppressed.)

In the California 2016 HIV Integrated Plan, the Sacramento TGA identified the following populations as those with the highest risk for HIV/AIDS: African Americans, Hispanics, Youth and Young Adults ages 19-24 years old, High-Risk Heterosexuals, and Men who have Sex with Men. African Americans continue to be over-represented in the HIV epidemic in the TGA, followed by Hispanics.

The TGA's 2020 Service Category Plan Included Minority AIDS (MAI) Initiatives that impact positive health outcomes along the HIV Care Continuum for populations experiencing health inequities. The primary goal of the Sacramento TGA's Minority AIDS Initiative Plan is to

enhance access to ambulatory medical care and provide ongoing assistance to keep high-risk clients in medical care. Services funded through the MAI grant operate street-side and home-based medical case management services targeted to the TGA's emerging high-risk populations: African American and Hispanic men and women who are substance users/IDUs; homeless; and formerly or about to be incarcerated.

Outcomes by Race/Ethnicity:

During FY22, there were 663 MAI Medical Case Management clients. Of the 663 MAI clients, 24 clients (3.06%) did not have a reported viral load test since January 1, 2022, so it is unknown if they were virally suppressed or in medical care during the reporting period.

Of the overall 639 total clients having received a viral load during the reporting period, 63.5% were Black or African American (406 clients), the TGA's largest MAI population. However, of the 406 total Black or African American clients, 87.7% (356 clients) were Virally Suppressed. Whereas Hispanic/Latinx accounted for 23.9% of the total MAI clients and 89.5% were virally suppressed. Please refer to the chart on the next page.

Clients receiving a Viral Load Test in the Reporting Period

Race/Ethnicity	FY22 Total Number of Clients by Race	FY22 Number of Clients within Race Category Achieving Viral Load Suppression	FY22 Percent of Clients within Race Category Achieving Viral Load Suppression
American Indian/ Alaskan Native	22	21	95.5%
Asian	46	45	97.8%
Black or African American	406	356	87.7%
Hispanic or Latinx	153	137	89.5%
Native Hawaiian/ Pacific Islander	12	12	100.0%
Totals	639	571	89.4%

Outcomes by Age:

Of the overall 639 total MAI clients having received a viral load during the reporting period by age group, youth and young adults ages 19-24 had a viral suppression rate of 84.21%;

MAI clients between 25-44 years of age had a viral suppression rate of 86.85%; and adults aged 45 and older had a viral load suppression rate of 91.26%.

Total Clients Receiving a Viral Load during the Reporting Period

Age Group	FY22 Total MAI Clients	FY22 Total Viral Suppression	FY22 Percent Virally Suppressed by Age Group
0-18 Years	3	3	100.0%
19-24 Years	19	16	84.21%
25-44 Years	251	218	86.85%
45+	366	334	91.26%
Totals	639	571	89.36%

Outcomes by Gender:

Of the overall 639 total MAI clients having received a viral load during the reporting period by gender, transgender client decreased their viral suppression rates over the prior reporting period.

Total Clients Receiving a Viral Load during the Reporting Period

Gender	FY22 Total MAI Clients	FY22 Total Viral Suppression	FY22 Percent Virally Suppressed by Gender
Male	457	405	88.62%
Female	159	150	94.34%
Transgender	23	16	69.57%
Totals	639	571	89.36%

I.d.ii. MAI Performance, Programming and/or Interventions Impacting Health Outcomes:

Since the inception of the MAI program in the Sacramento TGA, the field-based medical case management model has demonstrated its effectiveness in keeping clients in care and improving their health outcomes. In FY22, the health outcomes of the MAI clients indicated that 73.6% of RW MAI clients achieved viral load suppression. This is a decrease over the prior year. The health outcomes of the MAI clients at the end of FY21 show that the percentage of RW MAI clients that achieved viral load suppression was 82.7%. Even with the decrease in FY22, these

viral suppression rates among RW MAI clients are well above the most recent National rate (66%)[2] and State rate (63%)[3] of viral suppression.

I.d.iii. MAI Challenges and Barriers:

The Minority AIDS Initiative in the Sacramento Transitional Grant area served 663 clients. The difficult lifestyles of these high-risk clients have demanded an intensive field-based medical case management system that is highly responsive to their on-going needs. The program's success in maintaining clients in medical care has achieved its projected goals. However, it would not be possible without the MAI subrecipients' collaborative efforts with all agencies within the TGA. MAI subrecipients continue to reach the targeted populations and make great in-roads with linking the clients to care.

In Sacramento, the MAI subrecipients have been able to build trust within the community to reach the targeted population and forge the working relationship necessary with clients and other agencies to ensure on-going medical services are received. The subrecipients utilize a combination of in-home medical case management services, street-side medical case management and pre/post incarceration medical case management services to reach those in need. In previous years, many an hour was spent in a client's place of residence or on the side of a river encouraging clients to seek and maintain care. Again, this year with COVID, telehealth was extremely important and once field-based visits resumed, they were vital to keeping clients in care.

However, affordable housing is reported as the client's greatest barrier. In a Sacramento report by Apartment List.com[4], Sacramento's January rent growth ranked number 73 among the nation's 100 largest cities. The median rent is 20.7% higher in Sacramento than in similar national areas. Additionally, housing shortages result in increased rental costs.

Transportation is typically the second most reported barrier in the TGA. Although bus and light-rail systems are available in the greater Sacramento metropolitan area, they are extremely inadequate to serve the large metropolitan area covered by this county, and the rural counties have little to no public transportation systems.

Medical case managers spend an enormous amount of time transporting clients to and from medical appointments. However, medical case managers utilize this time to obtain pertinent medical and psychosocial information on clients, to case conference with physicians and psychosocial professionals, and assist the client in accessing needed prescriptions. Some of the field-based medical case management is a critical component to maintaining clients in care, as case managers are able to go to the clients rather than requiring clients to travel to them. This helps overcome the transportation barriers that clients experience in this TGA.

[2] https://www.cdc.gov/nchhstp/newsroom/2021/2019-national-hiv-surveillance-system-reports.html#:~:text=In%202019%2C%2066%25%20of%20people,diagnosis%20in%2045%20U.S.%20jurisdictions

[3] https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California_HIV_Surveillance_Report2020_ADA.pdf

[4] https://www.apartmentlist.com/rent-report/ca/sacramento

II. Final FY 2022 Service Category Plan Table and HIV Care Continuum Services Table

FY2022 Final Service Category Table
See **Attachment A**

FY2022 Final Care Continuum
See **Attachment B**

III. Certification of Aggregate Administrative Expenditures

CERTIFICATION OF AGGREGATE ADMINISTRATIVE COSTS
See Attachment F.

IV. FY 2022 WOMEN, INFANTS, CHILDREN AND YOUTH (WICY) REPORT:

Women, Infants, Children and Youth (WICY): Part A and Part A MAI Only: By February of 2023, the TGA had exceeded its required expenditures for Women, Infants, Children and Youth. Total expenditures for WICY must meet a minimum of 18.37% of the total Part A grant award less the fiscal administrative costs. At year-end, WICY total expenditures represented 26.98% (Part A and Part A MAI) of the grant award direct service expenditures.

	% Women	% Infants	% Children	% Youth
CDC Epidemiological	15.95%	0.00%	0.04%	2.37%
FY22 Sacramento TGA Data	**22.43%**	**0.00%**	**0.15%**	**4.4%**

See Attachment C.
Total expenditures for WICY must meet a minimum of 18.32% of the total Part A and Part A MAI direct service grant award. At year-end, WICY expenditures ($789,786) represented 26.98% (Part A and Part A MAI) of the grant award direct service expenditures. See **Attachment C**.

FY22 Annual Progress Report Attachments

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Attachment A

FY 22 Sacramento TGA Service Category Table and Comments

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Attachment A: Service Category Plan Table

Recipient Name: County of Sacramento
Grant Number: H89HA00048

Part A Service Category Plan Table

Service Categories	FY 2022 Estimated					FY 2022 Actual						
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Expended Amount	Variance %	Unduplicated Clients	Variance %	Service Units	Variance %	Average Cost per Service Unit
Core Medical Services												
AIDS Drug Assistance Program (ADAP) Treatment	2	Not Presently Funded				Not Presently Funded						-
AIDS Pharmaceutical Assistance (LPAP)	Not Ranked	Not Presently Funded				Not Presently Funded						-
Early Intervention Services	Not Ranked	Not Presently Funded				Not Presently Funded						-
Health Insurance Premium & Cost Sharing Assistance	3	$ 20,540	14	1 unit = 1 Vendor Paid Insurance, Medical Visit or Deductible Co-pay dollar	18673	$ 10,232.00	-50%	11	-21%	9322	-50%	$1.10
Home & Community Based Health Service	Not Ranked	Not Presently Funded				Not Presently Funded						-
Home Health Care	Not Ranked	Not Presently Funded				Not Presently Funded						-
Hospice	Not Ranked	Not Presently Funded				Not Presently Funded						-
Medical Case Management (Incl. Treatment Adherence)	5	$ 991,565	743	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	50773	$ 1,095,443.00	10%	1592	114%	64554	27%	$16.97
Medical Nutrition Therapy	16	$ 16,660	75	1 unit - 1 Medical Nutritional Therapy face-to-face encounter	666	$ 3,037.00	-82%	25	-67%	61	-91%	$49.79
Mental Health Services	7	$ 399,764	551	1 unit = 1 face to face or other encounter	6571	$ 464,789.00	16%	488	-11%	9221	40%	$50.41
Oral Health Care	4	$ 383,119	463	1 unit = 1 visit or vendor dollar	135454	$ 276,794.00	-28%	365	-21%	156868	16%	$1.76
Outpatient/ Ambulatory Health Services	1	$ 442,406	893	1 unit = 1 visit or vendor dollar	61239	$ 387,791.00	-12%	1339	50%	61313	0%	$6.32
Substance Abuse Outpatient Care	11	$ 201,661	190	1 unit = 1 face to face or other encounter	5618	$ 159,661.00	-21%	146	-23%	5899	5%	$27.07
CORE MEDICAL TOTAL		$ 2,455,715.00				$ 2,397,747.00						
Support Services												
Child Care Services	14	$ 30,931	12	1 unit = 1 Vendor Child Care Dollar	28119	$ 20,000.00	-35%	9	-25%	18433	-34%	$1.09
Emergency Financial Assistance	15	$ 65,447	151	1 unit = 1 Vendor Paid Other Critical Need	59497	$ 84,383.00	29%	144	-5%	76925	29%	$1.10
Food Bank/ Home Delivered Meals	14	Funded by Part B Only				Funded by Part B Only						-

Attachment A: Service Category Plan Table

Health Education/ Risk Reduction	17	$ 11,334	25	1 unit = 1 face to face or other encounter	453	$ 11,334.00		82	228%	303	-33%	$37.41
Housing	13	$ 21,861	31	1 unit = 1 Vendor paid lodging dollar	19874	$ 9,957.00	-54%	14	-55%	9052	-54%	$1.10
Legal Servies (Other Professional Services)	Not Ranked	Not Presently Funded				Not Presently Funded						-
Linguistics Services	Not Ranked	Not Presently Funded				Not Presently Funded						-
Medical Transportation	10	$ 85,736	301	1 unit = 1 One-Way trip or Vendor transportation dollar	62815	$ 101,898.00	19%	426	42%	82000	31%	$1.24
Non-Medical Case Management Services	6	$ 54,582	49	1 unit = 1 Benefits Counseling face to face or other encounter	2183	$ 45,082.00	-17%	132	169%	2837	30%	$15.89
Outreach Services	18	$ 17,506	75	1 unit = 1 face to face or other encounter	700	$ 14,980.00	-14%	19	-75%	685	-2%	$21.87
Outreach Services MAI	19	Funded by Part B Only				Funded by Part B Only						
Permanency Planning	Not Ranked	Not Funded with Part A Funds				Not Funded with Part A Funds						-
Psychosocial Support	Not Ranked	Not Funded with Part A Funds				Not Funded with Part A Funds						-
Referral For Health Care Supportive Services	Not Ranked	Not Presently Funded				Not Presently Funded						-
Rehabilitation Services	Not Ranked	Not Presently Funded				Not Presently Funded						-
Respite Care	Not Ranked	Not Presently Funded				Not Presently Funded						-
Substance Abuse-residential	12	$ 63,408	21	1 unit = 1 Detox Hour	9501	$ 58,408.00	-8%	19	-10%	9672	2%	$6.04
SUPPORT SERVICES TOTAL		$ 350,805.00				$ 346,042.00						
GRAND TOTAL		$ 2,806,520.00				$ 2,743,789.00						

FY 2022 PART A Allocations		
	Core Medical Services	**Support Services**
FY 2022 Percentages	87.50%	12.50%

FY 2022 PART A Expenditures		
	Core Medical Services	**Support Services**
FY 2022 Percentages	87.39%	12.61%

FY 2022 PART A + MAI Allocations		
	Core Medical Services	**Support Services**
FY 2022 Percentages	88.27%	11.73%

FY 2022 PART A + MAI Expenditures		
	Core Medical Services	**Support Services**
FY 2022 Percentages	88.18%	11.82%

Part A Service Category	Comments
AIDS Drug Assistance Program (ADAP) Treatment	Not funded with Part A Funds
AIDS Pharmaceutical Assistance (LPAP)	Not funded with Part A Funds
Early Intervention Services	Not funded with Part A Funds
Health Insurance Premium & Cost Sharing Assistance	The TGA expended less funds in this service category than anticipated.
Home & Community Based Health Service	Not funded with Part A Funds
Home Health Care	Not funded with Part A Funds
Hospice	Not funded with Part A Funds
Medical Case Management (Incl. Treatment Adherence)	This service category is the gateway to Ryan White services. Additional funds were allocated to meet the service demand.
Medical Nutrition Therapy	The service provider experienced a staffing shortage which resulted in fewer clients receiving services until a nutritionist was hired.
Mental Health Services	Although fewer clients were served than anticipated, additional funds were allocated to meet the service demand of those receiving mental health services.
Oral Health Care	Although there were decreases in expenditures and unduplicated clients, units of services increased indicating clients experienced greater dental needs.
Outpatient/ Ambulatory Health Services	This service category was 12% overspent, the TGA served 50% more unduplicated clients. All of the other categories are to support clients keeping their ambulatory care appointments.
Substance Abuse Outpatient Care	While there were decreases in expenditures and the number of unduplicated clients, there was a 5% increase in the unit of service provided.
Child Care Services	With the initiation of tele-health services, fewer clients were in need of child care services.
Emergency Financial Assistance	Despite a decrease in unduplicated clients, EFA expenditures and units of service provided exceeded the projected allocations.
Food Bank/ Home Delivered Meals	Not funded with Part A Funds

Health Education/ Risk Reduction	Health Education/Risk Reduction expenditures were on target with anticipated allocations despite a 228% increase in the number of unduplicated clients.
Housing	There were decreases in expenditures, units of services and the number of unduplicated clients.
Linguistics Services	Not funded with Part A Funds
Medical Transportation	Transportation expenditures increased 19% while unduplicated clients increased 42%. Transportation continues to be a reported barrier for clients.
Non-Medical Case Management Services	Despite Non-Medical Case Management (NMCM) services underspending in anticipated allocations at year-end, NMCM exceeded projections in unduplicated clients and units of service.
Other Professional Services	Not funded with Part A Funds
Outreach Services	Not funded with Part A Funds
Psychosocial Support	Not presently funded with Part A Funds
Referral For Health Care Supportive Services	Not funded with Part A Funds
Rehabilitation Services	Not funded with Part A Funds
Respite Care	Not funded with Part A Funds
Substance Abuse-residential	Residential Substance Abuse services slightly under performed in expenditures and unduplicated clients however there was an increase in units of service provided.

Attachment A: Service Category Plan Table

Recipient Name:
Grant Number: H89HAXXXXX

MAI Service Category Plan Table

Service Categories	FY 2022 Estimated						FY 2022 Actual						
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Subpop(s) of Focus	Expended Amount	Variance %	Unduplicated Clients	Variance%	Service Units	Variance %	Average Cost per Service Unit
Core Medical Services													
Medical Case Management (Incl. Treatment Adherence)	5	$ 135,112	443	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	23469	Black/African American	$ 125,920	-7%	429	-3%	13933	-41%	$9.04
Medical Case Management (Incl. Treatment Adherence)	5	$ 37,777	200	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	3929	Hispanic/Latino	$ 43,229	14%	156	-22%	5379	37%	$8.04
Medical Case Management (Incl. Treatment Adherence)	5	$ 5,355	43	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	454	Asian	$ 7,049	32%	47	9%	593	31%	$11.89
Medical Case Management (Incl. Treatment Adherence)	5	$ 5,040	21	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	840	American Indian/Alaskan Native	$ 5,814	15%	22	5%	699	-17%	$8.32
Medical Case Management (Incl. Treatment Adherence)	5	$ 833	8	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	491	Native Hawaiian/ Pacific Islander	$ 2,104	153%	12	50%	132	-73%	$15.94
CORE MEDICAL TOTAL		$ 184,117					$ 184,117						
Support Services													
SUPPORT SERVICES TOTAL		$ -					$ -						
GRAND TOTAL		$ 184,117.0					$ 184,117						

FY 2022 MAI Allocations		
	Core Medical Services	**Support Services**
FY 2022 Percentages	100.00%	

FY 2022 MAI Expenditures		
	Core Medical Services	**Support Services**
FY 2022 Percentages	100.00%	

Attachment A: Service Category Plan Table

MAI Service Category	Comments
MAI Medical Case Management Black/African American Men, Women and Youth	This service category is the gateway to Ryan White services. There was a decrease in expenditures, units of service and unduplicated Black/African American clients.
MAI Medical Case Management Hispanic/Latinx Men, Women and Youth	This service category is the gateway to Ryan White services. Although there was a a decrease in the number of unduplicated clients, expenditures and units of service increased for Hispanic/Latinx clients.
MAI Medical Case Management Asian Men, Women and Youth	This service category is the gateway to Ryan White services. There was an increase in unduplicated Asian clients, units of services and expenditures during the reporting period.
MAI Medical Case Management American Indian/Alaskan Native Men, Women and Youth	This service category is the gateway to Ryan White services. Despite a decrease in the units of servies, there was an inrease in expenditures and unduplicated Amerian Indian/Alaskan Native clients.
MAI Medical Case Management Native Hawaiian/Pacific Islander Men, Women and Youth	This service category is the gateway to Ryan White services. Despite a decrease in the units of servies, there was an inrease in expenditures and unduplicated Native Hawaiian/Pacific Islander clients.

Attachment B

FY 22 Care Continuum

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Diagnosis-Based HIV Care Continuum Services Table					
Indicate surveillance data source as local, jurisdictional or CDC. Data source should remain the same for each year in the 3-year grant cycle. Client level data is not an acceptable source of surveillance data.	**Jurisdictional - California State Office of AIDS**				
Stages of the HIV Care Continuum					
I. Diagnosed: Percentage of persons aged ≥13 years with HIV infection who know their serostatus.					
Goal	Prevent new HIV infections.	**Objective**	By 2025, increase the percentage of people with HIV infection who know their serostatus to at least 95 percent. (Source: HNSP, Indicator 1***)		
FY 2022 Baseline					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. Data Source: NHSS 202012 (Reference Source: Vol 31*).	151		**Denominator:** Number of persons aged ≥13 years with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year. ****	151	100%
FY 2022 Actual				Percentage Change from Baseline to Actual	**#VALUE!**
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. Data Source: NHSS 202012 (Reference Source: Vol 31*).	N/A		**Denominator:** Number of persons aged ≥13 years with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year. ****	N/A	#VALUE!
Comments for any stage with percentage change less than 1% or greater than 6%:	Sacramento Ryan White funds do not support Testing and therefore cannot report "Diagnosed" within the Ryan White system.				
II. Receipt of Care: Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.					
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).		
FY 2022 Baseline					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	3913		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	4793	82%
FY 2022 Actual				Percentage Change from Baseline to Actual	**18%**
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	2315		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	2315	100%
Comments for any stage with percentage change less than 1% or greater than 6%:	Extensive work was done by subrecipients to make sure the information was put into our database to ensure data was obtained and recorded.				

III. Retained in Care: Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.					
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).		
FY 2022 Baseline					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	2668		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	4793	56%
FY 2022 Actual			Percentage Change from Baseline to Actual		**-11%**
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	1030		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	2315	44%
Comments for any stage with percentage change less than 1% or greater than 6%:	As we have expressed to our Project Officers, healthy people only go to their doctor once a year and labs are ordered once as well. It hard to achieve this objective as a result.				
IV. Viral Suppression: Percentage of persons with diagnosed HIV infection whose most recent HIV viral load test in the past 12 months showed that HIV viral load was suppressed.					
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).		
FY 2022 Baseline					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200 copies/mL at the most recent viral load test. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	3913		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	4793	82%
FY 2022 Actual			Percentage Change from Baseline to Actual		**3%**
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200 copies/mL at the most recent viral load test. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	1948		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	2315	84%
Comments for any stage with percentage change less than 1% or greater than 6%:	We exceeded this goal				

V. Linkage to Care: Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.					
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with newly diagnosed HIV infection who are linked to HIV medical care within one month of diagnosis to at least 95%. (Source: NHSP, Indicator 5***).		
FY 2022 Baseline					
Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	131		**Denominator:** Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.	151	87%
FY 2022 Actual			Percentage Change from Baseline to Actual		**-49%**
Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	82		**Denominator:** Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.	219	37%
Comments for any stage with percentage change less than 1% or greater than 6%:	We have consistantly been working on data integrity issues with our subrecipients and our IT department to achieve this goal.				

Numerator and Denominator Definitions Sources:

*2018 Updated Edition: Volume 31, Diagnoses of HIV Infection in the United States and Dependent Areas, 2018
**Volume 25, Number 2: Monitoring Selected HIV Prevention and Care Objectives using Surveillance Data, United States and 6 Dependent Areas, 2018
***HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States 2021-2025, 2021
****The Diagnosed stage measures the percentage of the total number of people with HIV whose infection has been diagnosed. To determine this percentage, the denominator for the Diagnosed

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Attachment C

FY 22 WICY Report

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Attachment C: FY22 WICY Report

FY2022 PART A WICY EXPENDITURES REPORT

Section A: Identifying Information	FY 2022 TOTAL Service Expenditures	$ 2,927,906.00
County of Sacramento		
Grant Number: H89HA00048		

Section B: Percent of HIV/AIDS Cases in the EMA/TGA	Note: *In some cases the below cells will automatically convert the percentage based upon the numbers entered. Therefore, if the percent of estimated living HIV/AIDS cases for children in your EMA/TGA is 0.02%, you must input the number as .0002 so when the cell converts it, it becomes 0.02%.*							
CDC Data Percentage (insert based on applicable percentages on CDC data tab)	Women:	15.95%	Infants:	0.00%	Children:	0.04%	Youth	2.37%
Total Part A Funds Used to Provide Services in FY 2022:	#1. Amount	#2. Percent	#3. Amount	#4. Percent	#5. Amount	#6. Percent	#7. Amount	#8. Percent
	$656,626.00	**22.43%**	**$50.00**	**0.00%**	**$4,317.00**	**0.15%**	**$128,793.00**	**4.40%**
Are you requesting a WICY Waiver? (select "**yes**" or "**no**" in the dropdown menu in cell B13):	No							

Section C: WICY Waiver Expenditures FY 2022 *(If you have Part A Expenditures less than the Percent of HIV/AIDS Cases in the EMA/TGA for any WICY Population, complete the Expenditure information below. This information will serve as the justification for the Waiver)*	**Use CDC Data from Calendar Year 2021 for FY 2022 Reporting of WICY Expenditure Report**							
Total Part B Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Total Part C Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Total Part D Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Total Medicaid Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Total Medicare Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Total CHIP Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Other Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Other Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Other Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Other Funds Used to Provide Services in FY 2022:	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%
Total	$ -	0.00%	$ -	0.00%	$ -	0.00%	$ -	0.00%

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Attachment D

FY22 Client Demographic Reports

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County of Sacramento
Department of Health Services
Public Health

Clients by CD4 Report

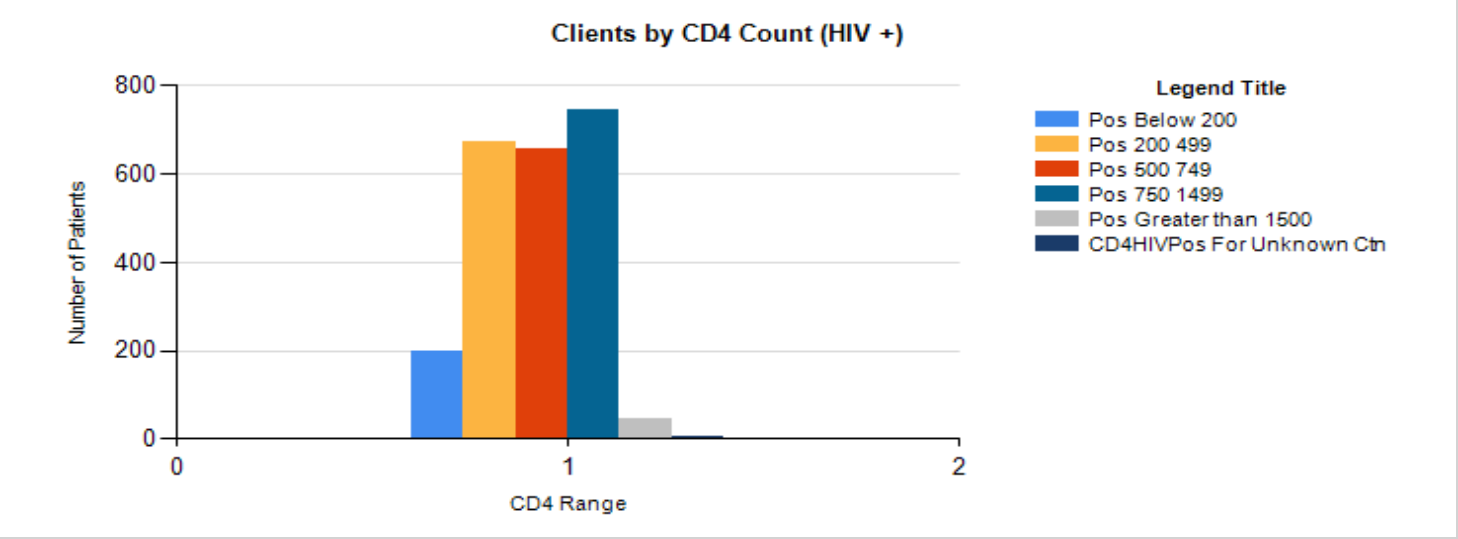
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Numeric Analysis	CD4 Range	Number of Clients HIV+	Number of Clients HIV-	Percentage HIV+
	Below 200	198	0	8.55%
	200 - 499	671	0	28.98%
	500 - 749	655	0	28.29%
	750 - 1499	745	0	32.18%
	Greather than 1500	45	0	1.94%
	Unknown/Unreported	1	0	0.04%
	Group Total	**2,315**	**0**	**99.98%**
	Total Clients	**2315**		**99.98%**

Visual Analysis:



This report is a summary of client counts by age group (ie. clients who had service details within a specific date range)

County of Sacramento
Department of Health Services
Public Health

Clients by Viral Load Report

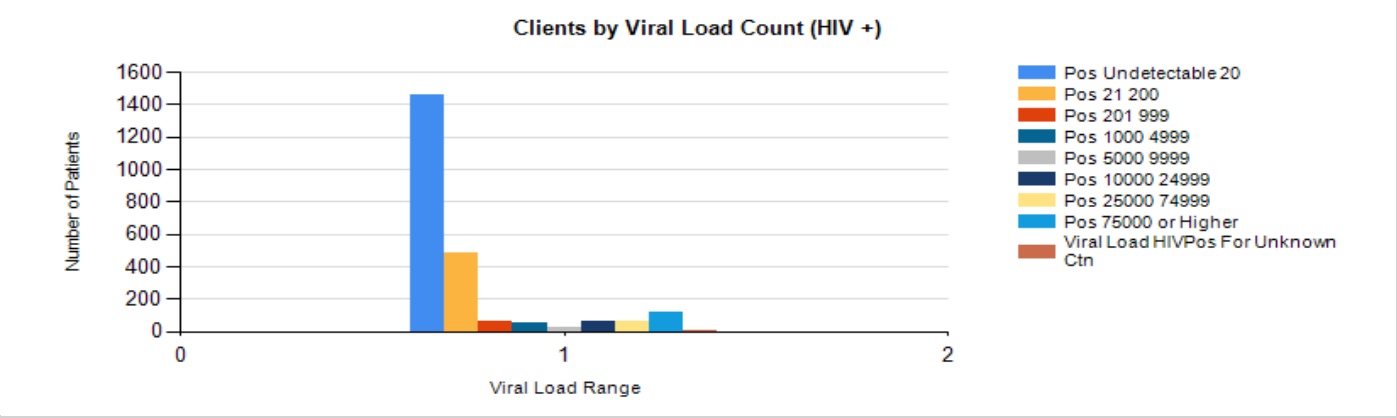
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Numeric Analysis	CD4 Range	Number of Clients HIV+	Number of Clients HIV-	Percentage HIV+
	Unknown/Unreported	2	0	0.09%
	<= 20 (Undetectable)	1,457	0	62.94%
	21 - 200 (Virally suppressed <=200)	484	0	20.91%
	201 - 999	64	0	2.76%
	1,000 - 4,999	51	0	2.20%
	5,000 - 9,999	24	0	1.04%
	10,000 - 24,999	58	0	2.51%
	25,000 - 74,999	59	0	2.55%
	75,000 or Higher	116	0	5.01%
	Group Total	**2,315**	**0**	**100.00%**
	Total Clients	**2315**		**100.00%**

Visual Analysis:



This report is a summary of client counts by age group (ie. clients who had service details within a specific date range)

County of Sacramento
Department of Health Services
Public Health

Clients by County Report

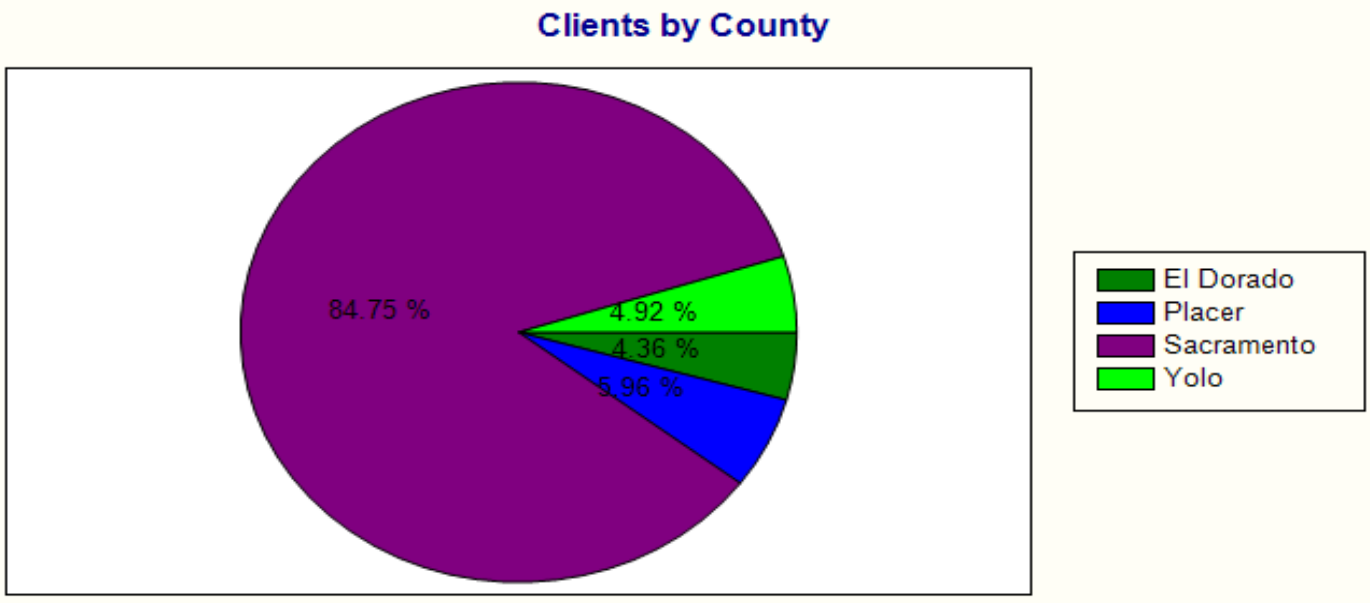
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Numeric Analysis	County	Number of Clients	Percentage
	El Dorado	101	4.36%
	Placer	138	5.96%
	Sacramento	1,962	84.75%
	Yolo	114	4.92%
	Total Clients	2,315	99.99%

Visual Analysis:



This report is a distinct count of clients for each county who had services details within the specified date range.

County of Sacramento
Department of Health Services
Public Health

Clients by Age Report

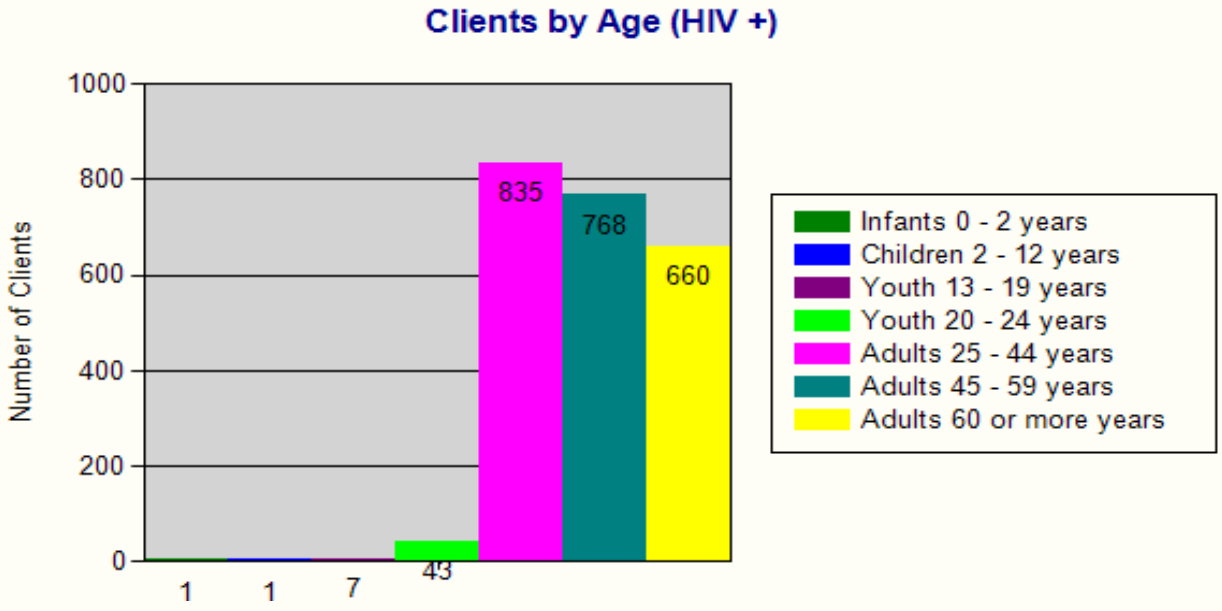
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Numeric Analysis	Age Category	Number of Clients HIV+	Number of Clients HIV-	Percentage HIV+	Percentage HIV-
	Infants 0 - 2 years	1	0	0.04%	0.00%
	Children 3 - 12 years	1	0	0.04%	0.00%
	Youth 13 - 19 years	7	0	0.30%	0.00%
	Youth 20 - 24 years	43	0	1.86%	0.00%
	Adults 25 - 44 years	835	0	36.07%	0.00%
	Adults 45 - 59 years	768	0	33.17%	0.00%
	Adults 60 or more years	660	0	28.51%	0.00%
	Group Total	2,315	0	99.99%	0.00%
	Total Clients	2315		99.99%	

Visual Analysis:



This report is a summary of client counts by age group (ie. clients who had service details within a specific date range)

County of Sacramento
Department of Health Services
Public Health

Clients by Gender Report

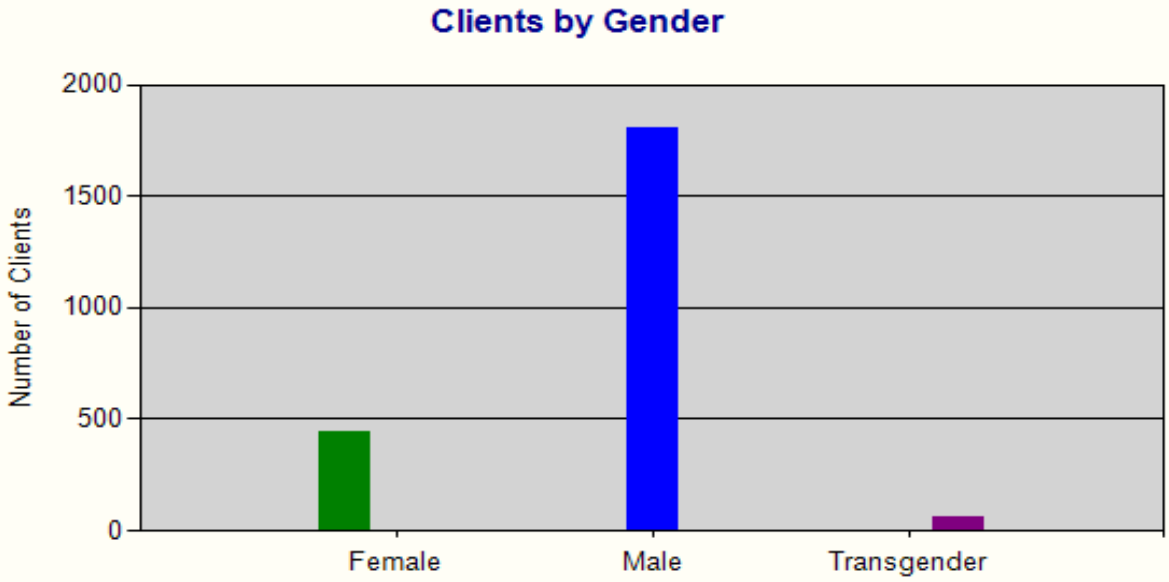
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Numeric Analysis	Age Category	Number of Clients	Percentage
	Female	446	19.27%
	Male	1,807	78.06%
	Transgender	62	2.68%
	Total Clients	2,315	100.01%

Visual Analysis:



This report is a distinct count of clients for each gender who had services details within the specified date range.

County of Sacramento
Department of Health Services
Public Health

Clients by Transmission Method Report

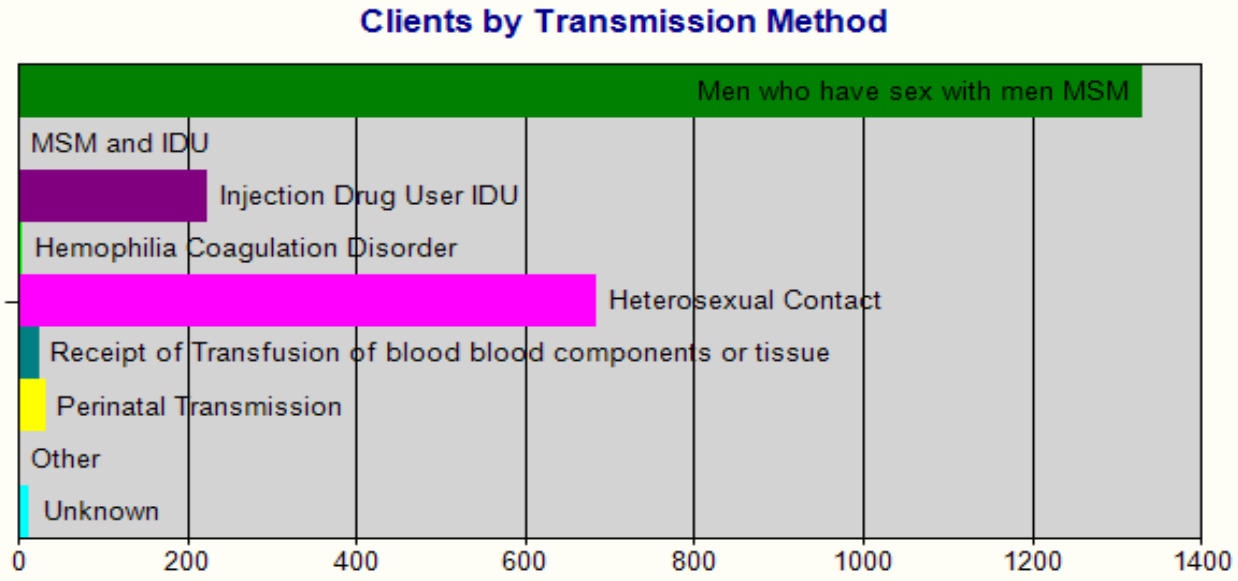
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Numeric Analysis	Transmission Method	Number of Clients	Percentage
	Men who have sex with men (MSM)	1,331	57.49%
	Injection Drug Use (IDU)	224	9.68%
	MSM and IDU	0	0.00%
	Hemophilia/Coagulation disorder	6	0.26%
	Heterosexual contact	684	29.55%
	Receipt of blood transfusion, blood components, or tissue	25	1.08%
	Perinatal transmission	32	1.38%
	Other	0	0.00%
	Undetermined/Unknown/Risk not reported or identified	13	0.56%
	Total Clients	2,315	100.00%

Visual Analysis:



This report gives a count of clients for each transmission method (who had service details for the passed period)

County of Sacramento
Department of Health Services
Public Health

Income By Persons in Household Report

DHS - CARE System
Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2022 To February, 2023
Using US Poverty Guidelines from 2022

Persons in Household	No Income			100% of Poverty			101-138% of Poverty			139-250% of Poverty			251-300% of Poverty			Over 300%		
	Guide	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct
1	0	560	24.19%	$13,590	548	23.67%	$18,754	273	11.79%	$33,975	228	9.85%	$40,770	182	7.86%	$40,771	121	5.23%
2	0	36	1.56%	$18,310	75	3.24%	$25,268	40	1.73%	$45,775	34	1.47%	$54,930	27	1.17%	$54,931	29	1.25%
3	0	15	0.65%	$23,030	30	1.30%	$31,781	10	0.43%	$57,575	8	0.35%	$69,090	11	0.48%	$69,091	3	0.13%
4	0	7	0.30%	$27,750	11	0.48%	$38,295	11	0.48%	$69,375	11	0.48%	$83,250	4	0.17%	$83,251	4	0.17%
5	0	2	0.09%	$32,470	8	0.35%	$44,809	2	0.09%	$81,175	5	0.22%	$97,410	4	0.17%	$97,411	0	0.00%
6	0	3	0.13%	$37,190	7	0.30%	$51,322	1	0.04%	$92,975	2	0.09%	$111,570	0	0.00%	$111,571	1	0.04%
7	0	0	0.00%	$41,910	0	0.00%	$57,836	0	0.00%	$104,775	0	0.00%	$125,730	0	0.00%	$125,731	0	0.00%
8	0	0	0.00%	$46,630	2	0.09%	$64,349	0	0.00%	$116,575	0	0.00%	$139,890	0	0.00%	$139,891	0	0.00%
Total		623	26.91%		681	29.42%		337	14.56%		288	12.44%		228	9.85%		158	6.83%

Total Clients 2,315

Returns a result set of client counts by income level and number of persons in household. Client counts include only those clients with

County of Sacramento
Department of Health Services
Public Health

Clients by Ethnicity Report

DHS - CARE System
Client Demographic Reports

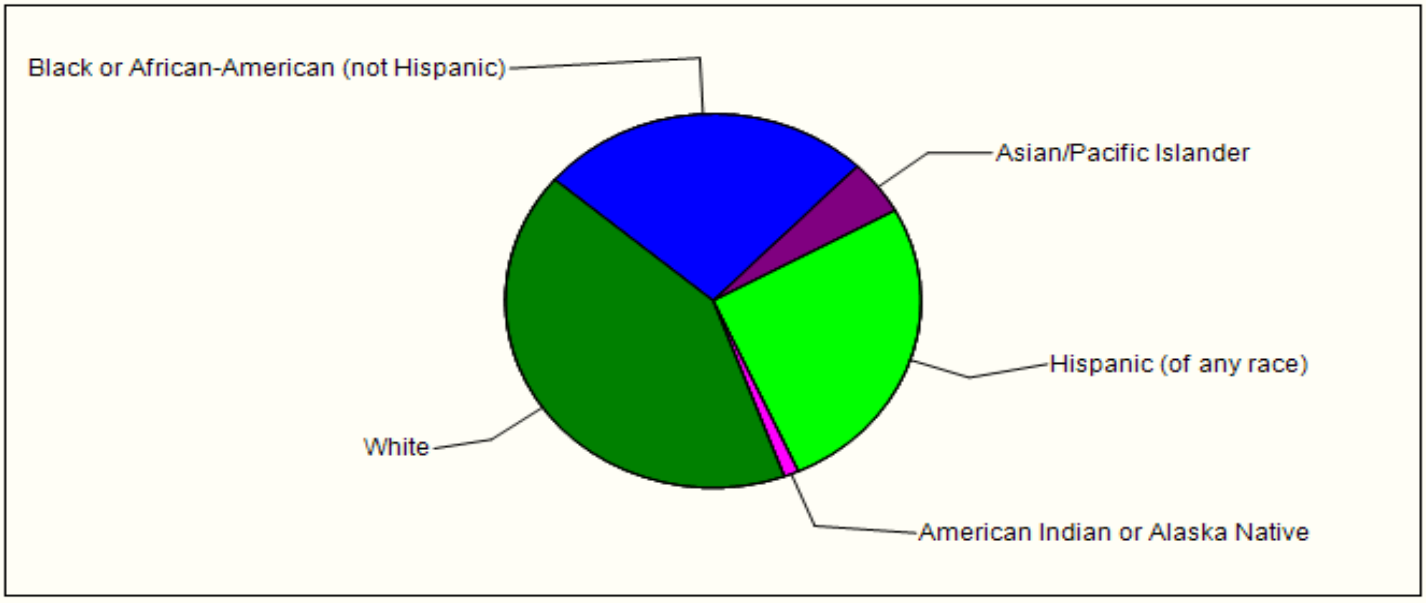
Selection Criteria: Reporting on Dates From March, 2022 To February, 2023

Ethnicity	Number of Clients	Percentage of Current Clients	Percentage of AIDS Prevalence	Percentage of HIV & AIDS	Percentage of General Population
White	967	41.77%	50.50%	48.30%	51.90%
Black or African-American (not Hispanic)	602	26.00%	23.70%	22.70%	7.50%
Asian/Pacific Islander	110	4.75%	3.30%	4.10%	13.00%
Hispanic (of any race)	609	26.31%	18.90%	20.70%	22.80%
American Indian or Alaska Native	27	1.17%	0.40%	0.40%	0.40%
Total Clients	2,315	100.00%	96.80%	96.20%	95.60%

*AIDS and HIV Prevalence rates for Native Hawaiian/Pacific Islander are included in the Asian prevalence figures.

**Percentage of AIDS Prevalence and Percentage of HIV/AIDS Prevalence does not total 100%. The race categories above are the required categories for the Ryan White Services Report. Whereas, the State Epidemiological information includes Multi-Race and Unspecified/Other which account for the remaining percentages.

Visual Analysis:



This report calculates ethnicity totals based on both race (tblClients.lngRaceID) and hispanic distribution (tblClients.strHispanicDist). Client counts include those clients who had service detail records in the specified date range.

Attachment E

FY22 Performance Outcomes

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FY2022
Performance Outcomes

Please note that unless otherwise noted, the Performance Outcomes include all Ryan White clients served during the Fiscal Year regardless of funding sources.

CHILD CARE		**Total Clients: 9**
Performance Measure	**Indicator**	**Outcome**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	1. 3/9, 33.3%
	Quality of Care	
1. Standards of Care for Child Care are met.	1. 100% of child care providers will comply with child care service standards. *(site visit)*	1. 100%
2. Awareness of child care services.	2. 75% of clients with children under 15 living in the home will be made aware of available child care resources funded by Ryan White. *(client satisfaction survey)*	2. Overall 67.5% of the clients stated the question was not applicable; however 17 clients (12.5%) stated child care was made available to them.
3. Child care for HIV-related service appointments.	3. 100% of clients surveyed who requested child care services for medical or support service appointments will have referrals or financial assistance made available, as funding is available. *(postcard survey)*	3. Only one response which stated Not Applicable.

EMERGENCY FINANCIAL ASSISTANCE		**Total Clients 147**
Performance Measure	**Indicator**	**Outcome**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	1. 48/147, 32.65%
	Quality	
1. Adherence to Standards of Care for Direct Emergency Assistance.	1. 100% of providers will comply with applicable Emergency Financial Assistance service standards. *(site visit)*	1. 100%

FOOD BANK/HOME DELIVERED MEALS		**Total Clients: 265**
Performance Measure	**Indicator**	
1. HAB Core Measure: HIV Viral Load Suppression.	1. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	1. 222/265, 83.77%
	Quality	
1. Standards of Care for Food Bank/Home Delivered Meals are met.	1. 100% of providers offering Food Bank/Home Delivered Meals will comply with Food and Nutrition service standards. *(site visit)*	1. 96.6%
2. Improved Management of HIV/AIDS	2. 60% of clients receiving Food Bank/Home Delivered Meal services will report that these services have allowed them to better manage living with HIV/AIDS. *(postcard survey)*	2. 14/14, 100%
3. Improved Quality of Life	3. 60% of clients receiving Food Bank/Home Delivered Meal services will report improved quality of life. *(postcard survey)*	3. 11/14, 79%
4. Improved Medical Status	4. 60% of clients receiving Food Bank/Home Delivered Meal services will report improved ability to remain in medical care. *(postcard survey)*	4. 13/14, 92.9%

HEALTH EDUCATION AND RISK REDUCTION		**Total Clients: 235**
Performance Measure	**Indicator**	**Outcome**
1. HAB Systems-Level Measures: Linkage to HIV Medical Care	1. Number/Percentage of newly diagnosed HIV+ persons linked to care within 30 days of their HIV+ diagnosis.	1. 28/43 65.12%
	Quality	
1. Standards of Care for Health Education and Risk Reduction are met.	1. 100% of Health Education and Risk Reduction (PS) providers will comply with Health Education and Risk Reduction service standards. *(site visit)*	1. 100%

HEALTH INSURANCE PREMIUM AND COST-SHARING ASSISTANCE		**Total Clients: 11**
Performance Measure	**Indicator**	
1. HAB Core Measure: HIV Viral Load Suppression.	1. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	1. 9/11, 81.82%
Quality		
1. Standards of Care for Health Insurance Premium and Cost-Sharing Assistance are met.	1. 100% of Health Insurance Premium and Cost-Sharing Assistance providers will comply with Health Insurance Premium and Cost-Sharing Assistance service standards. *(site visit)*	1. 95.7%
2. Linkage documentation.	2. 100% of all referrals and linkages to services for HIV+ clients receiving Health Insurance Premium and Cost-Sharing Assistance services shall be documented.	2. 100%
3. Health care referrals.	3. 100% of HIV+ clients who do not have an identified primary care provider will receive a referral to an appropriate physician or clinic. *(chart review)*	3. 95.7%
4. Payment processing.	4. 100% of clients who received Health Insurance Premium and Cost Sharing Assistance will indicate payments had been processed and approved for medical co-payments and/or health insurance premiums. (chart review)	4. 100%

HOUSING		**Total Clients: 22**
Performance Measure	**Indicator**	**Outcome**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1. 10/22, 45.45%
Quality		
1. Standards of Care for Housing are met.	1. 100% of providers will comply with applicable Housing Assistance service standards. *(site visit)*	1. 98.5%
2. Improved or stable housing.	2. 60% of all clients surveyed who received housing assistance will report improved or stable housing. *(postcard survey)*	2. 3/8, 33.3% One client responded not applicable.
3. Improved quality of life.	3. 60% of clients surveyed who received housing assistance will report improvements in or maintenance of their general health status and/or quality of life. *(postcard survey)*	3. 8/9, 88.9%

MEDICAL CASE MANAGEMENT including PEDIATRIC TREATMENT ADHERENCE		**Total Clients: 1,592**
Performance Measure	**Indicator**	**Outcome**
Medical Case Management: 1. HAB MCM Measure: Medical Case Management: Care Plan.	1. 95% of clients will have a care plan developed based upon assessment. *(chart review)*	1. 94.75%
2. HHS Measure: Retention in HIV Medical Care.	2. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	2. 416/1592, 26.13%
3. HAB Core Measure: HIV Viral Load Suppression.	3. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	3. 1161/1592, 72.93%
4. HHS Measure: Housing Status.	4. Number/Percent of Ryan White clients stably/permanently housing.	4. 1225/1592, 76.95%
Pediatric Treatment Adherence: 1. HHS Measure: Retention in HIV Medical Care.	**Pediatric Treatment Adherence** 1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year. *(year-end report)*	1. 8/10, 80%
2. HAB Core Measure: Prescription of HIV Antiretroviral Therapy.	2. Number/Percentage of HIV+ patients, regardless of age, prescribed HIV antiretroviral therapy. *(year-end report)*	2. At year end: 10/10, 100%. Some clients transitioned to adult services.
3. HAB Core Measure: HIV Viral Load Suppression.	3. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year. *(year-end report)*	3. 9/10, 90%
Continued on next page		

MEDICAL CASE MANAGEMENT including PEDIATRIC TREATMENT ADHERENCE Continued:		
Quality of Care		
Medical Case Management: 1. Standards of Care for medical case management are met.	**Medical Case Management:** 1. 95% of medical case management charts reviewed will comply with Medical Case Management service standards. *(site visit)*	1. 91.6%
2. Acuity Scale is used as client assessment tool.	2. 95% of clients will be assessed using an acuity scale. *(chart review)*	2. 94.5%
3. Care Plan Development.	3. 95% of clients will have a care plan developed based upon assessment. *(chart review)*	3. 94.75%
4. Maintenance or improvement of health status and quality of life.	4a. 60% of clients surveyed who received medical case management services will report adherence to their anti-retroviral drug treatment plans. *(postcard survey)* 4b. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic. *(chart review)*	4a. 95/101, 94.1% 4b. 100%
Pediatric Treatment Adherence: 1. 1. Accurate antiretroviral agents for HIV dispensed.	**Pediatric Treatment Adherence:** 1. 100% of Medication Adherence (Pediatric) providers will dispense medications (including prescriptions for antiretroviral agents for HIV) according to PHS Pediatric HIV Treatment guidelines. *(site visit)*	1. 100%
2. Medication dispensation.	2. 100% of pediatric clients will receive their needed medication within 48 hours.	2. 10/10, 100%
3. Assessed for sensitivities, resistance, and side effects	3. 100% of clients receiving treatment adherence services will be assessed for sensitivities, resistance, and side effects at least once every six months by a registered nurse AND a pharmacist. *(chart review)*	3. 100%
4. Medication Adherence.	4. 75% of clients receiving treatment adherence services will adhere to medication program. *(year-end outcomes from UCD)*	4. 90%
5. Improved health indicators.	5. 70% of pediatric clients receiving treatment adherence services will show improved health indicators. *(chart review)*	5. 50% have improved over the past reporting period.
6. Adherence counseling.	6. 85% of pediatric clients will receive HIV medication adherence counseling at least twice in a 6 month period. *(database)*	6. 100%

MEDICAL NUTRITIONAL THERAPY 66111\4		**Total Clients: 66**
Performance Measure	**Indicator**	
1. HAB Core Measure: HIV Viral Load Suppression.	1. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	1. 57/66, 86.36%
Quality		
1. Standards of Care for Medical Nutritional Therapy are met.	1. 100% of Medical Nutritional Therapy providers will comply with Medical Nutritional Therapy service standards. *(site visit)*	1. 100%
2. Individualized nutritional plans.	2. 100% of clients receiving medical nutritional therapy will have an individualized nutritional plan developed within 60 days of assessment by the licensed registered dietitian. (chart review)	2. 100%

MEDICAL TRANSPORTATION		**Total Clients: 525**
Performance Measure	**Indicator**	
1. HAB Systems-Level Measures: Linkage to HIV Medical Care	1. Number/Percentage of newly diagnosed HIV+ persons linked to care within 30 days of their HIV+ diagnosis.	1. 12/22, 54.55%
2. HHS Measure: Retention in HIV Medical Care.	2. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	2. 171/525, 32.57%
Quality		
1. Standards of Care for Medical Transportation are met.	1. 100% of Transportation providers will comply with Medical Transportation service standards. *(site visit)*	1. 98.5%
2. Availability of medical transportation services.	2. 75% of clients surveyed who showed evidence of need for medical transportation services will receive medical transportation for HIV/AIDS-related care appointments. *(postcard survey)*	2. 15/20, 75% report they "always" receive services.

MENTAL HEALTH THERAPY		**Total Clients: 501**
Performance Measure	**Indicator**	**Outcomes**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1. 170/501, 33.93%
Quality of Care		
1. Standards of Care for Mental Health Therapy are met.	1. 100% of mental health providers will comply with Mental Health service standards. *(site visit)*	1. 95.6%
2. Health Care Referrals	2. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic. *(chart review)*	2. 100%
3. Decreased mental health symptoms.	3. 60% percent of clients who receive Mental Health services will report a decrease in symptoms that initiated referral into mental health services. *(postcard survey)*	3. 9/10, 90%
4. Improved functionality.	4. 60% of clients surveyed who received mental health counseling will report improved functionality. *(postcard survey)*	4. 10/10, 100%

NON-MEDICAL CASE MANAGEMENT		**Total Clients: 1,158**
Performance Measure	**Indicator**	**Outcome**
1. HAB Core Measure: Prescription of HIV Antiretroviral Therapy.	1. Number/Percentage of HIV+ patients, regardless of age, prescribed HIV antiretroviral therapy.	1. 1051//1158, 90.76%
2. HAB Core Measure: HIV Viral Load Suppression.	2. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	2. 894/1158, 77.2%
Quality of Care		
1. Standards of Care for Benefits and Enrollment Case Management are met.	1. 90% of Benefits and Enrollment Case Management charts reviewed will comply with Case Management (non-medical) service standards. *(site visit)*	1. 14.7%
2. Benefits and Enrollment assistance.	2. 95% of people requesting Benefits and Enrollment case management will receive advice and assistance in obtaining needed services. *(site visit)*	2. 100%
3. Referrals to non-Ryan White entitlement programs.	3. 95% of clients receiving Benefits and Enrollment case management services will be referred to all appropriate (non-Ryan White) entitlement programs to maximize benefits. *(site visit)*	3. 100%
4. Health care referrals.	4. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic. *(chart review)*	4. 100%
5. Improved quality of life.	5. 60% of clients surveyed who received Case Management (non-medical) services will report improved quality of life. *(postcard survey)*	5. 10/12, 83.3%
6. Follow-up	6. 100% of clients will receive case management (non-medical) follow-up. *(site visit)*	6. 100%

ORAL HEALTH CARE		**Total Clients: 634**
Performance Measure	**Indicator**	**Outcomes**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	1. 202/634, 31.86%
2. HAB Oral Care Measures: Oral Health Services: Dental Treatment Plan.	2. Number/Percent of clients receiving oral health care services will have a dental treatment plan. (Chart review)	2. 100%
Quality		
1. Adherence to Standards of Care for Dental Services.	1. 100% of dental care providers will comply with Oral Health Care service standards. *(site visit)*	1. 100%
2. Appropriate specialty care.	2. 100% of clients receiving specialty oral health services will receive appropriate dental care as determined by County authorization review. *(database)*	2. 100%
3. Improved oral health.	3. 60% of clients surveyed who received Oral Health Care will report improved oral health through self-report. *(postcard survey)*	3. 2/2, 100%

OUTPATIENT/AMBULATORY CARE		**Total Clients: 1,794**
Performance Measure	**Indicator**	**Outcomes**
1. Receipt of Care	1. Number/Percentage of HIV+ patients, regardless of age, with at least one CD4 or viral load test.	1. 1538/1794, 85.73%
2. HHS Measure: Retention in HIV Medical Care.	2. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	2. 428/1794, 23.86%
3. HAB Core Measure: Prescription of HIV Antiretroviral Therapy.	3. Number/Percentage of HIV+ patients, regardless of age, prescribed HIV antiretroviral therapy.	3. 1585/1794, 88.35%
4. HAB Core Measure: HIV Viral Load Suppression.	4. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	4. 1307/1794, 72.85%
5. HHS Measure: Housing Status.	5. Number/Percent of Ryan White outpatient/ambulatory care HIV+ clients stably/permanently housing.	5. 1275/1794, 71.07%
6. Minimize health disparities by ensuring access to primary medical care services by people of color.	6. Number/Percent of clients accessing primary medical care will be reflective of TGA's proportion of PLWH/A by race/ethnicity. *(database)*	6. See Note 1
7. Minimize health disparities by ensuring access to primary medical care services by women, infants, children and youth (WICY).	7. Number/Percent of clients accessing primary medical care will be reflective of TGA's proportion of WICY living with HIV/AIDS. *(database)* Number and percentage of persons with HIV viral suppression.	7. See note 2
Quality of Care		
1. Improved adherence to Public Health Service Guidelines for the treatment of people living with HIV/AIDS.	1. 100% of primary care services offered will meet PHS guidelines. *(site visit)*	100%
2. Mortality Rate Reduction.	2. Decreased or stable mortality rate for all HIV+ persons in routine outpatient/ambulatory care. *(database)*	2. FY22: 49 clients FY21: 25 clients 96% increase in FY22 over FY21.
3. Viral Load Suppression.	3. Number/Percentage of persons with HIV Viral Load Suppression will exceed National standards. (National Data: Viral Suppression 66% in 2019)	3. 1307/1794, 72.85%

Note 1: Black, Hispanic and people of color are over-represented in the Sacramento TGA as they exceed their percent of the HIV/AIDS Prevalence in the TGA.

Number/Percent of ambulatory care clients is reflective of TGA's proportion of PLWH/A by race/ethnicity.	Number of Ambulatory Care Clients	Percent of Ambulatory Care Clients	Percent of TGA's HIV/AIDS Prevalence as of 12/31/20
White	744	41.5%	46.5%
Black/African American	502	28.0%	22.0%
Hispanic	425	23.7%	21.3%
Asian/Pacific Islander	91	5.1%	3.9%
American Indian/Alaskan Native	32	1.8%	0.4%

Note 2: WICY Ambulatory Care expenditures in FY22 are 28.12% of the total Part A Ambulatory Care expenditures. ($104,662 out of $377,206). 8.61% over the TGA's WICY proportion established by CDC at 18.36%.

Number/Percent of ambulatory care clients is reflective of TGA's proportion of PLWH/A by WICY.	Number of Ambulatory Care WICY Clients	WICY Percent of All Ambulatory Care Clients	Percent of TGA's HIV/AIDS WICY Prevalence
Women	257/1794	14.3%	15.95%
Infants	0/1794	-	0%
Children	1/1794	0.06%	0.04%
Youth	29/1794	1.6%	2.37%

OUTREACH SERVICES See note below **Total Clients: 388**		
Performance Measure	**Indicator**	**Outcome**
1. HAB Systems-Level Measures: Linkage to HIV Medical Care	1. Number/Percentage of newly diagnosed HIV+ persons linked to care within 30 days of their HIV+ diagnosis.	1. 12/20, 60%
Quality		
1. Standards of Care for Outreach services are met.	1. 100% of outreach providers will comply with Outreach service standards. *(site visit)*	1. 97.9%
2. Outreach referrals	2. 100% of all referrals and linkages to services for HIV+ clients receiving Outreach services shall be documented.	2. 100%
3. Health care referrals.	3. 100% of HIV+ clients who do not have an identified primary care provider at initial contact will receive a referral to an appropriate physician or clinic. *(chart review)*	3. 100%

The outcome indicators above are for both MAI Outreach services and Non-MAI Outreach services as they are tracked by service and not by race.

SUBSTANCE ABUSE TREATMENT		**Total Clients: 165 (Residential 19; Outpatient: 146)**
Performance Measure	**Indicator**	**Outcomes**
	Health	
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1a. Outpatient: 52/146, 35.62% 1b. Residential: 6/19, 31.58%
2. HAB Core Measure: HIV Viral Load Suppression.	2. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	2a. Outpatient: 108/146, 73.97% 2b. Residential: 15/19, 78.95%
	Quality of Care	
1. Standards of Care for Substance Abuse Treatment are met.	1. 100% of substance abuse providers will deliver services according to Standards of Care. *(site visit)*	1. 100%
2. Residential Treatment Participation	2. 25% of clients entering residential substance abuse treatment will complete residential treatment program. (provider exit reports)	2. Although there were only 19 clients, these clients participated in residential/detox services 27 times during the fiscal year. Of the 27 attempts, 2 client outcomes are unknown. 15/25, 60% completed detox and/or residential services.
3. Health Care Referrals	3. 100% of clients who do not have an identified primary care provider will receive a referral to an appropriate physician or clinic upon completion of substance abuse treatment. *(database)*	3a. Outpatient: 100% 3b. Residential: 100%
4. Current care plan.	4. 80% of clients will have a current care plan in their files. (chart review)	4a. Outpatient: 100% 4b. Residential: 100%
5. Reduced risk behaviors.	5. a. 60% of clients surveyed who received outpatient substance abuse services will reduce risk behaviors for substance use as measured by self-report. *(postcard survey)* b. 60% of clients surveyed who received outpatient substance abuse services will reduce risk behaviors for transmission of HIV and other communicable diseases as measured by self-report. *(postcard survey)*	5a. 13/13, 100% 5b. No responses in FY22

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Attachment F

FY 22 Aggregate Administrative Costs

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RYAN WHITE HIV/AIDS PROGRAM PART A
FINAL CERTIFICATION OF AGGREGATE ADMINISTRATIVE EXPENDITURES

REPORTING PERIOD - March 1, 2022 – February 28, 2023

RECIPIENT	County of Sacramento
GRANT NUMBER	H89HA00048
AGGREGATE TOTAL OF ALL HIV SERVICE DOLLARS EXPENDED	$3,367,961
AVAILABLE AGGREGATE ADMIN EXPENDITURES	$351,840
ACTUAL AGGREGATE ADMINISTRATIVE EXPENDITURES	$322,204
ACTUAL AGGREGATE ADMIN EXPENDITURE PERCENTAGE	9.57%

I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts were for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812)

Print Name of Financial Officer: Adriane Rosemond	Date: 6/6/2023
Signature of Financial Officer:	

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SACRAMENTO TGA
ASSESSMENT OF THE ADMINISTRATIVE MECHANISM: FY 2022-2023

RECIPIENT REPRESENTATIVE: Chelle Gossett, Danielle Caravella

COMMITTEE MEMBERS / OTHER STAFF / CONSULTANTS INVOLVED: Melissa Willet, Richard Benavidez, Jake Bradley-Rowe, Dennis Poupart, Lenore Gotelli, John Kincaid, and Angelina Olweny

DATE OF ASSESSMENT: 06/15/2023

QUARTER/FISCAL YEAR REVIEWED: FY22 3rd and 4th Quarter, Overall FY22

SCORING TOOL COMPLETED BY: Danielle Caravella

SACRAMENTO TGA
FY22 ADMINISTRATIVE MECHANISM ASSESSMENT TOOL

Following is a summary of the rating scale for assessing the efficiency and effectiveness of the administrative mechanisms for the Sacramento Ryan White CARE Act (RWCA) Program. The assessment will determine the proportion of standards met and exceeded, the proportion of standards met at minimum, and the proportion of standards met and not met for each rating category, and determine an overall assessment based upon the proportion of standards met and exceeded, the proportion of standards met at minimum, and the proportion of standards not met across all categories.

Several standards on the following pages are followed by a number in brackets. This number denotes the weight that the standard carries in relation to the other standards in that category. For example, if a standard is followed by [2], the rating for that standard will be counted twice when determining the proportion of standards met and exceeded, met at minimum, or not met. If there is no number following the standard, the standard carries a weight of 1. The weight of each standard applies when determining the proportion of standards met and exceeded, met at minimum, met or not met.

QUANTITATIVE ANALYSIS

Each standard on the scoring tool is written to measure compliance with an outcome that can be measured in quantifiable terms. These standards are written to answer the following questions: "was the task accomplished; to what extent was the task accomplished?" Recipient compliance with each standard is assessed using the following rating scale:

Rating	Compliance Measure	Description of Rating
+	*Standard Met and Exceeded*	*The intent of the standard is consistently met and exceeded, and the processes are not in need of significant improvement.*
=	*Standard Met*	*The standard is met and processes are in place to ensure continued achievement. This rating indicates that the panel considered the standard as measurable solely on accomplishment or failure.*
√	*Standard Met at Minimum*	*The intent of the standard is primarily met, but the processes could still be improved. Recommendations should be provided.*
-	*Standard Not Met*	*The intent of the standard is primarily not met, and the processes should be given the majority of the resources for improvement. Recommendations should be provided.*

QUALITATIVE ANALYSIS

In addition to the quantitative analysis of outcome measures, a narrative summary will be included in the assessment report to provide a qualitative analysis of the processes used to address each standard. This qualitative analysis will answer the following questions: "how was the task accomplished; were the processes used efficient, were the processes fair, were the processes comprehensive, what were the barriers or external factors to accomplishing the standard, could the processes be improved?" The qualitative analysis will be summarized in the narrative report under the following sections for each Rating Category: (a) strengths, (b) weaknesses, (c) external factors, and (d) comments/recommendations for improvement.

#	*Rating Category*	*Standards*	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
1	**PROCUREMENT PROCESS**	A. Procurement process consists of standardized steps and format across all potential applicants.	+	+	+
		B. Dissemination of information regarding availability of funds and request for proposal (RFP) process includes multiple media sources across TGA to solicit new applicants.	+	+	+
		C. Proposed procurement start and end dates are adhered to.	+	+	+
		D. Appropriate vendors for each priority are targeted and provided notice regarding the availability of funds and RFP process.	+	+	+
		E. All requirements for HRSA Policies and Procedures, Council Directives, Standards of Care, Outcome Measures, and Performance Indicators are included in the RFP and discussed at the Bidders Conference.	+	+	+
		F. A standardized process with timeframes is in place for the renewal of contracts.	+	+	+
		G. Contract renewal is completed in accordance with the written, standardized contract renewal process.	=	+	+
		H. The contract renewal process includes an analysis of each provider's ongoing compliance with contractual obligations, including review of quantitative and fiscal issues.	+	+	+
		I. The annual contract renewal process includes an analysis of each provider's ongoing compliance with quality management plans.	=	+	+
		J. The Recipient completes and submits the grant application, in coordination with the Planning Council, for the procurement of Part A funds by the applicable deadline.	+	N/A	+
		K. Weaknesses identified by HRSA in the prior year's Part A application are specifically addressed by the Recipient in developing the Part A application for the current year.	+	N/A	+
		L. The Recipient completes and submits the grant application, in coordination with the Planning Council, for the procurement of State RW Part B funds by the applicable deadline.	+	N/A	+
		M. The Recipient completes and submits the application for carryover funds, in coordination with the Planning Council, by the applicable deadline.	+	+	+
		N. In an RFP year, the Recipient provides monthly RFP status updates to the Council.	+	+	+

FY22 Recipient – AdAC Monitoring

Comments: None noted.

#	Rating Category	*Standards*	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
2	**FISCAL MONITORING**	A. Monthly invoices and other fiscal information is tracked through a standardized system.	+	+	+
		B. Contractual requirements define the various types of corrective action that can be implemented by the Recipient if invoices are not submitted on time.	+	+	+
		C. Ongoing fiscal reviews are conducted and completed for all Contractors and include the following: ▪ Monthly contract analysis reports ▪ Monthly claim reports ▪ Monthly invoice summary reports ▪ Individual client analysis reports, as needed ▪ Review of agency audits.	+	+	+
		D. On-site fiscal reviews are conducted and completed annually for all Contractors.	Tabled to 4th Quarter	+	+
		E. A written report is provided to each Contractor no later than 90 days from the date of the site visit.	Tabled to 4th Quarter	-	-
		F. Standardized On-Site Fiscal Monitoring Tool is used consistently and comprehensively across all contracted service providers.	Tabled to 4th Quarter	+	+
		G. The person(s) conducting fiscal site visits have documented training and/or experience in fiscal evaluation and use of the on-site fiscal monitoring tool.	Tabled to 4th Quarter	+	+
		H. Technical assistance is provided to each contractor as requested and as deemed necessary from fiscal review.	+	+	+
		I. Recipient implements Corrective action for each contractor as deemed necessary from fiscal review, on-site fiscal monitoring and as defined by contractual requirements.	+	=	+
		J. Fiscal audits are conducted for each contractor as deemed necessary from fiscal review and as defined by HRSA and /or Sacramento County DHS policies and procedures.	+	+	+

Comments: None noted.

#	*Rating Category*	*Standards*	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
3	**PROGRAM MONITORING**	A. Formal program monitoring site visits to assess overall quality and components of service delivery are conducted and completed in accordance with HRSA's RW National Monitoring Standards for all Contractors, and written results are forwarded to contractors.	Tabled to Q4	=	=
		B. Formal Quality Management monitoring site visits to assess continuous quality improvement efforts are conducted and completed in accordance with HRSA's RW National Monitoring Standards for all contractors, and written results are forwarded to contractors.	Tabled to Q4	=	=
		C. Standardized On-Site Program Monitoring Tool is used consistently and comprehensively across all contracted service providers.	Tabled to Q4	+	+
		D. The person(s) conducting program monitoring site visits have documented training and/or experience in program evaluation and use of the on-site program monitoring tool.	Tabled to Q4	+	+
		E. Contractual requirements define the various types of potential corrective action that can be implemented by the Recipient.	+	+	+
		F. Technical assistance is provided to each contractor as requested and as deemed necessary from program monitoring site visits and/or Providers Caucus meetings.	+	+	+
		G. Written site visit reports will be completed within 90 days of a site visit	Tabled to Q4	-	-
		H. Recipient monitors that corrective action is conducted by contractors, as deemed necessary from program monitoring site visits and as defined by contractual requirements.	Tabled to Q4	+	+
		I. Contractor compliance with Standards of Care is monitored through site visits, client satisfaction surveys, grievance requests, and outcome measures.	+	+	+
		J. Contractor compliance with outcome measures and performance indicators are monitored through site visits and annual outcome indicators applicable to each service provided.	Tabled to Q4	+	+
		K. Contractors are monitored for compliance with service utilization objectives on an ongoing basis through monthly contract analysis reports.	+	+	+
		L. Assessment of client satisfaction at all service sites is conducted annually.	+	+	+

Comments: The = was given in FA & FB because while the monitoring was conducted the written results were not provided on time due to Recipient capacity and competing deadlines/priorities

FY22 Recipient – AdAC Monitoring

#	*Rating Category*	*Standards*	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
4	**TRACKING SYSTEMS**	A. HRSA Conditions of Award are in compliance on an ongoing basis.	+	+	+
		B. Service utilization, demographics and contract compliance are tracked through a standardized system.	+	+	+
		C. Requests for and response to technical assistance from Contractors are tracked with dates included.	=	=	=
		D. Outcomes of technical assistance are tracked.	=	=	=
		E. Unspent and unobligated funds, inclusive of Direct Services, Recipient Administrative Agent, and Quality Management funding categories, are tracked and reported to the Council, on a minimum of a quarterly basis, and included in a year-end report.	+	+	+

Comments: The amount of TA needed exceeds the capacity of the Recipient to document on a daily basis even though the TA is being provided

	Rating Category	***Standards***	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
5	**CONTRACT DEVELOPMENT**	A. Contracts include requirements that service providers must comply with all HAB/HRSA and CARE Act policies and procedures, including all changes to such requirements that may occur during contract year.	+	+	+
		B. Contracts include clauses to ensure compliance with any established and approved "directives" from the Council, including service delivery models on how to best meet the needs of the EMA/TGA.	+	+	+
		C. Contracts include requirements for contractor compliance with Ryan White program web-based data collection system.	+	+	+
		D. Contracts include clauses to ensure compliance with Council adopted Standards of Care.	+	+	+
		E. Contracts include language, which holds subcontractors accountable to the same contractual requirements of the lead agency.	+	+	+
		F. Contracts include language, which holds the lead agency liable for subcontractor compliance with contractual obligations.	+	+	+
		G. Outcome measures and performance indicators are included in all service contracts for those categories with adopted outcome measures and performance indicators.	+	+	+
		H. Contract language defines and assures the Recipient's method and ability to terminate any contract when Contractor performance is unsatisfactory.	+	+	+
		I. Service contracts between the Recipient and contracting agencies are ~~negotiated~~ initiated for each Contractor within 90 days of "notice of grant award" from the Federal Government.	+	+	+
		J. Service contracts between the Recipient and contracting agencies are signed by the Recipient and Contractor and implemented within 120 days of "notice of grant award" from the Federal Government. *(Signed Memorandum of Agreements between county governments may serve as operational contracts for the purposes of compliance with this standard.)*	=	+	+

Comments: None noted

#	Rating Category	Standards	FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)	FY22 3rd and 4th Quarter Scores	Overall FY22 Final Score
6	**ALLOCATION, PRIORITY SETTING, REALLOCATION AND CARRYOVER**	A. The Recipient disseminates in accordance with the Planning Council's PAC 01, Priority Setting and Resource Allocation Process for each Council approved service priority allocation amount including Direct Services, Planning Council Support, Recipient Administrative and Quality Management.	+	+	+
		B. The Recipient provides the Council with a summary of approved service category allocations compared to actual contracted funds, including identification of the Recipient use of the 10% margin for Recipient adjustments.	+	+	+
		C. Summary of priorities and allocations is available at each Council meeting and is adjusted to reflect changes due to reallocations or carryover funds.	+	+	+
		D. The Recipient ensures that all direct service contractors, Recipient Administrative and Quality Management funding categories submit a budget justification detailing utilization projections and plans to spend the balance of their contract within the remaining program year.	+	+	+
		E. The Recipient ensures that all direct service contractors, Recipient Administrative and Quality Management funding categories contractors submit revised Scopes of Work and revised budgets when contracts are reduced or increased during the budget year.	+	+	+
		F. Summaries of budget justifications for all direct service categories, Recipient Administrative and Quality Management funding categories are reported to the Council as part of the reallocation process.	+	+	+
		G. The Recipient assesses contractor spending patterns, analyzes trends by agency, summarizes contractor requests and budget justifications, and prepares recommendations to the PAC for the use of reallocation funds.	+	+	+
		H. All stages of the reallocation process, ~~including the processing of contracts~~ are completed ~~within the timeframes~~ as required by the Council approved PAC 002 Policies and Procedures.	+	+	+
		I. Request for carryover funds is developed in coordination with the PAC, and the request is submitted in advance of the deadline announced by HRSA.	+	+	+

Comments: None Noted

#	*Rating Category*	*Standards*	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
7	**COMMUNICATION AND REPORTING**	A. Standardized expenditure reports are provided to the Council monthly, quarterly and at year-end.	+	+	+
		B. Standardized reports with descriptive narrative of aggregate client demographics and service utilization by service category are provided to the Council quarterly.	+	+	+
		C. Standardized expenditure, demographics and service utilization reports as provided by the Recipient are accurate.	+	+	+
		D. Reports are provided by the Recipient to the Council on a quarterly basis regarding contractor Technical Assistance requests, follow-up and outcomes.	+	+	+
		E. Recipient will develop a timeline identifying site visit scheduling, occurrences, and completion of corrective action reports.	+	+	+
		F Summary reports regarding site visits and required follow up are provided to the Council through the Administrative Assessment Committee (AdAC).	+	+	+
		G The findings of the assessment of client satisfaction surveys are provided to the Council annually.	+	+	+
		H Contact information for Contractors is provided to the Council.	+	+	+
		I. The Recipient follows the procedures adopted by the Council and Recipient regarding information requests from the Council to the Recipient.	+	+	+

Comments: None noted.

#	Rating Category	Standards	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
8	**BARRIERS AND CONCERNS**	A. The Recipient provides comprehensive written reports regarding concerns or barriers to accomplishing Recipient tasks, and possible solutions or action steps taken to overcome those concerns, augmented by verbal reports as needed, to the Executive Committee of the Council, which forwards the Recipient reports to the full Council.	+	+	+
		B. The Recipient provides reports regarding any sanctions on Contractors to the Executive Committee of the Council, which forwards the Recipient reports to the full Council.	N/A	N/A	N/A
		C. The Recipient attends Council, Executive Committee and Priorities and Allocations Committee meetings.	+	+	+
		D. Requested Recipient reports are provided at Council, Executive Committee and PAC meetings when Recipient staff is unable to attend meeting in person.	+	+	+
		E. The Recipient attends any additional Council Committee meetings where Recipient representation is necessary for completion of Committee business.	+	+	+
		F. Recipient makes recommendations for changes to directives when directives cause observed barriers to care for the client population or have been deemed to violate state or federal laws or regulatory policies.	+	+	+

Comments: None Noted

#	Rating Category	Standards	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
9	**TIMELINESS**	A. Payment for services is ~~made~~ initiated to each Contractor within 30 days of receiving an accurate and complete invoice once contracts are executed.	+	+	+
		B. Notification of potential corrective action is provided to Contractors within 30 days of monthly invoice becoming overdue.	+	+	+
		C. Corrective action is provided to Contractors within 45 days of monthly invoices becoming overdue.	+	+	+
		D. Notification of spending trends is provided to the Council in the Recipient's monthly reports.	+	+	+
		E. Standardized Recipient financial and data reports are provided to the Council within 30 days of Council requests.	+	+	+
		F The Recipient provides monthly and quarterly reports to the Executive Committee for review, which forwards the Recipient reports to the full Council for approval.	+	+	+
		G. Recipient reports are sent in pre-meeting packets to Committee and Workgroups when a minimum of 3 weeks notice of an information request is provided to Recipient.	N/A	N/A	N/A
		H. A standardized system is in place to require Contractors to submit accurate and complete invoices, client intake forms and narrative reports in a timely manner.	+	+	+
		I. Notification to the Council of the amount of funds projected to be available for carryover is reported as outlined in PAC 002 timeline.	+	+	+

Comments: None Noted

#	*Rating Category*	*Standards*	*FY22 1st & 2ND Quarter Score (Unless Otherwise Noted)*	*FY22 3rd and 4th Quarter Scores*	***Overall FY22 Final Score***
10	**FLEXIBILITY**	A. Recipient modifies existing systems as necessary to ensure continuous delivery of service to clients using CARE Act funds.	+	+	+
		B. Recipient considers advances to Contractors of up to 10% of each individual total contract award.	N/A	N/A	N/A
		C. Recipient implements, monitors, and enforces Council directives.	+	+	+

Comments: None Noted

HIV Health Services Planning Council

ADMINISTRATIVE ASSESSMENT COMMITTEE

~~(916) 876-5548 ~ hiv-hspc@saccounty.net~~

COMMITTEE OVERVIEW

Purpose Statement:
The Administrative Assessment Committee (AdAC) shall assess and develop recommendations for improving the efficiency and effectiveness of the administrative mechanisms for rapidly disbursing CARE Act funds to the areas of greatest need within the Sacramento Transitional Grant area (TGA).

Committee Responsibilities:
The Administrative Assessment Committee (AdAC) is responsible for conducting the Health Resources and Services Administration (HRSA) mandated function of assessing the variety of processes involved in ensuring that the TGA is able to proficiently disburse funds in the region. In performing this task, AdAC is charged with:

1) Developing an annual assessment tool that consists of standards by which the TGA will evaluate its success in achieving its responsibilities;
2) Reviewing documentation of the TGA's fulfillment of standards on a bi-annual (twice yearly) basis;
3) Recording the findings of the annual assessment, including strengths, weaknesses, and recommendations for improvement to the TGA's efforts;
4) Developing a plan of correction based upon assessment findings;
5) Reporting findings to the Executive Committee, the Council, and HRSA;
6) Monitoring efforts year-round to determine progress towards plan of correction.

Desired Experience of Members:
AdAC is a technical committee requiring a broad skill set from its members. To successfully evaluate the efficiency and effectiveness of administrative mechanisms, AdAC members must have:

- Understanding of the Ryan White CARE Act
- Awareness of Recipient, Planning Council, and Planning Council staff activities;
- Historical understanding of the TGA's development;
- Experience with program evaluation.

Expectations of Members:
For continuity and uniformity in assessment efforts, AdAC requires a consistent membership, with as little change over on an annual basis as

possible. In addition to being able to commit to a multiple year membership, members are expected to:

1) Attend and actively participate in all AdAC meetings;
2) Review meeting materials prior to arriving at the meeting;
3) Abide by established assessment process policies and procedures;
4) Provide objective assessments based upon data/information provided;
5) Provide constructive recommendations for improving processes;
6) Continually identify Council Members who may be interested in membership on AdAC;
7) Act as an informal mentor to new Committee members;
8) Sign Oath of Confidentiality at each meeting

Meetings:
The Administrative Assessment Committee meets as determined by the Committee.

Contact Information:
Staff support is provided by Angelina Olweny who can be contacted at (916) 325-1630, Angelina.olweny@valleyvision.org ~~Paula Gammell who can be reached at (916) 876-5548 or gammellp@saccounty.net~~

Approved by the HIV Health Services Planning Council on ~~8/24/22.~~

Richard Benavidez, Chair

Service Priority Historical Data for FY10 - FY23 with Planning for FY24

SERVICE CATEGORY	Core	Support	FY15	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24
Ambulatory/Outpatient Medical Care	**X**		1	1	1	1	1	1	1	1	1	1
AIDS Pharmaceutical Assistance	X										2	2
Health Insurance Premium Payments	**X**		3	3	3	3	3	3	3	3	3	3
Oral Health Care	**X**		4	4	4	4	4	4	4	4	4	4
Medical Case Management Services (including Pediatric Treatment Adherence Counseling)	**X**		6	6	6	5	5	5	5	5	5	5
Case Management (Non-Medical)		**X**	7	7	7	6	6	6	6	6	6	6
Food Bank/Home Delivered Meals		**X**				14	14	14	14	14	7	7
Mental Health Services	**X**		5	5	5	7	7	7	7	7	8	8
Psycho-Social Support		**X**					Part B				9	9
Medical Transportation Services		**X**	8	8	8	8	8	8	8	8	10	10
Substance Abuse Services - Outpatient	**X**		9	9	9	9	9	9	9	9	11	11
Substance Abuse Services – Residential		**X**	17	17	17	10	10	10	10	10	12	12
Housing Assistance		**X**	Part of DEFA		10	11	11	11	11	11	13	13
Child Care Services		**X**	11	11	11	12	12	12	12	12	14	14
Emergency Financial Assistance		**X**	12	12	12	13	13	13	13	13	15	15
Medical Nutritional Therapy	**X**		13	13	13	15	15	15	15	15	16	16
Health Education Risk Reduction		**X**	14	14	14	16	16	16	16	16	17	17
Outreach Services		**X**	15	15	16	18	18	18	18	18	18	18

Outreach MAI Services		**X**	16	16	15	17	17	17	17	17	19	19
Treatment Adherence - Pediatric	**X**		**10**	**10**	Now Part of MCM							
Linguistic Services		**X**									20	20
Home & Community Bsed Health Services	**X**										21	21
Home Health Care	**X**										22	22
Hospice	**X**										23	23
Legal Servies		**X**									24	24
Permanency Planning		**X**									25	25
Referral for Health Care & Support Services		**X**									26	26
Rehabilitation Services		**X**									27	27
Respite Care		X									28	28
ADAP/Prescription Medications	**X**		2	2	2	2	2	2	2	2	29	29
Early Intervention Services	**X**										30	30

HIV Health Services Planning Council
PRIORITIES AND ALLOCATIONS COMMITTEE

COMMITTEE OVERVIEW

Statement of Purpose:
The purpose of the Priorities and Allocations Committee (PAC) is to support the mission of the HIV Health Services Planning Council. To this end, PAC shall review and act on data and information to establish proposals for the annual funding priorities and service allocations for Ryan White CARE Act funds.

Statement of Values:
The PAC is dedicated to considering the following values in recommending service priorities and funding allocations:

- Compassion – Assisting those who cannot support themselves
- Equity – Relatively equal portions with attention paid to severe need
- Fairness – Similar cases treated in a similar fashion
- Utilitarianism – Greatest good for the greatest number
- Nuanced Inclusiveness – Since there are real differences among participants regarding both need and ability, a process for assessing these differences will be developed, thereby allowing for differential distribution.

Committee Responsibilities:
PAC is the body through which the HIV Health Services Planning Council receives recommendations on how best to utilize Ryan White funds throughout the TGA. To provide sensible recommendations, PAC is charged with:

1) Reviewing quantitative and qualitative information on service needs, use, costs, outcomes; and availability (internal and external to Ryan White);
2) Determining which services are most needed by people living with HIV (regardless of funding source) and establishing service category priorities;
3) Projecting annual need for essential services;
4) Calculating reasonable allocation allotments for essential services;
5) Developing annual funding request;
6) Sets directives for service delivery in order to increase access by special populations or otherwise ensure fair distribution of resources.
7) Revising annual allocations based upon actual award/changes in actual service cost or utilization patterns.

Desired Experience of Members:
Because PAC must access and consider a wide range of inputs, desired membership qualities are broad. Desired experience includes:

- Understanding of issues impacting people living with HIV;
    - Service consumers
    - Service providers

- Budgeting expertise, or a willingness to learn the process;
- Familiarity with the health and human service delivery community;
- Recipient staff.

Expectations of Members:
PAC provides critical recommendations to the Council regarding the use of Ryan White funds. It is imperative that members

1) Commit to regularly attend and actively participate in PAC meetings;
2) Thoroughly review meeting materials prior to arriving at the meeting;
3) Abide by approved policies and procedures when discussing priorities and allocations;
4) Provide recommendations on how reviewed material should play into the priority setting and allocation processes;
5) Consider all data prior to making decisions and provide unbiased input;
6) Offer prioritization and allocation proposals justified by reviewed data/information;
7) Identify additional data needs;
8) Identify methods for improving processes;
9) Suggest ideas on how services could best be delivered;
10) Continually identify individuals who may be interested in membership on PAC.

Meetings:
Unless otherwise indicated, the Priorities and Allocations Committee meets on the first Wednesday of the months of March, May, June ~~July~~, September, and January, from 9:00 a.m. – 11:00 a.m., at the Sacramento County Health Center, 4600 Broadway, Conference Room 2020, Sacramento, CA 95817.

Contact Information:
Staff support is provided by Angelina Olweny who can be reached at (916) 325-1630 or Angelina.olweny@valleyvision.org

Signed:  Date: ~~04/26/2023~~

Richard Benavidez, Chair

HIV Health Services Planning Council

Quality Advisory Committee

FY22 Performance Indicator Results from Client Survey Postcards

The Federal Government requires that all local Ryan White programs collect data regarding the performance of its funded service categories. In response, the HIV Health Services Planning Council, in coordination with the Ryan White Fiscal Agent, has developed a series of performance indicators for each funded service. The indicator data is collected through a variety of sources, including: The Sacramento TGA Client Database (SHARE); Fiscal Agent site visits of contracted agencies; and service surveys. The first two collection strategies will occur as part of existing, routine Ryan White Program operations. The service surveys require Provider participation. This report addresses the service survey which was conducted via postcards.

Methodology

- Survey postcards were distributed to providers during October 2022.
- Providers were given survey postcards for services provided at their respective agencies. The goal was to survey 25% of clients receiving any service, at any agency.
- Providers were to distribute the postage-paid postcard service surveys to clients from November 1 through January 31, 2022.
- Postcards were to be provided to clients upon the conclusion of a Ryan White client encounter.
- Clients were to be informed that:
    - The survey is anonymous and responses will not be connected to the individual.
    - Inform the client that the survey is being used to help determine how services could be better delivered and funded and that their response is very important to future planning and service delivery efforts.
    - Explain to the client that the survey is brief, and postage has been pre-paid, so all they have to do is answer the questions by checking the appropriate boxes and mail the survey at their convenience.
- Weighted responses used a 5-point rating scale of disagree to agree with 5 being the highest/agree and 1 being the lowest/disagree.

Outcomes:

There were 1,363 postcards distributed to providers to give to clients from November to February 2023 for consumer input on services received during FY2022. Of the 1,363 postcards given to providers to distribute, there was a response rate of 17.3% (236 postcards received), an increase from the 11.1% response rate in fiscal year 2021 (174 postcards returned out of 1,566 postcards distributed to providers).

Service Utilization and Survey Return Rates:
Below is a summary of the Postcard surveys rate of return based on the number distributed and percent of clients.

While Postcards are distributed to Providers, there is no mechanism to ensure they are appropriately distributed to clients. Unfortunately, even if appropriately distributed, there is no guarantee a client will take the time to complete and return the (postage paid) Postcard Survey.

Fiscal Year 2022						
Service Category	Postcards distributed	Postcards Returned	Return Rate	Number of Total Clients	Percent of Total Clients Surveyed	Percent of Total Clients Survey Return Rate
Child Care	9	1	11.1%	9	100.0%	11.1%
Emergency Financial Assistance	55	6	10.9%	147	37.4%	4.1%
Food Bank/Home Delivered Meals	55	14	25.5%	265	20.8%	5.3%
Health Education/Risk Reduction	51	0	0.0%	235	21.7%	0.0%
Health Insurance Premium Payment and Co-Pay Assistance	1	0	0.0%	11	9.1%	0.0%
Housing	11	9	81.8%	22	50%	40.9%
Medical Case Management	299	100	33.4%	1592	18.8%	6.3%
Medical Nutritional Therapy	50	0	0.0%	66	75.8%	0.0%
Medical Transportation	78	20	25.6%	525	14.9%	3.8%
Mental Health	83	10	12.0%	501	16.6%	2.0%
Non-Medical Case Management	151	12	7.9%	1158	13.0%	1.0%
Oral Health	102	2	2.0%	634	16.1%	0.3%
Outpatient Ambulatory Care	299	48	16.1%	1794	16.7%	2.7%
Outreach Services	63	1	1.6%	388	16.2%	0.3%
Substance Abuse Residential (Detox)	6	0	-	19	31.6%	0.0%
Substance Abuse Outpatient	50	13	26.0%	146	34.2%	8.9%

Fiscal Year 2021						
Service Category	Postcards distributed	Postcards Returned	Return Rate	Number of Total Clients	Percent of Total Clients Surveyed	Percent of Total Clients Survey Return Rate
Child Care	11	5	45.5%	12	91.7%	41.7%
Emergency Financial Assistance	25	4	16.0%	143	17.5%	2.8%
Food Bank/Home Delivered Meals	50	6	12.0%	405	12.3%	1.5%
Health Education/Risk Reduction	36	0	0.0%	191	18.8%	0.0%
Health Insurance Premium Payment and Co-Pay Assistance	3	2	66.7%	9	33.3%	22.2%
Housing	10	5	50%	41	24.4%	12.2%
Medical Case Management	373	81	21.7%	1547	24.1%	5.2%
Medical Nutritional Therapy	20	0	0.0%	114	17.5%	0.0%
Medical Transportation	90	28	31.1%	467	19.3%	6.0%
Mental Health	140	15	10.7%	433	32.3%	3.5%
Non-Medical Case Management	191	27	14.1%	1104	17.3%	2.4%
Oral Health	125	1	0.8%	613	20.4%	0.2%
Outpatient Ambulatory Care	360	0	0.0%	1750	20.6%	0.0%
Outreach Services	94	0	0.0%	379	24.8%	0.0%
Substance Abuse Residential (Detox)	2	0	-	9	22.2%	0.0%
Substance Abuse Outpatient	36	0	0.0%	152	23.7%	0.0%

Service Category	2022 Number of Total Clients	2021 Number of Total Clients	2020 Number of Total Clients	2019 Number of Total Clients
Child Care	9	12	17	19
Emergency Financial Assistance	147	143	273	185
Food Bank/Home Delivered Meals	265	405	391	197
Health Education/Risk Reduction	235	191	293	159
Health Insurance Premium Payment and Co-Pay Assistance	11	9	9	27
Housing	22	41	18	137
Medical Case Management	1593	1547	1724	1,516
Medical Nutritional Therapy	66	114	162	535
Medical Transportation	525	467	427	555
Mental Health	501	433	696	795
Non-Medical Case Management	1121	1104	752	1,161
Oral Health	634	613	481	602
Outpatient Ambulatory Care	1796	1754	1761	1,851
Outreach Services	388	379	962	906
Psychosocial Support				34
Substance Abuse Residential (Detox)	19	9	6	39
Substance Abuse Outpatient	146	152	220	307

SERVICE CATEGORY FINDINGS:

Child Care

9 total unduplicated clients served in FY22
12 total unduplicated clients served in FY21

There was only 1 response in FY22. There were 5 responses in FY21.

Child Care Weighted responses:	2022	2021
❖ Better Manage Living with HIV/AIDS:	5.0	4.6
❖ Improved Quality of Life:	5.0	3.8
❖ Improved ability to remain in medical care:	5.0	4.6

Emergency Financial Assistance

147 total unduplicated clients served in FY22
143 total unduplicated clients served in FY21

Only 6 consumers of the 55 postcard recipients (10.9%) responded to this service in FY22. There were 4 responses (16%) in FY21.

Number of Emergency Financial Assistance Visits per year:

	2022	2021
1 appointment	16.7%	33.3
2 – 3 appointments	33.3%	33.3
4 or more appointments	50.0%	33.3

All the respondents in FY22 (100%) reported receiving referrals or financial assistance when requested.

Emergency Financial Assistance Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	4.83	5.0
❖ Improved Quality of Life:	4.83	4.5
❖ Improved ability to remain in medical care:	4.83	4.25

Food Bank/Home Delivered Meals

265 total unduplicated clients served in FY22
405 total unduplicated clients served in FY21

In FY22, 14 consumers of the 55 postcard recipients (25.5%) responded to this service. This represents 5.2% of the total (265) Food Bank/Home Delivered Meals recipients. 42.9% of the clients responding received four or more food bank services during the reporting period.

In FY21, six consumers of the 50 postcard recipients (12%) responded to this service. This represents 12.3% of the total (405) Food Bank/Home Delivered Meals recipients.

Number of Food Bank/Home Delivered Meals Visits per year:

	2022	2021
1 appointment	21.4%	16.7%
2 – 3 appointments	35.7%	33.3%
4 or more appointments	42.9%	50.0%

Health Indicator: Food Bank/Home Delivered Meals services have improved my general health/quality of life.

In FY22, 79% of the respondents stated that Food Bank/Home Delivered Meals services had improved their general health/quality of life, and 21% responded it was not applicable.

In FY21, 100% of the respondents stated that Food Bank/Home Delivered Meals services had improved their general health/quality of life.

Health Indicator: My nutritional intake has improved through Food Bank/Home Delivered Meals.

In FY22, 85% of the respondents stated that Food Bank/Home Delivered Meals services had improved their nutritional intake, and 15% said it was not applicable.

In FY21, 100% of the respondents stated that Food Bank/Home Delivered Meals services had improved their nutritional intake.

Food Bank/Home Delivered Meals Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	4.50	4.17
❖ Improved Quality of Life:	4.62	4.17
❖ Improved ability to remain in medical care:	4.38	3.83

Health Education and Risk Reduction Services

235 total unduplicated clients served in FY22
191 total unduplicated clients served in FY21

Similarly to FY21, there were no responses from clients receiving Health Education and Risk Reduction Services in FY22.

Health Education and Risk Reduction Services Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	N/A	N/A
❖ Improved Quality of Life:	N/A	N/A
❖ Improved ability to remain in medical care:	N/A	N/A

Health Insurance Premium Payment and Cost-Sharing Assistance

11 total unduplicated client served in FY22
9 total unduplicated clients served in FY21

In FY21, two consumers of the 3 postcard recipients (67.7%) responded. Unfortunately, there were no responses in FY2022.

Number of Health Insurance Premium Payment and Cost-Sharing Assistance Visits per year:

	2022	2021
1 appointment	N/A	-0-
2 – 3 appointments	N/A	50%
4 or more appointments	N/A	50%

Health Insurance Premium Payment and Cost-Sharing Assistance Weighted responses**:**	**2022**	2021
❖ Payments Processed Timely:	N/A	5.0
❖ Improved Quality of Life:	N/A	5.0
❖ Improved ability to remain in medical care:	N/A	5.0

Housing

22 total unduplicated clients served in FY22
41 total unduplicated clients served in FY21

In FY22, there were 9 responses (81.8%) from the 11 survey postcards distributed. This was a return rate of 39.1% of the total clients (23) receiving housing services in FY2022. All respondents in 2022 stated that their general health status/quality of life has improved with housing services. In FY22 37.5% of the respondents indicated their Housing Situation had improved or was stable, a decrease from FY21 where 80% of respondents indicated their Housing Situation had improved or was stable

In FY21, there were 5 responses (50%) from the 10 survey postcards distributed. This was a return rate of 12.2% of the total clients (41) receiving housing services in FY2021. All respondents in 2021 stated that their general health status/quality of life has improved with housing services.

Housing Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	4.4	5.0
❖ Improved Quality of Life:	4.1	4.6
❖ Improved ability to remain in medical care:	4.3	5.0

Medical Case Management

1,592 total unduplicated clients served in FY22
1,547 total unduplicated clients served in FY21

In FY22, of the 299 postcards distributed for medical case management services, 100 consumers (33.4%) responded to this service category. This represented 6.3% of all consumers (1,592) who accessed medical case management in FY 2022. Of the 100 responses, 58.4% reported attending four or more medical case management visits during the reporting period.

Comparatively, in FY21, of the 373 postcards mailed for medical case management services, only 81 consumers (21.7%) responded to this service category. This represents 5.2% of all consumers (1,547) who accessed medical case management in FY 2021. Of the 81 responses, 44.4% reported attending four or more medical case management visits during the reporting period.

Health Indicator: 60% of clients receiving medical case management services will report adherence to their anti-retroviral drug treatment plans.

In FY22, 100 individuals completed the Medical Case Management Client Surveys. Of them, 94.1% of the respondents reported that Medical Case Management services help them adhere to their anti-retroviral drug treatment plans. 3 clients stated it was not-applicable.

In FY21, 81 individuals completed the Medical Case Management Client Surveys. Of them, 94.9% of the respondents reported that Medical Case Management services helped them adhere to their anti-retroviral drug treatment plans. 1 client stated it was not-applicable.

Medical Case Management Weighted responses:	**2022**	2021
❖ Improved Knowledge of Available Services:	4.7	4.6
❖ Better Manage Living with HIV/AIDS:	4.6	4.6
❖ Improved Quality of Life:	4.6	4.5
❖ Improved ability to remain in medical care:	4.7	4.6

Medical Nutritional Therapy

66 total unduplicated Medical Nutritional Therapy clients in FY22
114 total unduplicated Medical Nutritional Therapy clients in FY21

In FY22, there were 50 postcards distributed to the 66 unduplicated recipients. Unfortunately, no one responded.

In FY21, there were 20 postcards distributed to the 114 unduplicated recipients. Unfortunately, no one responded.

Medical Nutritional Therapy Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	N/A	N/A
Improved Quality of Life:	N/A	N/A
Improved ability to remain in medical care:	N/A	N/A

Medical Transportation Services

525 total unduplicated clients served in FY22
467 total unduplicated clients served in FY21

In FY22, there were 78 postcards distributed to providers offering Medical Transportation Services. Of the 78 postcards distributed, 20 (25.6%) consumers responded to the Medical Transportation services postcard survey. This represented a response of 3.8% of the total consumers (525) receiving medical transportation services.

In FY21, there were 90 postcards distributed to providers offering Medical Transportation Services. Of the 90 postcards distributed, 28 (31.1%) consumers responded to the Medical Transportation services postcard survey. This represented a response of 6% of the total consumers (467) receiving medical transportation services.

Health Indicator: 75% of clients showing evidence of need for medical transportation services will receive medical transportation for HIV/AIDS-related care appointments.

In FY22, 75% of clients, compared to 96% of respondents in FY21, reported ALWAYS being able to access Medical Transportation services.

Medical Transportation Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	4.9	4.7
❖ Improved Quality of Life:	4.8	4.7
❖ Improved ability to remain in medical care:	4.9	4.8

Mental Health

501 total unduplicated clients served in FY22
433 total unduplicated clients served in FY21

In FY22, there were 83 postcards distributed to providers, however, only 10 clients (12%) responded to the survey. This represents 2.0% of the consumers (501) who accessed the services.

In FY21, 140 postcards were distributed to providers, and only 10.7% (15 clients) responded to this service category.

Health Indicator: - 60% of clients receiving mental health counseling will report improved daily functionality.

	2022	2021
Yes	100%	100%
No	-	-
Not Applicable	-	-

Health Indicator: - Increase in the percent of unduplicated clients reporting a decrease in symptoms that initiated referral into mental health services.

	2022	2021
Yes	90%	100%
No	-	-
Not Applicable	10%	-

Mental Health Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	4.3	4.5
❖ Improved Quality of Life:	4.5	4.9
❖ Improved ability to remain in medical care:	4.6	4.9

Non-Medical Case Management

1,158 total unduplicated clients served in FY22
1,104 total unduplicated clients served in FY21

In FY22, of the 151 postcards distributed for non-medical case management services, there was a response rate of 7.9% (12 consumers responded) to this service category. This represents 1.0% of the total (1,158) non-medical case management clients served in FY22. In FY21, there were 27 responses out of the 191 postcards distributed.

Number of Non-Medical Case Management Visits per year:

	2022	2021
1 appointment	8.3%	15.8%
2 – 3 appointments	16.7%	52.6%
4 or more appointments	75%	31.6%

Health Indicator: 60% of clients receiving non-medical case management services will report adherence to their anti-retroviral drug treatment plans.

In FY22, 83.3% of all respondents stated that Non-Medical Case Management helps them with adherence to anti-retroviral therapy and two clients stated it does not help them. Comparatively, in FY21, no respondents stated that Non-Medical Case Management does not help them with adherence to anti-retroviral therapy, but two responded it was not applicable.

Non-Medical Case Management Weighted responses:

	2022	2021
❖ Improved Knowledge of Available Services:	4.5	4.5
❖ Better Manage Living with HIV/AIDS:	4.4	4.3
❖ Improved Quality of Life:	4.3	4.4
❖ Improved ability to remain in medical care:	4.5	4.6

Oral Health Care

634 total unduplicated clients served in FY22
613 total unduplicated clients served in FY21

In FY22, of the 102 oral health care postcards distributed, 2 consumers responded (2%) to this service category. This represents 0.3% of the total consumers (634) who accessed dental care. This is a slight increase in the response rate compared to the 0.8% responding consumers (1 out of 613 total clients) who accessed the service in FY 2021.

Health Indicator: - 60% of clients receiving Oral Health Care will report improved oral health through self report.

Of individuals completing Client Surveys, 100% of the respondents reported improved oral health in FY22.

Oral Health Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	5.0	5.0
❖ Improved Quality of Life:	5.0	5.0
❖ Improved ability to remain in medical care:	5.0	5.0

Outpatient Ambulatory Care

1,794 total unduplicated clients served in FY22
1,754 total unduplicated clients served in FY21

In FY22, there were 299 outpatient ambulatory care surveys distributed. Of the 299 surveys, there were 48 responses (16.1%). This is a large increase in the response rate compared to the 0% responding consumers (0 out of 360 surveyed clients) who accessed the service in FY 2021. This represents 2.7% of the total consumers (1,794) who accessed Ambulatory care services.

Number of Outpatient Ambulatory Care Visits per year:

	2022	2021
1 appointment	14.6%	N/A
2 – 3 appointments	43.9%	N/A
4 or more appointments	41.5%	N/A

Outpatient Ambulatory Care Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	4.8	N/A
❖ Improved Quality of Life:	4.6	N/A
❖ Improved ability to remain in medical care:	4.8	N/A

Outreach Services

388 total unduplicated clients served in FY22
379 total unduplicated clients served in FY21

In FY22 there were 63 surveys distributed to clients who had received outreach services. Of the 63 surveys distributed, there was 1 response.

Similarly, in FY21, none of the 94 postcards distributed to providers were returned by consumers.

Learn HIV Status:
No relevant responses were received in FY21 or FY22.

If Positive, did you receive a medical referral:
No relevant responses were received in FY21 or FY22.

If Positive, did you receive a referral to a non-medical service provider for assistance with social services:
No relevant responses were received in FY21 or FY22.

If Negative, did you receive information on risk reduction services:
No relevant responses were received in FY21 or FY22.

Substance Abuse Treatment - Residential

In FY22,19 total unduplicated clients received Residential Substance Abuse Services
In FY21, 9 total unduplicated clients received Residential Substance Abuse Services

In FY22, there were no responses from the 6 postcard recipients to this service category.
In FY21, there were no responses from the 2 postcard recipients from this service category.

Health Indicator: 60% of clients entering outpatient substance abuse services will reduce risk behaviors for substance use.

There were no responses received in FY21 or FY22.

Health Indicator: 60% of clients entering outpatient substance abuse services will reduce risk behaviors for transmission of HIV and other communicable diseases as measured by self-report.

There were no responses received in FY21 or FY22.

Substance Abuse Residential Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	N/A	N/A
❖ Improved Quality of Life:	N/A	N/A
❖ Improved ability to remain in medical care:	N/A	N/A

Substance Abuse Treatment - Outpatient

In FY22, 146 total unduplicated clients received Outpatient Substance Abuse Services
In FY21, 152 total unduplicated clients received Outpatient Substance Abuse Services

In FY22, 26% (13) of the 50 postcard recipients responded to this service category. This represents 8.9% of the total consumers (146) accessing outpatient substance abuse treatment.

In FY21, there were no responses from the 36 postcards distributed in this service category.

Health Indicator: 60% of clients entering outpatient substance abuse services will reduce risk behaviors for substance.

In FY22, 100% of the respondents reported risk reduction behavior for substance abuse. There were no responses in FY21.

Health Indicator: 60% of clients entering outpatient substance abuse services will reduce risk behaviors for transmission of HIV and other communicable diseases as measured by self-report.

In FY22, 92.3% of the respondents (12 out of 13) reported risk reduction behavior for HIV/Communicable Disease Transmission. There were no responses in FY21.

Substance Abuse Outpatient Weighted responses:	**2022**	2021
❖ Better Manage Living with HIV/AIDS:	5.0	N/A
❖ Improved Quality of Life:	5.0	N/A
❖ Improved ability to remain in medical care:	5.0	N/A

Client Comments:

Substance Abuse Outpatient
Food Cards
Wonderful services here at OCH
Saved my life!
These are wonderful people and I appreciate all of the loving help.
The services and the community are superior, thank you.
Shalon is wonderful.
This program helps you.
Oral Health
Like a thumb, you never know how teeth affect everything until they are damaged or sick
My only complaint is extremely long wait times, but staff is excellent
EFA
Thanks for maintaining services
SHRA Advocacy Needed, Causing distress
Housing
I need to start eating healthier.
This is not only wanted but needed as well. This is greatly appreciated, thank you dearly.
Ambulatory Care
Extremely Long Wait times when you call the phone.
Dr. MK is the best, and very caring to the patients. She cares about us. Praying she is always here. She is one of the best.
Love One Community Health
I wish the doctors here spent more time with the patients like 5 to 10 min more.
OCH has helped me so much. Thank you.
Dr. Frank Molina is the best!
Amazing, good service 100/100
Always have trouble getting pills delivered
Thanks to these doctors I am alive
Thank you Ryan White
OCH is amazing
Keep up the good work
I get taken care of well here
Sac County has been very helpful to my needs and they check on me regularly
Best Medical Service There Is
Outreach
The staff have been very helpful and very nice.

Summary:

During Fiscal Year 2022, there were 2,315 clients receiving services in the Ryan White Transitional Grant Area (TGA) and Yolo County at the time the survey was initiated. In an attempt to collect outcome data, the Quality Advisory Committee initiated its annual postcard service survey. The goal was to survey at least 25% of the clients receiving service in any service category. Of the 1,363 surveys distributed, the TGA had a response rate of 17.3% (236 responding clients out of 1,363 possible service responses). It is unknown if all the postcards were distributed to clients or whether or not a client received surveys for more than one service received as there is no method to document the process.

Although the overall response rates differ between the two fiscal years making it difficult to draw solid conclusions, it should be noted that there were some significant differences in the number of clients served in each service category. The greatest *decrease* in services was in Housing Services which decreased by 46.3% from 41 clients in FY21 to 22 clients in FY22. This may be due in part to the loss of the additional COVID Care Act funding that was received in FY21.

The greatest *increase* was in the Residential Substance Abuse Services category where there was a 111.1% increase in clients from 9 in FY21 to 19 in FY22.

Service Category	2022 Number of Total Clients	2021 Number of Total Clients	Percent Different	Decrease or Increase
Substance Abuse Residential (Detox)	19	9	111.1%	Increase
Health Education/Risk Reduction	235	191	23.0%	Increase
Health Insurance Premium Payment and Co-Pay Assistance	11	9	22.2%	Increase
Mental Health	501	433	15.7%	Increase
Medical Transportation	525	467	12.4%	Increase
Non-Medical Case Management	1158	1104	4.9%	Increase
Oral Health	634	613	3.4%	Increase
Medical Case Management	1592	1547	2.9%	Increase
Emergency Financial Assistance	147	143	2.8%	Increase
Outpatient Ambulatory Care	1794	1750	2.5%	Increase
Outreach Services	388	379	2.4%	Increase
Substance Abuse Outpatient	146	152	-3.9%	Decrease
Child Care	9	12	-25%	Decrease
Food Bank/Home Delivered Meals	265	405	-34.6%	Decrease
Medical Nutritional Therapy	66	114	-42.1%	Decrease
Housing	22	41	-46.3%	Decrease

This is one of several performance measures utilized by the Sacramento Transitional Grant Area to measure the TGA's quality of services. Other measures include an agency client satisfaction survey, chart reviews, site visits, needs assessments and alike. Overall, the TGA

exceeded the outcome indicators and the weighted responses indicate clients are satisfied with the services, in that, the services help manage their HIV/AIDS, maintain their quality of life and remain in medical care. The clients' comments were overwhelmingly positive with only a few recommendations, concerns, or issues.

###

County Executive
Ann Edwards

Deputy County Executive
Chevon Kothari
Social Services

County of Sacramento

Department of Health Services
Timothy W. Lutz, Director

Divisions
Behavioral Health Services
Primary Health
Public Health
Departmental Administration

May 23, 2023

2022 Client Satisfaction Survey Results

The Ryan White CARE Program provides Ryan White funded Subrecipients with a Client Satisfaction Survey at periodic intervals throughout the fiscal year. The Ryan White Providers then distribute the surveys to clients who are requested to complete and return the surveys to the Ryan White CARE Program staff in a pre-addressed and postage-paid return envelope, which is stapled to the survey.

Surveys are then tallied to measure the client's impression of the overall performance of the entire program and not a particular agency itself. This offers a better understanding as to how the Ryan White program performs as a collaborative.

The following document will provide survey results. This report will cover the past fiscal year, from March 1, 2022, to February 28, 2023. There were 79 surveys returned this fiscal year from the Subrecipients in the Sacramento Ryan White CARE Program; compared to 34 in FY21.

EXECUTIVE SUMMARY

The FY22 Client Satisfaction Survey resulted in 79 returned surveys. There were 2,315 total clients served during FY22. This amounts to a 3.41% survey rate; an increase from the 1.41% survey rate in FY21. Not all clients received surveys and therefore, it denotes the percentage of clients that returned surveys and not a response rate as the number distributed to clients and not returned is unknown. Clients completed these surveys at their leisure and may or may not have completed all questions. As such, each question was averaged by the number of responses for that particular question. Unfortunately, there were some agencies where no responses were received, and the number of responses per agency varied.

Of the survey respondents, 46.8% of the clients reported on Question 5, being able to obtain an appointment the same day they made contact with the agency, which is an increase from 36.4% the prior fiscal year. Regardless of what day the appointment was scheduled, 70.5% reported having to wait under 10 minutes (Q4) for their appointment to begin, which is an improvement over 57.6% the prior year. All the clients, 100%, felt the respective agencies make them feel welcomed, comfortable, and respected (Q6), compared to 100% the prior fiscal year. 100% of clients reported receiving assistance from the agency with their questions about services at the agency (Q7). 98.7% reported the agency provided them information about services they may be eligible for at other agencies (Q8), which is a decrease compared to 100% the prior fiscal year.

Concerning childcare services (Q9), 67.5% of the clients stated childcare services were not applicable. This is a decrease from the prior year in which 73.5% of respondents indicated childcare was not applicable to their needs. Only 10.4% of the clients were made aware of childcare services while 22.1% stated they were unaware of childcare services. All clients should be informed that childcare services are available through the Ryan White system of care.

100% of clients reported that staff respects their privacy (Q10) compared to 97.1%, in the prior fiscal year. 20.5% of clients report not knowing how to file a complaint/grievance with an agency (Q11), which is a slight improvement from FY21 in which 23.5% of clients did not know how to file a grievance/complaint. 7.9% of clients reported that no one has discussed how to avoid infecting others with HIV (Q12), a slight increase from the prior year in which 5.9% of clients stated no one discussed how to avoid transmitting HIV to others.

Of those clients responding to the surveys, 28% have been clients at the agency they received the survey from for over 5 years (Q2). This is a slight decrease over the prior year where 33.3% of survey respondents reported retention at the agency for over five years. 77 respondents rated their overall satisfaction with the surveyed agency (Q15) for a combined satisfaction rate of 9.59 on a scale of 10 compared to 9.82 in FY21.

Client feedback can be found below in the responses to questions 13, 14, and 16.

2022 SACRAMENTO REGIONAL

RYAN WHITE PROGRAM

CLIENT SATISFACTION SURVEY RESULTS

Below is a summary of the performance of the Transitional Grant Area as a whole. The scores were obtained by totaling all agencies responses.

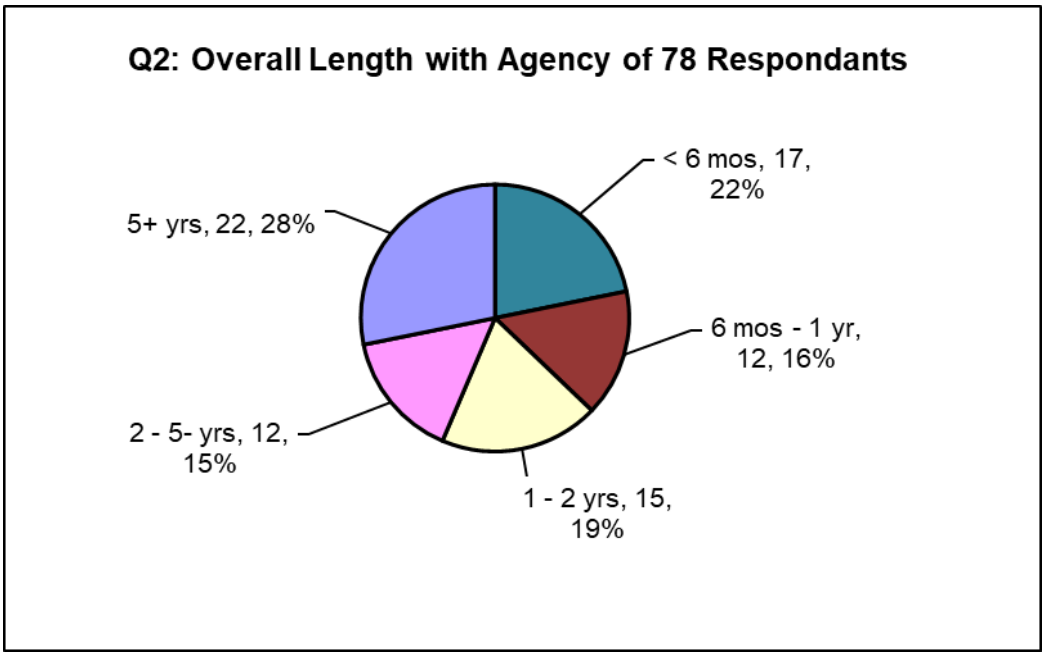
1. What service(s) do you receive at this agency?

0	Ambulatory Care	0	Residential Hospice	1	Food and Nutrition
0	Medical Case Mgmt	0	Substance Abuse	0	Health Insurance
1	Oral Health	0	Adult Care/Respite	3	Housing/Utilities
0	Home Health Care	0	Alternative/Complimentary	0	Outreach
2	Mental Health	0	Buddy/Companion	1	Transportation
1	Prescriptions	0	Childcare	72	Other Support
		1	Other Counseling	4	Other Critical Need

2. How long have you been a client at this agency? 78 of the 79 clients responded to this question. *Of the 78 clients responding:*

Agency	**< 6 mos**	**6 mos - 1 yr**	**1 - 2 yrs**	**2 - 5- yrs**	**5+ yrs**	**Total Per Agency**	**Percent of Survey Respondents by Agency out of Total Respondents (78)**	**Percent of Respondents out of total TGA Clients (2,315)**
3402	1	1	2	2	11	**17**	**21.8%**	0.73%
3414	0	0	0	0	1	**1**	**1.3%**	0.04%
0903	0	0	0	0	0	**0**	**0.0%**	0.00%
3415	7	5	5	2	3	**22**	**28.2%**	0.95%
3416	0	3	3	0	0	**6**	**7.7%**	0.26%
3411	0	0	0	2	2	**4**	**5.1%**	0.17%
5701	0	0	0	0	0	**0**	**0.0%**	0.00%
3417	6	0	0	1	0	**7**	**9.0%**	0.30%
0902	0	2	3	5	5	**15**	**19.2%**	0.65%
3418	3	1	2	0	0	**6**	**7.7%**	0.26%
3419	0	0	0	0	0	**0**	**0.0%**	0.00%
Totals	**17**	**12**	**15**	**12**	**22**	**78**	**100.0%**	3.37%

As seen in the pie chart below, approximately 28% of the 78 respondents have maintained working relationships with Ryan White funded providers for more than five years.



3. Overall, how would you rate the quality of the services you receive at this agency?

   This question had a ranking between 0 and 10 with 10 being Excellent.

   Number of Responses: **78** Average of All Responses: **9.64%**

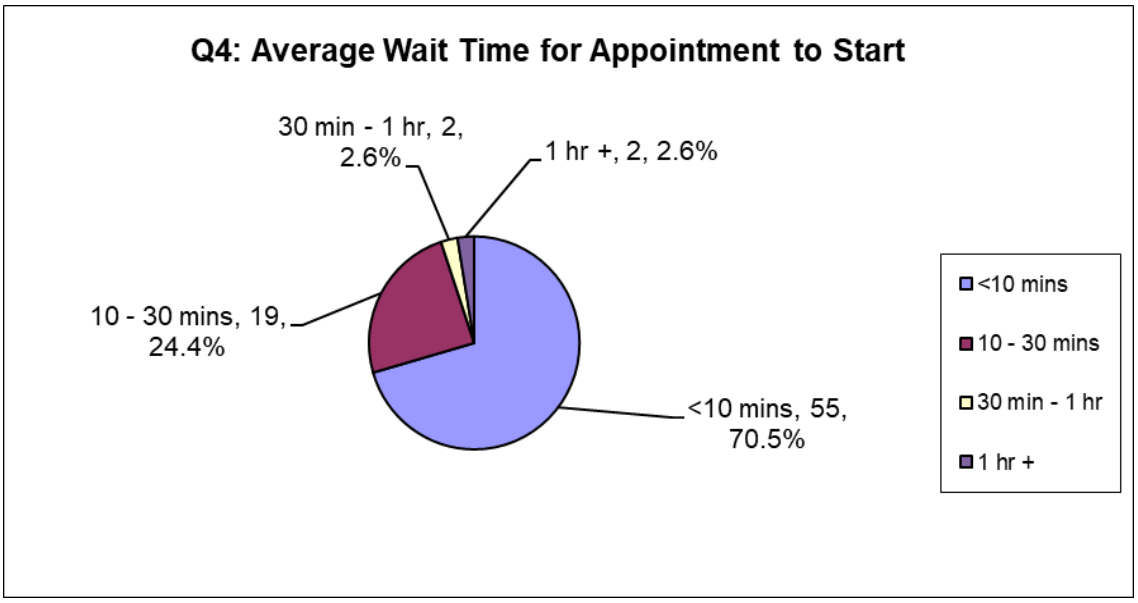
   The average of all responses decreased to 9.64% in FY2022 compared to 9.91% in FY2021. There were 78 responses in FY2022 compared to 34 in FY2021. Despite an increase in the response rate for this question, the respondents reported a 0.27% decrease in the quality of services being received.

4. What is the average time that you wait for your appointment to start at this agency?

78 (98.7%) of the 79 clients answered the question. Their responses are below.

Regardless of what day the appointment was scheduled, 70.5% reported having to wait under 10 minutes for their appointment to begin. This is higher than in FY21 in which 57.6% waited under 10 minutes for their appointment to begin.

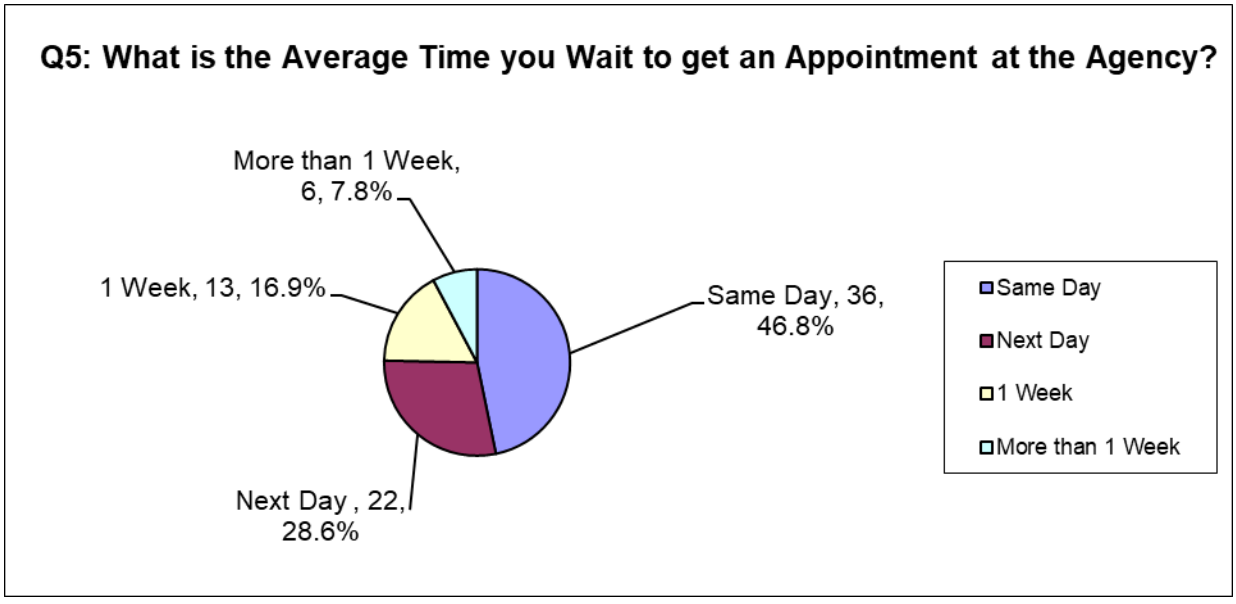
Agency	**<10 mins**	**10 - 30 mins**	**30 min - 1 hr**	**1 hr +**	**Total Respondents**	**Percent of Total Respondents (78)**	**Percent of Total Clients in TGA (2315)**
3402	7	7	2	1	17	21.8%	0.7%
3414	1	0	0	0	1	1.3%	0.0%
0903	0	0	0	0	0	0.0%	0.0%
3415	16	5	0	0	21	26.9%	1.0%
3416	5	1	0	0	6	7.7%	0.3%
3411	3	1	0	0	4	5.1%	0.2%
5701	1	0	0	0	1	1.3%	0.0%
3417	3	3	0	1	7	9.0%	0.3%
0902	14	1	0	0	15	19.2%	0.6%
3418	5	1	0	0	6	7.7%	0.3%
3419	0	0	0	0	0	0.0%	0.0%
Totals	**55**	**19**	**2**	**2**	**78**	**100.0%**	**3.4%**



5. What is the average time you wait to get an appointment at this agency?

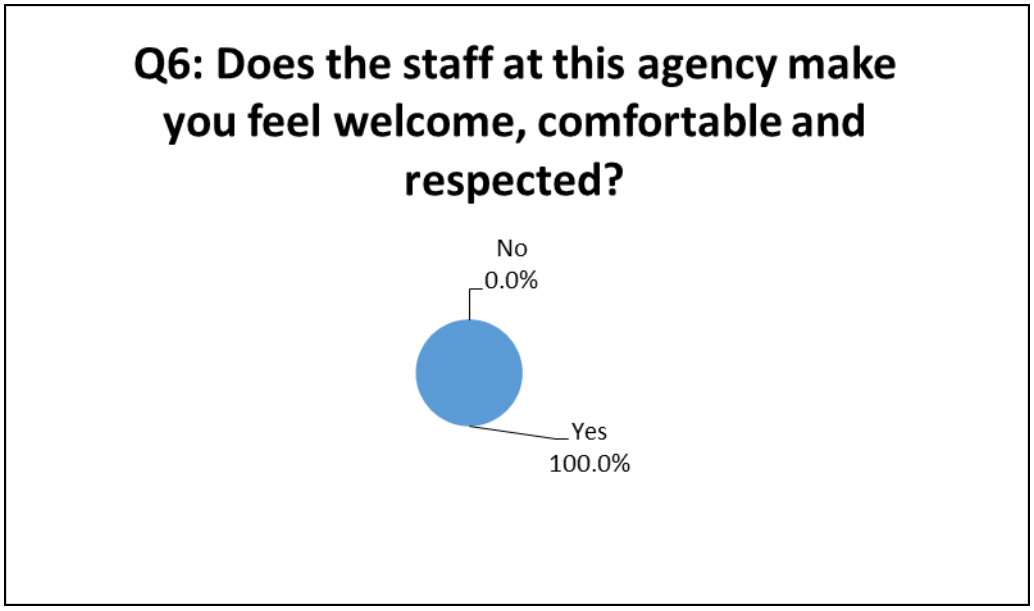
In Fiscal Year 2022, 77 (97.5%) of the 79 clients answered the question. Their responses are below. In FY22, only 46.8% indicated they received an appointment the same day which is an increase compared to 36.4% in Fiscal Year 21.

Agency	**Same Day**	**Next Day**	**1 Week**	**More than 1 Week**	**Total Per Agency**	**Total Respondents by Agency out of Total Respondents (77)**	**Percent of Total TGA Clients (2315)**
3402	3	5	7	2	17	22.1%	0.73%
3414	1	0	0	0	1	1.3%	0.04%
0903	0	0	0	0	0	0.0%	0.00%
3415	10	8	2	1	21	27.3%	0.91%
3416	3	2	1	0	6	7.8%	0.26%
3411	3	0	1	0	4	5.2%	0.17%
5701	1	0	0	0	1	1.3%	0.04%
3417	3	1	2	0	6	7.8%	0.26%
0902	9	6	0	0	15	19.5%	0.65%
3418	3	0	0	3	6	7.8%	0.26%
3419	0	0	0	0	0	0.0%	0.00%
Totals	**36**	**22**	**13**	**6**	**77**	**100.0%**	**3.3%**



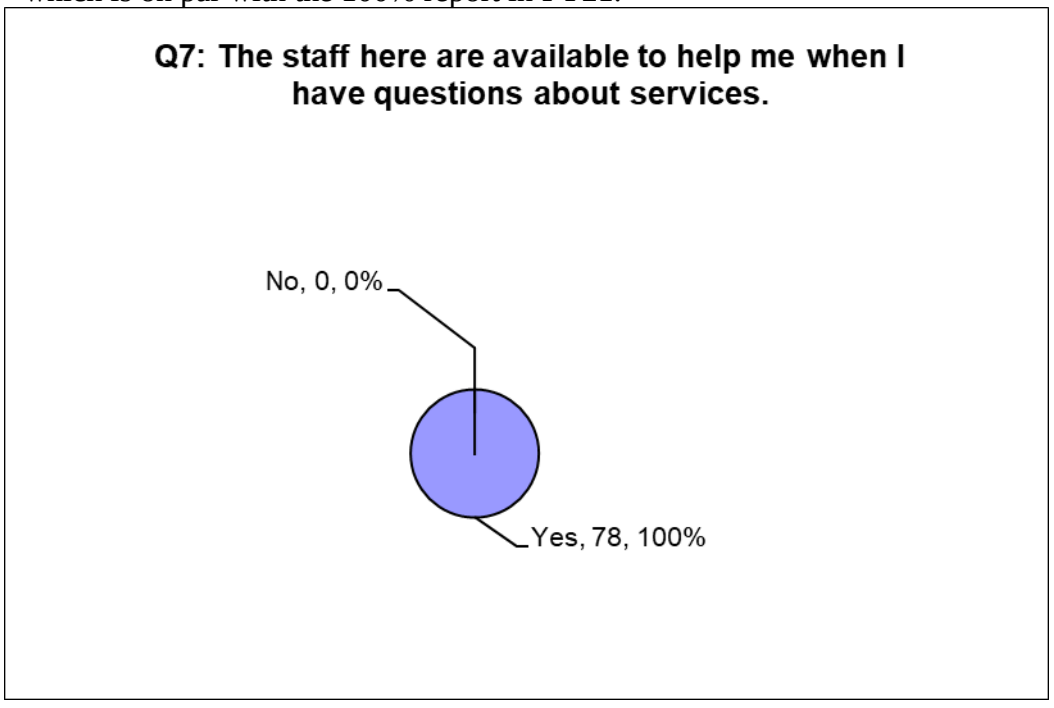
6. Does the staff at this agency make you feel welcome, comfortable, and respected?

Of the 78 clients responding to the question, 100% reported that staff made them feel welcomed, comfortable, and respected compared to 100% the prior fiscal year.



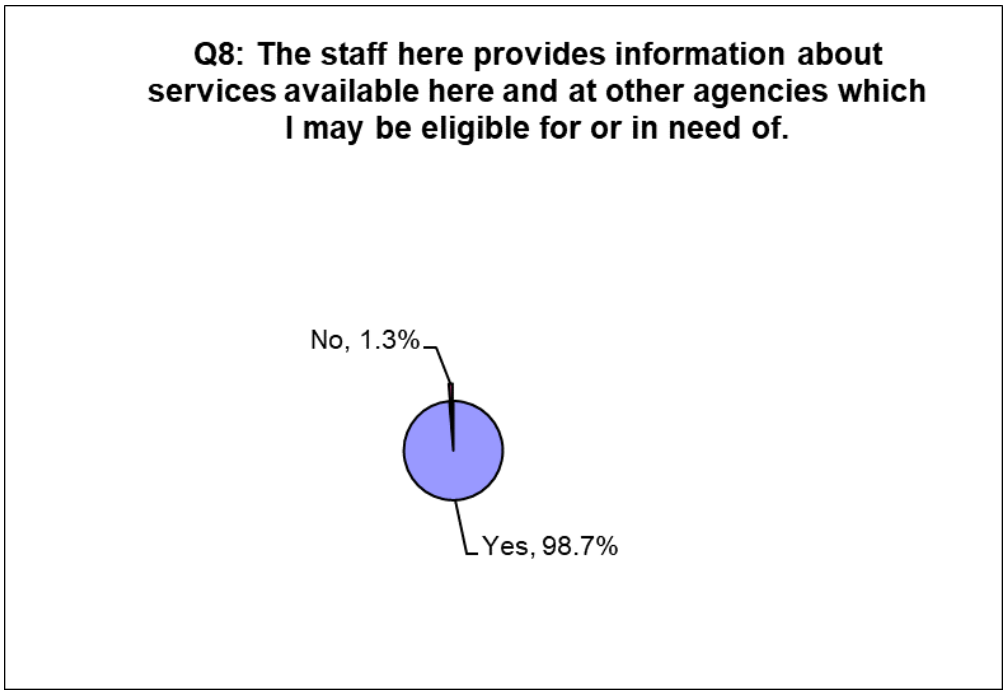
7. The staff here is available to help me when I have questions about services:

78 clients answered the question. Of the 78 clients responding to the question, 100% indicated the staff is available to assist when the client has questions about services which is on par with the 100% report in FY21.



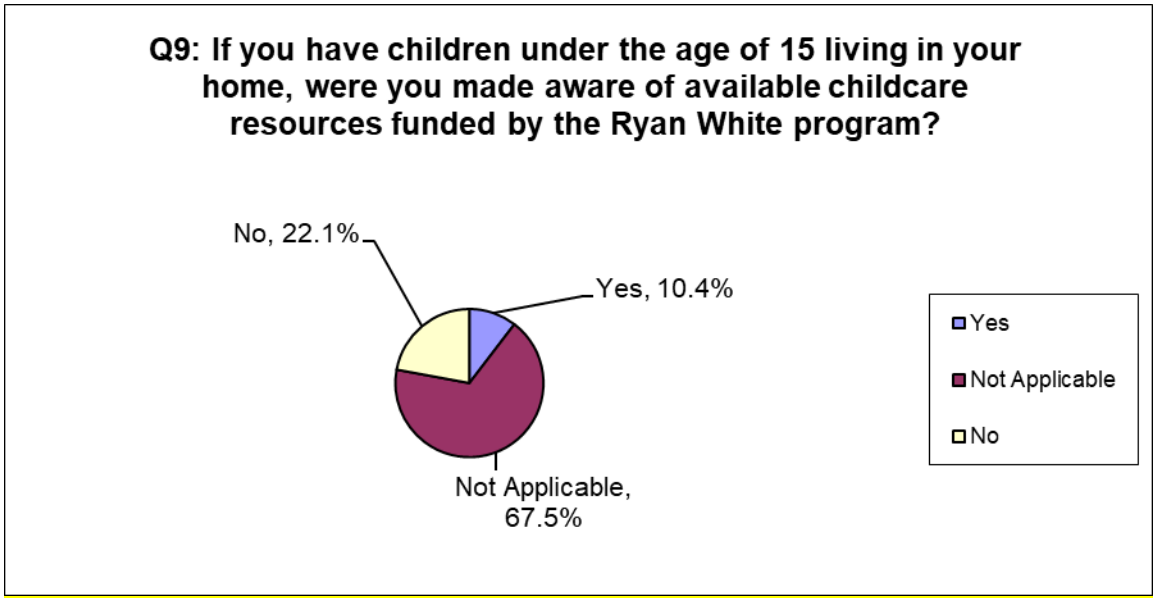
8. The staff here provides information about my eligibility for services available here and at other agencies which I may need.

98.7% of respondents (78 of 79) answered the question. Of the 78 clients responding to the question, 98.7 (77) indicated the staff did inform them about services. This is a slight decrease compared to 100% in Fiscal Year 2021.



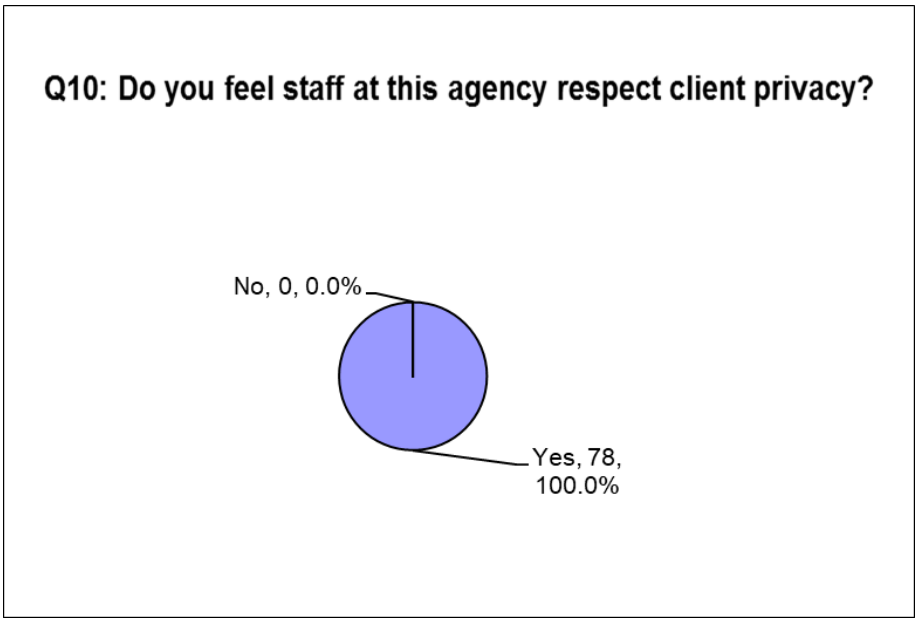
9. If you have children under the age of 15 living in your home, were you made aware of available childcare resources funded by the Ryan White program?

In Fiscal Year 2022, 77 out of 79 respondents answered the question. 67.5% (52 clients) responded that the question was not applicable to them. Of the 25 clients responding either "yes" or "no", 32% (8 clients) responded yes they were made aware of child care services; while 68% (17 clients) stated that they were not made aware of child care services.



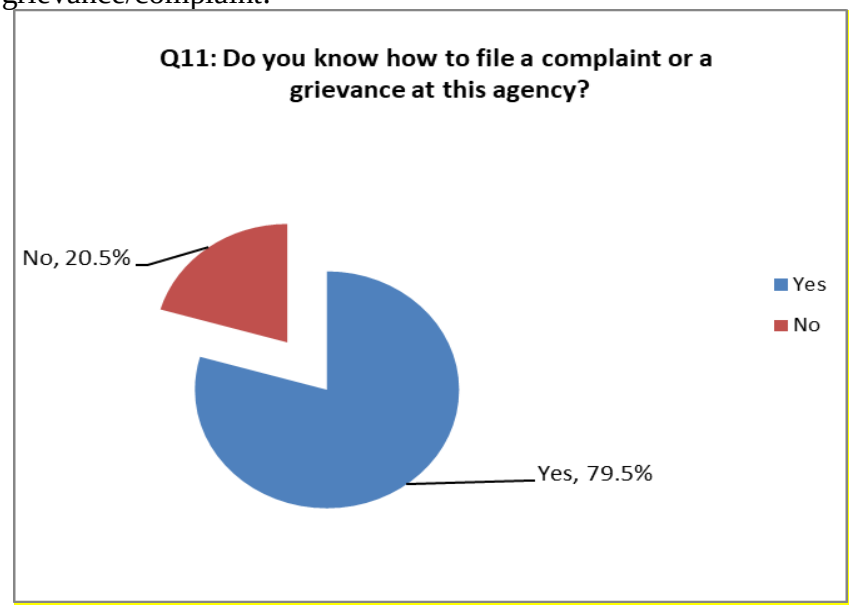
10. Do you feel that the Staff at this agency respect client privacy?

In this fiscal year, 100% of respondents (78 out of 79), indicated agency staff respect client privacy. In the prior fiscal year, 97.1% of respondents indicated that agency staff respect client privacy.



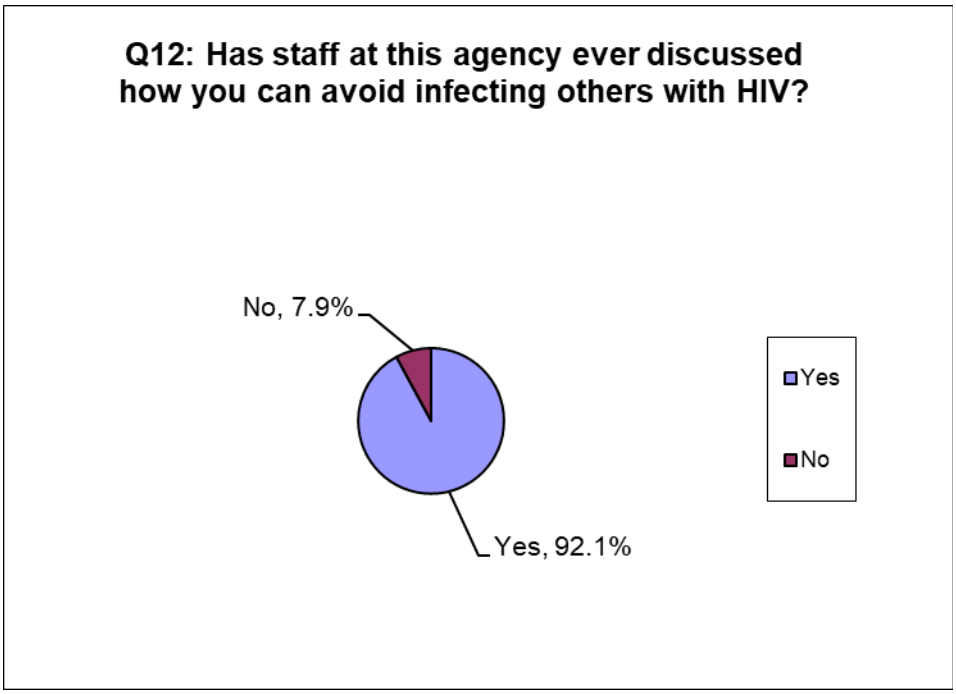
11. Do you know how to file a complaint or a grievance at this agency?

78 of 79 clients answered the question. Of the clients answering the question, 62 (79.5%), indicate they know how to file a grievance/complaint while 20.5% did not know how. This is a slight increase from FY21 in which 76.5% of clients knew how to file a grievance/complaint.



12. Has staff at this agency ever discussed how you can avoid infecting others with HIV?

In 2022, 76 out of 79 clients responded to the question, compared to 34 clients responding to the question in FY21. In 2022, the TGA saw a decrease in clients reporting that staff *discussed how to avoid* infecting others with HIV compared to fiscal year 2021. In 2022, 92.1% reported being informed about how to avoid infecting others compared to 94.1% in fiscal year 2021. Conversely, there has been a slight increase in clients reporting agencies have not discussed how to avoid infecting others. In 2022, 7.9% of clients reported *not discussing how to avoid* infecting others compared to 5.9% in 2021.



13. Please list any services provided at this agency that you needed but did not receive at this agency:

1	Gas
2	Housing
3	Housing Programs
4	Scholarship for cert. Program
5	I need vision, dental, and 1 on 1 therapy.
6	I don't know
7	More food and gas cards
8	More funds for food and gas
9	Extra food and gas
10	Not that I can think of
11	None that I can think of, but if I had to say anything it would be in regard to housing

12	Housing/Grocery Gift Cards
13	Legal Services
14	Primary Care
15	Not that I can think of
16	Housing and Career Search
17	All good
18	Every Service is Covered
19	Services ART
20	None apply, I get all the services I need
21	Computer Classes
22	Hotel Voucher
23	Free Food Coupons

14. Please list any ideas that you have for improving or adding services at this agency:

1	I don’t think so
2	Everything is okay
3	More gift cards/bus passes
4	There is nothing to improve with SFAF
5	Bus passes
6	Gas Cards and Apartment Referrals
7	Bus passes
8	Pharmacy needs to keep medication confidential and not categorize it. Please be kind and respectful.
9	None
10	I would need to receive better food in bags. Can’t eat can goods
11	Needs to increase the budget to increase for food and gas.
12	Foodbank
13	Need peer counseling, food bank, and transportation driver
14	Foodbank
15	Foodbank
16	Foodbank
17	More programs like this
18	None

19	Network with other sponsors and agencies to ensure the completion of the program with perm housing and resources.
20	Screen door and Gate Buzzer
21	More Money for services
22	More gas and more food
23	No
24	Housing/grocery gift cards
25	No ideas
26	They were perfect
27	Wish it was easier to find the clinic, need better signage
28	No ideas at the moment
29	The way referrals are done, the process needs to be sped up
30	An all women's HIV group
31	Everything is so far so good
32	None at this time
33	Please make it so that people that are in need of rental assistance do so anonymous forms so that they do not have to disclose or worry about disclosing to their landlords.
34	None
35	No ideas at the moment
36	Support groups
37	Poetry and a computer class
38	More things like bus tickets
39	Housing services, rental services
40	When possible would like to resume a women's group

15. Please rate your overall satisfaction with the services at this program:

This question had a ranking between 0 and 10 with 10 being Very Satisfied.

In Fiscal Year 2022:

Number of Responses: 77 out of 79 = 97.5% of all Respondents answered the question.

The Average of All Responses: **9.59% FY22 satisfaction rate.**

In Fiscal Year 2021:

Number of Responses: 33 out of 34 = 97.1% of all Respondents answered the question.

The Average of All Responses: **9.82% FY21 satisfaction rate.**

16. Please provide additional comments about your satisfaction rating below:

1	I've always had good results with the clinic insofar as my AOD, my case manager, and various staff members.
2	I don’t have a car and transportation to my mental health is essential.
3	Thank you very much for all your services
4	Very helpful with helping and making sure that clients are very well taken care of.
5	No
6	Golden Rule services are excellent. Anytime I need them they are always available and positive. Also very prompt.
7	I gave it a nine because there is always room for improvement.
8	I’m satisfied.
9	Golden Rule is a great organization that helps our community, understand how HIV works and gives us info on how to live better lives and tell us how to live longer.
10	Need food bank
11	There’s a counselor there that rocks.
12	A certain counselor works hard for me and helps me out
13	They are doing a good job
14	The program works if you work it
15	A counselor at the company is top notch
16	Would like more housing options
17	Thank you for everything
18	I always feel comfortable and safe being seen there
19	No changes are needed.
20	I feel the staff here are very effective and help with any extra they can. I’ve always felt that they do their best with what they have to work with.
21	Very good
22	Greater services.
23	Nice people
24	My case worker always answers my call or texts. She treats me with the utmost respect. Always lets me know of anything I can benefit from. My case worker is wonderful.
25	All medical staff has been wonderful to me.
26	I love my case manager
27	This agency has by far met all of my expectations.
28	10 so far because it is very helpful.
29	I’m safer being a client at sunburst
30	Sunburst has an amazing vibe. Instead of feeling like a place where I can receive mental health services, which can sometimes feel a bit demoralizing. The energy and comfortable pace of the staff remind
31	I love sunburst as it is.
32	None at the moment
33	Thank you
34	They have helped very much

35	Excellent agency and staff members, very little wait time, they respect your time.
36	I enjoy the people at the Sunburst office. I love the people who come to Sunburst. I ADORE MY CASE MANAGER.
37	The best thing I have seen yet
38	Golden rule services is by far the best agency in all of Sacramento that I have dealt with so far.
39	I need mental help and I get it at Sunburst.
40	The staff is very supportive
41	The assistance I receive from Sunburst is amazing.
42	I am very proud that we met. I love the services. Thank you.
43	My case manager and Executive Director are very professional and make sure all my needs are met.
44	The agency is better than any agency I ever had and I love the way my worker treats me. I think they're a perfect 10.
45	**** Four stars.
46	Wonderful.
47	Enjoy being a recipient.
48	The agency has been very supportive and kind. I appreciate them very much.
49	Everyone has been a treat. No complaints. The counselor is amazing.
50	I Have been a patient for many years, I am happy with the services. I am proud of my recovery and stable housing. I recommend my family and friend to come here.
51	My Doctors are courteous and friendly.
52	Felt great speaking with the staff. Always helpful.
53	Excellent.
54	The signs at the front show No Privacy. Coming in for either clinic.
55	Thankful.
56	The staff is always very friendly and helpful.

####

Sacramento Transitional Grant Area
2022

RYAN WHITE (RW) PROGRAM

HIV NEEDS ASSESSMENT

Improving services through direct input from People Living With HIV.

Prepared for:
The Sacramento HIV Health Services Planning Council

Prepared By:
Lili Carbone Joy, MPH
Community Health Impact (CHI)
3621 Loma Drive
Shingle Springs, CA 95682
Phone: 530.306.9861
Fax: 530.677.2194
E-mail: lcjcs@sbcglobal.net

Submitted To:
Sacramento Ryan White CARE Program
HIV Health Services Planning Council
9616 Micron Ave., Suite 930
Sacramento, CA 95827
Phone: (916) 876-5548
Fax: (916) 875-5888
Email: HIV-HSPC@SacCounty.net
Website: www.sacramento-tga.com

SACRAMENTO REGION RYAN WHITE PROGRAM
2022 HIV NEEDS ASSESSMENT

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ACKNOWLEDGMENTS

The 2022 Sacramento TGA's HIV Needs Assessment has been a collaborative effort among Ryan White (RW) Comprehensive AIDS Resources Emergency (CARE) Program, RW service providers, consumers of RW services, and the HIV Health Services Planning Council (the Council). The Council would like to recognize the following individuals and organizations for their dedication to plan, coordinate, implement and evaluate a community HIV Needs Assessment of RW clients:

Members of the HIV Health Services Planning Council

Members of the Planning Council Needs Assessment Committee:

Ronnie Miranda (Chair)
Richard Benavidez
Jake Bradley-Rowe
Kristina Kendricks-Clark
Joshua Kooman
Dennis Poupart

Ryan White Service Providers in Sacramento Region:

CommuniCare Health Centers
Golden Rule Services
Harm Reduction Services
One Community Health
Sacramento Sexual Health Clinic
Sierra Foothills AIDS Foundation
Sunburst Projects
UC Davis Pediatric Infectious Disease

Ryan White CARE Program Staff:

Danielle Caravella, MPH, Health Educator, Sacramento County DHS
Paula Gammell, MPA, RW Program Planner, Sacramento County DHS
Chelle Gossett, RW CARE Program Coordinator/AIDS Director, Sacramento County DHS

Consultant:

Lili Carbone Joy, MPH, Community Health Impact

Most importantly, the Planning Council would like to thank each Person Living with HIV/AIDS (PLWH) who took the time and effort to participate in the needs assessment process by completing the comprehensive survey. Without each of these people, the needs assessment would not have been possible.

Appreciation is extended to every survey respondent for their openness to the survey process and truthful responses to detailed questions. The results presented in this HIV Needs Assessment represent their individual and cumulative input about a vast array of issues related to HIV prevention and treatment. By learning more about PLWH, their unmet service needs and barriers to care, the Sacramento TGA can more effectively focus its resources to further meet the service needs of people living with HIV and at increased risk of HIV transmission.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H89HA00048, HIV Emergency Relief Projects Grant, in the amount of $3,518,394. This information, content and conclusions are those of the author(s) and should not be construed as the official position or policy of nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

SACRAMENTO REGION RYAN WHITE PROGRAM
2022 HIV NEEDS ASSESSMENT

EXECUTIVE SUMMARY

A. BACKGROUND

The Ryan White (RW) HIV Health Services Planning Council (HHSPC) is required by the federal Health Services Resource Administration (HRSA) to conduct a tri-annual survey of PLWH served by the RW Program as part of its RW Part A funding for the Sacramento Transitional Grant Area (TGA) of Sacramento, El Dorado, and Placer Counties. The goal of the HIV Needs Assessment is to collect and analyze input provided directly by RW clients through a standardized survey tool. The detailed analysis of RW client input assists the Council to strategically allocate funding resources to meet the service needs of clients across all demographic groups, and to reduce barriers to care through tailored delivery methods.

In 2020, due to the challenges of COVID-19, HRSA allowed each TGA to conduct a smaller survey process targeting a specific subpopulation once it could safely do so according to CDC guidelines. Given the trends of the HIV epidemic over time, the Council voted to survey young adults ages 19-29 in 2020-21. Of the 190 youth and young adult RW clients served in FY20, 18 PLWH completed the survey, which was 9.5% of the target population.

Thankfully, the Council was able to return to a full RW Client Needs Assessment in 2022. Of the 2,408 RW clients served in FY2021/22, 7.9% (191) completed the survey. This response rate is higher than the 7.3% of RW clients who completed the most recent comprehensive survey of all ages of RW clients which was conducted in 2018, prior to the COVID-19 pandemic. The current 2022 HIV Needs Assessment of RW clients uses the 2018 Needs Assessment survey as the baseline for comparative analysis, along with findings from the 2020 Youth and Young Adult HIV Needs Assessment as applicable.

B. DEMOGRAPHICS, HIV EPIDEMIOLOGY AND CO-OCCURRING CONDITIONS

B-1. Demographics of Need Assessment Respondents

The 2022 survey respondents were representative of the TGA's HIV/AIDS epidemiology and 2021 RW client caseload in terms of race, gender, mode of HIV transmission, county of residence, housing status and poverty level with few exceptions.

Race. Racial representation among Latinx increased between the 2018 and 2022 Needs Assessment, from 18% to 24%. African Americans, whose representation among RW clients in 2021 was close to 4 times greater than their representation in the TGA's general population (26% vs. 7%), were 28% of the 2022-23 Needs Assessment survey respondents. Whites were underrepresented among 2022 survey respondents compared to their representation among 2021 RW clients (37% vs. 43%).

Gender. Males were underrepresented among 2022 survey respondents as compared to their representation among 2021 RW clients (68% vs. 79%), while female RW clients were overrepresented among survey respondents (24% vs. 19%). Transgender Male to Female and Non-Binary were each 2% of 2022 survey respondents and 4% did not specify gender.

Age. RW clients ages 20-44 were underrepresented among survey respondents (25% vs. 37%) while RW clients ages 45 and older were overrepresented (72% vs. 63%).

Mode of HIV transmission. Men who have Sex with Men (MSM) were underrepresented among 2022 survey respondents compared to their representation among 2021 RW clients (47% vs. 58%) while those who did not specify were overrepresented (14% vs. 4%).

Housing Status. The 2022 survey asked RW clients which places they had lived over the prior 12-months. A large percentage (26.2%) reported they had been homeless (car, camping, street), or in temporary housing (shelter, motel). This extreme rate of homelessness/temporary housing among RW clients continues to be disproportionately high when compared to the TGA's general population, which was 0.48% based on the 2022 Point-in-Time homeless count coordinated by the US Department of Housing and Urban Development (HUD). It must be noted that HUD's count includes those who report being unsheltered, in emergency shelter or in temporary shelter on the day of being surveyed, rather than anytime during the prior 12-months as in the RW survey.

County of residence. 85% of 2022 survey respondents were from Sacramento County, 8% from Placer, 1% from El Dorado, 9% from Yolo and 2% unspecified. RW clients from all counties in the TGA were well represented in the 2022 survey with the exception of El Dorado, which were 4% of 2021 RW clients.

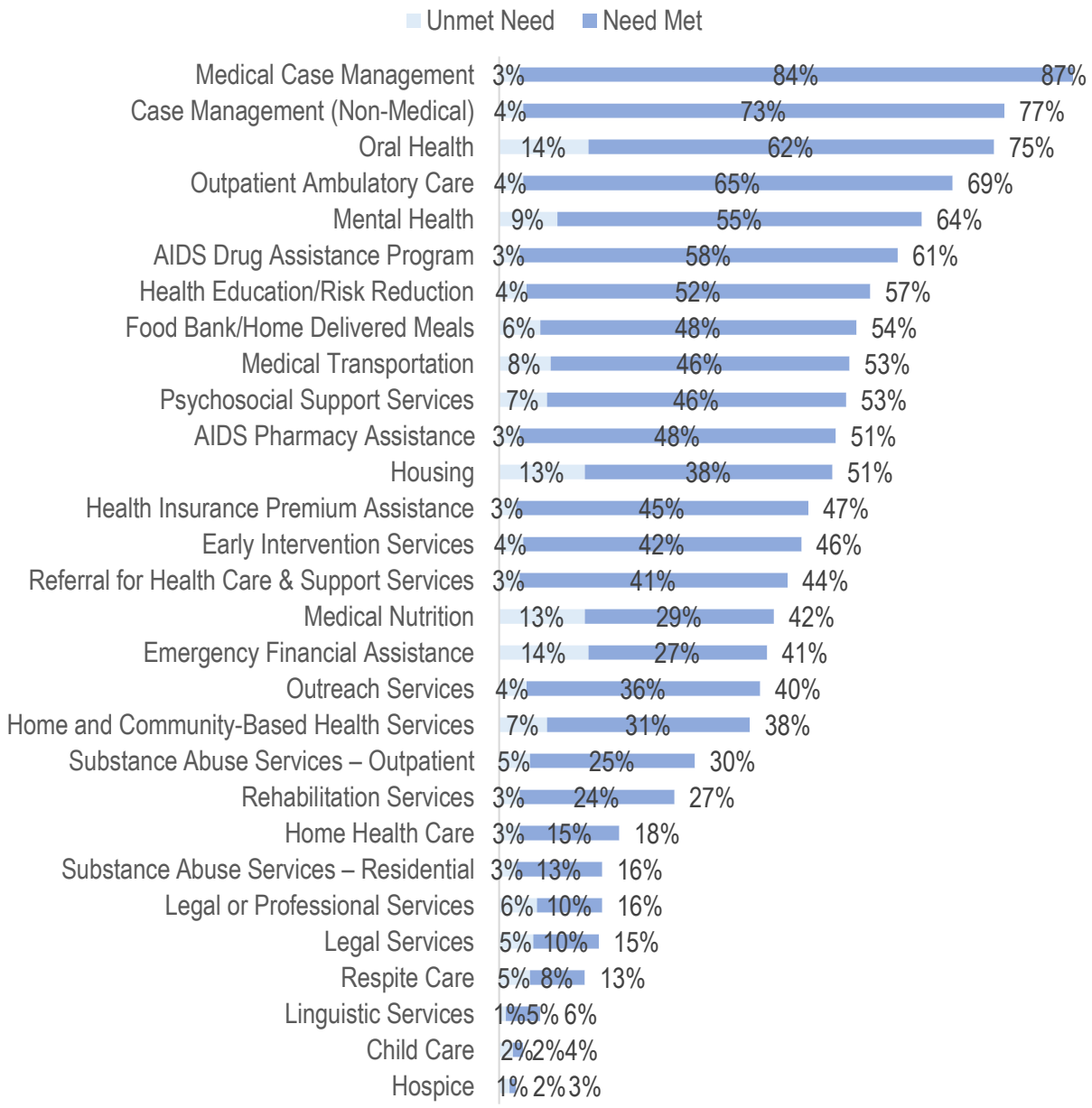
Poverty level. RW funded services are used as "payer of last resort" and each RW client must have no other means of paying for services. 70.2% of 2021 RW clients and 60.7% of 2022 survey respondents and were living below the Federal Poverty Level (e.g., <$13,590 for an individual) as compared to 11.1% of the TGA general population in 2021.

C: SERVICE DEMAND AND UNMET NEED

C-1. Service Demand: Need Met plus Unmet Need

Service Demand (Total Need) includes the percent of survey respondents who reported that they needed and received the service (Need Met) ***plus*** the percent who needed the service but could not receive it due to at least one barrier to care (Unmet Need). For example, as shown in the following bar graph, Medical Case Management has the highest Total Need (87%) which is a sum of Unmet Need (3%) + Need Met (84%). Non-Medical Case Management had the second highest service demand (77%) with 73% need met and 4% unmet need.

Service Demand (Unmet Need plus Need Met) by Service Category
2022 Needs Assessment



a. Service Demand: Demographic Disparities

Demographic Disparities in service demand are provided in this section with overall demand noted for each service category in parentheses. Highlighted disparities are those that have a difference of more than 10% between one demographic group and the next highest group among the demographic categories.

Gender

- Women reported at least 10% greater need than men for the following services: Mental Health, Medical Transportation, Housing, Medical Nutrition, Emergency Financial Assistance, and Home/Community Based Health Services.
- Men reported at least 20% greater need than women for ADAP and Health Insurance Premium Assistance.

Race

- Whites reported at least 10% greater need for Ambulatory Care than Blacks and Hispanics.
- Blacks reported at least 10% greater need for Home/Community-Based Health Services and Housing than Whites and Hispanics.

Mode of HIV Transmission

- Compared to Heterosexuals and MSMs, IDUs reported at least 10% greater need for Medical Case Management, ADAP, Psychosocial Support Services, AIDS Pharmacy Assistance, Housing, Early Intervention Services, Referral for Health Care and Support Services, Home/Community-Based Health Services, Substance Abuse Services (both Outpatient and Residential), and Legal or Professional Services
- Heterosexuals reported at least 10% greater need for Medical Nutrition than IDUs or MSMs.

Age

- Compared to those aged 45+, respondents ages 20-44 reported at least 10% greater need for Health Insurance Premium Assistance, Early Intervention Services, Referral for Health Care and Support Services, Emergency Financial Assistance, Outreach Services, and Legal or Professional Services.
- Respondents aged 45+ reported at least 10% greater need for Medical Case Management, Medical Nutrition, and Home/Community Based Health Services compared to those aged 20-44.

Housing Status

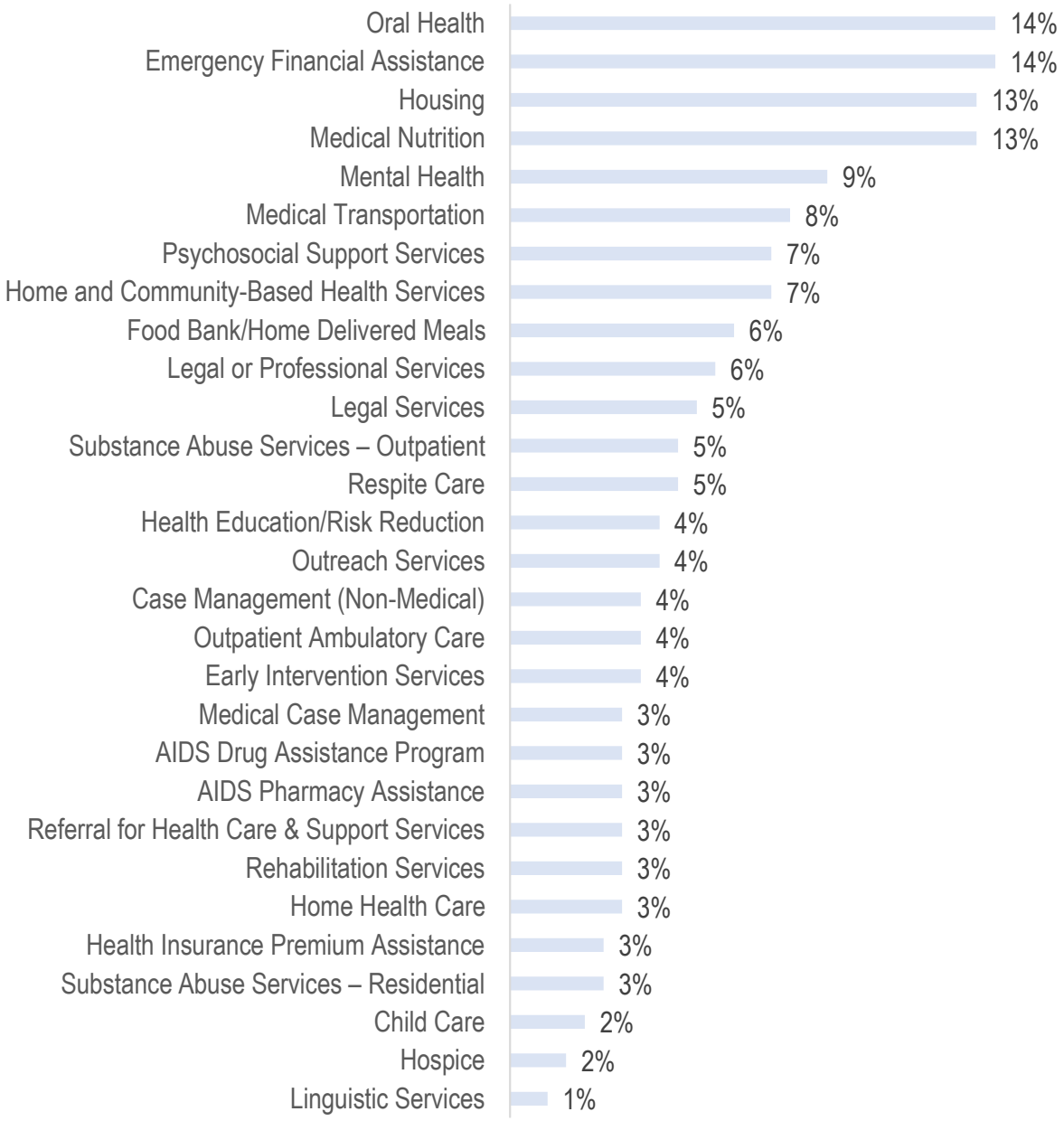
- Respondents with stable housing reported at least 10% greater need for Ambulatory Care and Home/Community Based Health Services than those with unstable housing.
- Compared to respondents with stable housing, those with unstable housing reported at least 10% higher need in many categories, with 20% greater need for Food Bank / Home Delivered Meals, Housing, Referral for Health Care and Support Services, Emergency Financial Assistance, Outpatient Substance Abuse Treatment, and Legal or Professional Services.

C-2. Unmet Need by Service Category

Unmet Need by service category is the percentage of respondents who needed but did not receive the service due to at least one Barrier to Care for that service. As can be noted from the definition above, Unmet Need is a subset of Service Demand. Unmet Need is a critical factor to analyze in determining which services RW clients are having the greatest difficulty obtaining due to barriers to care.

The following bar graph ranks the services with unmet need from highest to lowest. The five services with the highest unmet need include: Oral Health, Emergency Financial Assistance, Housing, Medical Nutrition and Mental Health Services.

Unmet Need by Service Category
2022 Needs Assessment



a. Unmet Need: Demographic Disparities

Demographic Disparities in unmet need are provided in this section and highlight disparities that have a difference of more than 10% between one demographic group and the next highest group among the demographic categories.

Gender

- Women reported at least 10% greater unmet need than men for Medical Transportation and Medical Nutrition.

Race

- African Americans have at least a 10% higher unmet need for Medical Nutrition than Whites and Hispanics

Mode of HIV Transmission

- IDU's have at least a 10% greater unmet need for Psychosocial Support Services and Legal or Professional Services compared to Heterosexuals or MSMs.

Age

- Compared to those aged 45+, respondents ages 20-44 reported a 10% greater unmet need for Emergency Financial Assistance.

Housing Status

- Respondents experiencing unstable housing report a 12% greater unmet need for Emergency Financial Assistance compared to those in stable housing.

D. BARRIERS TO CARE

D-1. Barriers to Care

The primary goal of the Needs Assessment survey process is to identify strategies to reduce barriers to care so that service demand and unmet need can be met for the majority of service categories across all demographic groups. As described above, Barriers to Care assessed in the survey are organized under five types of barriers: Knowledge, Access, Financial, Personal and Health.

a. Barriers to Care Categories

In the 2021 Young Adult HIV Needs Assessment survey tool, the barriers to care section was improved by specifying that the section only needed to be completed for those services that had an unmet need (client checked box that they needed the service but did not receive it due to a barrier to care). To add further depth to the survey tool in 2022, barriers to care were asked separately by each service category to learn what barriers were more likely to decrease access to which services.

To help the TGA gain a better understanding about which level of the service system the barriers to care exist, they were classified into five categories of "Knowledge", "Access," "Financial," "Personal" and "Health". The barrier to care categories go from examining broad-based TGA-wide "Access" and "Knowledge" issues to more specific client-based "Financial", "Health" and "Personal" issues. The following provides a description of barriers to care categories covered in the 2022 Needs Assessment:

- **Knowledge Barriers** include facts not known by the client that limit access to services, such as: "Didn't know service was available", "Didn't know I was eligible for service", "Didn't know how to get service", "Didn't know where to receive service".

- **Access Barriers** include factors that limit a client's ability to access a service when they need it and include barriers such as: "Appointments not soon enough", "Times not convenient,", "No childcare", "Language barriers" and "No cell phone".

- **Financial Barriers** include issues such as: "Co-pay was too high", "Service costs too much" and "No insurance coverage".

- **Personal Barriers** include issues that create challenges to accessing services, such as: "Treated with disrespect," "Jail/Prison history": and "Wanted privacy of HIV status, mental health or substance use".

- **Health Barriers** include medical issues such as: "Didn't want to take medications"; "Hard to navigate system due to physical, mental or substance use issues"; "Thought viral load was undetectable".

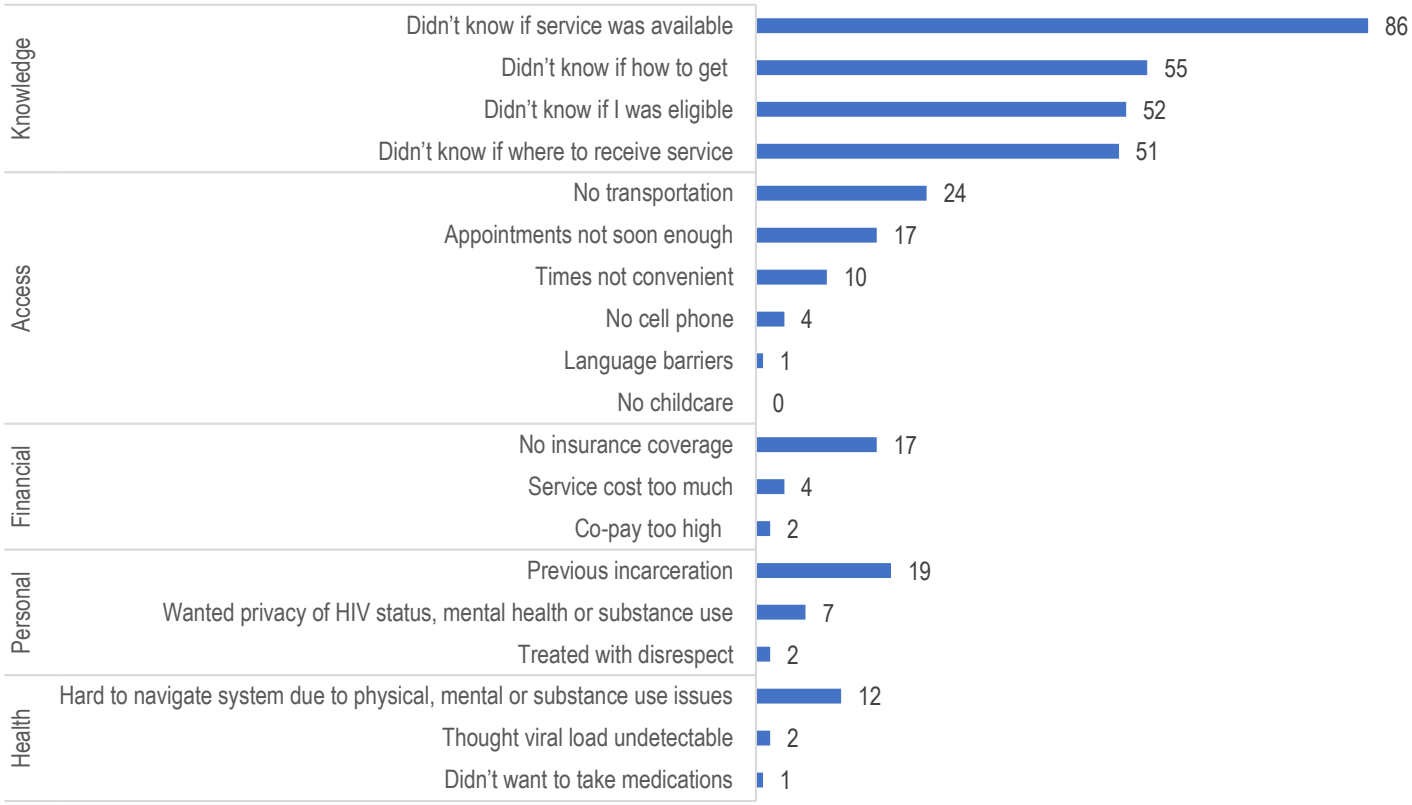
b. Barriers to Care Category Rankings

The primary goal of the Needs Assessment survey process is to identify strategies to reduce barriers to care so that service demand and unmet need can be met for the majority of service categories across all demographic groups. As described above, Barriers to Care assessed in the survey are organized under five types of barriers: Knowledge, Access, Financial, Personal and Health.

Respondents with unmet needs most commonly reported barriers to care in the following two areas: Knowledge Barriers (31%) and Access Barriers (15%). The least commonly reported barriers to care for respondents with unmet need were related to the respondents' Health (4%).

At Least One Knowledge Barrier	At Least One Access Barrier	At Least One Financial Barrier	At Least One Personal Barrier	At Least One Health Barrier
31%	15%	8%	6%	4%

Several respondents that indicated at least one barrier to care in a barrier category (e.g., Knowledge Barrier) may not have selected a specific sub-barrier to care (e.g., didn't know how to get).



c. Barriers to Care by Service Category

Follows is a graphical display of the barriers to care reported by service category by 2022 survey respondents. This table shows the type and frequency of barriers to care by service category, with services having the highest unmet need at the top. For example, 14% of respondents indicated an unmet need for Emergency Financial Assistance. Of these respondents, 77% indicated they had a knowledge barrier to receiving that service.

BARRIERS TO CARE BY SERVICE CATEGORY AND BARRIER CATEGORY
Ranked by Unmet Need

Category	% with Unmet Need	% with Knowledge Barrier	% with Access Barrier	% with Financial Barrier	% with Personal Barrier	% with Health Barrier
Emergency Financial Assistance	14%	77%	8%	8%	8%	4%
Oral Health	14%	42%	31%	19%	0%	4%
Housing	13%	56%	20%	8%	20%	8%
Medical Nutrition	13%	76%	20%	4%	12%	0%
Mental Health	9%	35%	18%	6%	12%	6%
Medical Transportation	8%	80%	27%	13%	7%	13%
Home and Community-based Health Services	7%	79%	14%	7%	7%	7%
Psychosocial Support Services	7%	50%	36%	21%	7%	14%
Food Bank/Home Delivered Meals	6%	92%	17%	0%	17%	0%
Legal or Professional Services	6%	91%	9%	9%	9%	9%
Legal Services	5%	100%	10%	10%	10%	0%
Respite Care	5%	78%	11%	11%	0%	0%
Substance Abuse Services – Outpatient	5%	44%	33%	0%	22%	11%
Health Education/Risk Reduction	4%	63%	13%	0%	13%	0%
Outreach Services	4%	75%	13%	13%	13%	13%
Case Management (Non-Medical)	4%	57%	14%	0%	29%	0%
Early Intervention Services	4%	71%	14%	14%	14%	0%
Outpatient Ambulatory Care	4%	43%	43%	14%	14%	0%
AIDS Drug Assistance Program	3%	83%	0%	0%	0%	0%
AIDS Pharmacy Assistance	3%	100%	0%	0%	0%	0%
Home Health Care	3%	83%	0%	0%	0%	0%
Medical Case Management	3%	50%	0%	0%	17%	17%
Referral for Health Care & Support Services	3%	83%	17%	17%	17%	17%
Rehabilitation Services	3%	100%	33%	0%	17%	17%
Health Insurance Premium Assistance	3%	20%	20%	80%	0%	0%
Substance Abuse Services – Residential	3%	60%	0%	0%	0%	0%
Child Care	2%	25%	25%	0%	25%	0%
Hospice	2%	33%	0%	0%	33%	33%
Linguistic Services	1%	50%	0%	0%	0%	0%

d. Sub-Barrier Categories by Service Category

Knowledge Barriers

- Emergency Financial Assistance, Medical Nutrition and Housing were among the services with the most respondents indicating at least one knowledge barrier to care.

- Among the more commonly reported knowledge barriers to services were respondents a) not knowing Emergency Financial Assistance and Medical Nutrition were available and b) not knowing how to get Housing services.

Access Barriers

- Oral Health, Housing, Medical Nutrition and Psychosocial Support Services were among the categories with the most respondents indicating at least one access barrier to care.
- Among the more commonly reported access barriers to services were respondents indicating oral health appointments were not soon enough.

Financial Barriers

- Oral Health, Health Insurance Assistance and Psychosocial Support Services were among the categories with the most respondents indicating at least one financial barrier to care.
- Among the more commonly reported financial barriers to services were respondents indicating they did not have insurance coverage for Oral Health, Health Insurance Assistance and Psychosocial Support Services.

Personal Barriers

- Housing and Medical Nutrition were among the categories with the most respondents indicating at least one personal barrier to care.
- Among the more commonly reported personal barriers to services were respondents indicating previous incarceration contributed to unmet Housing needs.

Health Barriers

- Housing and Medical Transportation were among the categories with the most respondents indicating at least one health barrier to care.
- Among the more commonly reported health barriers to services were respondents indicating their own health issues made it hard to navigate the system, resulting in unmet Housing needs.

e. Barriers to Care: Demographic Disparities

This following table shows the percentage of respondents in each demographic group indicating at least one barrier resulting in an unmet need in one or more service categories.

- IDUs were at least 10% more likely to report at least one access or personal barrier to care than Heterosexuals or MSMs.
- Respondents experiencing unstable housing were 13% more likely to report at least one knowledge barrier compared to respondents in stable housing.

BARRIERS TO CARE
CLIENT DEMOGRAPHICS

Demographic		At Least One Knowledge Barrier	At Least One Access Barrier	At Least One Financial Barrier	At Least One Personal Barrier	At Least One Health Barrier
Overall		31%	15%	8%	6%	4%
Gender	Female	36%	16%	7%	4%	7%
	Male	28%	16%	8%	6%	3%
Race	African American	31%	15%	6%	7%	6%
	Hispanic / Latinx	26%	13%	9%	9%	2%
	White	32%	17%	10%	3%	3%
Transmission	Heterosexual	35%	13%	6%	2%	4%
	IDU	39%	***33%***	11%	***17%***	11%
	MSM	26%	13%	9%	7%	3%
Age	20-44	29%	10%	8%	6%	6%
	45+	31%	17%	8%	6%	4%
Housing	Stable Housing	27%	15%	8%	4%	2%
	Unstable Housing	***40%***	15%	8%	10%	8%

Note: RW survey asked "over last 12-months, have you lived in any of following places: stable (housed); unstable (homeless, car, camping, street, shelter, motel couch surfing).

E. HIV PREVENTION PRACTICES AND PARTNER SERVICES

E-1. HIV Prevention Practices

Pre-Exposure Prophylaxis (PrEP)

The last two HIV Needs Assessments, the 2021 survey of young adults ages 19-29, as well as the current 2022 survey of all ages of RW clients, have included questions about HIV prevention practices, including PrEP. PrEP is the use of anti-retroviral medications (ART) to help keep HIV negative people from becoming infected with HIV. 2022 RW clients living with HIV reported that only 23% of them had ever heard of PrEP prior to completing the Needs Assessment Survey. This finding is concerning given the effort that has been made in the Sacramento TGA over the last several years to increase the use of PrEP.

- 23% of all ages of survey respondents had never heard of PrEP.
- Of those who had heard about PrEP, 11% of young adults and 9% of all ages were not sure how PrEP would affect their sex life.
- Only 33% of 2021 young adults and 23% of 2022 all ages of respondents reported that they feel comfortable talking to their HIV negative partner(s) about PrEP.
- Less than half of survey respondents (44% of young adults and 37% of all ages) reported they would disclose that they are HIV positive if their partner was on PrEP.

Condom Use

- 15% of RW clients surveyed in the 2022 Needs Assessment reported use of a condom when they have vaginal or anal sex
- 12% of RW clients living with HIV reported they don't use condoms because their viral load is undetectable

HIV Disclosure

RW clients' disclosure of their HIV status to sexual partners needs improvement to effectively decrease the spread of HIV and other STIs and to decrease stigma associated with HIV/STIs. Overall, young adult RW clients ages 19-29 surveyed in 2021 disclosed their HIV status at higher rates than all ages of RW clients surveyed in 2022, as follows:

- 58% of RW clients surveyed in 2022 reported they always disclose their HIV status to every sex partner.
- 6% reported that they sometimes disclose their HIV status with some partners.
- 36% reported they never report their HIV status because they don't have sex (21%); viral load is undetectable (5%); always use condoms (3%); partners are HIV+ (3%), don't feel comfortable disclosing (3%); or most of partners are on PrEP (1%).

E-2. Partner Services

The last two Needs Assessments of PLWH in the TGA's RW Program, the 2021 survey of young adults ages 19-29, as well as the current 2022 survey of all ages of RW clients, have included questions about Partner Services. These services, which are free to all RW clients, assist HIV positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV. As can be seen below, there clearly is more work that needs to be done to educate all RW clients and PLWH in the TGA about Partner Services and to facilitate their use of these important services to prevent new HIV transmissions.

- Less than half of RW clients surveyed in 2022 (41%) reported that they had been informed of Partner Services before completing the Needs Assessment survey tool.
- Only 12% of RW clients surveyed in 2022 had ever used Partner Services, which was only slightly higher than the 6% of young adult clients surveyed in 2021.
- Although prior use of Partner Services is extremely low, it's encouraging that 43% of all RW clients surveyed in 2022 reported that they would be willing to use Partner Services.

F. IMPLICATIONS OF NEEDS ASSESSMENT FINDINGS

F-1. Implications for RW Priority Setting and Allocations

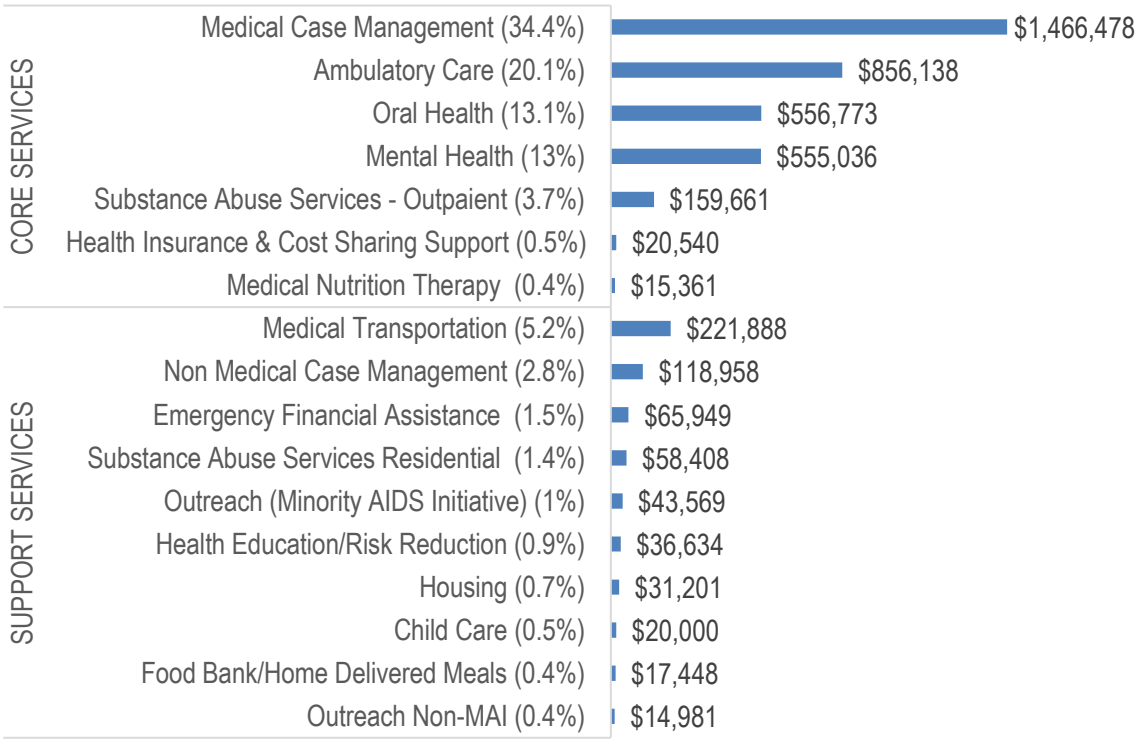
a. FY22 RW Program Direct Service Allocations

To use the data from the Needs Assessment Survey to assist the Planning Council in Setting Priorities and Allocations, it is important to understand Ryan White funding in the context of other TGA funding sources for PLWH. The RW CARE Act strives for 100% access to care for all persons living with HIV/AIDS, regardless of their ability to pay, and is required to use its funds as a "payer of last resort" by maximizing resources from other funding sources prior to using RW CARE Act funds.

Within the Sacramento TGA, FY22 expenditures for each direct service category of the Ryan White Part A, RW Part A Minority AIDS Initiative (MAI), and California State RW Part B and Part B MAI programs, for each service category, are shown in the following bar graph. Medical Case Management was the largest direct service

expenditure at 34.4%; Ambulatory/Outpatient Medical Care was the second largest expenditure at 20.1% and Oral Health Services was the third highest expenditure at 13.1%.

FY22 RW CARE Program (Part A, Part A MAI, Part B, and Part B MAI Funds)
Direct Service Allocations



a. Direct Service Allocations 2020 Compared to 2022

The following table displays allocations by service category for FY20 compared to FY22, including absolute and percentage changes. Overall funding increased by $633,635, a 17% change. Medical Case Management and Oral Health had the largest absolute increases, $278,419 and $202,855 respectively. Also, Health Insurance Cost Sharing and Residential Substance Use Treatment increased by 162% and 402% respectively. There were some categories with significantly reduced allocations, notably Non-Minority AIDS Initiative (MAI) outreach (-77%), Medical Nutrition Therapy (-69%), Child Care, (-21%), and Outpatient Substance Use Treatment (-21%).

CHANGE IN RW DIRECT SERVICE ALLOCATIONS
FY2020 AND FY2022

Core/Support	Service Category	2020	2022	Δ	%Δ
CORE SERVICES	Medical Case Management	$1,188,059	$1,466,478	+$278,419	+23%
	Ambulatory Care	$854,758	$856,138	+$1,380	+0%
	Oral Health	$353,918	$556,773	+$202,855	+57%
	Mental Health	$452,030	$555,036	+$103,006	+23%
	Substance Abuse Services - Outpatient	$200,981	$159,661	-$41,320	-21%
	Health Insurance & Cost Sharing Support	$7,803	$20,540	+$12,737	+163%
	Medical Nutrition Therapy	$48,865	$15,361	-$33,504	-69%
SUPPORT SERVICES	Medical Transportation	$155,382	$221,888	+$66,506	+43%
	Non-Medical Case Management	$85,412	$118,958	+$33,546	+39%
	Emergency Financial Assistance	$78,457	$65,949	-$12,508	-16%
	Substance Abuse Services Residential	$11,642	$58,408	+$46,766	+402%
	Outreach (Minority AIDS Initiative)	$35,169	$43,569	+$8,400	+24%
	Health Education/Risk Reduction	$29,048	$36,634	+$7,586	+26%
	Housing	$16,296	$31,201	+$14,905	+91%
	Child Care	$25,200	$20,000	-$5,200	-21%
	Food Bank/Home Delivered Meals	$18,178	$17,448	-$730	-4%
	Outreach Non-MAI	$64,192	$14,981	-$49,211	-77%
	TOTAL	$3,627,410	$4,261,045	+$633,635	+17%

b. Implications for Priority Setting

The 2022 HIV Needs Assessment provides input from RW clients who are living with HIV. The analysis of client input regarding service demand, unmet need and barriers to care for treatment services, as well as prevention and support services, provides the HIV Planning Council with important information for making priority setting decisions for the Sacramento TGA.

There were several services that were ranked with both a high service demand *and* a high unmet need by survey respondents. These services are particularly important to improve access to because clients need them at a high rate, but they have not been able to receive them due to high rates of barriers to care.

The following 7 services - out of 29 services - ranked the highest for combined service demand and unmet need in the 2022 HIV Needs Assessment with "High" defined as a ranking in the top half of service categories for both demand and unmet need. These disparities are imperative to address while establishing priorities for the RW Program.

HIGHEST RANKED SERVICES
TOP HALF FOR BOTH SERVICE DEMAND AND UNMET NEED
2022 Needs Assessment

Service Category	2022 Unmet Need	2022 Unmet Need Rank	2022 Total Demand	2022 Total Demand Rank
Oral Health	14%	1	75%	3
Mental Health	13%	3	51%	12
Food Bank / Home Delivered Meals	9%	5	64%	5
Housing	8%	6	53%	9
Medical Transportation	7%	7	53%	10
Psychosocial Support Services	6%	9	54%	8
Health Education/Risk Reduction	4%	14	57%	7

- ***Oral Health.*** Despite a recent increase in funding between FY20 and FY22. Oral Health has the highest unmet need and is the third highest in overall demand. This input clarifies that additional funding for and access to Oral Health continues to be of primary importance to RW clients.

- ***Mental Health.*** There was a lower percent increase in funding for Mental Health than Oral Health over the last two years; but Mental Health still ranks highly in both unmet need (#3) and service demand (#12).

  Food Bank and Home Delivered Meals receive the second lowest RW FY22 funding level, however, this category has the fifth highest overall demand and fifth highest unmet need compared to other service categories.

- ***Housing Services.*** FY22 funding for Housing services is among the lowest levels compared to other service categories, however, it is the ninth highest in service demand and is the sixth highest in unmet need.

- ***Medical Transportation.*** Despite a recent increase in funding for FY22, Medical Transportation is among those services with the highest unmet need and service demand.

- ***Psychosocial Support Services*** are among those services with the highest unmet need and service demand; however, these services are not part of the FY22 budget.

- ***Health Education and Risk Reduction.*** FY22 funding is among the lowest levels compared to other service categories, however, it is among the highest in demand and unmet need.

- ***Partner Services*****,** which assist PLWH in notifying sexual and/or needle sharing partners of possible HIV exposure, was significantly underutilized by 2022 respondents. 59% reported they hadn't been informed of Partner Services before this survey. 56% reported they would use Partner Services but only 12% had used them before. There is more funding needed to educate PLWH about Partner Services and to facilitate their use.

- ***Pre-Exposure Prophylaxis (PrEP),*** the use of medications to reduce HIV transmission was significantly underutilized by 2022 survey respondents. 23% had never heard of PrEP. Of those who had heard about PrEP, 9% were not sure how PrEP would affect their sex life; 77% reported that they don't feel comfortable

talking to their HIV negative partner(s) about PrEP; and 83% reported they wouldn't use condoms for sex if their partner was on PrEP. Education about PrEP and referrals to PrEP navigation services need to be an integral part of the HIV Continuum of Care.

- 23% of all ages of survey respondents had never heard of PrEP.
- Of those who had heard about PrEP, 11% of young adults and 9% of all ages were not sure how PrEP would affect their sex life.
- Only 33% of 2021 young adults and 23% of 2022 all ages of respondents reported that they feel comfortable talking to their HIV negative partner(s) about PrEP.
- Less than half of survey respondents (44% of young adults and 37% of all ages) reported they would disclose that they are HIV positive if their partner was on PrEP.

a. <u>Implications for Allocations</u>

- ***Oral Health, Housing, Emergency Financial Assistance, and Medical Nutrition*** had much higher unmet needs than other categories: 13-14% of respondents had unmet needs in these four categories vs 9% or fewer for all other categories. Of these, Oral Health and Housing also were in the top half in total demand, with more than half of respondents indicating a need for these two services, a large proportion of which went unmet.

- ***Oral Health and Housing.*** These gaps between supply and demand for Oral Health and Housing persist despite recent significant increases in allocations (+57% and +91% respectively between 2020 and 2022). Given these persistent gaps, allocations for these services should be revisited.

- ***Oral Health, Outpatient Medical Care and Mental Health.*** The FY22 allocation for Oral Health of $556,773 was similar to or less than the allocations for Outpatient Care and Mental Health, although client demand and unmet need for the latter two were lower than for Oral Health. These three categories comprised 56% of the total FY22 allocations, and because of their magnitude, they demand extra scrutiny to ensure client needs are being appropriately prioritized. The primary barrier unique to Oral Health that should be addressed when revisiting allocations is appointment availability.

- ***Housing.*** The $31,201 RW allocation in FY22 for Housing was among the lowest for all service categories and was less than 1% of total allocated for the fiscal year. 2022 COVID funds also were used for housing to supplement RW funding. The magnitude of funding for Housing services should be revisited given the high demand and unmet need. Greater attention and outreach also should be afforded to communities for which housing needs appear to be greater, including women, IDUs, and clients who have a history of experiencing unstable housing.

- ***Emergency Financial Assistance and Medical Nutrition.*** While demand may not be high, unmet needs for these services are among the most prominent. Despite this gap, the cumulative allocations for these two services are less than 2% of the $4.3 million total for FY22. In addition to revisiting the magnitude of allocations for these services, special attention should be paid to communities in greatest need, including women and blacks for Medical Nutrition; and clients experiencing unstable housing along with those age 20-44 for Emergency Financial Assistance.

- ***Food- and Meal-related Services*** were the fifth highest in overall demand and unmet need, however the category is the second lowest among all allocations at $17,448, or 0.4% of total. Notably, allocations in this

category were reduced since FY20 even though the allocations increased overall by 17%. Considering the level of demand and unmet need for food and meals, the magnitude of funding for these services should likely continue to be revisited in future years. In 2023, for example, the Council allocated an additional $32,500 to this service category.

F-2. IMPLICATIONS FOR SERVICE SYSTEM IMPROVEMENTS

Although not meant to be an exhaustive list of strategies, follows are examples of improvements for the HIV Health Services Planning Council to consider by focusing on services with the highest reported unmet need and barriers to care among survey respondents. In addition, these systemic improvements should be targeted to subpopulations with disproportionate unmet need and barriers to care.

- Knowledge barriers for RW clients were the top four most commonly reported barriers to care, as follows: 1) didn't know service was available, 2) didn't know how to get the service, 3) didn't know if I was eligible and 4) didn't know where to receive the service. Improved outreach and case management for PLWH should continue to be prioritized and models of care should continue to be enhanced. Service providers should work to improve awareness of available services through direct client contact at all levels of care, including targeted outreach, case management and educational campaigns.

- The RW Program should continue to use its sophisticated database, Sacramento HIV/AIDS Reporting Engine (SHARE), to keep RW service providers informed about clients who are not retained in outpatient medical care. For example, SHARE generates a monthly laboratory report which tracks the date of each client's most recent CD4 and HIV viral load tests and distributes analysis to each RW service provider. This report, among others, should continue to be distributed to RW service providers to assist them in identifying clients who are out of HIV medical care; to resolve data issues; to track progress of CQI projects; to identify areas for program improvement; and to assist with retaining clients in all aspects of medical care.

- To support retention in ongoing medical care, Case Managers and other support staff could increase efforts to contact patients directly to inquire about needs and encourage re-entry into medical care. All RW service agencies should continue making appointment reminder calls, facilitating transportation assistance; and implementing/maintaining "no-show" tracking and follow up protocols including contacting patients within 24 hours of any missed appointment.

- RW service agencies should be encouraged to increase use of peer advocates to provide outreach to specific populations and locations to get and retain PLWH in ongoing medical care.

- The Council could consider increased technical assistance, capacity building and networking with current RW service organizations throughout the TGA to educate them about findings and implications of the Needs Assessments to work towards a collaborative approach to improving the overall HIV system of care in the TGA.

- The Council should continue to network with other organizations throughout the Sacramento Region to maximize additional funding opportunities and services for PLWH.

- The Planning Council's Quality Advisory Committee should continue to involve RW consumers in quality improvement efforts by collecting feedback through the annual postcard survey to evaluate services. Expanded efforts to solicit input from PLWH and service providers should be explored as part of the RW Program's

Continuous Quality Improvement (CQI) efforts. For example, facilitated focus groups should be conducted to evaluate the RW program delivery system, including coordination of care and collaboration between service providers.

F-3. IMPLICATIONS FOR FUTURE NEEDS ASSESSMENTS

The HIV Needs Assessment Survey Tool was revised for 2022 to streamline the questions of Service Need, Need Met, and Unmet Need by RW service category. In addition, the survey collected data on Barriers to Care, and Sub-Barriers by service category. This format resulted in more consistent answers from survey respondents as compared to the TGA's past needs assessments. The survey was able to be completed in less time and with less confusion among survey respondents than in previous surveys.

Based on the responses from the new survey format in 2022, there are several potential improvements to both the survey format and content that could help improve the reliability and utility of survey responses for the next survey. There are several questions that the Council, through its Needs Assessment Committee (NAC), may consider making adjustments to for future Needs Assessment Survey Tool and survey process. These recommendations are made at the conclusion of this report (see Section F-4).

SECTION A: METHODOLOGY

A-1. BACKGROUND

The Sacramento HIV Health Services Planning Council (Council) is responsible for the prioritization and allocation of funding under the Ryan White (RW) Treatment Extension Act of 2009 - formerly the RW Comprehensive AIDS Resources Emergency (CARE) Act. A unique characteristic of the RW CARE Act is its inclusion of local control of funding decisions and, very importantly, input from People Living with HIV (PLWH) into those decisions.

The RW HIV Health Services Planning Council (HHSPC) is required by the federal Health Services Resource Administration (HRSA) to conduct a tri-annual survey of PLWH as part of its RW Part A funding for the Sacramento Transitional Grant Area (TGA) of Sacramento, El Dorado, and Placer Counties. The goal of the RW Client HIV PLWH Needs Assessment is to collect and analyze client input on Service Needs, Unmet Needs, and Barriers to Care to assist the Planning Council (the Council) with effective planning for service funding and delivery.

In 2020, due to the challenges of COVID-19, HRSA allowed each TGA to conduct a smaller survey process targeting a specific subpopulation once it could be safely conducted according to CDC guidelines. Given the trends of the HIV epidemic over time, the Council voted to survey young adults ages 19-29 in 2020-21. Of the 190 youth and young adult RW clients served in FY20, 18 PLWH completed the survey, which was 9.5% of the target population.

The most recent comprehensive HIV Needs Assessment of all ages of RW clients was conducted in 2018 and is used as the basis for the comparative analysis of this 2022 Needs Assessment which also targeted all ages of RW clients. Of the 2,408 FY21 RW clients, 7.9% completed the 2022 PLWH Needs Assessment survey. This reflects a higher response rate than the 7.3% of RW clients who completed the 2018 HIV Needs Assessment survey.

A-2. NEEDS ASSESSMENT PROCESS

a. Consumer Survey Process

RW Planning Council and RW service provider agency staff conducted survey sessions, both in group and one-on-one settings. The 2022 PLWH Needs Assessment survey tool was created in English but was administered in Spanish during survey sessions as needed. All surveys were completed anonymously.

In total, of the 2,408 clients in the target population of clients served by the RW Program in FY21, 191 PLWH completed the needs assessment survey. Surveys were conducted at several RW Service Providers in the TGA, including the following: CommuniCare Health Centers, Golden Rule Services, Harm Reduction Services, One Community Health, RX Healthcare, Sacramento Sexual Health Clinic, Sierra Foothills AIDS Foundation, Sunburst Projects, UC Davis Pediatric Infectious Disease, and Volunteers of America.

Participants of the time-consuming survey process received a $20 grocery food voucher. Surveys with incentives are vulnerable to duplicate respondents seeking an additional incentive. To address the issue of potential duplicative surveys, staff maintained a list of each unique confidential identifier created for each survey participant to ensure that it was not used twice. Those several duplicate surveys that did occur were caught during the data entry phase of the survey process and those duplicate entries were not considered in the analyzed data set.

Additional quality control issues include the accuracy of information provided by survey respondents and the consistency of respondents' interpretation of the survey questions. While every effort was made to ensure that individuals completing the surveys fully understood the intent of each question, responses are ultimately based on each respondent's individual interpretation of each question.

Data for all survey respondents have been analyzed and are presented in the charts and graphs throughout this narrative report. In addition, to provide as complete a data set as needed for readers of this HIV Needs Assessment, the complete anonymous data set can be requested by contacting Danielle Caravella, MPH, Health Educator, RW CARE Program, at (916) 875-6021.

b. Revised Needs Assessment Survey Tool

The original HIV Needs Assessment survey instrument for the Sacramento TGA was designed and approved in 2003. The survey tool has been periodically modified over the years to clarify questions without changing the overall intent and structure of the original survey. In 2016, the Planning Council, through its Needs Assessment Committee, conducted a more extensive revision to address survey participant feedback that the tool was lengthy with several duplicative and extraneous questions that were sometimes confusing to PLWH.

The survey tool was revised and streamlined further for the 2020 Young Adult Targeted Survey Tool to increase the clarity of the Service Need / Service Received section. These improvements decreased the length of the survey tool while increasing usability. Questions were revised to get a specific understanding of which RW services had an "Unmet Need", which means that the client needed the service but was not able to receive it due to Barriers to Care. Survey respondents were asked to check one of the following boxes for each RW service:

- I did not need the service (Not Needed)
- I needed the service and received it (Need Met)
- I needed the service but did not receive it (Unmet Need)

Analysis of Total Service Demand and Unmet Need for each service category allows for a clear picture of what services are needed most by RW clients, and which services they are having the most difficulty obtaining due to confronting Barriers to Care. Total Service Demand includes Need Met (the percent of respondents who needed and received the service) plus Unmet Need (the percent who needed but did not receive the service).

The 2022 Needs Assessment Survey Tool was improved further based on feedback from the Planning Council and Needs Assessment Committee. The Barriers to Care section was improved by noting it only needed to be completed for those services that had an Unmet Need (client checked box that they needed the service but did not receive it due to a Barrier to Care). In addition, to help assess which levels of the service system the Barriers to Care exist, they were classified into five barrier categories spanning from broad-based TGA-wide "Access" issues to more specific client-based "Financial", "Personal", Knowledge" and "Health" issues.

The Barriers to Care section was further improved by expanding it to assess barriers to care by each Service Category. Although this added a couple of pages to the survey, it was determined it would allow for more complete information that could assist with improving access to care across all service categories.

To allow for trending of findings over time, survey tool questions have remained consistent for demographics (i.e., age, race, gender, mode of HIV transmission, health insurance, and educational level); co-morbidities (i.e.,

substance use, other medical diagnoses, homelessness); and medical care history (i.e., stage of HIV infection, level of care, viral load, medication adherence, other STIs, mental health care, and other co-occurring conditions).

c. Data Analysis

2022 Needs Assessment data from each completed survey was entered by staff of the HIV Health Services Planning Council using Microsoft Excel. All open-ended questions and survey comments were compiled. Data were checked for consistency and skip patterns. Survey data were analyzed by Lili Carbone Joy, MPH, Community Health Impact, using Microsoft Excel. Data were analyzed to identify meaningful findings in distributions of PLWH demographics, co-morbidities, services needed, services with unmet need, and barriers to care (including personal, access, and financial barriers).

The 2022 PLWH Needs Assessment respondents are a sample of RW clients within the target population of all RW clients in the Sacramento TGA. The data are analyzed to find disparities both within the 2022 Needs Assessment respondents and, to the extent possible, between the 2022 and 2018 survey respondents. The 2018 Needs Assessment surveyed 177 RW clients of all ages (7.3% of RW clients). Because the focus of the most recent 2021 Needs Assessment was targeted to young adults and the sample size was 18 (9.5% of RW clients ages 19-29), the comparative analysis between the current 2022 survey of all ages of RW clients with the young adult findings was limited and is not included in this report.

The data and analytic findings are presented throughout this report through graphs and tables, as well as in narrative form. Numbers are rounded to the nearest integer (e.g., 16.7% is rounded to 17%). In cases where multiple rounded numbers are added together, the total may not appear to equal the sum of the parts.

SECTION B: DEMOGRAPHICS, HIV EPIDEMIOLOGY, AND CO-OCCURING CONDITIONS

B-1. DEMOGRAPHICS AND HIV EPIDEMIOLOGY

a. TGA Geography and HIV Epidemiology

The Sacramento Transitional Grant Area (TGA) is a large three-county area of 4,287 square miles, with a geography that includes the primarily urban and suburban County of Sacramento, and the primarily rural El Dorado and Placer Counties. Sacramento County is geographically the smallest of the three counties, but the most populous, accounting for 72% of the TGA's population in 2021 and 88.2% of the PLWH in the TGA as of 12/31/21. El Dorado County accounted for 9.0% of the TGA's population and 4.2% of the PLWH, while Placer accounted for 19% of the population and 7.1% of the PLWH.

The impact of the HIV epidemic on the Sacramento TGA continues to grow. Just over the last seven years, between 12/31/14 and 12/31/21, the number of Persons Living with HIV/AIDS (PLWH) in the TGA grew 26.9%, from 4,299 to 5,457. The growth in HIV/AIDS cases in the TGA was 3 times the growth of the TGA's general population during the same time period, from 2,025,283 to 2,194,442, or 8.7%.

This growth in the region's HIV epidemic continues to impact the RW Part A Comprehensive AIDS Resources Emergency (CARE) Act Program. During FY2021, the RW Program saw 195 new clients in the Part A TGA (164 in Sacramento County, 21 in Placer County, and 10 in El Dorado County). In addition, there were 15 new RW clients in Yolo County, a non-TGA RW Part B-funded county in the Sacramento Region.

Although Yolo County is not part of the RW Part A TGA, it receives RW Part B funds and many of its recipients receive medical care and other services from providers that receive RW Part A and Part B funding in Sacramento County. Therefore, the inclusion of RW clients from Yolo County is relevant to the HIV Needs Assessment process. The increase in new clients to the RW system of care in the TGA and Yolo County reflects a 22% increase in new RW clients over FY 2021.

b. Demographic Analysis

The 2022 HIV Needs Assessment Survey was completed by 191 PLWH, which represents 7.9% of the 2,408 RW clients in FY2021. This number of survey respondents reflects a slightly higher response rate than the 7.3% of RW clients who completed the 2018 PLWH Needs Assessment survey.

It is important to the HIV Health Services Planning Council (HHSPC or "the Council") that the needs assessment survey respondents are representative of RW Program clients living with HIV in terms of race, age, gender and mode of HIV/AIDS transmission. In addition, efforts are made to survey RW clients from all areas of the TGA. In the 2022 Needs Assessment, 85% of survey respondents were from Sacramento County, 8% from Placer, 1% from El Dorado, 9% from Yolo and 2% unspecified. RW clients from all counties in the TGA were well represented in the 2022 survey with the exception of El Dorado, which were 4% of 2021 RW clients.

The following table provides detailed demographic data across various entities as comparative benchmarks for the 2022 PLWH Needs Assessment survey respondents:

- 2021 TGA Census: General population data
- 2021 TGA: People Living with HIV in the TGA, including RW clients and PLWH not in RW care (5,457)
- 2021 RW: Ryan White clients (2,408)
- 2018 Needs Assessment: RW client survey respondents (177)

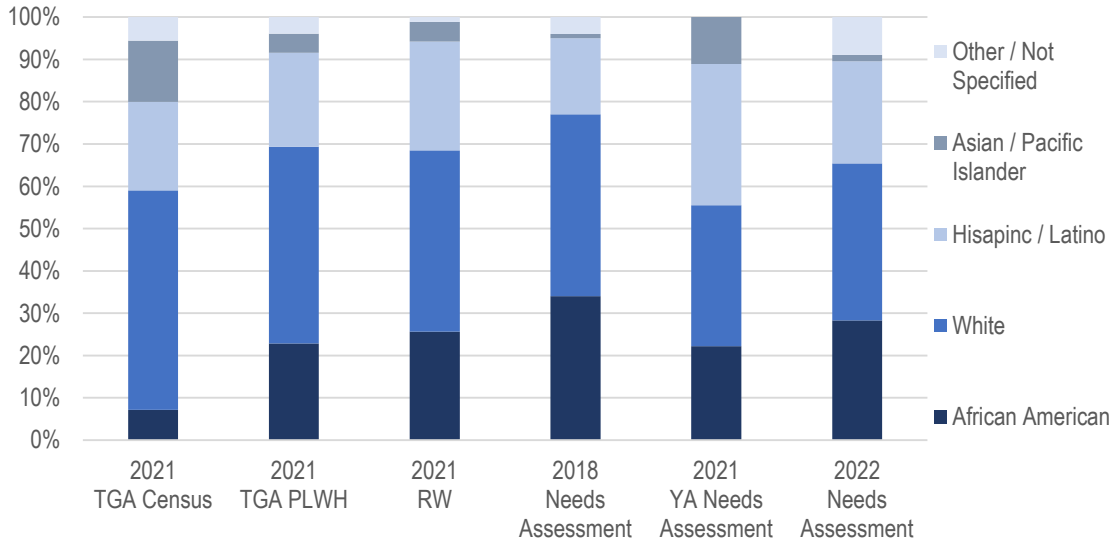
- 2022 Needs Assessment: RW client survey respondents (191)

As can be seen in the table below, the 2022 PLWH Needs Assessment survey respondents were representative of the TGA's HIV/AIDS epidemiology, RW client caseload, and 2018 Needs Assessment in terms of race, gender, and mode of HIV transmission, with several exceptions.

DEMOGRAPHICS		2021 TGA Census	2021 TGA PLWH 5,457	2021 RW 2,408	2018 Needs Assessment 171	2022 Needs Assessment 191
Race	African American	7%	23%	26%	34%	28%
	White	52%	46%	43%	43%	37%
	Asian / Pacific Islander	14%	5%	5%	1%	2%
	Hispanic / Latinx	21%	22%	26%	18%	24%
	Other / Not Specified	6%	4%	1%	4%	9%
Gender	Male	51%	82%	79%	71%	68%
	Female	49%	16%	19%	26%	24%
	Transgender / Nonbinary / Unspecified	0%	1%	2%	3%	8%
Age	≤19	25%	4%	1%	2%	2%
	20-44	34%	77%	37%	26%	25%
	45+	41%	20%	63%	66%	72%
	Not specified	0%	0%	0%	7%	1%
Mode of Transmission	MSM	NA	56%	58%	51%	47%
	IDU	NA	8%	10%	10%	9%
	MSM/IDU	NA	8%	0%	1%	1%
	Heterosexual	NA	23%	28%	16%	28%
	Other / Undetermined	NA	5%	4%	22%	14%

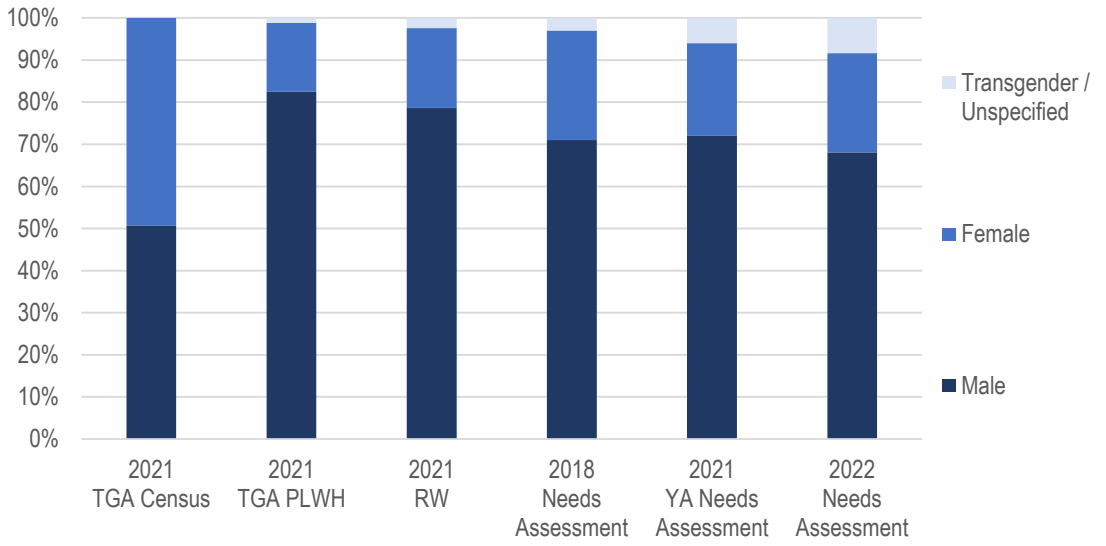
Racial Disparities in Representation

- Latinx increased between the 2018 and 2022 Needs Assessments, from 18% to 24%, which is more closely aligned with the percentage of Latinx RW clients in 2021 (26%).
- African Americans, whose representation among RW clients in 2021 was close to 4 times greater than their representation in the TGA's general population (26% vs. 7%), were overrepresented among 2021 RW clients (23%) and well represented among 2022 Needs Assessment survey respondents (28%).
- Whites were underrepresented among 2022 survey respondents compared to their representation among 2021 RW clients (37% vs. 43%).



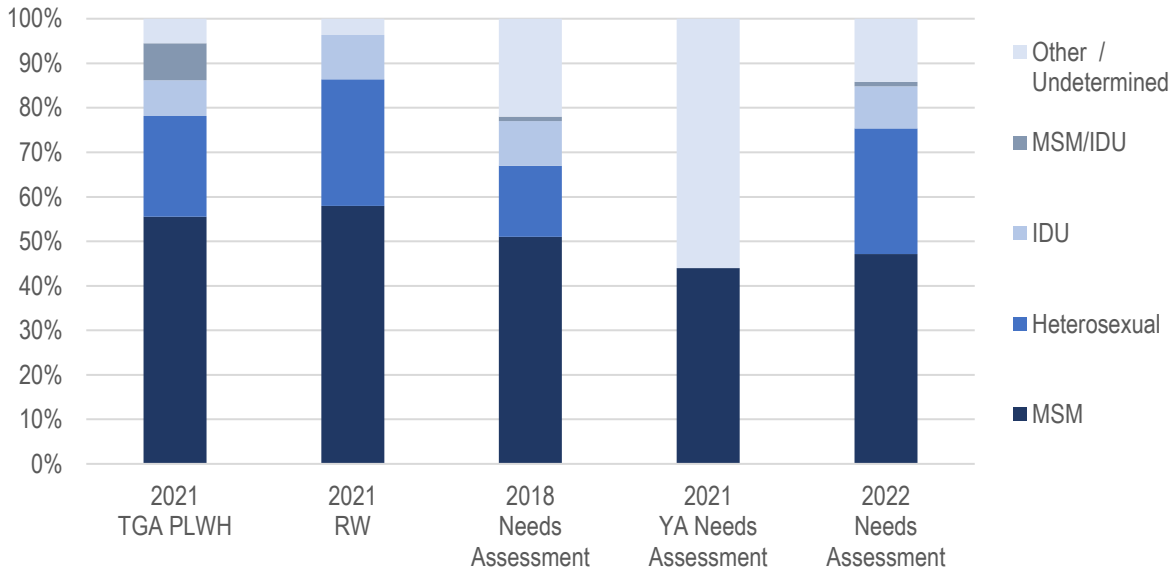
Gender Disparities in Representation

- Males were underrepresented among 2022 survey respondents as compared to their representation among 2021 RW clients (68% vs. 79%)
- Female RW clients were overrepresented among survey respondents (24% vs. 19%).
- Transgender Male to Female and Non-Binary were each 2% of 2022 survey respondents and 4% did not specify gender.



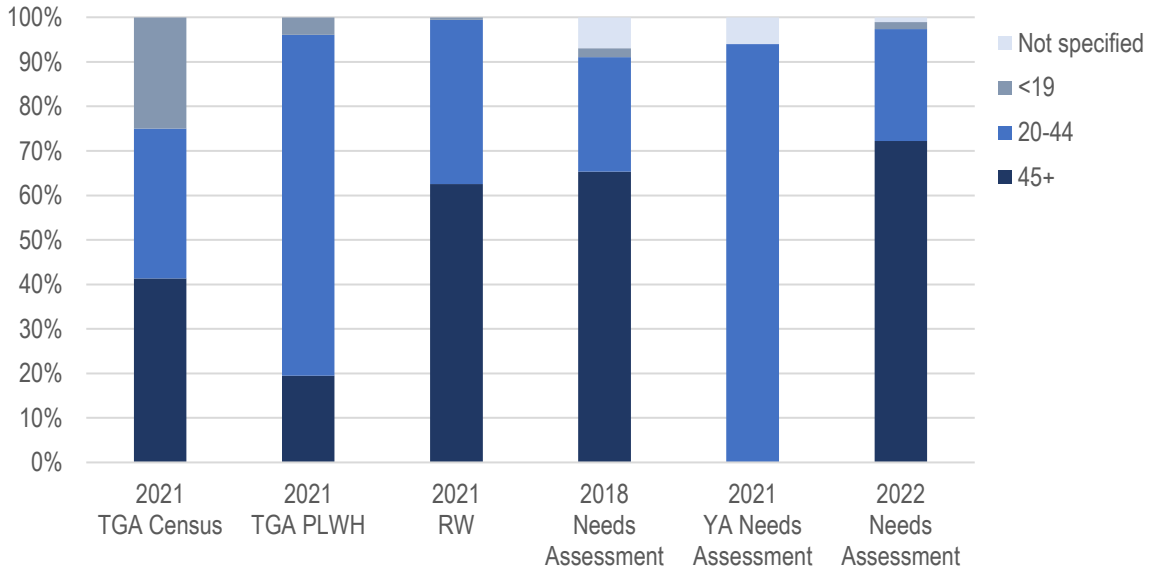
Mode of HIV Transmission Disparities in Representation

- Men who have Sex with Men (MSM) were underrepresented among 2022 survey respondents compared to their representation among 2021 RW clients (47% vs. 58%)
- "Other/Undetermined" were overrepresented (14%) among 2022 survey respondents compared to their representation among 2021 RW clients (4%)



Age Disparities in Representation

- RW clients ages 20-44 were underrepresented among survey respondents (25% vs. 37%)
- RW clients ages 45 years and older were overrepresented (72% vs. 63%)



B-2. HIV HEALTHCARE STATUS

a. Knowledge of HIV Status

2022 PLWH Needs Assessment survey respondents were asked how long they had known they were HIV positive. The highest percentage of PLWH had known their status for over 20 years (36%) and only 5% reported they had known for less than a year.

Knowledge of HIV+ Status	
Less than 1 year	5%
1-5 years	13%
6-10 years	14%
11-15 years	16%
15-20 years	16%
20+ years	36%

b. HIV Medical Care Engagement

2022 survey respondents were asked what HIV medical care they had received over the last 12 months. They reported high levels of engagement in meeting their HIV medical care needs as noted in the following table.

HIV Medical Care Engagement	
Seen a doctor	97%
Taken HIV medication (HAART)	96%
Had a test for Viral Load	93%
Had a test for CD4	93%

- 47% reported seeing their HIV doctor every 3 months; 40% every 6 months; and 6% saw them only once in the last year.
- 79% reported that they had never stopped seeing an HIV doctor for 12 months or more.
- 21% noted that had previously stopped seeing their HIV doctor for 12 months or more for the following reasons: felt fine / wasn't sick (2%); wanted a break (4%); didn't want to take medications (4%), viral load was undetectable (4%) couldn't afford it (2%); lost health insurance (1%); lost RW support services (1%); drinking/doing drugs (4%), had a mental health issue (4%); no transportation (3%), bad experience at clinic (3%), overwhelmed / forgetful (10%), inconvenient appointment times (1%), and other priorities (2%).

c. Factors Affecting HIV Medical Care Engagement

The most highly reported factor that helps to keep PLWH in care was wanting to stay healthy and live longer (70%); reducing the risk of transmission to others (61%); and being afraid of getting sick (56%). Additional factors reported to keep PLWH in care included the following:

Factors Increasing HIV Medical Care Engagement					
What kinds of things help you keep up with your HIV medical care?					
I want to stay healthy and live longer	70%	My HIV case manager or social worker	59%	The support of my family and friends	47%
My HIV doctor, nurse or clinician	54%	Seeing the benefits of treatment	39%	To reduce the risk of transmission to others	35%
I'm afraid of getting sick	34%	My faith, religion, or spirituality	28%	Staying sober	24%
A mentor at my clinic/agency	21%	An HIV group or program	18%	Other: advocate and self determination	4%

d. Health Status Self Rating

Although the goal is to see the RW clients rate their health status even higher, 62% of 2022 survey respondents reported that their physical health was either "much better" (47%) or "a little better" (15%) now than when they first sought treatment for their HIV infection. 20% reported it was about the same. 15% reported that their physical health was either "a little worse" (9%) or "much worse" (6%). These 2022 findings are very similar to the 2018 health status self ratings as noted below.

Health Status Self Rating		
How do you rate your physical health now as compared to when you first sought treatment for your HIV infection?		
	2018	**2022**
Much Better	54%	47%
About the Same	12%%	20%
A Little Better	15%	15%
A little Worse	9%	9%
Much Worse	7%	6%

B-3. CO-OCCURING CONDITIONS

The table below provides data on a range of issues and comorbidities that add to the complexity of care for PLWH across the TGA. Complicating factors such as homelessness, incarceration, STIs, other HIV-related comorbidities, poverty, insurance status, and income level are analyzed to determine where young adult PLWH surveyed in 2021 were over or underrepresented compared to all ages of PLWH in 2018.

Condition	2021 TGA Census	2019 RW	2018 Needs Assessment	2022 Needs Assessment	Notes / Sources for General Population Numerator
HCV	0.7%	1.9%	16.9%	19.9%	2016 CDC National Prevalence Estimate
Homeless /Temporary Housing	0.5%*	8.5%	18.7%	Total 26.2%** Homeless Temporary	2022 Placer, 2019 El Dorado and 2019 Sacramento County Homeless Point in Time Counts**
Uninsured	5.4%	6.0%	4.0%	3.7%	2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Recently Incarcerated	0.6%	4.0%	8.5%	2.6%	2019 California Board of State and Community Corrections
Under 100% FPL	11.1%	70.2%	68.5%	60.7%	2019 U.S. Census Bureau American Community Survey 1-Year Estimates

*"Homeless / Temporary Housing" for 2022 NA is defined as the percentage of respondents indicating any of the following in the prior 12 months: Homeless / car / camping / street; or Temporary housing / shelter / motel.
**2022 point-in-time homeless counts include those who are unsheltered or in emergency or temporary shelter on the day of survey.

a. Hepatitis C

The Hepatitis C (HCV) infection rate among 2022 RW Needs Assessment survey respondents was reported at over 20 times the HCV infection rate in the TGA's general population (20% vs. 0.7%). The 2022 Needs Assessment reported HCV rate also was higher than the 2018 Needs Assessment (16.9%).

b. Uninsured

The percent of Needs Assessment respondents without health insurance was the same in both the 2022 and 2018 RW Needs Assessment (4.0%). This percentage is lower than among 2021 RW clients (6.0%) as well as the TGA's 2021 general population (5.4%).

As seen in the table below, of the 2022 survey respondents who reported a known source of health insurance coverage, only a small minority (7%) had insurance through work or a private source, and the vast majority were on Medi-Cal (66%) and/or Medicare (43%).

Health Insurance Coverage 2022 Needs Assessment Respondents	
Health Insurance Type	**Percent***
Medi-Cal	66%
Covered California / ACA	5%
Employer-Based	4%
No Insurance	4%
Medicare	43%
Veterans Administration	2%
COBRA or OBRA	0%
Private Insurance	3%
Other	5%

** Each respondent may have multiple insurance sources.*

c. Under 100% Federal Poverty Level

Ryan White funded services are to be used as a "payer of last resort" and the client must have no other means of paying for RW services. Results from the 2018 and 2022 Needs Assessments, as well as 2021 RW clients, show increased rates of living below the Federal Poverty Level (FPL) than the TGA's general population as follows:

INCOME STATUS	2021 TGA Census	2021 RW Clients	2018 Needs Assessment	2022 Needs Assessment
Under 100% of FPL ($13,590 for an individual in 2022	11.1%	70.2%	68.5%	60.7%

d. Income Sources

Employment Income. A greater percentage of 2022 RW survey respondents were employed, both full and part time, as compared to 2018 respondents. 12% of 2022 respondents were employed full-time (33-40 hours per week) as compared to 5.1% of 2018 respondents. 11% were employed part time in 2022 vs. 10.2% in 2018.

Supplementary Income. Income sources other than through employment were reported by 2018 and 2022 Needs Assessment respondents at similar rates, although more respondents were not eligible for benefits in 2022 (12%) compared to 2018 (7%). As noted in the table below, the following supplementary income sources were reported at higher levels for 2022 respondents as compared to 2018: Food Stamps (28% vs. 60%); and Rent Supplement / Subsidized Housing (21% vs. 13%).

SUPPLEMENTARY INCOME*	2018	2022
Social Security Income (SSI)	40%	28%
Social Security Disability Income (SSDI)	31%	27%
CalFresh (Food Stamps)	28%	60%
Long Term Disability	16%	4%
Rent Supplement or Subsidized Housing	13%	21%
Not Eligible for Benefits	7%	12%
Short Term Disability	.6%	1%
State Disability Insurance (SDI)	11%	7%

SUPPLEMENTARY INCOME*	2018	2022
Veteran's Benefits (VA)	2%	2%
Worker's Compensation	0.6%	1%
Annuity/Life Insurance	0.6%	0%
Retirement	6%	4%
General Assistance	5%	4%
Women's Infants and Children (WIC)	3%	0%
TANF/Cal WORKS	1%	2%
RW Emergency Financial Assistance (EFA)**	1%	1%
Other (food/gas vouchers and other Social Security)	1.1%	6%

**Respondents report all supplementary income sources therefore total is greater than 100%.*
*** In Sac Co., EFA paid by RW doesn't cover rental assistance, utilities, and food but provides medication reimbursements. In rural counties, EFA may be used for all these needs when there are no other sources.*

e. Homeless / Unstable / Temporary Housing

The 2022 survey asked PLWH which places they had lived over the prior 12-months. A large percentage, 26.2%, reported that they had been homeless (car, camping, street), or temporarily housed (shelter or motel).

This extreme rate of homelessness/temporary housing among PLWH continues to be disproportionately high when compared to the TGA's general population, which was 0.48% based on the 20122Point-In-Time homeless count coordinated by the US Department of Housing and Urban Development (HUD). It must be noted that HUD's count includes those who report being unsheltered, in emergency shelter or in temporary shelter on the day of being surveyed, rather than anytime during the prior 12-months as in the RW survey.

Trying to adhere to a complex medical regimen is made even more challenging by the lack of stable housing many RW clients are faced with. Living in shelters, cars, motels and being homeless with inconsistent access to food and proper nutrition compounds the difficulties of adhering to medications, getting adequate sleep, and accessing healthcare.

f. Recently Incarcerated

The recently incarcerated rate among Needs Assessment survey respondents dropped significantly between 2018 and 2022, from 8.5% to 2.6%. Even with this improvement, however, the percent of PLWH surveyed in the Needs Assessments who were recently incarcerated is much higher than the 4% of 2019 RW clients and 0.6% of the TGA's 2021 general population who were recently incarcerated.

SECTION C: SERVICE DEMAND AND UNMET NEED

C-1. SERVICE DEMAND

a. Service Demand by Service Category

Service Demand (Total Need) is defined by the total number of survey respondents who needed each Ryan White service category. This includes both those who needed the service and received it (Need Met) plus those who needed the service but did not receive it due to Barriers to Care (Unmet Need).

Total Service Demand (Total Need) = Need Met + Unmet Need

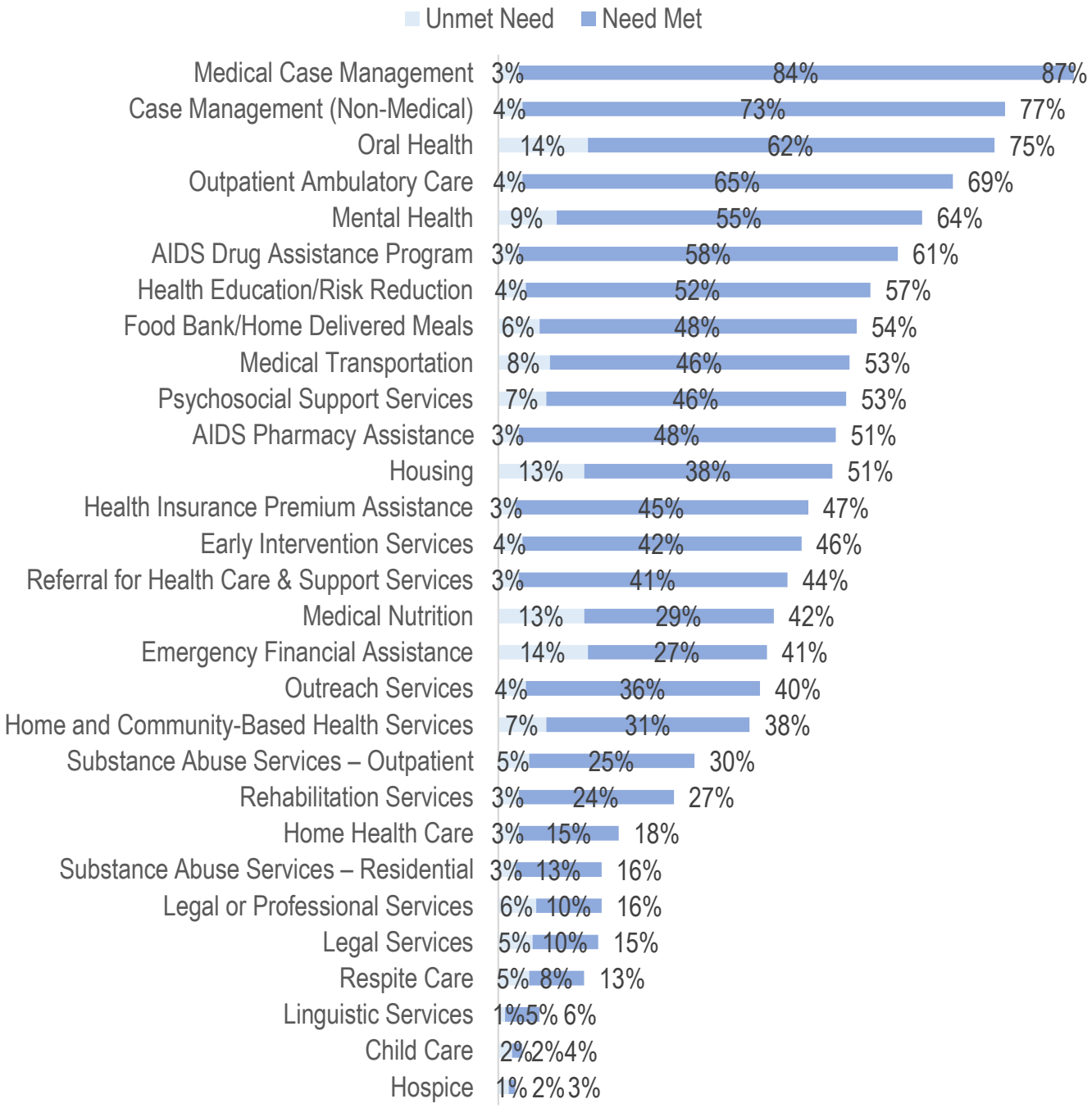
To gather data for each of these components of service demand, survey respondents were asked to check one of the following three boxes for each RW service:

- I did not need the service.
- I needed the service and received it (Need Met).
- I needed the service but did not receive it due to Barriers to Care (Unmet Need).

Given these improvements in the survey tool over time, a deeper analysis of Service Demand and Unmet Need for each service category allows for a clearer picture of what services are needed most by RW clients, and which services they are having the most difficulty obtaining due to barriers to care that they confront.

As can be seen in the graph below, Medical Case Management had the highest Service Demand (Total Need) at 87%. This total consists of the 84% that reported they needed and received Medical Case Management (Need Met) plus the 3% of who reported they needed the service but did not receive it due to barriers to care (Unmet Need). Non-Medical Case Management had the second highest service demand (77%) with 73% need met and 4% unmet need.

Service Demand by Service Category
2022 Needs Assessment Respondents
Service Demand (Total Need) = Unmet Need + Need Met



A further analysis of Service Demand is provided in the next section through a comparative analysis of 2022 and 2018 Needs Assessment Findings across service categories included in both surveys.

b. Trends in Service Demand

A notable finding overall is that the 2022 Needs Assessment of all ages of RW clients and 2021 Needs Assessment of young adult RW clients both reported service demands at a lower average percentage than the 2018 survey respondents of all ages (84% in 2018 and 41% in 2022). Only one service category, Medical Case Management, had a service demand that was higher among 2022 survey respondents (87%) than 2018 (82%).

The finding that service demand, which includes unmet need plus need met, was reported, on average, at lower rates in 2022 and 2021 compared to the 2018 Needs Assessment is likely due to a combination of factors, including but not limited to:

- ***Changes in the survey format.*** After the 2018 Needs Assessment, the survey tool was revamped to increase the clarity of the service demand, need met, and unmet need section of the survey by asking specific questions about each component. These improvements resulted in a significant decrease in the length of the survey tool and increased the usability and clarity of questions for the survey respondents.
- ***Covid-19 Pandemic.*** It is uncertain what role the pandemic has had on decreasing overall service demand, but it is likely that PLWH, due to their immunocompromised condition, often were more cautious over the last couple of years to reach out for and participate in services due to fear of exposure to Covid-19.

The following services had a decline in service demand of more than 30 percentage points between 2018 and 2022 survey respondents: Linguistic Services (-47%); Residential Substance Abuse Services (-40%); Emergency Financial Assistance (-40%); Medical Nutrition, Early Intervention Services, and AIDS Pharmacy Assistance (-36%); Home / Community-Based Health Services (-34%); Health Insurance Premium Assistance (-32%) and Referral for Health Care and Support Services (-31%).

A comparison of findings between the 2022 and 2018 PLWH Needs Assessments provides valuable input for program planning, implementation, and allocation of resources for the Sacramento Region's RW Program. The following table is ranked by 2022 service demand, which includes need met plus unmet need. The service categories with the highest service demand require a corresponding allocation of resources to meet client needs and address barriers to care which can limit clients' abilities to get their needs met.

Service Demand (Total Need)
Need Met + Unmet Need
2018 and 2022 Needs Assessment

Category	2018 Service Demand	2018 Rank	2022 Service Demand	2022 Rank	%Δ
Medical Case Management	82%	7	87%	1	6%
Non-Medical Case Management	90%	2	77%	2	-13%
Oral Health	82%	5	75%	3	-7%
Outpatient Medical Care	92%	1	69%	4	-22%
Mental Health	81%	8	64%	5	-17%
AIDS Drug Assistance Program	88%	3	61%	6	-27%
Health Education/Risk Reduction	78%	12	57%	7	-21%
Food Bank / Home Delivered Meals*	75%	15	54%	8	-20%

Service Demand (Total Need) Need Met + Unmet Need 2018 and 2022 Needs Assessment					
Category	**2018 Service Demand**	**2018 Rank**	**2022 Service Demand**	**2022 Rank**	**%Δ**
Medical Transportation	73%	16	53%	9	-19%
Psychosocial Support Services	73%	16	53%	10	-20%
AIDS Pharmacy Assistance	88%	4	51%	11	-36%
Housing	80%	10	51%	12	-29%
Health Insurance Premium Assistance	79%	11	47%	13	-32%
Early Intervention Services	82%	5	46%	14	-36%
Referral for Health Care & Support Services	75%	14	44%	15	-31%
Medical Nutrition	78%	12	42%	16	-36%
Emergency Financial Assistance	81%	9	41%	17	-40%
Outreach Services	NA		40%	18	
Home and Community-Based Health Services	72%	18	38%	19	-34%
Substance Abuse Services – Outpatient	58%	19	30%	20	-28%
Rehabilitation Services	NA		27%	21	
Home Health Care	NA		18%	22	
Substance Abuse Services – Residential	56%	20	16%	23	-40%
Legal or Professional Services	NA		16%	23	
Legal Services	NA		15%	25	
Respite Care	NA		13%	26	
Linguistic Services	53%	21	6%	27	-47%
Child Care	NA		4%	28	
Hospice	NA		3%	29	
Average Service Demand	84%		41%		-43%

As can be noted below, the following services were among the top ten services with the highest service demand in both the 2018 and 2022 Needs Assessments. Notably, the top six services with the highest service demand in 2022 were all in the top ten in 2018, as follows: 1) Medical Case Management, 2) Non-Medical Case Management, 3) Oral Health, 4) Outpatient Medical Care, 5) Mental Health, and 6) AIDS Drug Assistance Program.

SERVICE DEMAND (NEED MET + UNMET NEED) TOP TEN SERVICES 2018 AND 2022 NEEDS ASSESSMENT			
2018 All Ages		**2022 All Ages**	
1	Outpatient Medical Care	1	Medical Case Management
2	Non-medical Case Management	2	Non-Medical Case Management
3	AIDS Drug Assistance Program	3	Oral Health
4	AIDS Pharmacy Assistance	4	Outpatient Medical Care
5	Oral Health	5	Mental Health

SERVICE DEMAND (NEED MET + UNMET NEED) TOP TEN SERVICES 2018 AND 2022 NEEDS ASSESSMENT			
2018 All Ages		**2022 All Ages**	
6	Early Intervention Services	6	AIDS Drug Assistance Program
7	Medical Case Management	7	Health Education/Risk Reduction
8	Mental Health	8	Food Bank / Home Delivered Meals
9	Emergency Financial Assistance	9	Medical Transportation
10	Housing	10	Psychosocial Support Services

c. Service Demand: Demographic Disparities

Demographic Disparities in service demand are provided in this section with the overall demand noted for each service category in parentheses. Demographic disparities by service category are highlighted by ***bold italic*** and thick borders. Highlighted disparities are those that have a difference of more than 10% between one demographic group and the next highest group among the demographic categories.

GENDER
SERVICE DEMAND DEMOGRAPHIC DISPARITIES 2022

- Women reported at least 10% greater need than men for the following services: Mental Health, Medical Transportation, Housing, Medical Nutrition, Emergency Financial Assistance, and Home/Community Based Health Services.
- Men reported at least 10% greater need than women for ADAP and Health Insurance Premium Assistance.

Category	Female	Male
Medical Case Management (87%)	87%	88%
Case Management (Non-Medical) (77%)	78%	75%
Oral Health (75%)	71%	76%
Outpatient Ambulatory Care (69%)	69%	72%
Mental Health (64%)	***73%***	61%
AIDS Drug Assistance Program (61%)	51%	***62%***
Health Education/Risk Reduction (57%)	56%	56%
Food Bank/Home Delivered Meals (54%)	51%	54%
Medical Transportation (53%)	***62%***	49%
Psychosocial Support Services (53%)	51%	52%
AIDS Pharmacy Assistance (51%)	49%	50%
Housing (51%)	***58%***	47%
Health Insurance Premium Assistance (47%)	31%	***52%***
Early Intervention Services (46%)	49%	42%
Referral for Health Care & Support Services (44%)	40%	44%
Medical Nutrition (42%)	***53%***	36%
Emergency Financial Assistance (41%)	***47%***	35%
Outreach Services (40%)	36%	38%
Home/Community-Based Health Services (38%)	***51%***	35%
Substance Abuse Services – Outpatient (30%)	33%	28%
Rehabilitation Services (27%)	27%	25%
Home Health Care (18%)	18%	18%
Legal or Professional Services (16%)	13%	14%
Substance Abuse Services – Residential (16%)	9%	17%
Legal Services (15%)	11%	15%
Respite Care (13%)	9%	15%
Linguistic Services (6%)	7%	5%
Child Care (4%)	4%	3%
Hospice (3%)	2%	2%

RACE
SERVICE DEMAND DEMOGRAPHIC DISPARITIES 2022

- Whites reported at least a 10% greater need for Ambulatory Care than Blacks and Hispanics.
- Blacks reported at least a 10% greater need for Home/Community-Based Health Services and Housing than Whites and Hispanics.

Category	African American	White	Hispanic / Latinx
Medical Case Management (87%)	89%	94%	78%
Case Management (Non-Medical) (77%)	76%	73%	85%
Oral Health (75%)	78%	79%	72%
Outpatient Ambulatory Care (69%)	67%	***82%***	59%
Mental Health (64%)	63%	69%	54%
AIDS Drug Assistance Program (61%)	59%	61%	63%
Health Education/Risk Reduction (57%)	57%	54%	61%
Food Bank/Home Delivered Meals (54%)	56%	52%	57%
Medical Transportation (53%)	57%	56%	41%
Psychosocial Support Services (53%)	52%	56%	50%
AIDS Pharmacy Assistance (51%)	52%	48%	57%
Housing (51%)	***61%***	48%	41%
Health Insurance Premium Assistance (47%)	39%	46%	54%
Early Intervention Services (46%)	44%	45%	48%
Referral for Health Care & Support Services (44%)	43%	44%	46%
Medical Nutrition (42%)	44%	46%	30%
Emergency Financial Assistance (41%)	41%	39%	39%
Outreach Services (40%)	37%	39%	46%
Home/Community-Based Health Services (38%)	***52%***	38%	26%
Substance Abuse Services – Outpatient (30%)	26%	30%	35%
Rehabilitation Services (27%)	30%	31%	17%
Home Health Care (18%)	17%	18%	15%
Legal or Professional Services (16%)	15%	15%	15%
Substance Abuse Services – Residential (16%)	20%	18%	11%
Legal Services (15%)	19%	17%	11%
Respite Care (13%)	17%	11%	13%
Linguistic Services (6%)	2%	4%	13%
Child Care (4%)	4%	1%	4%
Hospice (3%)	4%	1%	2%

MODE OF HIV TRANSMISSION
SERVICE DEMAND DEMOGRAPHIC DISPARITIES 2022

- Compared to Heterosexuals and MSMs, IDUs reported at least a 10% greater need for Medical Case Management, ADAP, Psychosocial Support Services, AIDS Pharmacy Assistance, Housing, Early Intervention Services, Referral for Health Care and Support Services, Home/Community-Based Health Services, Substance Abuse Services (both Outpatient and Residential), and Legal or Professional Services
- Heterosexuals reported at least a 10% greater need for Medical Nutrition than IDUs or MSMs.

Category	Heterosexual	IDU	MSM
Medical Case Management (87%)	89%	***100%***	83%
Case Management (Non-Medical) (77%)	78%	72%	79%
Oral Health (75%)	76%	83%	77%
Outpatient Ambulatory Care (69%)	72%	78%	64%
Mental Health (64%)	69%	67%	67%
AIDS Drug Assistance Program (61%)	54%	***78%***	67%
Health Education/Risk Reduction (57%)	57%	67%	58%
Food Bank/Home Delivered Meals (54%)	63%	67%	48%
Medical Transportation (53%)	63%	72%	48%
Psychosocial Support Services (53%)	56%	***67%***	54%
AIDS Pharmacy Assistance (51%)	48%	***67%***	51%
Housing (51%)	54%	***72%***	43%
Health Insurance Premium Assistance (47%)	39%	50%	52%
Early Intervention Services (46%)	56%	***72%***	38%
Referral for Health Care & Support Services (44%)	41%	***67%***	44%
Medical Nutrition (42%)	***54%***	39%	38%
Emergency Financial Assistance (41%)	44%	50%	39%
Outreach Services (40%)	33%	39%	43%
Home/Community-Based Health Services (38%)	46%	***67%***	36%
Substance Abuse Services – Outpatient (30%)	31%	***56%***	29%
Rehabilitation Services (27%)	28%	33%	27%
Home Health Care (18%)	20%	28%	18%
Legal or Professional Services (16%)	19%	***33%***	13%
Substance Abuse Services – Residential (16%)	15%	***33%***	14%
Legal Services (15%)	11%	22%	18%
Respite Care (13%)	17%	22%	11%
Linguistic Services (6%)	11%	6%	3%
Child Care (4%)	6%	6%	2%
Hospice (3%)	6%	0%	2%

AGE
SERVICE DEMAND DEMOGRAPHIC DISPARITIES 2022

- Compared to those aged 45+, respondents aged 20-44 reported at least a 10% greater need for Health Insurance Premium Assistance, Early Intervention Services, Referral for Health Care and Support Services, Emergency Financial Assistance, Outreach Services, and Legal or Professional Services.
- Respondents aged 45+ reported at least a 10% greater need for Medical Case Management, Medical Nutrition, and Home/Community Based Health Services compared to those aged 20-44.

Category	20-44	45+
Medical Case Management (87%)	79%	***90%***
Case Management (Non-Medical) (77%)	77%	77%
Oral Health (75%)	73%	78%
Outpatient Ambulatory Care (69%)	65%	72%
Mental Health (64%)	58%	67%
AIDS Drug Assistance Program (61%)	60%	62%
Health Education/Risk Reduction (57%)	58%	56%
Food Bank/Home Delivered Meals (54%)	54%	55%
Medical Transportation (53%)	50%	56%
Psychosocial Support Services (53%)	56%	53%
AIDS Pharmacy Assistance (51%)	56%	49%
Housing (51%)	56%	49%
Health Insurance Premium Assistance (47%)	***58%***	44%
Early Intervention Services (46%)	***56%***	43%
Referral for Health Care & Support Services (44%)	***54%***	42%
Medical Nutrition (42%)	31%	***44%***
Emergency Financial Assistance (41%)	***54%***	37%
Outreach Services (40%)	***48%***	38%
Home/Community-Based Health Services (38%)	23%	***44%***
Substance Abuse Services – Outpatient (30%)	35%	29%
Rehabilitation Services (27%)	25%	28%
Home Health Care (18%)	19%	18%
Legal or Professional Services (16%)	***23%***	13%
Substance Abuse Services – Residential (16%)	15%	17%
Legal Services (15%)	13%	16%
Respite Care (13%)	13%	14%
Linguistic Services (6%)	8%	5%
Child Care (4%)	6%	3%
Hospice (3%)	6%	1%

HOUSING STATUS
SERVICE DEMAND DEMOGRAPHIC DISPARITIES 2022

- Respondents reporting stable housing during the prior 12-months of survey reported at least a 10% greater need for Ambulatory Care and Home/Community Based Health Services than those reporting unstable housing (homelessness, unstable/couch surfing, or temporary housing/shelter/motel.

- Compared to respondents with stable housing, those with unstable housing reported at least a 10% greater need in many categories, with a 20% greater need for Food Bank / Home Delivered Meals, Housing, Referral for Health Care and Support Services, Emergency Financial Assistance, Outpatient Substance Abuse Treatment, and Legal or Professional Services.

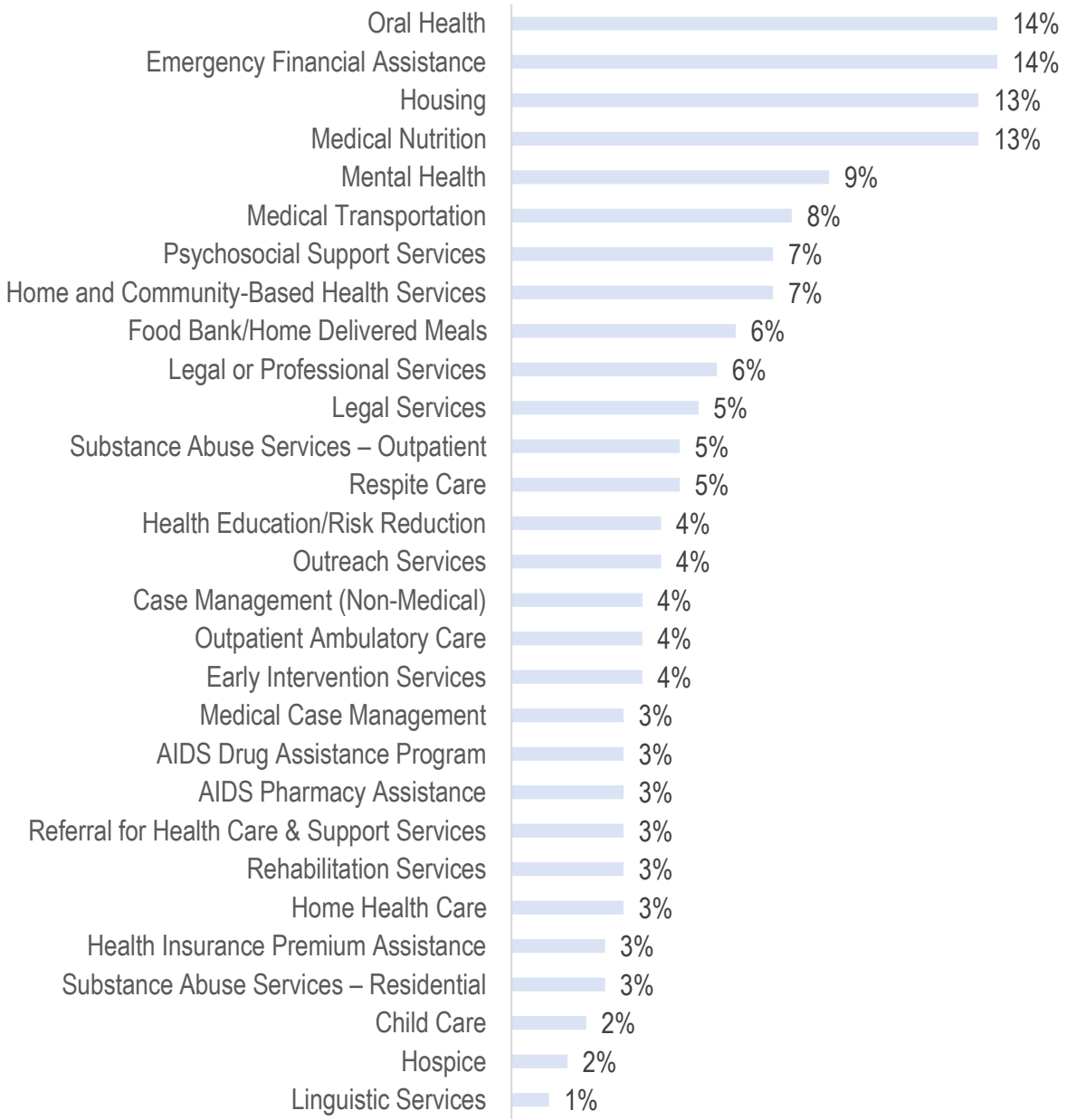
Category	Stable Housing	Unstable Housing
Medical Case Management (87%)	88%	87%
Case Management (Non-Medical) (77%)	77%	77%
Oral Health (75%)	74%	78%
Outpatient Ambulatory Care (69%)	***73%***	60%
Mental Health (64%)	63%	67%
AIDS Drug Assistance Program (61%)	59%	65%
Health Education/Risk Reduction (57%)	53%	***65%***
Food Bank/Home Delivered Meals (54%)	48%	***68%***
Medical Transportation (53%)	49%	***63%***
Psychosocial Support Services (53%)	50%	***60%***
AIDS Pharmacy Assistance (51%)	47%	***60%***
Housing (51%)	37%	***82%***
Health Insurance Premium Assistance (47%)	44%	***55%***
Early Intervention Services (46%)	42%	***55%***
Referral for Health Care & Support Services (44%)	37%	***60%***
Medical Nutrition (42%)	42%	42%
Emergency Financial Assistance (41%)	34%	***55%***
Outreach Services (40%)	35%	***50%***
Home/Community-Based Health Services (38%)	***43%***	28%
Substance Abuse Services – Outpatient (30%)	21%	***50%***
Rehabilitation Services (27%)	24%	33%
Home Health Care (18%)	20%	15%
Legal or Professional Services (16%)	9%	***30%***
Substance Abuse Services – Residential (16%)	11%	***25%***
Legal Services (15%)	15%	15%
Respite Care (13%)	10%	***20%***
Linguistic Services (6%)	8%	3%
Child Care (4%)	3%	5%
Hospice (3%)	2%	3%

C-2. UNMET NEED

a. Unmet Need by Service Category

Unmet Need is the percentage of clients who needed a service but were unable to receive it due to confronting one or more Barriers to Care. Unmet Need is a critical factor to analyze to determine the services RW clients are having the greatest difficulty obtaining.

UNMET NEED
2022 HIV NEEDS ASSESSMENT



As shown in the graph above, 2022 survey respondents reported the following services categories in the top 10 services they needed but were unable to receive: Oral Health and Emergency Financial Assistance (14%); Housing

and Medical Nutrition (13%); Mental Health (9%); Medical Transportation (8%); Psychosocial Support and Home/Community-Based Health Services (7%); Food Bank / Home-Delivered Meals and Legal Services (6%).

b. Trends in Unmet Need

The most notable finding is that the 2022 HIV Needs Assessment respondents reported unmet needs at a much lower percentage, on average, than 2018 respondents (5.5% in 2022 and 30% in 2018).

The following services had a decline in unmet need of more than 30% between 2018 and 2022 surveys: Home and Community-Based Services (-42%); Linguistic Services (-40%); Housing (-35%); Food Bank / Home Delivered Meals (-34%); and AIDS Pharmacy Assistance (-32%) (see shaded rows below). These findings demonstrate that there have been decreases in barriers to care and improvements in access to these services over the last several years.

Unmet Need
2018 and 2022 Needs Assessment Surveys
Comparative Analysis

Category	2018 Unmet Need	2018 Rank	2022 Unmet Need	2022 Rank	%Δ
Oral Health	27%	12	14%	1	-14%
Emergency Financial Assistance	42%	3	14%	1	-28%
Housing	48%	2	13%	3	-35%
Medical Nutrition	41%	4	13%	3	-28%
Mental Health	18%	18	9%	5	-9%
Medical Transportation	37%	7	8%	6	-29%
Psychosocial Support Services	24%	14	7%	7	-17%
Home and Community-Based Health Services	50%	1	7%	7	-42%
Food Bank / Home Delivered Meals*	40%	6	6%	9	-34%
Legal or Professional Services	NA		6%	10	
Legal Services	NA		5%	11	
Substance Abuse Services – Outpatient	31%	9	5%	12	-26%
Respite Care	NA		5%	12	
Health Education/Risk Reduction	18%	18	4%	14	-13%
Outreach Services	NA		4%	14	
Case Management (Non-Medical)	16%	20	4%	16	-13%
Outpatient Ambulatory Care	15%	21	4%	16	-12%
Early Intervention Services	24%	15	4%	16	-20%
Medical Case Management	29%	11	3%	19	-26%
AIDS Drug Assistance Program	21%	17	3%	19	-18%
AIDS Pharmacy Assistance	36%	8	3%	19	-32%
Referral for Health Care & Support Services	21%	16	3%	19	-18%
Rehabilitation Services	NA		3%	19	
Home Health Care	NA		3%	19	

Unmet Need 2018 and 2022 Needs Assessment Surveys Comparative Analysis					
Category	**2018 Unmet Need**	**2018 Rank**	**2022 Unmet Need**	**2022 Rank**	**%Δ**
Health Insurance Premium Assistance	30%	10	3%	25	-27%
Substance Abuse Services – Residential	27%	12	3%	25	-25%
Child Care	NA		2%	27	
Hospice	NA		2%	28	
Linguistic Services	41%	4	1%	29	-40%
Average Unmet Need	30%		5.6%		

* Shaded rows had 30% or greater decline in Unmet Need between 2018 and 2022 surveys.

Further analysis of unmet need trends between 2018 and 2022 shows that, of the service categories that ranked in the top ten for highest unmet needs, half (50%) were in the top rankings both years. This shows that clients were having the most difficulty obtaining these services in both 2018 and 2022: Emergency Financial Assistance, Housing, Medical Nutrition, Medical Transportation, and Home and Community-Based Services.

UNMET NEED TOP TEN SERVICES 2018 AND 2022 NEEDS ASSESSMENTS			
2018 All Ages		**2022 All Ages**	
1	Home and Community-Based Health Services	1	Oral Health
2	Housing	1	Emergency Financial Assistance
3	Emergency Financial Assistance	3	Housing
4	Medical Nutrition	3	Medical Nutrition
5	Linguistic Services	5	Mental Health
6	Food Bank / Home Delivered Meals	6	Medical Transportation
7	Medical Transportation	7	Psychosocial Support Services
8	AIDS Pharmacy Assistance	7	Home and Community-Based Health Services
9	Substance Abuse Services – Outpatient	9	Food Bank / Home Delivered Meals*
10	Health Insurance Premium Assistance	10	Legal or Professional Services

c. Unmet Need: Demographic Disparities

Demographic Disparities in unmet need are provided below and highlight disparities that have a difference of more than 10% between one demographic group and the next highest group among the demographic categories.

GENDER
UNMET NEED DEMOGRAPHIC DISPARITIES 2022

- Women reported at least a 10% greater unmet need than men for Medical Transportation and Medical Nutrition.

Category	Female	Male
Oral Health (14%)	11%	12%
Emergency Financial Assistance (14%)	18%	11%
Housing (13%)	13%	12%
Medical Nutrition (13%)	***20%***	9%
Mental Health (9%)	7%	8%
Medical Transportation (8%)	***16%***	4%
Home and Community-Based Health Services (7%)	11%	5%
Psychosocial Support Services (7%)	7%	6%
Food Bank/Home Delivered Meals (6%)	4%	5%
Legal or Professional Services (6%)	7%	5%
Legal Services (5%)	2%	6%
Substance Abuse Services – Outpatient (5%)	9%	4%
Respite Care (5%)	2%	5%
Health Education/Risk Reduction (4%)	4%	3%
Outreach Services (4%)	2%	3%
Outpatient Ambulatory Care (4%)	0%	5%
Case Management (Non-Medical) (4%)	2%	3%
Early Intervention Services (4%)	2%	2%
Medical Case Management (3%)	2%	3%
AIDS Drug Assistance Program (3%)	2%	2%
AIDS Pharmacy Assistance (3%)	4%	2%
Home Health Care (3%)	2%	2%
Referral for Health Care & Support Services (3%)	2%	4%
Rehabilitation Services (3%)	4%	3%
Health Insurance Premium Assistance (3%)	2%	2%
Substance Abuse Services – Residential (3%)	4%	2%
Child Care (2%)	4%	1%
Hospice (2%)	2%	1%
Linguistic Services (1%)	0%	1%

RACE
UNMET NEED DEMOGRAPHIC DISPARITIES 2022

- African Americans have at least a 10% higher unmet need for Medical Nutrition than Whites and Hispanics

Category	African American	White	Hispanic / Latinx
Oral Health (14%)	6%	14%	15%
Emergency Financial Assistance (14%)	19%	10%	11%
Housing (13%)	15%	14%	9%
Medical Nutrition (13%)	***19%***	8%	9%
Mental Health (9%)	6%	6%	13%
Medical Transportation (8%)	9%	7%	2%
Home and Community-Based Health Services (7%)	7%	6%	7%
Psychosocial Support Services (7%)	6%	7%	9%
Food Bank/Home Delivered Meals (6%)	7%	6%	7%
Legal or Professional Services (6%)	4%	8%	4%
Legal Services (5%)	2%	8%	4%
Substance Abuse Services – Outpatient (5%)	7%	3%	7%
Respite Care (5%)	9%	1%	2%
Health Education/Risk Reduction (4%)	2%	3%	7%
Outreach Services (4%)	2%	4%	4%
Outpatient Ambulatory Care (4%)	2%	3%	7%
Case Management (Non-Medical) (4%)	2%	1%	7%
Early Intervention Services (4%)	4%	1%	4%
Medical Case Management (3%)	2%	3%	2%
AIDS Drug Assistance Program (3%)	4%	0%	4%
AIDS Pharmacy Assistance (3%)	6%	1%	2%
Home Health Care (3%)	2%	3%	0%
Referral for Health Care & Support Services (3%)	6%	3%	2%
Rehabilitation Services (3%)	4%	4%	2%
Health Insurance Premium Assistance (3%)	0%	3%	7%
Substance Abuse Services – Residential (3%)	2%	1%	2%
Child Care (2%)	2%	1%	2%
Hospice (2%)	2%	1%	0%
Linguistic Services (1%)	0%	1%	0%

MODE OF TRANSMISSION
UNMET NEED DEMOGRAPHIC DISPARITIES 2022

- IDU's have at least a 10% greater unmet need for Psychosocial Support Services and Legal or Professional Services compared to Heterosexuals or MSMs.

Category	Heterosexual	IDU	MSM
Oral Health (14%)	11%	11%	13%
Emergency Financial Assistance (14%)	17%	17%	11%
Housing (13%)	20%	22%	8%
Medical Nutrition (13%)	22%	17%	9%
Mental Health (9%)	7%	6%	10%
Medical Transportation (8%)	13%	11%	6%
Home and Community-Based Health Services (7%)	13%	11%	4%
Psychosocial Support Services (7%)	6%	***17%***	7%
Food Bank/Home Delivered Meals (6%)	6%	6%	8%
Legal or Professional Services (6%)	7%	***17%***	3%
Legal Services (5%)	2%	11%	7%
Substance Abuse Services – Outpatient (5%)	6%	11%	3%
Respite Care (5%)	9%	0%	4%
Health Education/Risk Reduction (4%)	9%	6%	1%
Outreach Services (4%)	6%	6%	4%
Outpatient Ambulatory Care (4%)	2%	6%	4%
Case Management (Non-Medical) (4%)	4%	6%	3%
Early Intervention Services (4%)	6%	6%	2%
Medical Case Management (3%)	4%	6%	3%
AIDS Drug Assistance Program (3%)	4%	0%	3%
AIDS Pharmacy Assistance (3%)	6%	0%	2%
Home Health Care (3%)	6%	0%	2%
Referral for Health Care & Support Services (3%)	6%	6%	2%
Rehabilitation Services (3%)	6%	6%	1%
Health Insurance Premium Assistance (3%)	0%	0%	4%
Substance Abuse Services – Residential (3%)	6%	0%	1%
Child Care (2%)	4%	6%	0%
Hospice (2%)	6%	0%	0%
Linguistic Services (1%)	4%	0%	0%

AGE
UNMET NEED DEMOGRAPHIC DISPARITIES 2022

- Compared to those aged 45+, respondents aged 20-44 reported a 10% greater unmet need for Emergency Financial Assistance.
- Compared to those aged 20-44, respondents aged 45+ reported a 6% greater need for Medical Nutrition and Mental Health.

Category	20-44	45+
Oral Health (14%)	17%	12%
Emergency Financial Assistance (14%)	***21%***	11%
Housing (13%)	13%	13%
Medical Nutrition (13%)	8%	14%
Mental Health (9%)	4%	10%
Medical Transportation (8%)	4%	9%
Home and Community-Based Health Services (7%)	6%	7%
Psychosocial Support Services (7%)	6%	8%
Food Bank/Home Delivered Meals (6%)	8%	5%
Legal or Professional Services (6%)	6%	6%
Legal Services (5%)	4%	5%
Substance Abuse Services – Outpatient (5%)	4%	5%
Respite Care (5%)	6%	4%
Health Education/Risk Reduction (4%)	4%	4%
Outreach Services (4%)	8%	3%
Outpatient Ambulatory Care (4%)	6%	3%
Case Management (Non-Medical) (4%)	8%	1%
Early Intervention Services (4%)	2%	4%
Medical Case Management (3%)	6%	2%
AIDS Drug Assistance Program (3%)	0%	4%
AIDS Pharmacy Assistance (3%)	2%	3%
Home Health Care (3%)	2%	3%
Referral for Health Care & Support Services (3%)	4%	3%
Rehabilitation Services (3%)	4%	3%
Health Insurance Premium Assistance (3%)	4%	2%
Substance Abuse Services – Residential (3%)	6%	1%
Child Care (2%)	2%	2%
Hospice (2%)	4%	1%
Linguistic Services (1%)	2%	1%

HOUSING STATUS
UNMET NEED DEMOGRAPHIC DISPARITIES 2022

- Respondents experiencing homelessness/unstable/temporary housing within the prior 12-months reported a 12% greater unmet need for Emergency Financial Assistance compared to those in stable housing.

Category	Stable Housing	Unstable Housing
Oral Health (14%)	14%	13%
Emergency Financial Assistance (14%)	10%	**22%**
Housing (13%)	11%	18%
Medical Nutrition (13%)	11%	17%
Mental Health (9%)	8%	10%
Medical Transportation (8%)	8%	8%
Home and Community-Based Health Services (7%)	6%	10%
Psychosocial Support Services (7%)	8%	7%
Food Bank/Home Delivered Meals (6%)	4%	12%
Legal or Professional Services (6%)	4%	10%
Legal Services (5%)	5%	7%
Substance Abuse Services – Outpatient (5%)	4%	7%
Respite Care (5%)	5%	5%
Health Education/Risk Reduction (4%)	2%	8%
Outreach Services (4%)	3%	7%
Outpatient Ambulatory Care (4%)	4%	3%
Case Management (Non-Medical) (4%)	3%	5%
Early Intervention Services (4%)	3%	5%
Medical Case Management (3%)	2%	5%
AIDS Drug Assistance Program (3%)	3%	3%
AIDS Pharmacy Assistance (3%)	2%	5%
Home Health Care (3%)	4%	2%
Referral for Health Care & Support Services (3%)	3%	3%
Rehabilitation Services (3%)	2%	5%
Health Insurance Premium Assistance (3%)	4%	0%
Substance Abuse Services – Residential (3%)	1%	7%
Child Care (2%)	2%	3%
Hospice (2%)	1%	3%
Linguistic Services (1%)	1%	2%

C-3. HIGHEST RANKED SERVICES: SERVICE DEMAND AND UNMET NEED

There were several services that were ranked with both a high service demand *and* a high unmet need by survey respondents. These services are particularly important to improve access to because clients need them at a high rate, but they have not been able to receive them due to high rates of barriers to care.

The following seven services ranked the highest for combined service demand and unmet need in the 2022 HIV Needs Assessment with "High" defined as a ranking in the top half of service categories for both service demand and unmet need.

HIGHEST RANKED SERVICES
TOP HALF OF SERVICE DEMAND AND UNMET NEED
2022 Needs Assessment

Service Category	2022 Unmet Need	2022 Unmet Need Rank	2022 Total Demand	2022 Total Demand Rank
Oral Health	14%	1	75%	3
Mental Health	13%	3	51%	12
Food Bank / Home Delivered Meals	9%	5	64%	5
Housing	8%	6	53%	9
Medical Transportation	7%	7	53%	10
Psychosocial Support Services	6%	9	54%	8
Health Education/Risk Reduction	4%	14	57%	7

SECTION D: BARRIERS TO CARE

D-1. BARRIERS TO CARE OVERVIEW

a. Barriers to Care Categories

In the 2021 Young Adult Needs Assessment survey tool, the barriers to care section was improved by specifying that the section only needed to be completed for those services that had an unmet need (client checked box that they needed the service but did not receive it due to a barrier to care). To add further depth to the survey tool in 2022, barriers to care were asked separately by each service category to learn what barriers were more likely to decrease access to which services.

To help the TGA gain a better understanding about which level of the service system the barriers to care exist, they were classified into five categories of "Knowledge", "Access," "Financial," "Personal", and "Health". The barrier to care categories go from examining broad-based TGA-wide "Access" and "Knowledge" issues to more specific client-based "Financial", "Health", and "Personal" issues. The following provides a description of barriers to care categories covered in the 2022 Needs Assessment:

- **Knowledge Barriers** include facts not known by the client that limit access to services, such as: "Didn't know service was available", "Didn't know I was eligible for service", "Didn't know how to get service", and "Didn't know where to receive service".

- **Access Barriers** include factors that limit a client's ability to access a service when they need it and include barriers such as: "Appointments not soon enough", "Times not convenient", "No childcare", "Language barriers", and "No cell phone".

- **Financial Barriers** include issues such as: "Co-pay was too high", "Service costs too much", and "No insurance coverage".

- **Personal Barriers** include issues that create challenges to accessing services, such as: "Treated with disrespect", "Jail/Prison history", and "Wanted privacy of HIV status, mental health or substance use".

- **Health Barriers** include medical issues such as: "Didn't want to take medications"; "Hard to navigate system due to physical, mental or substance use issues", and "Thought viral load was undetectable".

b. Barriers to Care Category Rankings

The primary goal of the Needs Assessment survey process is to identify strategies to reduce barriers to care so that service demand and unmet need can be met for the majority of service categories across all demographic groups. As described above, Barriers to Care assessed in the survey are organized under five types of barriers: Knowledge, Access, Financial, Personal, and Health.

Respondents with unmet needs most commonly reported barriers to care in the following two areas: Knowledge Barriers (31%) and Access Barriers (15%). The least commonly reported barriers to care for respondents with unmet need were related to the respondents' Health (4%).

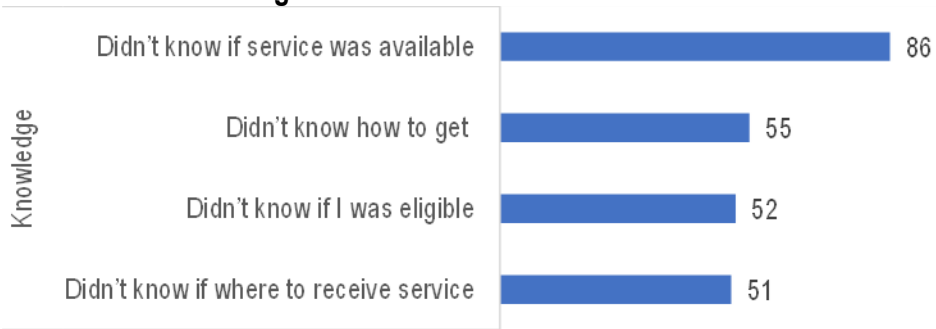
At Least One Knowledge Barrier	At Least One Access Barrier	At Least One Financial Barrier	At Least One Personal Barrier	At Least One Health Barrier
31%	15%	8%	6%	4%

Among the detailed sub-barriers, the four most commonly reported were each of the four included in the Knowledge category (51-86 respondents), i.e., didn't know the service was available, didn't know how to get it, didn't know whether they were eligible, and didn't know where to receive the service. The next most common sub-barriers were a combination of access, personal, and financial barriers: lack of transportation (24), previous incarceration (19), appointments not soon enough (17), and no insurance coverage (17).

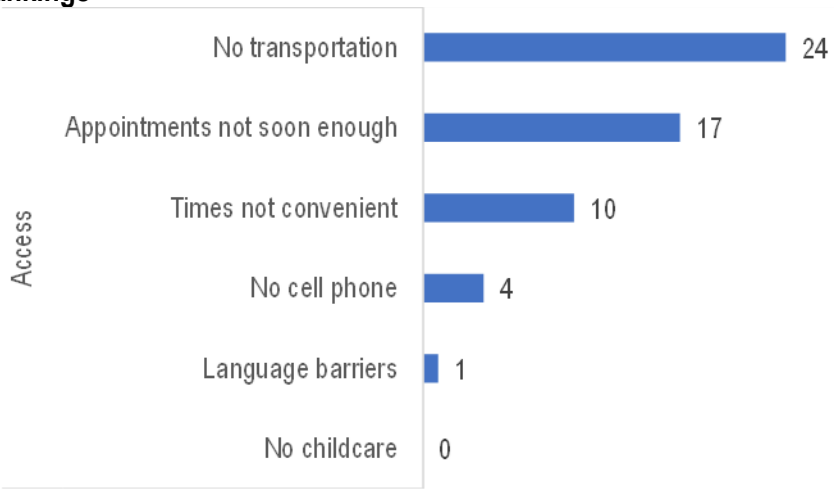
Notably, several respondents who indicated at least one barrier to care in a barrier category (e.g., Knowledge Barrier) may not have selected a specific sub-barrier to care (e.g., didn't know how to get).

2022 BARRIERS TO CARE RANKINGS			
RANK	**BARRIER TO CARE**	**CATEGORY**	**# Reported**
1	Didn't know if service was available	Knowledge	86
2	Didn't know how to get	Knowledge	55
3	Didn't know if I was eligible	Knowledge	52
4	Didn't know if where to receive service	Knowledge	51
5	No transportation	Access	24
6	Previous incarceration	Personal	19
7	Appointments not soon enough	Access	17
7	No insurance coverage	Financial	17
9	Hard to navigate system due to physical, mental or substance use issues	Health	12
10	Times not convenient	Access	10
11	Wanted privacy of HIV status, mental health or substance use	Personal	7
12	No cell phone	Access	4
12	Service cost too much	Financial	4
14	Co-pay too high	Financial	2
14	Treated with disrespect	Personal	2
14	Thought viral load undetectable	Health	2
17	Language barriers	Access	1
17	Didn't want to take medications	Health	1
19	No childcare	Access	0

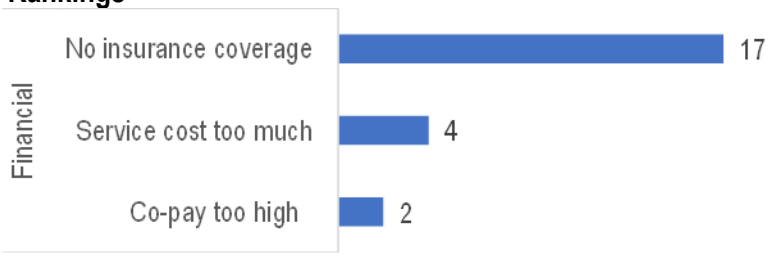
c. Knowledge Barriers to Care Rankings



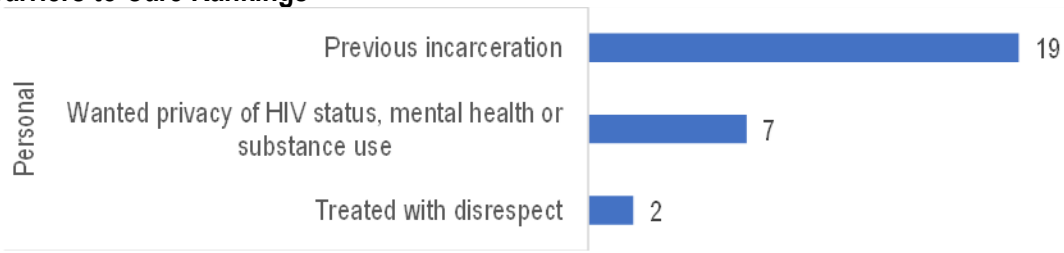
d. Access Barriers Rankings



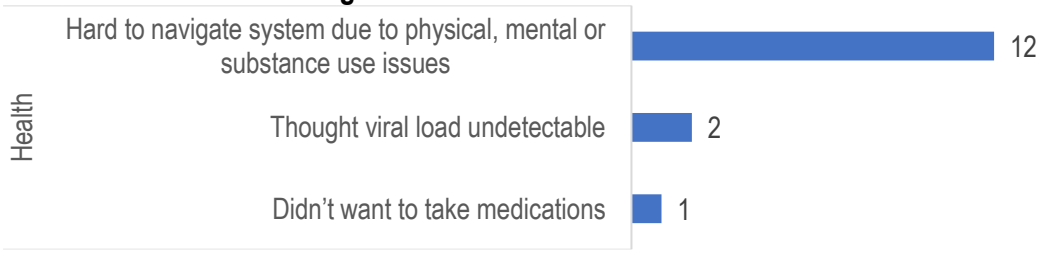
d. Financial Barriers to Care Rankings



e. Personal Barriers to Care Rankings



f. Health Barriers to Care Rankings



D-2. BARRIERS TO CARE BY SERVICE CATEGORY

Follows is a graphical display of the barriers to care reported by service category by 2022 survey respondents. This table shows the type and frequency of barriers to care by service category, with services having the highest

unmet need at the top. For example, 14% of respondents indicated an unmet need for Emergency Financial Assistance. Of these respondents, 77% indicated they had a knowledge barrier to receiving that service.

With few exceptions, Knowledge barriers were the greatest contributors to unmet need for most service categories. Further in this section are graphs that analyze client's reporting of sub-barriers in each barrier to care category.

BARRIERS TO CARE BY SERVICE CATEGORY AND BARRIER CATEGORY
Ranked by Unmet Need

Category	% with Unmet Need	% with Knowledge Barrier	% with Access Barrier	% with Financial Barrier	% with Personal Barrier	% with Health Barrier
Emergency Financial Assistance	14%	77%	8%	8%	8%	4%
Oral Health	14%	42%	31%	19%	0%	4%
Housing	13%	56%	20%	8%	20%	8%
Medical Nutrition	13%	76%	20%	4%	12%	0%
Mental Health	9%	35%	18%	6%	12%	6%
Medical Transportation	8%	80%	27%	13%	7%	13%
Home and Community-based Health Services	7%	79%	14%	7%	7%	7%
Psychosocial Support Services	7%	50%	36%	21%	7%	14%
Food Bank/Home Delivered Meals	6%	92%	17%	0%	17%	0%
Legal or Professional Services	6%	91%	9%	9%	9%	9%
Legal Services	5%	100%	10%	10%	10%	0%
Respite Care	5%	78%	11%	11%	0%	0%
Substance Abuse Services – Outpatient	5%	44%	33%	0%	22%	11%
Health Education/Risk Reduction	4%	63%	13%	0%	13%	0%
Outreach Services	4%	75%	13%	13%	13%	13%
Case Management (Non-Medical)	4%	57%	14%	0%	29%	0%
Early Intervention Services	4%	71%	14%	14%	14%	0%
Outpatient Ambulatory Care	4%	43%	43%	14%	14%	0%
AIDS Drug Assistance Program	3%	83%	0%	0%	0%	0%
AIDS Pharmacy Assistance	3%	100%	0%	0%	0%	0%
Home Health Care	3%	83%	0%	0%	0%	0%
Medical Case Management	3%	50%	0%	0%	17%	17%
Referral for Health Care & Support Services	3%	83%	17%	17%	17%	17%
Rehabilitation Services	3%	100%	33%	0%	17%	17%
Health Insurance Premium Assistance	3%	20%	20%	80%	0%	0%
Substance Abuse Services – Residential	3%	60%	0%	0%	0%	0%
Child Care	2%	25%	25%	0%	25%	0%
Hospice	2%	33%	0%	0%	33%	33%
Linguistic Services	1%	50%	0%	0%	0%	0%

Knowledge Barriers

- Emergency Financial Assistance, Medical Nutrition, and Housing were among the services with the most respondents indicating at least one knowledge barrier to care.
- Among the more commonly reported knowledge barriers to services were respondents a) not knowing Emergency Financial Assistance and Medical Nutrition were available and b) not knowing how to get Housing services.

KNOWLEDGE BARRIERS					
Service Category	Didn't know if service was available	Didn't know if I was eligible	Didn't know how to get	where to receive service	At least one barrier
Emergency Financial Assistance	9	6	3	4	20
Medical Nutrition	7	4	6	5	19
Housing	4	4	7	5	14
Medical Transportation	3	1	4	1	12
Food Bank/Home Delivered Meals	3	1	1	5	11
Home/Community-Based Care	5	3	3	4	11
Oral Health	6	5	2	3	11
Legal or Professional Services	6	1	2	4	10
Legal Services	5	2	3	3	10
Psychosocial Support Services	3	1	2	2	7
Respite Care	5	4	4	3	7
AIDS Pharmacy Assistance	3	2	1	1	6
Mental Health	3	3	3	1	6
Outreach Services	3	1	0	1	6
Rehabilitation Services	2	0	3	3	6
AIDS Drug Assistance Program	3	3	2	2	5
Early Intervention Services	2	1	0	1	5
Health Education/Risk Reduction	2	1	2	0	5
Home Health Care	3	2	1	1	5
Referral for Health & Support Svcs	0	0	2	1	5
Case Management (Non-Medical)	2	1	0	0	4
Substance Use Svcs - Outpatient	2	2	2	0	4
Medical Case Management	2	1	0	0	3
Outpatient Ambulatory Care	1	2	0	0	3
Substance Use Svcs- Residential	1	0	1	0	3
Child Care	0	0	0	0	1
Health Insurance Assistance	1	1	1	1	1
Hospice	0	0	0	0	1
Linguistic Services	0	0	0	0	1

Access Barriers

- Oral Health, Housing, Medical Nutrition, and Psychosocial Support Services were among the categories with the most respondents indicating at least one access barrier to care.
- Among the more commonly reported access barriers to services were respondents indicating oral health appointments were not soon enough.

ACCESS BARRIERS							
Service Category	Appoint-ments not soon	Times not conven-ient	No transpor-tation	No childcare	Language barriers	No cell phone	At least one barrier
Oral Health	6	1	1	0	0	0	8
Housing	0	0	2	0	0	1	5
Medical Nutrition	1	3	2	0	0	0	5
Psychosocial Support Services	1	2	2	0	0	1	5
Medical Transportation	0	1	2	0	0	1	4
Mental Health	2	0	0	0	1	0	3
Outpatient Ambulatory Care	4	1	0	0	0	0	3
Substance Use Svcs - Outpatient	0	1	2	0	0	0	3
Emergency Financial Assistance	0	0	2	0	0	0	2
Food Bank/Home Delivered Meals	0	1	1	0	0	0	2
Home/Community-Based Care	0	0	1	0	0	1	2
Rehabilitation Services	1	0	1	0	0	0	2
Case Management (Non-Medical)	1	0	1	0	0	0	1
Child Care	0	0	1	0	0	0	1
Early Intervention Services	0	0	1	0	0	0	1
Health Education/Risk Reduction	0	0	1	0	0	0	1
Health Insurance Assistance	0	0	0	0	0	0	1
Legal or Professional Services	0	0	1	0	0	0	1
Legal Services	0	0	1	0	0	0	1
Outreach Services	0	0	1	0	0	0	1
Referral for Health & Support Svcs	0	0	1	0	0	0	1
Respite Care	1	0	0	0	0	0	1

Financial Barriers

- Oral Health, Health Insurance Assistance, and Psychosocial Support Services were among the categories with the most respondents indicating at least one financial barrier to care.
- Among the more commonly reported financial barriers to services were respondents indicating they did not have insurance coverage for Oral Health, Health Insurance Assistance, and Psychosocial Support Services.

FINANCIAL BARRIERS				
Service Category	Co-pay too high	Service cost too much	No insurance coverage	At least one barrier
Oral Health	0	0	3	5
Health Insurance Assistance	1	0	3	4
Psychosocial Support Services	0	0	3	3
Emergency Financial Assistance	0	0	0	2
Housing	0	2	0	2
Medical Transportation	0	0	1	2
Early Intervention Services	0	0	1	1
Home/Community-Based Care	0	0	1	1
Legal or Professional Services	0	0	1	1
Legal Services	0	1	0	1
Medical Nutrition	0	0	0	1
Mental Health	0	0	1	1
Outpatient Ambulatory Care	0	0	1	1
Outreach Services	0	0	1	1
Referral for Health & Support Svcs	0	1	1	1
Respite Care	1	0	0	1

Personal Barriers

- Housing and Medical Nutrition were among the categories with the most respondents indicating at least one personal barrier to care.
- Among the more commonly reported personal barriers to services were respondents indicating previous incarceration contributed to unmet Housing needs.

PERSONAL BARRIERS				
Service Category	Treated with disrespect	Previous incarceration	Wanted privacy of health status	At least one barrier
Housing	1	3	2	5
Medical Nutrition	0	1	0	3
Case Management (Non-Medical)	1	1	0	2
Emergency Financial Assistance	0	1	0	2
Food Bank/Home Delivered Meals	0	1	0	2
Mental Health	0	1	1	2
Substance Use Svcs - Outpatient	0	0	2	2
Child Care	0	1	0	1
Early Intervention Services	0	1	0	1
Health Education/Risk Reduction	0	1	0	1
Home/Community-Based Care	0	1	0	1
Hospice	0	0	1	1
Legal or Professional Services	0	1	0	1
Legal Services	0	1	0	1
Medical Case Management	0	1	0	1
Medical Transportation	0	0	0	1
Outpatient Ambulatory Care	0	0	0	1
Outreach Services	0	1	0	1
Psychosocial Support Services	0	1	0	1
Referral for Health & Support Svcs	0	1	0	1
Rehabilitation Services	0	1	0	1

Health Barriers

- Housing and Medical Transportation were among the categories with the most respondents indicating at least one health barrier to care.
- Among the more commonly reported health barriers to services were respondents indicating their own health issues made it hard to navigate the system, resulting in unmet Housing needs.

HEALTH BARRIERS				
Service Category	Didn't want to take medications	Hard to navigate system due to health issues	Thought viral load undetectable	At least one barrier
Housing	0	2	0	2
Medical Transportation	0	1	0	2
Psychosocial Support Services	0	1	1	2
Emergency Financial Assistance	0	1	0	1
Home/Community-Based Care	0	1	0	1
Hospice	0	1	0	1
Legal or Professional Services	0	0	1	1
Medical Case Management	0	1	0	1
Mental Health	0	1	0	1
Oral Health	0	0	0	1
Outreach Services	1	0	0	1
Referral for Health & Support Svcs	0	1	0	1
Rehabilitation Services	0	1	0	1
Substance Use Svcs - Outpatient	0	1	0	1

D-3. BARRIERS TO CARE: DEMOGRAPHIC DISPARITIES

This table shows the percentage of respondents in each demographic group indicating at least one barrier resulting in an unmet need in one or more service categories.

- IDUs were at least 10% more likely to report at least one access or personal barrier to care than Heterosexuals or MSMs.
- Respondents experiencing unstable housing were 13% more likely to report at least one knowledge barrier compared to respondents in stable housing.

BARRIERS TO CARE
CLIENT DEMOGRAPHICS

Demographic		At Least One Knowledge Barrier	At Least One Access Barrier	At Least One Financial Barrier	At Least One Personal Barrier	At Least One Health Barrier
Overall		31%	15%	8%	6%	4%
Gender	Female	36%	16%	7%	4%	7%
	Male	28%	16%	8%	6%	3%
Race	African American	31%	15%	6%	7%	6%
	Hispanic / Latinx	26%	13%	9%	9%	2%
	White	32%	17%	10%	3%	3%
Transmission	Heterosexual	35%	13%	6%	2%	4%
	IDU	39%	***33%***	11%	***17%***	11%
	MSM	26%	13%	9%	7%	3%
Age	20-44	29%	10%	8%	6%	6%
	45+	31%	17%	8%	6%	4%
Housing	Stable Housing	27%	15%	8%	4%	2%
	Unstable Housing	***40%***	15%	8%	10%	8%

Note: RW survey asked "over last 12-months, have you lived in any of following places: stable (housed); unstable (homeless, car, camping, street, shelter, motel couch surfing).

SECTION E: HIV PREVENTION PRACTICES AND PARTNER SERVICES

E-1 HIV PREVENTION PRACTICES

The 2021 Young Adult Needs Assessment of RW clients ages 19-29 was the first RW Needs Assessment to include a series of questions regarding HIV prevention practices and partner services. Although these services are not directly funded by the RW Part A Program, client input about their knowledge and use of HIV prevention strategies is imperative to improving outcomes along the full HIV Continuum of Care. Due to the usefulness of gathering feedback from RW clients about these HIV prevention issues, the 2022 HIV Needs Assessment included questions about HIV Prevention and Partner Services and are compared to the 2021 Young Adult Needs Assessment findings throughout.

a. Pre-Exposure Prophylaxis (PrEP)

PrEP is the use of anti-retroviral medications (ART) to keep HIV negative people from becoming infected with HIV. The table below shows the percentage of Needs Assessment respondents in 2021 (RW clients ages 19-29 only) and 2022 (RW clients of all ages) answering either yes or no to whether each of the following statements about PrEP was true for them:

Pre-Exposure Prophylaxis (PrEP) 2021 Young Adult and 2022 All Ages Needs Assessments		
Which of the following statements about PrEP are true for you?	**2021 Ages 19-29 % Yes**	**2022 All Ages % Yes**
I have never heard of PrEP.	22%	23%
I have heard of PrEP, but I am not sure how it will affect my sex life.	11%	9%
If my partner is on PrEP, I do not need to disclose that I am HIV positive.	6%	3%
If my partner is on PrEP, I would be less likely to use a condom.	22%	10%
Even with partner(s) on PrEP, I would disclose that I am HIV positive.	44%	37%
Even with partner(s) on PrEP, I would use condoms for anal or vaginal sex.	17%	20%
I feel comfortable talking to my HIV negative partner(s) about PrEP.	33%	23%

There is much more work to do in the Sacramento TGA regarding PrEP education and navigation based on both the 2021 Needs Assessment responses from young adults, as well as the 2022 Needs Assessment of all ages of RW clients. For example,

- 22% of Young Adults and 23% of all ages of survey respondents had never heard of PrEP.
- Of those who had heard about PrEP, 11% of young adults and 9% of all ages were not sure how PrEP would affect their sex life.
- Only 33% of 2021 young adults and 23% of 2022 all ages of respondents reported that they feel comfortable talking to their HIV negative partner(s) about PrEP.
- Less than half of survey respondents (44% of young adults and 37% of all ages) reported they would disclose that they are HIV positive if their partner was on PrEP.
- 17% of young adults and 20% of all ages reported that they would use condoms for anal or vaginal sex if their partner was on PrEP. This decreased use of condoms increases the risk for additional STIs such as Chlamydia, Gonorrhea, and Syphilis.

b. Condom Use and Sexual Health Practices

There is much more education and advocacy work to be done regarding low reported condom use in the TGA based on responses from both the young adult RW clients surveyed in the 2021 HIV Needs Assessment and all ages of RW clients surveyed in 2022. Overall, young adult RW clients surveyed in 2021 reported using condoms at a higher rate than all ages of RW clients surveyed in 2022. However, only 44% of young adults and 18% of all ages of clients surveyed reported the use of a condom when they have anal sex; and only 24% and 13% reported condom use when they have vaginal sex. 22% of young adults and 12% of all ages reported they don't use condoms because their viral load is undetectable.

Condom Use and Sexual Health Practices 2021 Young Adult Needs Assessment		
Which of the following statements about condom use are true for you?	**2021 Ages 19-29 % Yes**	**2022 All Ages % Yes**
I use a condom when I have anal sex.	44%	18%
I use a condom when I have vaginal sex.	24%	13%
I only have sex with one person, and we choose not to use condoms.	11%	10%
My sex partner is HIV+ so we don't use condoms.	0%	5%
My partner is on PrEP so condoms aren't needed.	0%	3%
My viral load is undetectable, so condoms aren't needed anymore.	22%	12%
I don't use condoms because my partner doesn't like them.	0%	1%
I don't use condoms because they cost too much.	0%	0%
I don't use condoms because I don't like them.	11%	7%
Other Sexual Health Practices:		
I have had sex to get money, drugs, housing, etc.	17%	5%

c. HIV Disclosure

RW clients' disclosure of their HIV status to sexual partners needs improvement to effectively decrease the spread of HIV and other STIs and to decrease the stigma associated with HIV/STIs. Overall, RW clients surveyed in the 2022 Needs Assessment reported disclosing their HIV status as follows:

- 58% of RW clients surveyed in 2022 reported they always disclose their HIV status to every sex partner.
- 6% reported that they sometimes disclose their HIV status with some partners.
- 36% reported they never report their HIV status because they don't have sex (21%); viral load is undetectable (5%); always use condoms (3%); partners are HIV+ (3%); don't feel comfortable disclosing (3%); or most of partners are on PrEP (1%).

HIV Disclosure 2021 Young Adult and 2022 All Ages Needs Assessments		
When do you disclose your HIV status to sex partners?	**2021 Ages 19-29 % Yes**	**2022 All Ages % Yes**
Always, with every partner.	61%	58%
Sometimes with some partners.	11%	6%
Never, I always use condoms.	0%	3%
Never. My viral load is undetectable.	6%	5%
Never. Most of my partners are HIV+.	0%	3%

HIV Disclosure 2021 Young Adult and 2022 All Ages Needs Assessments		
When do you disclose your HIV status to sex partners?	**2021 Ages 19-29 % Yes**	**2022 All Ages % Yes**
Never. I don't feel comfortable disclosing my HIV status.	6%	3%
Never. Most of my partners are on PrEP.	0%	1%
Never. I do not have sex.	11%	21%

d. Syringe Use and Practices

In terms of risk of HIV transmission due to syringe use, 17% of 2021 young adult respondents reported the use of syringes to inject non-prescription substances, and 11% reported sharing syringes or injection equipment. A larger percentage, 27% of 2022 all ages of respondents, reported the use of syringes to inject non-prescription substances, and 12% reported sharing needles or injection equipment. 6% of young adults and 4% of all ages of RW clients reported sharing needles for piercings and/or tattooing.

Syringe Use and Practices 2021 Young Adult and 2022 All Ages Needs Assessments		
Which of the following statements about syringe use practices are true for you?	**2021 Ages 19-29 % Yes**	**2022 All Ages % Yes**
I have used syringes to inject non-prescription substances.	17%	27%
I have shared syringes or injection equipment.	11%	12%
I have used someone else's syringes to inject myself.	6%	2%
I have had sex with someone who shares syringes.	0%	4%
I have shared needles for piercings and/or tattoos.	6%	4%

E-2 PARTNER SERVICES

The last two Needs Assessments of PLWH in the TGA's RW Program, the 2021 survey of young adults ages 19-29, as well as the current 2022 survey of all ages of RW clients, have included questions about Partner Services. These services, which are free to all RW clients, assist HIV positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV. As can be seen below, there clearly is more work that needs to be done to educate all RW clients and PLWH in the TGA about Partner Services and to facilitate their use of these important services to prevent new HIV transmissions.

Partner Services 2021 Young Adult and 2022 All Ages Needs Assessments		
Which of the following statements about Partner Services are true for you?	**2021 Ages 19-29 % Yes**	**2022 All Ages % Yes**
Have you been informed of Partner Services before this survey?	39%	41%
Have you used Partner Services before?	6%	12%
Would you be willing to use Partner Services?	56%	43%

As can be seen in the table above, less than half of RW clients surveyed in both 2021 (39% of young adults) and 2022 (41% of all ages of clients) reported that they had been informed of Partner Services before completing the Needs Assessment survey tool. Only 12% of all ages of RW clients surveyed in 2022 had ever used Partner Services, which was only slightly higher than the 6% of young adult clients surveyed in 2021.

Although prior use of Partner Services is extremely low, it's encouraging that 56% of young adult RW clients surveyed in 2021, and 43% of all RW clients surveyed in 2022, reported that they would be willing to use Partner Services. There clearly is a need to put RW resources and programming efforts into improving awareness about Partner Services and to increase access and use of these services among RW clients, as well as partners at increased risk of contracting HIV, to reduce the number of new HIV cases in the TGA.

SECTION F: IMPLICATIONS OF NEEDS ASSESSMENT FINDINGS

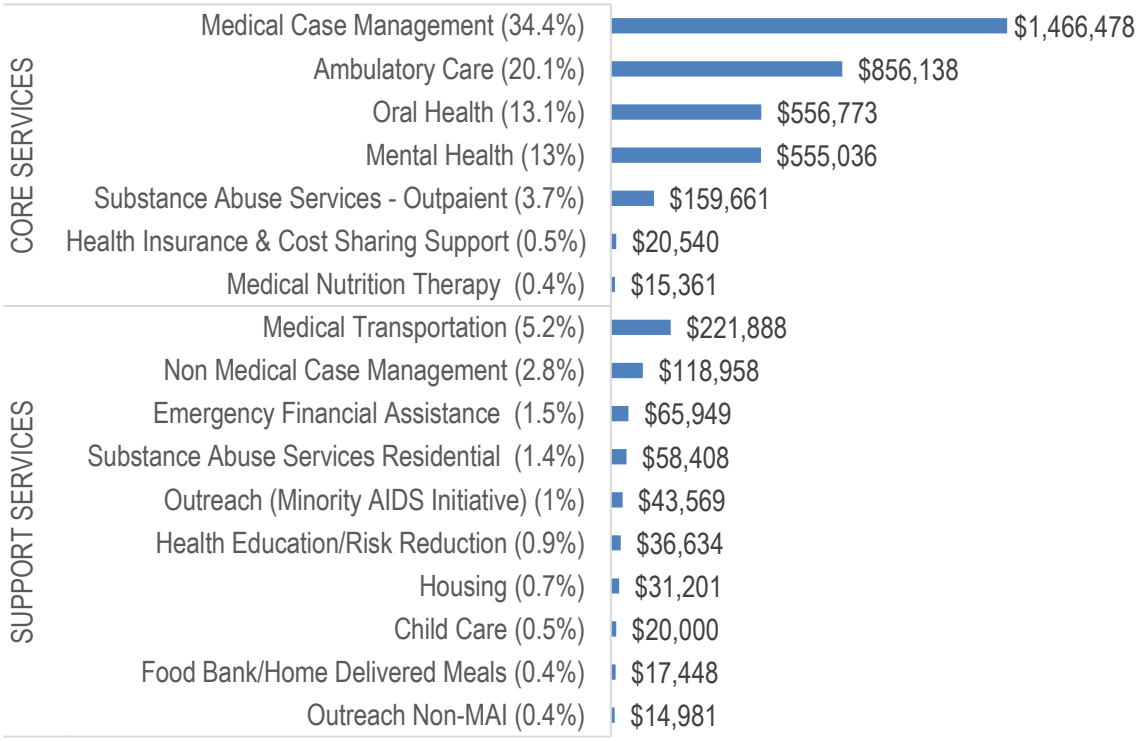
F-1. IMPLICATIONS FOR RW PRIORITY SETTING AND ALLOCATIONS

a. FY22 RW Program Direct Service Allocations

To use the data from the Needs Assessment Survey to assist the Planning Council in Setting Priorities and Allocations, it is important to understand Ryan White funding in the context of other TGA funding sources for PLWH. The RW CARE Act strives for 100% access to care for all persons living with HIV/AIDS, regardless of ability to pay, and is required to use its funds as a "payer of last resort" by maximizing resources from other funding sources prior to using RW CARE Act funds.

Within the Sacramento TGA, FY22 expenditures for each direct service category of the Ryan White Part A, RW Part A Minority AIDS Initiative (MAI), and California State RW Part B and Part B MAI programs, for each service category, are shown in the following bar graph. Medical Case Management was the largest direct service expenditure at 34.4%; Ambulatory/Outpatient Medical Care was the second largest expenditure at 20.1% and Oral Health Services was the third highest expenditure at 13.1%.

FY22 RW CARE Program (Part A, Part A MAI, Part B and RW Part B MAI Funds)
Direct Service Allocations



b. Direct Service Allocations 2020 Compared to 2022

The following table displays allocations by service category for FY20 compared to FY22, including absolute and percentage changes. Overall funding increased by $633,635, a 17% change. Medical Case Management and Oral Health had the largest absolute increases, $278,419 and $202,855 respectively. Also, Health Insurance Cost Sharing and Residential Substance Use Treatment increased by 162% and 402% respectively. There were some categories with significantly reduced allocations, notably Non-Minority AIDS Initiative (MAI) outreach (-77%), Medical Nutrition Therapy, (-69%) Child Care, (-21%), and Outpatient Substance Use Treatment (-21%).

CHANGE IN RW DIRECT SERVICE ALLOCATIONS
FY2020 AND FY2022

Core/Support	Service Category	2020	2022	Δ	%Δ
CORE SERVICES	Medical Case Management	$1,188,059	$1,466,478	+$278,419	+23%
	Ambulatory Care	$854,758	$856,138	+$1,380	+0%
	Oral Health	$353,918	$556,773	+$202,855	+57%
	Mental Health	$452,030	$555,036	+$103,006	+23%
	Substance Abuse Services - Outpatient	$200,981	$159,661	-$41,320	-21%
	Health Insurance & Cost Sharing Support	$7,803	$20,540	+$12,737	+163%
	Medical Nutrition Therapy	$48,865	$15,361	-$33,504	-69%
SUPPORT SERVICES	Medical Transportation	$155,382	$221,888	+$66,506	+43%
	Non-Medical Case Management	$85,412	$118,958	+$33,546	+39%
	Emergency Financial Assistance	$78,457	$65,949	-$12,508	-16%
	Substance Abuse Services Residential	$11,642	$58,408	+$46,766	+402%
	Outreach (Minority AIDS Initiative)	$35,169	$43,569	+$8,400	+24%
	Health Education/Risk Reduction	$29,048	$36,634	+$7,586	+26%
	Housing	$16,296	$31,201	+$14,905	+91%
	Child Care	$25,200	$20,000	-$5,200	-21%
	Food Bank/Home Delivered Meals	$18,178	$17,448	-$730	-4%
	Outreach Non-MAI	$64,192	$14,981	-$49,211	-77%
	TOTAL	$3,627,410	$4,261,045	+$633,635	+17%

c. Implications for Priority Setting

The 2022 RW HIV Needs Assessment provides input from RW clients who are living with HIV. The analysis of client input regarding service demand, unmet need, and barriers to care for treatment services, as well as prevention and support services, provides the HIV Planning Council with important information for making priority setting decisions for the Sacramento TGA.

There were several services that were ranked with both a high service demand *and* a high unmet need by survey respondents. These services are particularly important to improve access to because clients need them at a high rate, but they have not been able to receive them due to high rates of barriers to care.

The following 7 services - out of 29 services - ranked the highest for combined service demand and unmet need in the 2022 HIV Needs Assessment with "High" defined as a ranking in the top half of service categories for both demand and unmet need. These disparities are imperative to address while establishing priorities for the RW Program.

HIGHEST RANKED SERVICES
TOP HALF FOR BOTH SERVICE DEMAND AND UNMET NEED
2022 Needs Assessment

Service Category	2022 Unmet Need	2022 Unmet Need Rank	2022 Total Demand	2022 Total Demand Rank
Oral Health	14%	1	75%	3
Mental Health	13%	3	51%	12
Food Bank / Home Delivered Meals	9%	5	64%	5
Housing	8%	6	53%	9
Medical Transportation	7%	7	53%	10
Psychosocial Support Services	6%	9	54%	8
Health Education/Risk Reduction	4%	14	57%	7

- ***Oral Health.*** Despite a recent increase in funding between FY20 and FY22, Oral Health has the highest unmet need and is the third highest in overall demand. This input clarifies that additional funding for, and access to, Oral Health continues to be of primary importance to RW clients.

- ***Mental Health.*** There was a lower percentage increase in funding for Mental Health than Oral Health over the last two years, but Mental Health still ranks highly in both unmet need (#3) and service demand (#12).

- ***Food Bank and Home Delivered Meals*** receive the second lowest FY22 funding level, however, this category has the fifth highest overall demand and fifth highest unmet need compared to other service categories.

- ***Housing Services.*** FY22 funding for Housing services is among the lowest levels compared to other service categories, however, it is the ninth highest in service demand and is the sixth highest in unmet need.

- ***Medical Transportation.*** Despite a recent increase in funding for FY22, Medical Transportation is among those services with the highest unmet need and service demand.

- ***Psychosocial Support Services*** are among those services with the highest unmet need and service demand; however, these services are not part of the FY22 budget.

- ***Health Education and Risk Reduction.*** FY22 funding is among the lowest levels compared to other service categories, however, it is among the highest in demand and unmet need.

- ***Partner Services,*** which assist PLWH in notifying sexual and/or needle sharing partners of possible HIV exposure, was significantly underutilized by 2022 respondents. 59% reported they hadn't been informed of Partner Services before this survey. 56% reported they would use Partner Services but only 12% had used them before. There is more funding needed to educate PLWH about Partner Services and to facilitate their use.

- ***Pre-Exposure Prophylaxis (PrEP),*** the use of medications to reduce HIV transmission was significantly underutilized by 2022 survey respondents. 23% had never heard of PrEP. Of those who had heard about PrEP, 9% were not sure how PrEP would affect their sex life; 77% reported that they don't feel comfortable talking to their HIV negative partner(s) about PrEP; and 83% reported they wouldn't use condoms for sex if their

partner was on PrEP. Education about PrEP and referrals to PrEP navigation services need to be an integral part of the HIV Continuum of Care.

- 23% of all ages of survey respondents had never heard of PrEP.
- Of those who had heard about PrEP, 11% of young adults and 9% of all ages were not sure how PrEP would affect their sex life.
- Only 33% of 2021 young adults and 23% of 2022 all ages of respondents reported that they feel comfortable talking to their HIV negative partner(s) about PrEP.
- Less than half of survey respondents (44% of young adults and 37% of all ages) reported they would disclose that they are HIV positive if their partner was on PrEP.

d. Implications for Allocations

- ***Oral Health, Housing, Emergency Financial Assistance, and Medical Nutrition*** had much higher unmet needs than other categories: 13-14% of respondents had unmet needs in these four categories vs 9% or fewer for all other categories. Of these, Oral Health and Housing also were in the top half in total demand, with more than half of respondents indicating a need for these two services, a large proportion of which went unmet.

- ***Oral Health and Housing.*** These gaps between supply and demand for Oral Health and Housing persist despite recent significant increases in allocations (+57% and +91% respectively between 2020 and 2022). Given these persistent gaps, allocations for these services should be revisited.

- ***Oral Health, Outpatient Medical Care and Mental Health.*** The FY22 allocation for Oral Health of $556,773 was similar to or less the allocations for Outpatient Care and Mental Health, although client demand and unmet need for the latter two were lower than for Oral Health. These three categories comprised 56% of the total FY22 allocations, and because of their magnitude, they demand extra scrutiny to ensure client needs are being appropriately prioritized. The primary barrier unique to Oral Health that should be addressed when revisiting allocations includes appointment availability.

- ***Housing.*** The $31,201 allocation in FY22 for Housing was among the lowest for all service categories and was less than 1% of the total allocated for the fiscal year. 2022 COVID funds also were used for housing to supplement RW funding. The magnitude of funding for Housing services should be revisited given the high demand and unmet need. Greater attention and outreach also should be afforded to communities for which housing needs appear to be greater, including women, IDUs, and clients who have a history of experiencing unstable housing.

- ***Emergency Financial Assistance and Medical Nutrition.*** While demand may not be high, unmet needs for these services are among the most prominent. Despite this gap, the cumulative allocations for these two services are less than 2% of the $4.3 million total for FY22. In addition to revisiting the magnitude of allocations for these services, special attention should be paid to communities in greatest need, including women and blacks for Medical Nutrition; and clients experiencing unstable housing along with those aged 20-44 for Emergency Financial Assistance.

- ***Food- and Meal-related Services*** were the fifth highest in overall demand and unmet need, however, the category is the second lowest among all allocations at $17,448, or 0.4% of the total. Notably, allocations in this category were reduced since FY20 even though the total allocations increased overall by 17% between 2020

and 2022. Considering the level of demand and unmet need for food and meals, the magnitude of funding for these services should likely continue to be revisited in future years. In 2023, for example, an additional $32,500 has been allocated to this service category.

F-3. IMPLICATIONS FOR SERVICE SYSTEM IMPROVEMENTS

Although not meant to be an exhaustive list of strategies, follows are examples of improvements for the HIV Health Services Planning Council to consider by focusing on services with the highest reported unmet need and barriers to care among survey respondents. In addition, these systemic improvements should be targeted to subpopulations with disproportionate unmet need and barriers to care.

- Knowledge barriers were the top four most commonly reported barriers to care, as follows: 1) didn't know service was available, 2) didn't know how to get the service, 3) didn't know if I was eligible, and 4) didn't know where to receive the service. Improved outreach and case management for PLWH should continue to be prioritized and models of care should continue to be enhanced. Service providers should work to improve awareness of available services through direct client contact at all levels of care, including targeted outreach, case management, and educational campaigns.

- The RW Program should continue to use its sophisticated database, Sacramento HIV/AIDS Reporting Engine (SHARE) to keep RW service providers informed about clients who are not retained in outpatient medical care. For example, SHARE generates a monthly laboratory report that tracks the date of each client's most recent CD4 and HIV viral load tests and distributes analysis to each RW service provider.

- This report, among others, should continue to be distributed monthly to assist providers in identifying clients who are out of HIV medical care; to resolve data issues; to track progress of CQI projects; to identify areas for program improvement; and to assist with retaining clients in all aspects of medical care.

- To support retention in ongoing medical care, Case Managers and other support staff could increase efforts to contact patients directly to inquire about needs and encourage re-entry into medical care. All RW service agencies should continue making appointment reminder calls, facilitating transportation assistance; and implementing/maintaining "no-show" tracking and follow up protocols, including contacting patients within 24 hours of any missed appointments.

- RW service agencies should be encouraged to increase the use of peer advocates to provide outreach to specific populations and locations to get and retain PLWH in ongoing medical care.

- The Council could consider increased technical assistance, capacity building, and networking with current RW service organizations throughout the TGA to educate them about findings and implications of the Needs Assessments to work towards a collaborative approach to improving the overall HIV system of care in the TGA.

- The Council should continue to network with other organizations throughout the Sacramento Region to maximize additional funding opportunities and services for PLWH.

- The Planning Council's Quality Advisory Committee should continue to involve RW consumers in quality improvement efforts by collecting feedback through the annual postcard survey to evaluate services. Expanded

efforts to solicit input from PLWH and service providers should be explored as part of the RW Program's Continuous Quality Improvement (CQI) efforts. For example, facilitated focus groups should be conducted to evaluate the RW program delivery system, including coordination of care and collaboration between service providers.

F-4. IMPLICATIONS FOR FUTURE NEEDS ASSESSMENTS

The HIV Needs Assessment Survey Tool was revised for 2022 to streamline the questions of Service Need, Need Met, and Unmet Need by RW service category. In addition, the survey collected data on Barriers to Care, and Sub-Barriers by service category. This format resulted in more consistent answers from survey respondents as compared to the TGA's past needs assessments. The survey was able to be completed in less time and with less confusion among survey respondents than in previous surveys.

Based on the responses from the new survey format in 2022, there are several potential improvements to both the survey format and content that could help improve the reliability and utility of survey responses for the next survey. There are several questions that the Council, through its Needs Assessment Committee (NAC), may consider making adjustments to for future Needs Assessment Survey Tool, as follows:

- Federal Poverty Level calculations and comparisons require information on the number of people living in one's household. In addition to Needs Assessment Survey Tool's income question (Section 2, #2), the survey should ask "How many people are in your household?" The number of dependents and children is not required to determine FPL percent.

- The question about whether a respondent has used a syringe to inject substances in the past 12 months (Section 2, #11a) should be restricted to substances not prescribed by a medical provider.

- The Hepatitis C Virus (HCV) Needs Assessment survey question (Section 2, #12) asks "Has a medical or service provider ever told you that you have hepatitis C?" HCV comparisons become problematic if each entity (Census, RW Program, Needs Assessment, etc.) ask the question differently. The HCV question should be narrowed to whether a person is currently HCV positive and whether they have been newly infected in the last 12 months (i.e., incidence).

- The 2022 Needs Assessment housing question (Section 3, #13) asks "Over the last 12 months, have you lived in any of the following places? Check all that apply". Homeless, unstable and temporary housing counts for the 2022 Needs Assessment respondents include anyone with those housing types in the last 12 months, are which may not be comparable to other point-in-time housing figures for other populations (e.g., TGA, RW). TGA housing questions were based on current point-in time housing status. The Council should consider revising the survey to ask about current point-in-time housing status and require a single choice response.

- In reviewing the answers to the question "What is the most likely way that you contracted HIV" (Section 4, #22), the response to which is intended to be a single selection of listed choices, at least 4 respondents indicated "Heterosexual" and "IDU" either a) through comments in the "Other" box or b) by multi-selecting two boxes. This suggests that there may be an unmet epidemiological need to track "Heterosexual/IDU" transmission which would be similar to the current "MSM/IDU" category. Alternately, the MSM/IDU category could be removed from the list of options and respondents may be prompted to select only one box. Either of

these changes to the survey tool would require changes to the RW and TGA data collection processes, which may complicate historical trending.

- Some questions requiring a "Y" or "N" response were sometimes entered as "X". Some single-select or multi-select responses were sometimes entered as something other than "X". These responses were adjusted on a case-by-case basis to conform with the intended survey response format in an effort to standardize the accounting of question responses during data entry process. In the future, it would be beneficial if the survey administration process includes a careful quality assurance review of the written survey responses to verify that the form was properly filled out prior to completion of the survey session and prior to providing the survey respondent with a gift card.

- Survey formatting related to barriers to care for unmet needs sometimes resulted in inconsistent responses and data input in the "sub-barriers" section, which made analysis of response data for this section of the survey challenging. The example below provides a suggested update to the survey format that would more clearly prompt respondents to select specific sub-barriers. Survey data input also would need to be updated to accommodate the increased specificity, including nineteen options/rows for each sub-barrier, indicating whether the respondent selected the specific sub-barrier or not.

BARRIERS TO CARE				
D	**E**	**F**	**G**	**H**
Knowledge Didn't know: 1) if service was available 2) if I was eligible 3) how to get 4) where to receive service	**Access** 1) Appointments not soon enough 2) times not convenient 3) no transportation 4) no childcare 5)language barriers 6) no cell phone	**Financial** 1) co-pay too high 2) service cost too much 3) no insurance coverage	**Personal** 1) treated with disrespect 2) previous incarceration 3) wanted privacy of HIV status, mental health or substance use	**Health** 1) didn't want to take medications 2) hard to navigate system due to physical, mental or substance use issues 3) thought viral load undetectable
Check all that apply:				
① ② ③ ④	①②③④⑤⑥	① ② ③	① ② ③	① ② ③

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Committee Development, Organization and Appointment

No: GOV 01
Date Approved: 12/98
Date Revised: ~~06/24/20~~
Date Reviewed: 06/24/20

BACKGROUND

Committees carry out the majority of Council activity. The authority to establish a committee is stipulated in Article V Committee Structure Section 5.1 of the Bylaws. The effectiveness of a committee is dependent on diverse membership and a well-articulated work plan. The operational structure of committee work is determined by group process and the specific charge of the committee. In this manner, committees remain dynamic and able to address a variety of tasks necessary for the success of the Council.

POLICY

~~The~~ Council membership will establish a structure of committees necessary to accomplish ongoing business and planning activities. There shall be at minimum an Executive and Governance Committee. The Executive Committee shall have decision-making authority in those business matters necessary for the uninterrupted operation of the Council and within the parameters established by ~~the~~ Council general membership.

COMMITTEE TYPES

The Council may use three types of committees as defined below;

1. Standing — formed primarily from Council membership for permanent and ongoing functions

2. Ad Hoc — formed from Council and community members to address a specific issue, task or activity that once resolved requires no further or ongoing meeting (commonly referred to as Work Groups)

3. Advisory formed from experts in a particular field or subject matter for the purpose of advising the Council on complex or sensitive issues

The Council may establish any number of standing committees including, but not limited to, priorities and allocation, needs assessment, service standards, administrative assessment and Council development.

ROLES, RESPONSIBILITIES AND TERMS

Committee Chairs

- The ~~Council or the~~ Council Chair, as delegated by the general membership ~~at the direction of the membership,~~ will appoint committee chairs annually
- The Council Chair will represent ~~Shall be the Committee Representative~~ matters of the ~~for~~ Executive Committee
- The Council Chair may call for a committee or ad hoc group to address specific needs of the Council including desired goals and objectives tasked to the committee
- All committee chairs ~~S~~ ~~hall~~ will be a member of the Council in good standing except as otherwise noted with regard to ad hoc or specially convened work groups
- All committee chairs ~~Will~~ consider the membership of the committee and ~~will~~ appoint new members based on the intent of the committee and reflective diversity ~~as needed~~
- ~~Will coordinate establishment of any new committee including development of goals, objectives or desired product~~
- All committee chairs will manage scheduling, communication and facilitation of committee work~~Will notify members of location, day and hour of committee meeting~~
- All committee chairs ~~Will prepare,~~ in cooperation with Council staff, will facilitate the setting of agendas, conducting of business and monitoring of the respective committee work plan ~~the committee meeting agenda~~
- ~~Ensures that the committee's work plan is carried out in the most efficient manner reasonable~~
- ~~Ensures that tasks are completed in a timely manner~~
- Committee decorum will honor ~~Facilitates~~ open, honest, and objective ~~and~~ critical discussion
- All committee chairs are expected to ~~A~~attend~~s~~ ~~the~~ Executive Committee meetings as appropriate ~~regularly~~
- Committee chairs and members represent the interests of both the

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Councilsel and service community to enhance communication and cooperation between all stakeholder groups. ~~Serves as a conduit of communication between committee members, council membership at large and the community~~

- Ad hoc committee chairs may invite interested parties of special expertise without Council member standing at the discretion of the Council Chair
- ~~Prepares written and verbal reports on committee activities~~
- ~~Cooperates with Council staff~~

Council ~~Committee~~ Vice Chair

- Will be elected by ~~Committee~~ the Council membership ~~will elect~~
- Is a standing member of the Council or an alternate
- May ~~A~~assist~~s~~ the chair with the business of the ~~activities of conducting efficient meetings~~ Council
- Will chair Council meetings is the absence of the Council Chair
- Will Chair~~s~~ the Executive ~~c~~Committee in the absence of the chair
- ~~Represents the committee to Executive Committee in the absence of the chair~~
- General committee chairs may designate a committee vice chair

Committee Principles ~~Membership~~

- Participation on committees is encouraged of all members ~~Committee membership is expected of each Council member~~
- Active recruitment of member participation on committee is a shared responsibility of the Council Chair, Executive Committee and membership at large
-
- Terms for Committee participation ~~The length of membership term shall~~ will be two years and ~~is~~ renewable ~~indefinitely~~
- Committee participants will represent diversity, interest or requisite knowledge reflective of the ~~Composition shall be maintained (optimal) between 5 and 11 with individuals possessing interest or skill base relative to the~~ committee charge
- Optimal membership is between 5 and 11 individuals or as determined by the function and purpose of the group defined by the Council Chair or majority membership.
- ~~Composition for the~~ Executive Committee composition is ~~shall be~~ stipulated ~~determined as outlined~~ in Article V Committee Structure Section 5.4 of the Bylaws
- ~~Should a Committee fail to include a majority of Council members, the Council Chair, with the assistance of Council staff, shall pursue Council members not actively participating on a Committee to sit as Committee members~~
- ~~Diversity of stakeholders must be reflected in Committee membership.~~
- ~~All committee members, regardless of Council membership, must complete an "Application for Appointment to Sacramento Transitional Grant Area (TGA) HIV Health Services Planning Council, Committees or Work Groups" prior to serving on a committee.~~
- ~~All committee members, regardless of Council membership, must sign the Council's "Acknowledgement of HIV Health Services Planning Council Policies and Including Attendance, Conflict of Interest and Confidentiality."~~
- Committees are self-governed to accomplish the established work-plan through team dynamics, delegation of tasks, commitment, and fulfillment of responsibilities, constructive debate and timely response to the Council members at large.
- Minority opinions are to be represented as part of the majority action taken with respect to informing the Council of the majority recommendation
- Meetings will be conducted in accordance with Robert's Rules of Order Newly Revised, most current edition.
- All committee meetings are open to the public, except for closed sessions as defined in the most current bylaws and/or the Brown Act with associated amendments.
- Committee meetings will comply with all disclosure, open meeting,

noticing, conflict of interest and general procedural requirements applicable to full membership Council meetings.

- Notice of committee member anticipated absences will be communicated to the committee chair or Council support staff

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Alternates and Non-Council Members

- Committee alternates may be appointed in accordance with rules set out for Council Alternates in the Bylaws Article III, Section 3.6.
- A committee chair may invite a person or persons to participate in committee activities for the purpose of technical assistance, training or other contributions pertinent to the work plan of the specific committee.
- *Members of the public*: may attend and participate in the discussion during allotted time at any (non-closed) committee meeting consistent with the procedures adopted for the general Council meetings
- General Council members may attend any committee meeting as non-voting members
- Council support staff may engage in discussion at the discretion of the committee chair for the provision of administrative guidance, matters of contractual necessity and fiscal governance

Ex Officio Members

- Ex Officio members have the full rights and responsibilities of other members unless otherwise stated in the Council Bylaws.
- Officers of the Planning Council will sit as ex officio members of all committees with full voting privileges, but will not be included in establishing quorum.
- While Ex Officio members may vote in general committee session commonly this is the exception rather than the rule.
- Officers of the Planning Council may sit as ex officio members of all committees with full voting privileges, but will not be included in establishing the quorum.

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Council Staff

- ~~Solicit Council members for interest in standing committee service~~
- ~~Provide the committee chairs with a sign-up list of interested Council members~~
- ~~Schedule and publicize meeting times, location and agendas~~
- ~~Minutes of committee activity will be documented at each meeting~~
- Provides general administrative support for the maintenance of

established committees or work groups
- Coordinates the publication of meeting notices, distribution of agenda, minutes and the archiving of referenced materials, establishing the meeting venue and location and maintaining incidentals related to the effective function of committee work
- Maintains committee attendance records

Documentation

- An agenda will be developed for each meeting reflecting the annual work plan, new and old business, current meeting date and proposed future meeting date
- Minutes will be recorded for all open session committee meetings documenting the activities and actions taken by the members of the committee consistent with standard rules of order

- ~~Provide committees with technical assistance, training or process facilitation as requested~~
- ~~Ensure the timely dissemination of agendas, minutes and support documents~~
- ~~Ensure the timely dissemination of committee reports to the Council~~
- ~~Maintain committee meeting attendance records and provide the Council Chair an attendance report as requested~~

~~Committee Work:~~

- ~~Committees may work flexibly in order to accomplish assigned tasks~~
- ~~During regular meetings, committee members plan together, and all take part in discussions and decisions~~
- ~~As needed, all committee members are expected to perform work outside of regular meetings, including, but not limited to, ongoing communication, timely project or activity input, and ability to provide real-time briefing to Council members as appropriate.~~

~~PROCEDURES FOR MEETINGS~~
~~Meeting access and Notification~~

- ~~Meeting times and locations are scheduled and coordinated by Council staff.~~
- ~~All committee meetings are open to the public, except for closed sessions as defined in the most current bylaws and/or the Brown Act with associated amendments.~~
- ~~Meeting times and places, and to the extent possible, meeting agenda items will be announced to all Council members and to members of the public through Council mailings and other means of communication~~
- ~~A closed session is permissible only as allowed in accordance with the Brown Act~~

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- Members expecting to be absent from a scheduled meeting are to notify the Council Staff as soon as possible

Quorum

- Business is conducted only if a quorum is present
- As defined in Article VI meetings and Operating Procedures Section 6.3 Quorum of the Bylaws
- Attendance by a member via telephone conference call is allowable

Agenda

- An agenda will be produced for each meeting reflecting the annual work plan or issues at hand
- Agenda items not addressed in the course of the meeting will be carried over to the next scheduled meeting and prioritized at the beginning of the succeeding agenda
- Time will be allotted for public comment at each meeting
- Public comment may be limited to previously announced agenda topics at the discretion of the Chair
- Public comment may be limited to a time constraint at the discretion of the Chair.

Decision-making Process

- Each chair will facilitate a group process that best addresses the dynamics of committee membership to ensure timely and successful outcomes
- The chair will ensure that discussion is focused and that all views are represented
- Meetings will be conducted in accordance with Robert's Rules of Order Newly Revised, most current edition.
- If a minority of a committee holds a position different from a majority recommendation, the minority's position will be submitted as a part of the committees report for information purposes

Meeting Participation

- *Appointed members*: Committee members may make motions and vote in committee.
- *Council staff*: Staff members do not participate in the discussion of an agenda item except when called upon by a committee member
- *Invited Advisory Guests*: the chair may invite a person or persons to attend a meeting to participate in the discussion of one or more agenda items, or to provide technical assistance, training or other expertise.
- *Council members not appointed to the committee*: may attend any

committee meeting and may participate in the discussion of agenda items but shall not be permitted to vote.

- *Members of the public*: may attend and participate in the discussion during allotted time at any (non-closed) committee meeting, but may not make motions or vote on issues

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Committee Development, Organization and Appointment

No: GOV 01
Date Approved: 12/98
Date Revised:
Date Reviewed: 06/24/20

BACKGROUND

Committees carry out the majority of Council activity. The authority to establish a committee is stipulated in Article V Committee Structure Section 5.1 of the Bylaws. The effectiveness of a committee is dependent on diverse membership and a well-articulated work plan. The operational structure of committee work is determined by group process and the specific charge of the committee. In this manner, committees remain dynamic and able to address a variety of tasks necessary for the success of the Council.

POLICY

Council membership will establish a structure of committees necessary to accomplish ongoing business and planning activities. There shall be at minimum an Executive and Governance Committee. The Executive Committee shall have decision-making authority in those business matters necessary for the uninterrupted operation of the Council and within the parameters established by Council general membership.

COMMITTEE TYPES

The Council may use three types of committees as defined below;

1. Standing — formed primarily from Council membership for permanent and ongoing functions

2. Ad Hoc — formed from Council and community members to address a specific issue, task or activity that once resolved requires no further or ongoing meeting (commonly referred to as Work Groups)

3. Advisory formed from experts in a particular field or subject matter for the purpose of advising the Council on complex or sensitive issues

The Council may establish any number of standing committees including, but not limited to, priorities and allocation, needs assessment, service standards, administrative assessment and Council development.

ROLES, RESPONSIBILITIES AND TERMS

Committee Chairs

- The Council Chair, as delegated by the general membership will appoint committee chairs annually
- The Council Chair will represent matters of the Executive Committee
- The Council Chair may call for a committee or ad hoc group to address specific needs of the Council including desired goals and objectives tasked to the committee
- All committee chairs will be a member of the Council in good standing
- All committee chairs consider the membership of the committee and appoint new members based on the intent of the committee and reflective diversity
- All committee chairs will manage scheduling, communication and facilitation of committee work
- All committee chairs in cooperation with Council staff, will facilitate the setting of agendas, conducting of business and monitoring of the respective committee work plan
- Committee decorum will honor open, honest, and objective critical discussion
- All committee chairs are expected to attend Executive Committee meetings as appropriate
- Committee chairs and members represent the interests of both the Council and service community to enhance communication and cooperation between all stakeholder groups.
- Ad hoc committee chairs may invite interested parties of special expertise/experience without Council member standing at the discretion of the Council Chair

Council Vice-Chair

- Will be elected by the Council membership

- Is a standing member of the Council or an alternate
- May assist the Council Chair with the business of the Council
- Will chair Council meetings in the absence of the Council Chair
- Will Chair the Executive Committee in the absence of the chair
- General committee chairs may designate a vice-chair

Committee Principles

- Participation on committees is encouraged of all Council members
- Active recruitment of member participation on committee is a shared responsibility of the Council Chair, Executive Committee and membership at large
- Terms for Committee participation will be two years and renewable
- Committee participants will represent diversity, interest or requisite knowledge reflective of the committee charge
- Optimal membership is between 5 and 11 individuals or as determined by the function and purpose of the group defined by the Council Chair or majority membership.
- Executive Committee composition is stipulated in Article V Committee Structure Section 5.4 of the Bylaws
- Committees are self-governed to accomplish the established work-plan through team dynamics, delegation of tasks, commitment, and fulfillment of responsibilities, constructive debate and timely response to the Council members at large.
- Minority opinions are to be represented as part of the majority action taken with respect to informing the Council of the majority recommendation
- Meetings will be conducted in accordance with Robert's Rules of Order Newly Revised, most current edition.
- All committee meetings are open to the public, except for closed sessions as defined in the most current bylaws and/or the Brown Act with associated amendments.
- Committee meetings will comply with all disclosure, open meeting, noticing, conflict of interest and general procedural requirements applicable to full membership Council meetings.
- Notice of committee member anticipated absences will be communicated to the committee chair or Council support staff

Alternates and Non-Council Members

- Committee alternates may be appointed in accordance with rules set out for Council Alternates in the Bylaws Article III, Section 3.6.
- A committee chair may invite a person or persons to participate in committee activities for the purpose of technical assistance, training or other contributions pertinent to the work plan of the specific committee.
- *Members of the public*: may attend and participate in the discussion during allotted time at any (non-closed) committee meeting consistent with the procedures adopted for general Council meetings
- General Council members may attend any committee meeting as non-voting members
- Council support staff may engage in discussion at the discretion of the committee chair for the provision of administrative guidance, matters of contractual necessity and fiscal governance

Ex-Officio Members

- Ex Officio members have the full rights and responsibilities of other members unless otherwise stated in the Council Bylaws.
- While Ex Officio members may vote in general committee session commonly this is the exception rather than the rule.
- Officers of the Planning Council may sit as ex officio members of all committees with full voting privileges, but will not be included in establishing the quorum.

Council Staff

- Provides general administrative support for the maintenance of established committees or work groups
- Coordinates the publication of meeting notices, distribution of agenda, minutes and the archiving of referenced materials, establishing the meeting venue and location and maintaining incidentals related to the effective function of committee work
- Maintains committee attendance records

Quorum

- Business is conducted only if a quorum is present
- As defined in Article VI meetings and Operating Procedures Section 6.3 Quorum of the Bylaws

Agenda

- An agenda will be produced for each meeting reflecting the annual work plan or issues at hand
- Agenda items not addressed in the course of the meeting will be carried over to the next scheduled meeting and prioritized at the beginning of the succeeding agenda
- Time will be allotted for public comment at each meeting
- Public comment may be limited to previously announced agenda topics at the discretion of the Chair
- Public comment may be limited to a time constraint at the discretion of the Chair.

Documentation

- An agenda will be developed for each meeting reflecting the annual work plan, new and old business, current meeting date and proposed future meeting date
- Minutes will be recorded for all open session committee meetings documenting the activities and actions taken by the members of the committee consistent with standard rules of order

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

Subject: Officer Elections

No.: GOV 10
Date Approved: 01/26/05
Date Revised: 08/26/15
Date Reviewed: 06/24/20

Background:
As stipulated ~~noted~~ in Section 4.4 of the Bylaws of the HIV Health Services Planning Council, "Officers are nominated and elected by the members of the Council to serve for three years. Officers will be elected within the three months following the annual appointment of members." "Vacancies which occur prior to the end of a term of office shall be filled by an election at the next regular or special meeting of the Council and will serve until the next regular election of officers."

Policy:
Officers of the HIV Health Services Planning Council will be nominated and elected whenever ~~as soon as possible when positions become~~ vacant~~t~~cy exists by ~~through expiring~~ term~~s~~ expiration~~,~~ and removal or resignation from ~~offic~~office. ~~and will follow a uniform procedure to ensure consistency and fairness to all candidates.~~

~~**Procedure:**~~
Elections will be ~~formally~~ ~~announced~~ acknowledged and publicized one month prior to a ~~the~~ meeting of the Planning Council in anticipation of an election to fill the officer vacancy.~~wherein officer elections will be held.~~ ~~-~~A vacancy notice will be issued ~~Formal announcement will include a~~ identifying the office along with a ~~-~~description ~~of officer~~ of role~~s~~ and responsibilities of the officer. ~~as well as an overview of the nomination and election process.~~

Inclusive in the announcement of vacancy will be an overview of the nomination and election process sent to all seated Council members

A Council member may be nominated for more than one officer position vacancy.

A council member can serve only one office simultaneously

Election Procedure:

General ~~O~~officer elections will take place as follows: ~~in the following sequence: Chair and Vice Chair. Members may be nominated for more than one officer position, but may only serve in the capacity of one position at a time. All nominations and elections will occur in sequence, and distinct from one another. The following procedure shall be followed in the election of Planning Council officers:~~

1) Nominations for Chair will be taken from the floor, including self-nominations
2) Nominees will accept or decline nomination for the Chair ~~open position~~
3) Administrative ~~S~~staff will record all nominations provided from the floor
4) Each nominee will be allowed a chance to speak to their qualifications/intentions for the position
5) A question and answer session will follow the nominee speeches
6) Each nominee will cast his or her vote and step out of the room
7) Staff will moderate a brief open comment period for voting members
8) A currently seated officer of the council ~~Staff~~ will call the question of the election
9) By a show of hands, voting members will choose the new officer
10) Staff will record and announce the vote to members
11) Nominees will be called back in to the room for the formal announcement of the vote
12) ~~Proceed to nomination and election of the Vice Chair as outlined above.~~ The process will be repeated for the officer of vice chair*

* If there is only one nominee, the Council Chair may choose to make a direct appointment. This applies to Committee Chairs as well.

~~Do you want to permit the direct appointment of the Vice Chair or Committee Chairs by the Council Chair if there is only one nominee? If so, need draft language here.~~

Immediately following each vote, the newly elected officers will assume the responsibilities of their position.

Approved: Date: ~~6/24/20~~

Richard Benavidez, Chair

HIV Health Services Planning Council
Sacramento TGA

Policy and Procedure Manual

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