SECTION 1: INTRODUCTION

The Sacramento Transitional Grant Area (TGA) consists of the urban county of Sacramento, as well as the rural counties of El Dorado and Placer. The Sacramento TGA has been a Ryan White (RW) Part A Grantee since 1996 and has created a sophisticated, comprehensive continuum of high-quality HIV/AIDS medical care and support services for Persons Living with HIV (non-AIDS) or AIDS (PLWH) in the Part A service area. The impact of the HIV epidemic on the Sacramento TGA continues, even over the last five years. The overall general population growth in the TGA was 6.8% between 2011-2016. However, growth in PLWH in the Ryan White system of care was almost five times that (25.1%, from 2,290 to 2,622 cases).

As the demographics of the HIV/AIDS epidemic have changed throughout the years, the HIV/AIDS Continuum of Care has changed to meet the divergent needs of newly emerging populations of Persons Living with HIV/AIDS (PLWH). The TGA has a strong base of service providers in the region that are dedicated to making a difference in the fight against HIV/AIDS, and are committed to providing high quality services that meet consumer needs at all levels of the Care Continuum.

Throughout this grant application, it will become clear that the development and implementation of all aspects of the RW Part A Comprehensive AIDS Resources Emergency (CARE) Act Program in the Sacramento TGA are data-driven; and that all planning decisions are based on information that comes directly from PLWH. These sources include HIV/AIDS epidemiology data; RW CARE Program service utilization data; service utilization data from other sources of HIIV/AIDS funding; Continuous Quality Improvement (CQI) indicator data; Needs Assessment data and Client Satisfaction survey data collected directly from consumers of HIV/AIDS services throughout the TGA.

By having a thorough understanding of the needs of PLWH in the TGA, as well as the resources available to them, the RW CARE Program maximizes its use of RW Part A grant funds and makes sure that these funds are used as a payer of last resort. These Part A grant funds are essential to support the TGA's comprehensive continuum of high-quality HIV/AIDS care that links PLWH to primary medical care upon diagnosis, and ensures that each patient has access to the supportive services necessary to retain them in ongoing primary medical care.

SECTION 2: NEEDS ASSESSMENT

2.A. DEMONSTRATED NEED

2.A.1) Epidemiologic Overview

2.A.1)a) Summary of HIV Epidemic in Sacramento TGA

The TGA is a large three-county area in California comprising 4,287 square miles, with a geography that presents unique challenges to efficient delivery of health care to PLWH. Sacramento County is geographically the smallest of the three counties, but the most populous, accounting for 89.4% of the PLWH in the TGA as of 12/31/16. The rural county of Placer accounted for 6.7% and El Dorado County accounted for 3.9% of PLWH in the TGA as of 12/31/16.

In terms of geographical breakdowns of HIV/AIDS across the TGA's three counties, follows is trend data from the California Department of Public Health (CDPH) HIV Surveillance Report for each county in the TGA (2010-2016). As can be seen in tables below, HIV/AIDS Prevalence rose 33.1% in the TGA between 2010 and 2016, from 3,696

to 4,918 PLWH. The number of new HIV/AIDS infections only increased by 1 case (from 208 to 209) during the same seven-year timeframe. The rise in PLWH is occurring throughout the TGA, in the large urban County of Sacramento (+33.1%), as well as the rural counties of Placer (+39.8%) and El Dorado (+23.6%). Regarding new HIV/AIDS infections, the rural counties have experienced increases in HIV/AIDS incidence. HIV/AIDS incidence in El Dorado County rose from 1 to 4 cases, and Placer County rose from 10-17 cases, between 2010-2016. In urban Sacramento County, however, HIV/AIDS incidence dropped slightly (from 194 to 187 cases)

Overall, these statistics show that while there is some success in reducing the spread of new HIV infections in Sacramento County, the number of Persons Living with HIV or AIDS (PLWH) continues to rise throughout the Sacramento region. These increases in People Living with HIV/AIDS in the TGA continue to increase the costs of providing care for PLWH, and to increase the costs of working to reduce the number of new infections throughout both the urban and rural areas of the TGA, which have unique service needs and service delivery challenges.

HIV/AIDS Incidence (New Cases)

HIV/AIDS Incidence	CY10	CY11	CY12	CY13	CY14	CY15	CY16	% Change CY10-16
El Dorado	4	8	3	4	4	7	5	+25%
Placer	10	14	16	14	14	12	17	+70%
Sacramento	194	183	190	171	184	155	187	-3.6%
TGA Total	208	205	209	189	202	174	209	+.5%

HIV/AIDS Prevalence (People Living with HIV/AIDS)

PLWH Prevalence	CY10	CY11	CY12	CY13	CY14	CY15	CY16	% Change CY10-16
El Dorado	157	170	174	178	182	185	194	+23.6%
Placer	236	249	256	278	296	309	330	+39.8%
Sacramento	3,303	3,465	3,648	3,833	4,016	4,188	4,394	+33.0%
TGA Total	3,696	3,884	4,078	4,289	4,494	4,682	4,918	+33.1%

2.A.1)b) Socio-Demographic Characteristics of HIV Epidemic in TGA

2.A.1)b)i. Demographic Data (Attachment 3)

See Attachment 3, Table 1 for both HIV and AIDS Incidence (newly reported cases), as well as HIV and AIDS Prevalence (PLWH), detailed by demographics, over the past two-year reporting period (1/1/14 – 12/31/16) for the Sacramento TGA, as reported by the California State Electronic HIV/AIDS Reporting System (E-HARS).

Analysis of the overall trends in HIV/AIDS epidemiology for the three County TGA between the current reporting period (1/1/14-12/31/16) and past reporting periods is skewed by the fact that the reporting methodology for the Sacramento TGA has become more rigorous since the last reporting period making year over year comparisons distorted. Beginning with the current reporting period ending 12/31/16, the TGA is reporting "diagnosed" data which is more accurate than "reported" data which was previously used. "Diagnosed" data is more accurate because it goes through a more rigorous data verification process to ensure that the newly "reported" HIV or AIDS case was truly new for the TGA and had not been reported elsewhere outside of the TGA. Given the new methodology, the analysis throughout the Needs

Assessment of this Part A Grant Application will be skewed toward a lower number of HIV/AIDS cases in the current reporting period as compared to previous reporting periods. For this point forward, the TGA will use "diagnosed" HIV/AIDS incidence and prevalence data only and the epidemiological trend analysis will be more informative in future years.

With these caveats in mind, the HIV/AIDS epidemiological analysis comparing the current two-year reporting period ending 12/31/16 to the most recent reporting period ending 12/31/15 found that HIV incidence (the number of new HIV cases) decreased 2.0% (from 451 to 442) and AIDS incidence (number of new AIDS cases) decreased 38.5% (from 205 to 126 cases). Regarding HIV and AIDS prevalence (number of People Living with HIV or AIDS), the number of PLWH in the TGA increased 19.0% since the last reporting period (from 4,132 to 4,918 cases). Specifically, AIDS prevalence increased 12.3% (from 2,380 to 2,673) and HIV prevalence increased 28.1% (from 1,752 to 2,245 cases).

By conducting a more detailed analysis of available data for over the last five year period from the Sacramento County Department of Health and Human Services (DHHS) Epidemiology Department, California State Electronic HIV/AIDS Reporting System (E-HARS); the TGA's RW Database (Sacramento HIV/AIDS Reporting Engine – SHARE); the Ryan White Annual Statistical Summary Project (RASSP); the 2016 US Census Data; and 2015 California Department of Finance, the RW Part A Program found that there was a disproportionate impact of HIV/AIDS on the following populations over the last five year period in the Sacramento TGA:

African Americans. Although African Americans made up only 7.5% of the TGA's general population in 2016, they were 22.8% of PLWH (People Living with HIV or AIDS), 23.8% of new HIV cases (HIV incidence) and 19.8% of AIDS incidence during the current reporting period (1/1/14 – 12/31/16). There was virtually no growth among African Americans in the TGA's general population between 2011 and 2016 (0.8%). However, during the same timeframe, there was a 19.6% increase in the number of African American PLWH (People Living with HIV or AIDS): from 939 to 1,123 cases.

Hispanics. Between 2011 and 2016, there was an 11.8% increase in the number of Hispanics living in the TGA. However, the number of Hispanic PLWH in the TGA grew at nearly 5 times that rate (55.9%, from 574 to 895 cases). This rate of increase in Hispanic PLWH over the last five years was over two times the rate of increase in HIV/AIDS prevalence in the TGA overall (55.9% and 25.1%, respectively).

Youth and Younger Adults. Among youth ages 0-19, HIV prevalence increased by 52.9% between the 2011 and 2016 reporting periods (from 70 to 107 cases) compared to a 35.8% increase in HIV prevalence in the TGA overall (from 1,653 to 2,245 cases). Regarding AIDS prevalence among youth ages 0-19 during the same 5-year period, there was a 38.7% increase in AIDS prevalence (from 62 to 86 cases), compared to a 17.4% increase in AIDS prevalence in the TGA overall (from 2,277 to 2,673 cases).

Older Adults. Among adults 45 and older, AIDS prevalence increased 19.1% (from 392 to 467 cases) and HIV prevalence increased 33.3% (from 351 to 468 cases), between 2011 and 2016. The total number of PLWH ages 45 and older increased 25.8% (from 743 to 935 cases) over the last five years.

Men who Have Sex with Men (MSM). AIDS Prevalence among the MSM transmission category increased 21.6% between 2011 and 2016 (from 1,191 to 1,448 cases). HIV (not AIDS) prevalence increased 40.4% during the same period (from 924 to 1,297 cases). The total number of PLWH among the MSM population increased 29.8% (from 2,115 to 2,745 cases) over the last five years.

Injection Drug Users (IDU). The IDU transmission category was the only demographic group to experience a decrease in both HIV Prevalence and AIDS Prevalence over the last five years. AIDS Prevalence among the IDU transmission category decreased 3.3% between 2011 and 2016 (from 301 to 291 cases). HIV prevalence decreased 5.7% during the same five-year period (from 158 to 149 cases). Although HIV and AIDS prevalence has decreased slightly over the last five years among IDUs, the IDU population remains disproportionately affected by the HIV epidemic throughout the TGA. The Centers for Disease Control (CDC) estimates that only .3% of the TGA's general population was injection drug users in 2014, but IDUs represented 8.9% of PLWH in the TGA, and MSM/IDUs represented an additional 8.2% of PLWH, as of 12/31/16.

Men who Have Sex with Men and Inject Drugs (MSM/IDU). AIDS prevalence among MSM/IDUs increased 9.5% between 2011 and 2016 (from 241 to 264), and HIV prevalence increased 4.5% (from 133 to 139 cases) during the same five-year period. The total number of PLWH among the MSM/IDU population increased 7.8% (from 374 to 403 cases) over the last five years.

Heterosexuals. AIDS prevalence among heterosexuals increased 12.4% between 2011 and 2016 (from 442 to 497 cases), and HIV prevalence increased 8.6% (from 338 to 367 cases) during the same five-year period. The total number of PLWH among the heterosexual population increased 10.8% (from 780 to 864 cases) over the last five years.

A.1)b)ii. Socioeconomic Data

See Attachment 4: Co-Occurring Conditions Table for socioeconomic data for the Sacramento TGA's general population and RW Care Program clients. Analysis of this data shows the disproportionate impact of socioeconomic variables such as poverty, homelessness, and insurance status on the RW population as compared to the TGA's general population. Follows are several examples of socioeconomic characteristics of persons newly diagnosed with HIV, People Living with HIV or AIDS (PLWH), and persons at higher risk for HIV infection in the TGA for the most recent reporting period:

Homelessness. 7.4% of FY16 RW clients (up from 4.8% in FY15) reported themselves as either homeless (5.7%) (up from 3.5%) or in unstable housing (1.5%), as compared to a 2015 homeless/unstable housing rate of 0.22% of the general population in the Sacramento TGA. African Americans continue to be significantly overrepresented among RW clients who were homeless: African Americans made up 36% of the RW clients who were homeless vs. 25.3% of the overall RW population in FY16.

Poverty. In FY16, 97% of RW clients were under 400% of the Federal Poverty Level (FPL), 138% were under 138% of FPL, 61% were under 100% of FPL, and 20% had no income. Currently, more than half (62%) of RW clients earn less than 100% FPL compared to 15.8% of the overall TGA population in 2015.

Insurance Status. According to the California Health Interview Survey (CHIS), which surveyed over 21,034 adults, 754 teens and 2,157 children in 2014, 32.2% of the overall TGA population qualify for and receive Medicaid benefits in California (Medi-Cal). 47.5% of the TGA's FY16 RW clients, in comparison, were on Medi-Cal.

2.A.1)c) Emerging and Disproportionately Impacted Subpopulations

2.A.1)c)i. Identifying Emerging and Disproportionately Impacted Populations, Challenges and Costs

The TGA's HIV Epidemiological Surveillance and Ryan White data are consistent with Early Identification of HIV/AIDS (EIIHA), Unmet Needs and Continuum of Care data, all of which point to the TGA's populations that are at higher risk for HIV, as follows:

HIV Epidemiological (Epi) Surveillance Data

Surveillance data has been trended since the inception of the RW Program in the TGA in 1995, and shows a disproportionate impact on several populations over time. For example, since the TGA's first reporting period ending June 30, 1997, new AIDS cases among people of color more than doubled from 27% to 54.0%, in the current (1/1/14 - 12/31/16) reporting period, and total HIV and AIDS Prevalence increased from 29% to 48.6% among people of color. Regarding gender, there has been a large increase in the proportion of females among People Living with HIV (PLWH), which includes both HIV and AIDS prevalence, which has increased from 10% to 16.6% of all PLWH in the TGA between 1995 and 2016. Regarding HIV transmission risk, the percent of new AIDS cases from heterosexual contact more than doubled, from 7% in 1995 to an alarming 17.5% in 2016. MSM has dropped to 48.4% of new AIDS cases in 2014-16, as compared to 61% in 1994-95.

In addition to the most recent HIV Surveillance data, detailed Surveillance data from the California SOA for 2014 was used for the California Needs Assessment, which provided the basis for California's Integrated HIV Surveillance, Prevention and Care Plan "Laying a Foundation for Getting to Zero," both of which were finalized in September 2016, as follows:

California State Office of AIDS 2014 HIV Surveillance Data			
Demographic Exposure Group	Epi New HIV	Linked in 1 month	Virally Suppressed 6 months
	%	%	%
TGA Total	n/a	77%	41%
Transmission			
MSM	39%	79%	36%
High-Risk Heterosexual (HRH)	23%	79%	43%
Heterosexual (non-HRH)	6%	77%	39%
IDU	6%	90%	60%
White	39%	82%	42%
African American	18%	69%	31%
Hispanic	18%	78%	41%
Gender			
Male	65%	75%	39%
Female	18%	86%	48%
Age at Diagnosis			
13-24	13%	67%	30%
25-44	45%	76%	38%

As this table shows for Mode of HIV transmission, MSMs are the largest group in the TGA, followed by High Risk Heterosexuals and IDUs. Of the risk groups, Heterosexuals (non-HRH) are least likely to be linked to care in 1 month (77%) followed by High Risk Heterosexuals (79%) and MSMs (79%). These rates are comparable to the total rate for the TGA of 77%. However, IDUs exceed the TGA rate (90%). MSMs are least likely to be virally suppressed in 6 months (36%) followed by non-HRH (39%), both of which are lower than the total TGA rate (41%).

In terms of racial groups, African Americans are least likely to be both linked to care in 1 month (69%) and virally suppressed in 6 months (31%), lower than the TGA rate in both measures; followed by Hispanics (78% and 41%). For gender, males are less likely than females to be virally suppressed or linked to care within 1 month or virally suppressed.

In terms of age groups, PLWH ages 25-44 are the largest risk

>45	25%	85%	52%	group, and are the second less likely to be linked to care in 1 month and *second* less likely to be virally suppressed in 6 months (13-24 year-olds are the least likely to be linked to care or virally suppressed.)

Ryan White HIV/AIDS Program (RWHAP) Data

Race Trends. In FY13, for the first time since the inception of the TGA's RW Program, people of color became the majority of RW clients, and have stayed the majority through FY16. People of color rose from 37.7% to 50.6% of RW caseload between FY97 and FY16.

Gender Trends. The total number of RW females increased 84.8% between FY97 to FY16, from 270 to 499 clients.

Mode of HIV Transmission Trends. RW clients reporting heterosexual contact had an increase of 176% between FY95 and FY16, from 220 to 607 clients.

Age Trends. Although the number of RW clients ages 20-44 had decreased between 1997 and 2007 (from 1,045 to 713), clients ages 20-44 increased by 35.6% over the most recent 10 years (from 713 to 967) between 2007 and 2016. The number of Ryan White clients ages 13-24 increased by 57.2% from 1997 to 2007, and showed an increase of 46.5% over the most recent time period of 2008 to 2016 (from 71 to 104).

Unmet Need Data

Using the Current Method Unmet Need Framework, the TGA identified the three highest populations out of care in 2016 as MSM (51.1%), High-Risk (HR) Heterosexuals (20.5%) and IDU (10.5%). These three groups also ranked the highest among the total Epi population based on 2016 surveillance data; and ranked as the top three newly diagnosed populations as identified by the 2016 EIIHA Testing data.

Men who have Sex with Men (MSM) ranked as the highest out-of-care population. Within the MSM population with unmet need, Whites were the highest with unmet need (53.4%), followed by Hispanics (20%) and African Americans (18.6%).

High Risk (HR) Heterosexuals ranked as the second highest out of care category, with males representing 53% and females 47%. African American female HR Heterosexuals ranked highest out of care (20.4%), followed by African American males (18.6%), and White male and females equally (16.1%).

Injection Drug Users (IDUs) (which also included the MSM/IDU population) ranked the third highest of the out of care population, and was 59.1%% male IDUs. Stratified by race and gender, White male IDUs (30.2%) were the highest out of care IDU population followed by African American male and female IDUs equally at (15.7%) and Hispanic male IDUs (12.1%).

Race and Unmet Need. White PLWH who are out of care ranked the highest for MSM, IDU and MSM/IDU (Men who have Sex with Men and Inject Drugs). Hispanic PLWH ranked third in the Heterosexual-High Risk and MSM/IDU out-of-care categories, and second in the MSM out-of-care transmission category.

Gender and Unmet Need. Males were ranked higher than females in all out-of-care rankings by transmission except for HR Heterosexual, which ranked higher for females.

Age and Unmet Need. The majority of PLWH out of care were over age 45 (64.3%). The second highest category of out-of-care PLWH was between the ages of 25-44 (32.9%), even though this age groups represents only 19% of the total living HIV/AIDS cases in the TGA. The remaining 2.8% of out-of-care population were below the age of 19.

Emerging and Disproportionately Impacted Populations

The Sacramento TGA has identified three subpopulations as emerging populations and subpopulations most disproportionately impacted by HIV, that require special attention in FY17 and FY18, as described below. These subpopulations were identified through analysis of data from the following sources: a) HIV/AIDS epidemiological trends; b) data from the California SOA electronic HIV/AIDS Reporting System (e-HARS); c) RW SHARE service utilization and cost data; National HIV/AIDS Strategy data from SOA; d) TGA's FY13 HIV/AIDS Needs Assessment; e) TGA's 2012 Out-of-Care Needs Assessment; f) California Department of Public Health STD and TB Control Branches; g) US Census Bureau; and Centers for Disease Control and Prevention; and h) 2016 California Integrated HIV Prevention, Care and Surveillance Plan. Unique challenges for each subpopulation, as well as estimated costs to the Part A program, are described below for each new emerging population.

High-Risk (HR) Heterosexuals. High-Risk Heterosexual HIV transmission category is defined by the State to include those who are in one or more of the following risk groups: Partners of HIV+; Sex Workers; Partners of IDU; Partners of MSM; Partners of Sex Workers; Heterosexuals with a Syphilis/Gonorrhea Diagnosis; Stimulant Users. The Sacramento TGA also includes Heterosexuals with Multiple Partners in its definition for High-Risk Heterosexuals. The High-Risk Heterosexual category represents the second largest percentage of PLWH in the TGA (17.6%) as of 12/31/16; the second highest population of PLWH with Unmet Need (20.5%) in calendar year 2016; and the second highest category of newly diagnosed PLWH (8.96%). Within the TGA's total PLWH, African American women represent the highest percentage of High-Risk Heterosexuals (26%) followed by White men (20.4%) and White women (16.4%). Within the Unmet Need population, African American High-Risk Heterosexuals women and men were almost equally represented (20.4% and 18.6% respectively) followed by White men and women (16.1% each).

Among PLWH in the TGA, High-Risk Heterosexuals have surpassed Injection Drug Users in terms of mode of HIV transmission. Among PLWH in the TGA as of December 31, 2016, there were close to twice as many High-Risk Heterosexuals living with HIV (864) as compared to Injection Drug Users (440). In addition, within the High-Risk Heterosexual HIV transmission category, African American Females are disproportionately over-represented. As of 12/31/16, there were 224 High-Risk Heterosexuals who were African American Females, which represents 26% of High-Risk Heterosexuals in the TGA, as compared to African American Females being only 7.5% of PLWH in the TGA during the same time period.

To estimate the size of the heterosexual adult population in California, the State Office of AIDS used CHIS data which estimates that 94.8% of the adult population is heterosexual. The Centers for Disease Control's most recent estimate is that .4% of heterosexually active adults are considered at high risk for HIV infection (High-Risk (HR) Heterosexuals) and to whom PrEP should be promoted. To estimate the number of high-risk adult heterosexuals in the Sacramento TGA, these percentages were applied to the TGA's adult population, arriving at an estimate of 788,969 adults who are High-Risk Heterosexual in the TGA.

In the RW Program there continues to be an increase in the number of clients reporting heterosexual contact for HIV transmission risk since the last FY15 reporting period. There was over a 2-fold increase in the percent of PLWH with transmission due to heterosexual contact (HR and non-HR combined) between 1995 and 2016 (7% vs. 17.6%). The High-Risk Heterosexual category represents the second largest percentage of PLWH in the TGA (17.6%) as of 12/31/16. High-Risk Heterosexuals also represented the second highest population Out of Care (20.5%) in CY16, and the second highest category of newly diagnosed PLWH identified through the government funded testing sites (12/134 or 8.96%) for CY16.

Within the High-Risk Heterosexual category, the largest ethnic group among FY16 RW clients was African American (41.5%) followed by Whites (38.6%), Hispanic (15.2%), Asian/Pacific Islander (4.0%) and American Indian/Alaskan Native (0.8%). In FY16, 312 females in the RW system of care were infected with HIV via heterosexual contact (representing 51.4% of all RW clients infected by heterosexual contact). In FY16, African American women represented the highest percentage (26%) of heterosexuals infected with HIV, followed by Caucasian women (20.2%) and Caucasian men at 16.4%. Within the Out-of-Care population, the African American men and women were also equally represented (3.9%) followed by Caucasian men and women (3.6% and 3.5% respectively). The challenges in working with High-Risk Heterosexuals mirrors those of the other risk categories: stigma regarding homosexuality and bisexuality; limited trusting relationships due to fear of arrest and incarceration; addiction focused behaviors that make it challenging to have that concern for their own personal health and well-being; other high-risk behaviors including unprotected sex with multiple partners that puts them at additional risk of contracting HIV and other STDs. In addition, there is not a consistent understanding as to what is considered high-risk sexual behavior.

Youth and Young Adults.

There continues to be an increasingly disproportionate impact of the HIV epidemic on youth and young adults in the Sacramento TGA. Specifically, within the youth and young adult population, the target group for the Sacramento TGA is youth ages 13-24 years old, as they are the most likely to be out of care. Regardless of mode of HIV transmission, and regardless of race, the TGA is finding a greater proportion of PLWH ages 13-24 who are out-of-care with unmet needs than the overall population of PLWH. Specifically, in the Sacramento TGA, 19.2% of youth PLWH between the ages of 13-24 were out of care, as compared to the 16.2% of the TGA's overall PLWH population who were out of care as of 12/31/16.

Moreover, PLWH ages 13-24 in the Ryan White system of care had several outcomes along the HIV Care Continuum that were worse than RW clients overall in 2016. For example, RW clients ages 13-24 were less likely to be virally suppressed (71.2%) as compared to RW clients overall (83.8%). Further, in the RW system of care, only 45.6% of clients ages 20-24 years old were retained in care compared to 81.3% of the RW population overall.

Regarding youth ages 0-19 years old, HIV prevalence increased by 52.9% between the 2011 and 2016 reporting periods compared to a 35.8% increase in HIV prevalence in the TGA overall. Regarding AIDS prevalence among youth ages 0-19 during the same 5-year period, there was a 38.7% increase in AIDS prevalence, compared to a 17.4% increase in AIDS prevalence in the TGA overall.

Although this trend is occurring throughout the youth and young adult population, there is a disproportionate impact on Hispanic and African Americans ages 13-24. For example, in FY16, 40% of RW

clients age 13-24 were African American (42 out of 104) compared to 25% of RW clients overall (663 out of 2,622). In addition, there was a 36% increase in the number of Hispanic RW clients age 13-24 since FY15 (from 22 to 30).

There clearly is more work to be done to ensure that the 19.2% of youth between the ages of 13-24 who are currently out of care, are linked to care as soon as possible, and retained in care. Thankfully, however, there has been some successes in the TGA over the last year in increasing service utilization for clients age 13-24 years old in the RW system of care. By analyzing data by service categories and various demographic cross tabulations, the RW Program has determined where gaps in services exist, for which subpopulations, and is working to tailor outreach activities accordingly.

For example, compared to RW clients overall in FY16, clients ages 13-24 had significantly higher average expenditures per client for medical case management ($1,376 vs. $820), mental health services ($943 vs. $496) and ambulatory care ($1,164 vs. $712), showing increased access to care for this high-risk population. 82% of clients ages 13-24 accessed medical case management services (85/104) compared to 24% of RW clients overall (625/2,622). Medical transportation also experienced increased access by those ages 13-24: there was an 89% increase in the number of clients ages 13-24 who used medical transportation services since FY15. On the other hand, only 7% of clients ages 13-24 accessed oral health services compared to 24% of RW clients overall and there was a 30% decrease in the number of clients ages who used oral health care between FY15 and FY16.

Men who Have Sex with Men (MSM). MSM continue to represent the highest percentage of PLWH (55.8%) in the TGA as of 12/31/16. AIDS prevalence among MSM/IDUs increased 9.5% between 2011 and 2016 (from 241 to 264), and HIV prevalence increased 4.5% (from 133 to 139 cases) during the same five-year period. The total number of PLWH among the MSM/IDU population increased 7.8% (from 374 to 403 cases) over the last five years.

In addition to representing the highest percentage of PLWH in the TGA, the MSM population represents the highest percentage of PLWH with Unmet Need (51.1%), and the greatest number and percent of newly diagnosed (57.4%) in 2016. Further, in the current FY16 reporting period, RW clients with MSM/IDU as their mode of HIV transmission had the lowest Retention in Care rates compared to other modes of HIV transmission among RW clients. For example, the Retention in Care rate for MSM/IDU clients was 50.8% as compared to 76.2% for RW clients overall.

There are several RW service categories in which the MSM/IDU transmission category had the highest cost per client in FY16, with cost per MSM/IDU client much higher than the cost per RW client overall, as follows: emergency financial assistance ($550 vs. $278), health insurance premium assistance ($915 vs. $609), mental health services ($726 vs. $496), oral health care ($1,568 vs. $1,062) and outpatient substance abuse treatment ($909 vs. $644). Within these service categories, the average cost per IDU/MSM client was over 57.4% higher than the average cost per RW client overall ($1,056 vs. $671).

The challenges in working with the MSM and MSM/IDU population include issues such as the following: stigma regarding homosexuality, particularly within the African American, Hispanic, and Asian/Pacific Islander populations, including homophobia by religious communities that leads to isolation of MSM of color. These issues result in many MSM staying “closeted” which inhibits their ability to reach out for care and treatment services due the fear of others finding out about their sexuality

2.A.1)c)ii. Increasing HIV Cases and Need for HIV Related Services
Describe the increasing need for HIV-related services based on the relative increase of HIV cases.

HIV/AIDS Prevalence rose 33.1% in the TGA between 2010 and 2016, from 3,696 to 4,919 PLWH. The number of new HIV/AIDS infections only increased by 1 case (from 208 to 209) during the same seven-year timeframe. The rise in People Living with HIV (PLWH) is occurring throughout the TGA, in the large urban County of Sacramento (+33.1%), as well as the rural counties of Placer (+39.8%) and El Dorado (+23.6%).

Regarding new HIV/AIDS infections, the rural counties have experienced increases in HIV/AIDS incidence. HIV/AIDS incidence in El Dorado County rose from 1 to 4 cases; and Placer County rose from 10-17 cases), between 2010-2016. In urban Sacramento County, however, HIV/AIDS incidence dropped slightly (from 194 to 187 cases). Overall, these statistics show that while there is some success in reducing the spread of new HIV infections in Sacramento County, the number of Persons Living with HIV or AIDS (PLWH) continues to rise throughout the Sacramento region.

Most notably, the Sacramento TGA's Ryan White Program experienced an increase of 58.3% new (never been served in the TGA) clients in the RW Program. There were 345 new RW clients in FY 2016 as compared to 218 new RW clients in FY 2015. While this marks a 53.3% increase in new RW clients in Sacramento County, it reflects an 85.7% increase in new RW clients in El Dorado County and a 128.6% increase in RW clients in Placer County.

These increases in the Ryan White client population in the Sacramento TGA, including the large and recent increases in the rural counties of El Dorado and Placer Counties, are important to understand and address. The Sacramento TGA has unique characteristics that create challenges to the efficient and effective delivery of HIV/AIDS services throughout all three counties. The TGA is a large three-county area of 4,287 square miles, and most specialized services for HIV/AIDS 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.

In addition to geographic challenges in the TGA, another impact over the last several years has been implementation of the Affordable Care Act. Due to the limited availability of HIV specialists in the health care plans under the Affordable Care Act, additional PLWH are turning to the RW Program for care and treatment. In addition, as described in other sections of this grant application, increases in poverty throughout the TGA, combined with significant increases in the cost of living, including housing and transportation costs, continue to have a significant impact on people living with HIV throughout the TGA.

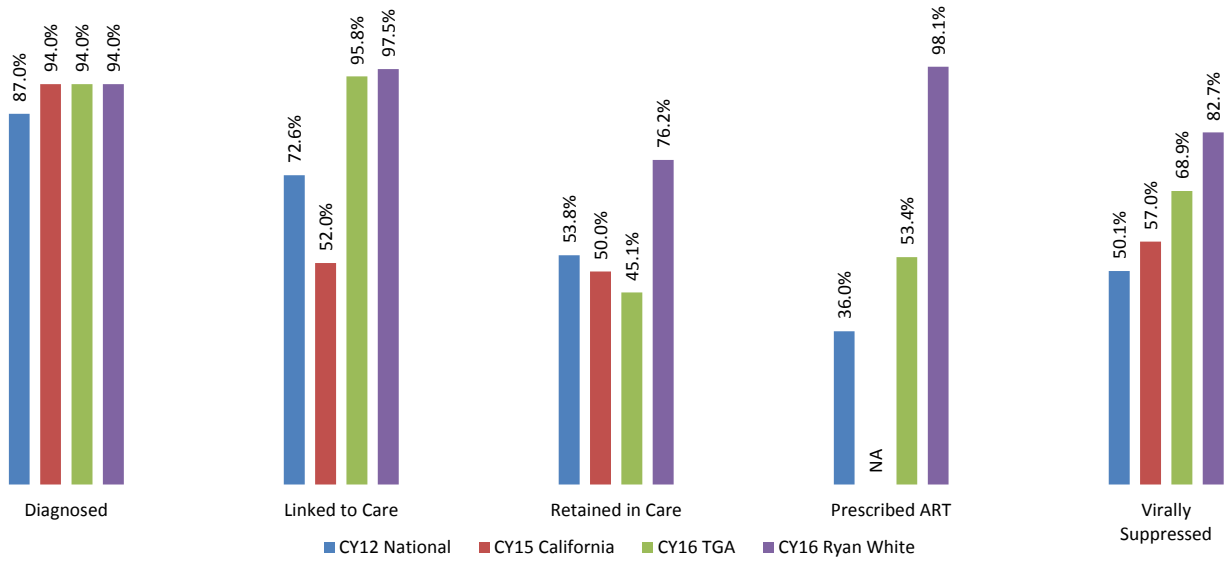
These increases in People Living with HIV/AIDS in the TGA continue to increase the costs of providing care for PLWH, and to increase the costs of working to reduce the number of new infections throughout both the urban and rural areas of the TGA, each with unique service needs and barriers to care.

By analyzing the most recent data for the TGA's HIV Continuum of Care, as described below, the RW system of care has been able to determine which subpopulations within the TGA are most at risk of HIV. In addition, the TGA has analyzed, among People Living with HIV, which subpopulations have increased needs for efforts and services related to Linkage to Care, Retention in Care and/or Prescription of Anti-Retroviral Treatment (ART). The TGA also has been able to determine which subpopulations are most or least likely to be virally suppressed. This analysis allows the Ryan White Program to tailor and target is HIV-related prevention and treatment efforts for each subpopulation throughout the TGA.

HIV Continuum of Care. The establishment and continued successes of the HIV/AIDS Continuum of Care in the TGA has been made possible through RW Part A funding since 1996. The TGA's Care Continuum, developed at the national level by Health and Human Services (HHS), and tailored by the RW HIV Health Services Planning Council (the Council) to address local needs, includes the following five levels of care: 1) Diagnosis of HIV Infection; 2) Linkage to care; 3) Retention in Care; 4) Access to Antiretroviral Therapy (ART); and 5) Viral Suppression. The TGA's RW Program's successes in retaining clients in care and achieving viral suppression is documented in the following bar graph in which the baseline rates of RW clients are compared not only to the National and California rates, but to the TGA's general HIV+ population rates for five HHS measures that comprise the National HIV/AIDS Strategy (NHAS). The following chart provides a graphic depiction of the HIV Continuum of Care in the Sacramento TGA using the diagnosis-based HIV Care Continuum. Data used for the following graph includes many data sources and definitions as follows:

- National "Diagnosed" rate based on data reported to National HIV Surveillance System; denominator *estimated* PLWH.
- California, TGA and RW "Diagnosed" numerators/denominators are *actual* numbers of reported cases.
- "Linked to Care" were newly diagnosed with at least one CD4, viral load or HIV-1 genotype test within 3 months of diagnosis.
- "Retained in Care" had =>2 visits per year at least three months apart during the reporting period.
- Source for national figures: National HIV/AIDS Strategy 2020, released July 2015.
- Source for California and TGA figures: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through 12/31/16 for the CY 2015 allowing a 12-month reporting delay.
- Source for TGA Ryan White RW ambulatory medical care services from SHARE database CY 2016.

INDICATORS AND PROGRESS FOR THE NATIONAL HIV/AIDS STRATEGY
NATIONAL, STATE, LOCAL HEALTH JURISDICTION AND RYAN WHITE PROGRAM CLIENTS



Data Source for Diagnosed is a calculated estimate based on data reported to the National HIV Surveillance System: the denominator is the estimated number of persons living with HIV (1.2 million nationally); the numerators are the actual numbers of reported cases for California (CY15) and the TGA through CY 16. The RW Programs do not fund testing, and cannot report "Diagnosed," therefore RW is based on algorithm used by the California SOA to determine number of diagnosed cases.
Data Source for National: National HIV/AIDS Strategy 2020, released July 2015.
Data Source for California: E-Hars Surveillance Data system, California SOA, as of December 31, 2016 released April 2017.
Data Source for TGA: E-Hars Surveillance Data System, California SOA, as of Dec 2016 released 7-14-17.
Data Source for Ryan White clients receiving Medical Care: Sacramento TGA SHARE Client level database CY16 as of August 2017.
Linked to Care definition: Ryan White Clients linked to care within 90 days.

Comparative analysis of RW, TGA, State and National data on progress toward NHAS objectives, as presented in the chart above, show the following overall observations:

- A greater proportion of PLWH with a new HIV diagnosis in CY16 were linked to HIV care within three months following diagnosis in the TGA (97.5%) than in the state in CY15 (52%) or nation in CY12 (72.6%). 97.5% of RW clients with a new diagnosis were linked to care during the most recent calendar year 2016.
- RW clients were more likely to be retained in care in CY16 (76.2%) than PLWH in the TGA during CY16 (45.1%). Additionally, a greater proportion of RW clients were retained in care than were nationwide in CY12 (53.8%) and in California in CY15 (50%).
- A greater proportion of RW clients in CY16 were prescribed ART (98.1%) and were virally suppressed (82.7%) than PLWH nationwide during CY12 (36.0% and 50.0% respectively). In CY16, PLWH in the TGA were more likely to be virally suppressed (68.9%) than in California (57%).

In addition, comprehensive data from California SOA for the NHAS HIV Care Continuum allowed for an in-depth analysis of linkage to, and retention in, HIV/AIDS medical care by subpopulations. The data show the following disparities among HIV transmission, age, and race within the TGA in CY15, the most recent complete data, as follows:

- Newly diagnosed IDUs (60%) were less likely to be linked to care (at least one HIV-related medical visit within 3 months of diagnosis) compared to the TGA's overall rate for newly diagnosed PLWH (97.5%).
- IDUs (59.6%) were less likely to be virally suppressed than PLWH in the TGA overall (68.9%).

- Newly diagnosed young adults aged 25-34 (83%) were less likely to be linked to care compared to the overall rate for newly diagnosed in the TGA (97.5%).
- Within the RW system of care, 19.2% of youth between the ages of 13-24 are out of care compared to the 16.2% of the TGA's overall population of out of care PLWH.
- A smaller proportion of younger adults aged 25-44 were virally suppressed (44%) than in the TGA overall (68.9%).
- Youth aged 13-24 (59.9%) were less likely to be virally suppressed than PLWH in the TGA overall (68.9%).
- Newly diagnosed Hispanics were less likely to be linked to care (88.7%) vs. the TGA overall (97.5%).
- African Americans less likely to be virally suppressed (63.5%) compared to the overall TGA rate (68.9%).

Analysis of 2015 California SOA surveillance data allows the TGA to determine which subpopulations are less like to be linked to care within 12 months (Hispanic Male IDU, Hispanic and White Heterosexual Females); less likely to be retained in care (African American, Hispanic, American Indian, Asian, and Heterosexuals); and less likely to have viral suppression: ages 13-24 (51%), Native Americans (58%), IDUs (50%), African American Male and Female (46% and 40% respectively), and Heterosexuals 76.6%.

2.A.2) Co-Occurring Conditions

Although data for conditions co-occurring with HIV (co-morbidities) is not available from the TGA's HIV Surveillance data, this data is available for the TGA's general population, as well as RW Program clients, as shown in detail in Attachment 4: Co-Occurring Conditions Table. The Co-Occurring Conditions Table provides a quantitative profile of FY16 RW clients compared to the TGA's general population in terms of co-morbidities and co-factors, such as STI rates, homelessness, formerly incarcerated, mental illness and substance abuse, including documentation of data sources.

An analysis of HIV epidemiology data, RW client data and TGA population data shows the disproportionate impact of comorbidities such as Hepatitis C, Sexually Transmitted Infections (STIs), mental illness, etc., on PLWH served through the RW program, as compared to the TGA's general population, as follows:

2.A.2)a) Sexually Transmitted Infections (STIs)

2016 data from the California Department of Public Health show that the TGA's general population has some of the highest STI rates in California. Out of 58 Counties, Sacramento County ranked #6 for Gonorrhea, #8 for Chlamydia and #9 for Syphilis. These high STI infection rates have an impact on the cost and complexity of care for the RW program, especially when considering that 72.9% of the FY16 RW caseload became infected with HIV through sexual contact.

Chlamydia. New Chlamydia cases in the TGA's general population increased by 47.1% (from 6,765 to 9,951 cases) between 2009 and 2015. In 2016, Sacramento County ranked #6 for Chlamydia out of 58 California Counties. Stratified by age and gender, Sacramento County ranked #3 for Chlamydia among females 15-24. Among RW clients, the number of cases of Chlamydia in FY16 was almost 3 times the number of Chlamydia cases in FY15 (42 cases in FY16 compared to 15 cases in FY15). In Sacramento County (where over 90% of the TGA population lives), STDs disproportionately impact teens and young adults, especially females. For example, the county-wide Chlamydia rate in 2016 was 566 per 100,000, but among teen females aged 15-19 it was 3,110 per 100,000 which was the highest in California. Among young adult females aged 20-24, the Chlamydia infection rate was 4,477 per 100,000. African American

females also were disproportionately impacted – their Chlamydia infection rate was 1,804 per 1,000 the highest among all ethnic groups. Gonorrhea had similar patterns of disproportionate impact among youth, females and African Americans.

Gonorrhea. The number of Gonorrhea cases in the TGA increased 62.8% between 2010 and 2016 (from 1,969 to 3,205 cases). This increase is on top of the 18.8% increase between 2009 and 2010 (from 1,658 to 1,969 cases). Among RW clients the number of Gonorrhea cases increased from 30 to 53 (76.7%) between 2015 and 2016 (this is on top of the 87.5% increase between FY14 and FY15, from 16 to 30 cases). The rate of Gonorrhea infection among RW clients in FY16 was much higher than the rate in the TGA's general population (2.02% vs. 0.15%). That is alarming, especially because in 2016 Sacramento County ranked #6 for Gonorrhea in California (out of 58 Counties). Stratified by age and gender, Sacramento County ranked #5 for Gonorrhea among females 15-19. Treatment for gonorrhea requires a diagnostic visit and six-month follow-up visits and labs. To increase the cost of complexity of care further, most of these visits for women require specialty medical care visits performed by a gynecologist.

Syphilis. In 2016, Sacramento County ranked #10 out of 58 California Counties, and increases have continued in the TGA's general population. The number of new Syphilis cases in the TGA increased 282% between 2012 and 2016 (from 147 to 561 cases). In FY16, the number of RW clients treated for Syphilis was 57.2% higher than in FY15 (217 vs. 138 cases). The 217 reported Syphilis cases among RW clients is an alarming 65.0% of all reported Syphilis cases in the Sacramento TGA, and 8.3% of the total FY16 RW caseload, which is well above the rate in the TGA's general population (0.018%) as reported by California Department of Public Health, STD Control Branch 2015. In the TGA's 2013 Needs Assessment, 5% of respondents reported a diagnosis of Syphilis, which is lower than the rate of 8.3% among the FY16 RW population with Syphilis. These high rates of Syphilis among RW clients have a big impact on the overall cost and complexity of care given the challenges of providing medical care to patients with numerous STIs in addition to their HIV/AIDS.

2.A.2)b) Hepatitis C

The Hepatitis C rate among FY16 RW clients was significantly higher than the TGA's general population in 2016 (13.5% vs. 0.99%). In the TGAs 2013 Needs Assessment, 15% of PLWH reported a Hepatitis C diagnosis. Predictably, the incidence was reported to be significantly higher among the IDU population. This alarmingly high rate of Hepatitis C among RW clients has significant consequences on the cost and complexity of care of the RW Program. The average cost of care for clients with Hepatitis C in FY16 was 29.9% higher than the average cost of care for RW clients overall ($2,297 vs. $1,768).

2.A.2)c) Tuberculosis

Within the TGA's general population, the TB incidence rate increased 42.2% between 2012 and 2013 (from 64 to 91 new cases) but then decreased 16.7% between 2013 and 2016 (from 91 to 78 cases), which is still above its 2012 rate. Within the FY16 RW program, there were 12 clients (0.46% of RW clients – which is exponentially higher than the rate of 0.004% in the TGA's general population) treated for latent or active TB.

2.A.2)d) Homelessness

7.4% of FY16 RW clients (up from 4.8% in FY15) reported themselves as either homeless (5.7%), or in unstable housing (1.6%), as compared to a 2016 homelessness rate of 0.22% of the general population in the Sacramento TGA. African Americans continued to be overrepresented among RW clients who were

homeless: African Americans made up 35.5% of the RW clients who were homeless vs. 25.3% of the overall RW population in FY16. In the 2013 Needs Assessment, an alarming 18% of survey respondents reported being currently homeless or having been homeless during the past two years. Homeless survey respondents reported Service Needs at rates of 10% or higher than respondents overall for the following services: medical nutrition, mental health, outpatient substance abuse treatment, food bank, health education / risk reduction, housing, transportation, other support services, social service case management and residential substance abuse treatment.

Although service needs have consistently been reported in the TGA's Needs Assessments in higher percentages by the homeless population than by RW clients overall, the average annual cost in FY16 per RW client who was homeless was 17.1% lower than the average cost per RW client who was permanently housed ($1,675 vs. $1,962), showing that the homeless population continues to be underserved. Overall expenditures per RW clients who were homeless decreased 5.1% between FY15 and FY16, from $1,761 to $1,675. Further, there were lower per-client costs for the homeless population than the permanently housed population in many service categories in FY16, including non-medical case management ($92 vs. $110); medical case management ($554 vs. $1,031); medical case management services ($554 vs. $1,031); outpatient ambulatory care ($538 vs. $765); oral health care ($828 vs. $1,045); mental health services ($352 vs. $568); housing services ($696 vs. $1,279); and transportation ($129 vs. $229).

2.A.2)e) Former Incarceration

There has consistently been a disproportionate impact of the formerly incarcerated population within the RW Program. The most recent data from the Bureau of Justice Statistics (2010), shows that 0.7% of prisoners in California are infected with HIV compared to 0.2% of PLWH in the TGA overall. In FY16, 11 RW clients indicated on their intake form that they had been released from a correctional facility within the past 12 months. One of the TGA's RW sub-recipients formerly ran California's prisoner Case Management program and maintains a close relationship with the prison system; receiving direct referrals as PLWH are released in the TGA.

The TGA conducted a targeted Needs Assessment (NA) to identify the service needs and gaps of twenty-one incarcerated PLWH in the TGA. 42.8% of survey respondents (9 of 21) were African Americans. Overall, the NA found a high need for food services, assistance with rent/utilities, and medical case management. Detailed analysis of the impact of this population on the RW Program's cost of care is complicated by the fact that, by definition, the RW clients who are defined as "recently incarcerated" must have been released from prison within the preceding 12 months, and therefore comparative data for the entire fiscal year are not available for this population.

2.A.2)f. Mental Illness

There is an extremely high rate of mental illness among RW clients. In FY16, 35.0% of RW clients accessed mental health services as compared to a 19.4% rate of mental illness in the TGA's general population as documented by the Substance Abuse and Mental Health Services Administration (SAMHSA) 2014. The high rates of mental illness among PLWH have serious implications on the RW system, especially for specific subpopulations (i.e., the homeless population and people with substance abuse issues).

For example, in FY16, the average annual cost per client for mental health care services was well over twice as high for RW clients ages 13-19 than for the RW population overall ($1,148 vs. $496); and 53.6% higher for females than for males ($676 vs. $440). Asian / Pacific Islanders had 25.2% higher RW mental

health costs in FY16 than clients overall ($621 vs. $496). The cost of care for mental health treatment for RW clients whose transmission method was "mothers at risk for perinatal transmission of HIV" was more than double than for RW clients overall ($1,158 vs. $496). Across exposure categories, mental health costs were 46.4% higher among the MSM/IDU population, than RW clients overall ($726 vs. $496). However, the cost of care for mental health services among the IDU population, a very high-risk group that often is self-medicating rather than seeking care, was 25.4% lower than the overall RW population ($370 vs. $496).

2.A.2)g. Substance Use Disorders

Overall, the IDU rates among RW clients and PLWH in the TGA are much higher than the TGA's general population, where IDU prevalence is estimated at 0.03% based on the national IDU rate (SAMHSA 2014). Injection drug use alone, or in combination with other risk factors, accounted for 7.0% of HIV incidence (new HIV infections), 12.9% of AIDS incidence, 21.0% of AIDS prevalence,13.4% of HIV prevalence, for a total of 17.3% of PLWH (People Living with HIV or AIDS) in the TGA as of 12/31/16. In comparison, the RW program served a smaller proportion of clients with IDU as mode of HIV transmission (13.8%) in FY16 as compared to the TGA's HIV/AIDS epidemiology data: 11.8% RW clients were infected through IDU alone, 2.0% were infected through IDU and MSM risk factor, demonstrating a need for continuation of increased outreach for the IDU population.

With this high rate of substance abuse among RW clients, the cost implications to the program are quite apparent. In FY16, the average cost of care for the RW IDU-only population was 29.3% higher than that of the overall RW population ($2,243 vs. $1,768), with higher than average cost per IDU client in several service categories: over 2 ½ times the RW client average for outreach ($1,095 vs. $419), 25.9% higher for emergency financial assistance ($350 vs. $278) and 11% higher for housing ($879 vs. $792).

2.A.3) Complexities of Providing Care
2.A.3)a) Impact and Response to RW Part A Funding Changes
2.A.3)a)i. Impact of Funding Changes

The biggest challenge to the RW program has been that the program's caseload has increased over time while total funding has remained constant with minor cost of living increases. Over the last 20 years, since the RW Part A Program was first implemented in the Sacramento TGA, the RW caseload has grown 79.3%, from 1,462 to 2,622 clients. These increases in RW client caseload, coupled with flat funding in overall funding and service capacity, have resulted in the elimination of several services (for example, home health care, buddy companion services, hospice, food assistance, and psychosocial support) over the years, and has lengthened FY16 waiting lists for services such as the following: ambulatory medical care (30 days for initial intake, 7 days for follow-up appointment); medical case management (8 people on waiting list; 15 days for appointments); child care medical case management (2 families/15 days); oral health care (180 days waiting list for routine care); and mental health services (60 days for psychiatric care, 60 days wait for therapist visit; 2 families on wait list); HOPWA (7 days); Medical Nutritional Therapy (1 – 2 days); Health Insurance Premium and Co-pay Assistance (1 -5 days).

In FY17, the following waiting lists have increased further. For example, there has been an increase from 180 days to 365 days for routine oral health care. The TGA has experienced a new waiting list of 7 days for outpatient substance abuse treatment services.

Federal, State and Municipal budget reductions affecting the TGA create a significant challenge to the Council regarding resource allocations. The Council is continuously apprised of potential losses or

program closures for PLWH throughout the TGA to determine impacts on the RW system. Funding adjustments are made by the Council to ensure the uninterrupted provision of RW services. Federal, State and local government budgets are adopted after RW fiscal year allocation decisions are made each year, and during the RW fiscal year the Council makes RW budget adjustments, or reallocations, based on these funding adjustments. The Council routinely requests and analyzes service utilization and expenditure reports from the RW Fiscal Agent to ensure that RW funding is always used as payer of last resort.

The impact of overall budget cuts on HIV related services during the recession has had a continued impact on PLWH throughout the TGA. While budgets are gaining some ground, the number of HIV+ clients coming into care also has increased. Many Part A RW care and treatment agencies rely on HIV prevention and testing funds to meet the diagnostic goals of the HIV/AIDS Continuum of Care, and care and treatment providers continue to be faced with increased waiting lists and service demands. The Sacramento County Public Health Division experienced a 65% reduction in local government funding over the past five years of the budget downfall, and has only recently begun to obtain additional local funding to staff those public health positions eliminated during the recession. Local funding for core HIV/AIDS services is the only budget that has not experienced a reduction, largely due to the Maintenance of Effort (MOE) requirement of the RW CARE Act legislation.

2.A.3)a)ii. Response to Funding Changes: Cost Containment and Transitional Planning

Regarding transitional planning, the Council prepares several allocation plans with alternate "worst-case" scenarios so that, if faced with TGA-wide funding reductions, the RW Program can respond while minimizing health risks. Any RW services that are discontinued because of overall RW funding decreases are allocated three-month transitional funding so that RW service providers and clients have the time and funds to reassess their care plans, reprioritize needs and develop transition plans. This way, clients are transitioned out of the RW programs that take the biggest funding reductions, rather than being cut off instantly. Regarding cost containment measures, the Council annually adopts "Service Directives" and "General Directives" to address cost containment. For example, a general directive requires that all Support Services must be administered through a Case Management system, and a "Service Directive" puts a limit on the amount of housing assistance a client may receive within a one-year period. The Council reevaluates the General and Service Directives annually to determine adjustments as necessary.

2.A.3)b) Poverty and Healthcare Coverage Among PLWH

The following table provides the TGA's current data on poverty and health care coverage in the Sacramento TGA: 77.5% enrolled in Medicaid and Medicare, 14.8% enrolled in other healthcare options, 7.7% uninsured, 75% at or below 138% of 2016 Federal Poverty Level (FPL) and 97% were under 400% of 2016 FPL.

SACRAMENTO TGA PLWH INSURANCE AND INCOME STATUS Ryan White FY 2016		
HEALTH INSURANCE STATUS		
Medicaid	1,231	46.5%
Medicare	787	29.8%
Medicare and Medicaid	31	1.2%
No insurance (RW included)	205	7.8%
Other public insurance	85	3.3%
Private insurance	211	8.0%
Other insurance	95	3.6%

SACRAMENTO TGA PLWH INSURANCE AND INCOME STATUS Ryan White FY 2016		
INCOME STATUS		
≤ 400% of Poverty	2,547	97%
≤ 138% Poverty	1,967	75%
< 100% Poverty	1,620	62%
No income	1,620	20%

The percentage of 2016 Federal Poverty Level used to determine RW eligibility in the Sacramento TGA is up to 300% of poverty. Sliding fee scale is applied from 100% to 300% according to HRSA National Monitoring Standards; with support services and case management services waiving fees entirely. For clients over 300% of poverty, the sliding scale still applies until the client documents that they have spent at least 10% of their income on health-related charges (i.e., insurance premiums, deductibles, co-payments, medications, etc.).

2.A.3)c) Factors Limiting Healthcare Access, Service Gaps and Addressing Gaps with Part A Funds
2.A.3)c)i. Factors Limiting Healthcare Access

The RW HIV Health Services Planning Council has conducted extensive HIV/AIDS Needs Assessments every 2-3 years since the inception of the RW Part A Program in the TGA in 1996. The goals of the Needs Assessments are to collect and analyze data on service needs, service gaps and barriers to care for PLWH to assist the Council with effective planning for both service funding and service delivery. Service needs, gaps and barriers to care are further analyzed by demographic groups such as race, age, gender, mode of HIV transmission, County of residence, and other co-factors such as homelessness, previous incarceration, other STDs, other co-morbidities, etc., to gain an understanding of the unique needs of each subpopulation throughout the TGA.

In FY15 and FY16 the Sacramento TGA participated in Needs Assessment activities developed by the State of California in finalizing the California Integrated HIV Prevention, Care and Surveillance Plan. Sacramento TGA representatives and RW clients provided input into the 2016 Statewide Needs Assessment process through surveys, teleconferences and town hall meetings. RW Part A co-authors provided specific local data and information that was incorporated into the Integrated HIV Plan. In preparation for the FY17 Needs Assessment, which will be completed by February 28, 2018, the TGA's Needs Assessment committee updated its survey tool and data collection processes, incorporating additional questions about prevention and partner counseling services.

In addition to the TGA-wide Needs Assessment, service gaps are identified by conducting a detailed analysis of trends in service utilization among RW clients. As can be seen in the following subsection that provides detailed information about services accessed by specific subpopulations of PLWH throughout the TGA, in terms of mode of HIV transmission, gender, race, age, etc., the RW Program continues to analyze, on an annual basis, those subpopulations that may be facing additional factors that are limiting access to healthcare. For example, Hispanic RW clients had the lowest cost per client in FY16 as compared to any other race and compared to the cost per RW client overall, showing that issues such as language barriers continue to exist among the Hispanic population in the TGA.

In terms of geographic variation in needs across the TGA, for those PLWH whose zip codes were available, the RW client data supports the TGA's FY16 Unmet Need data which identifies those locations where significant outreach programs must continue to be targeted. The TGA has a unique service delivery

challenge due to its diverse geography. The Sacramento TGA is a large three county area representing 4,287 square miles, or about 3% of the state, and is faced with challenging geographic barriers due to its size and predominantly rural nature (in terms of square mileage, not population). Based on the 2015 out-of-care analysis, of the 1,086 people who were aware of their HIV status but not-in-care, 90.4% resided in Sacramento County, 4.5% in El Dorado County and 5.1% in Placer County. Comparing the out-of-care data to the geographic distribution of PLWH throughout the TGA as of 12/31/16 (89.0% PLWH reside in Sacramento County, 3.9% El Dorado County and 6.7% Placer County), the data shows that the rural counties have a slightly higher percentage of PLWH out-of-care than Sacramento County.

Most specialized services for HIV/AIDS are centrally located in Sacramento. Without the availability of many specialized services in rural areas of the TGA, PLWH living in those areas must travel up to 90 miles, in each direction, to receive those services. This lack of specialized services in the rural counties, and the centralization of services in Sacramento, increases the complexity and cost of care. For example, the medical case management costs are much higher in the rural counties due to the challenge and cost of getting PLWH from outlying areas into the support services they need to maintain ongoing medical care and specialized services.

In terms of geographic variation within the County of Sacramento, the downtown and South Sacramento areas have the highest concentrations of out-of-care clients. The zip code data also correlates with the recent 2016 Testing Data identifying the highest risk populations of newly diagnosed HIV+ individuals by race and geographic location.

2.A.3)c)ii. Service Gaps for PLWH

The most important section of the TGA's Needs Assessments is the "Implications" section, which provides a summary of the highest ranked service needs, service gaps, barriers to care and demographic disparities among PLWH. In addition, the section provides recommendations for improvements to the RW Continuum of Care, at both the service provider level and system-wide level, to continue to further impact each subpopulation.

In addition to the TGA-wide Needs Assessments, service gaps are identified by the RW HIV Health Services Planning Council annually by conducting a detailed analysis of service utilization trends among RW clients. It must be noted that service gaps or service underutilization may be caused by decreased consumer awareness and demand for services, but can also be due to the lack of adequate service capacity in the TGA (for example, the RW oral health care provider and RW residential substance abuse treatment provider both have waiting lists for their services due to capacity issues). These are questions that are being assessed further during the FY17 Needs Assessment process.

Given those caveats, the following RW services were underutilized in FY16 as compared to FY15, in terms of cost per client as analyzed by various demographics. Comparing RW clients from various age groups found that those ages 20-44 had 11.7% lower cost per client for medical case management and 17.9% lower costs for outpatient medical care in FY16 as compared to FY15. Analysis by racial groups found that African Americans had 13.7% lower cost per client for ambulatory medical care. Hispanics had 21.9% lower costs for medical case management; 13.7% lower for mental healthcare, and 13.0% lower costs for ambulatory medical care. Female RW clients had 15.1% lower costs per client for ambulatory medical care while Male RW clients had 10.8% lower costs. Regarding mode of HIV transmission, Heterosexuals had 11.8% lower costs per client for medical case management and 8.7% lower costs for ambulatory medical care in FY16 as compared to FY15. Injection Drug Users had 6.7% lower costs per

client for ambulatory medical care while the MSM transmission category had 13.5% lower costs per client for medical care.

Further analysis of the FY16 RW client service utilization data was conducted to examine which subpopulations of PLWH in the TGA were underutilizing which HIV related RW services compared to other subpopulations. The RW Program conducted an analysis of HIV/AIDS epidemiological findings as of 12/31/16, general TGA wide population statistics, and RW service utilization data. For example, the following PLWH were underrepresented in the TGA's RW system of primary medical care in FY16 in terms of mode of HIV transmission, gender, race, and age, as follows:

- PLWH ages 20-44 were significantly underrepresented among RW clients in FY16 (36.9%) as compared to their representation among PLWH in the TGA (77.1%).
- PLWH ages 20-44 had lower service utilization than RW clients overall in FY16: the average cost per RW client ages 20-44 was 19.1% lower than the overall cost per RW client overall ($1,484 vs. $1,768).
- Hispanic RW clients had the lowest cost per client again in FY16 ($1,567) as compared to the overall cost per RW client overall ($1,768).
- MSM/IDUs were underrepresented among RW clients in FY16 (2.2%) as compared to their representation among PLWH in the TGA as of 12/31/16 (8.2%).
- MSMs were slightly underrepresented among RW clients in FY16 as compared to representation among PLWH in the TGA (47.5% of RW clients vs. 55.8% of PLWH).
- MSMs had lower service utilization than RW clients overall in FY16: the average cost per MSM client was 14.8% lower than the overall cost per RW client overall ($1,540 vs. $1,768).
- Male RW clients had lower cost per client than females in FY16: the average cost per male client was 58.7% lower than the average cost per female RW client ($1,588 vs. $2,520).
- The average annual cost in FY16 per RW client who was homeless or in unstable housing was 14.6% lower than the average cost per RW client who was permanently housed ($1,675 vs. $1,962), and overall expenditures per client decreased 16.2% between FY14 and FY16, from $1,999 to $1,675.

The FY17 Needs Assessment will further drill down into these findings to determine the factors that are limiting access to ambulatory medical care and medical case management, the crucial components of the continuum of care for these populations. This is critical to determine, especially since overall costs per client increased 11.5% across all service categories for RW clients overall (from $1,585 to $1,768) between FY15 and FY16, while costs for various subpopulations, as noted above, were lower for ambulatory medical care and medical case management.

2.A.3)c)iii. Addressing Gaps with Part A Funds

Once the needs, gaps and barriers for out-of-care PLWH have been determined, the Council's Priorities and Allocations Committee (PAC) prioritizes these findings by applying the Unmet Needs Estimate to the percentage of PLWH served by the RW program each year, as well as the average cost of care per RW client, to project the potential increased cost to the RW Program to serve the Unmet Need population in FY18. The FY16 RW caseload represents 53.3% of the TGA's reported PLWH (down from serving 64.3% of the TGA's reported PLWH in FY15). Applying the 53.3% to the out-of-care population (792 PLWH out-of-care), an additional 422 persons could need access to the RW system of care at a potential cost of $300,464 for ambulatory care alone – which averaged $712 per client per year in FY16. Since the average cost of care per client for *all* RW services was $1,768 in FY16, the potential additional funding needed rises to as much as $746,096 annually if 53.3% of the anticipated out-of-care clients accessed the RW system of care in FY18. This potential increased dollar figure is based on FY16 RW cost

figures and does not take into consideration the rising cost of living in California, which would increase this figure further. The increased FY18 Part A funding request will be needed not only to maintain services for the existing RW caseload, but to meet the demands of the Unmet Needs population.

By analyzing the Needs Assessment data, the Council developed four strategies to get PLWH into medical care, and to keep them in care: 1) strategies for Newly Diagnosed PLWH (improved linkages between prevention and care); 2) strategies for PLWH receiving non-primary medical care services (improved linkages between supportive and primary care services); 3) strategies for PLWH who have dropped out of care (improved provider-patient partnerships and collaborations with peers); and 4) strategies for PLWH never in care (peer facilitated linkages between points of entry, testing, counseling and primary care). The TGA is utilizing the strategies developed from Needs Assessment findings with all service providers in the continuum of care to enhance efforts to reach the out-of-care clients and address service gaps.

In addition, by using data from the Unmet Needs Estimate, the TGA's RW care providers work closely with Sacramento County DHHS HIV Prevention and Testing providers to outreach to communities located in those zip codes with the highest number of clients with unmet need. When clients are newly diagnosed with HIV, care providers, as well as testing sites, refer clients to Cares Community Health to be screened for RW eligibility and to receive free Partner Services (PS), which provides immediate access to counseling and resource referral, as well as health education/risk reduction counseling. All RW Medical Case Management sub-recipients are contractually required to make and document PS referrals to all HIV+ clients at least once a year. The program not only assists clients with problems of disclosure, but provides anonymous notification of HIV+ sex and needle sharing partners to provide information regarding their exposure, and assist them in getting tested.

The RW Program also funds a non-medical Case Management service entitled *Benefits and Enrollment Counseling* to enhance efforts to address service gaps with Part A funds. All RW Benefits and Enrollment Counselors have received certifications allowing them to assist clients with document preparation and upload applications into secure servers. The AIDS Drug Assistance Program (ADAP), the Covered California program (ACA) and the OA-HIPP programs all require such certifications. All Ryan White Benefit Counselors are multicultural, bilingual staff who assist clients in determining their eligibility for and application for many public benefits, in addition to those previously mentioned.

To further address service gaps, transportation services funded with RW Part A funds have been enhanced. While transportation assistance is available to clients in the form of bus vouchers, the RW Field-based Medical Case Management system also provides mileage reimbursement for Case Managers to escort clients to appointments. The TGA also recently increased funding for non-medical case management services, with multicultural and bilingual benefit counselors who assist clients through the application process to maximize access to public benefits, such as AIDS Drug Assistance Program (ADAP) and Covered California. These are just a few of the many efforts across the TGA to reduce service gaps and unmet need. Thankfully, these efforts are proving successful, as the Unmet Need Estimate decreased from 1,086 to 792 persons out-of-care between 2015 and 2016, a 27.1% decrease.

Strategies to Link Populations Into Care and Elimate Barriers to Improving Access

As a result of additional funding from the RW Part B Supplemental program in December of 2016, the TGA has expanded its transportation program to provide monthly bus passes, rather than daily passes, to RW clients with documented service needs to attend multiple appointments within a given week or month.

PLWH utilizing substance abuse and mental health services have several appointments weekly, in addition to scheduled ambulatory care appointments. The TGA also has added a Transportation Coordinator to arrange alternative transportation services for clients with mobility issues, thus eliminating the need for a Ryan White Case Manager to provide transportation for the client. This addition of a Transportation Coordinator has allowed Case Managers to be able to increase their capacity to provide additional services for the clients on their caseloads.

Part B supplemental funding also is being used to implement a wrap-around substance abuse/housing program targeting at the homeless out-of-care population. This program is providing PLWH with the opportunity to enter into Residential Substance Abuse Treatment for ninety days, and then be placed into a Transitional Housing program for up to six months while Housing Navigators identify permanent housing. The program has demonstrated its effectiveness in establishing housing stability; which has improved clients' ability to be retained in medical care; and to improve their ability to maintain adherence to ART with the goal of viral suppression. The wrap-around program addresses mental health, substance abuse (both residential and outpatient), transportation and food assistance services. These two new programs, expanded transportation and housing services, have been specifically designed to target the needs of the out-of-care populations. The TGA is requesting additional Part A funds for FY18 to allow these programs to continue beyond the expiration date of the one-year Part B Supplemental funding which ends in September of 2018.

2.B. Early Identification of Individuals with HIV/AIDS (EIIHA) FY 2018 EIIHA Plan

The TGA compiles its EIIHA data on a calendar year basis so that EIIHA target populations and testing results can be cross referenced to Surveillance data, Continuum of Care and Unmet Need data, allowing the TGA to evaluate changes in new high-risk populations from 1/1/16 – 12/31/16 as follows:

INDICATORS OF RISK Sacramento TGA Surveillance data, Unmet Need Data and Testing Data for 1/1/16-12/31/16								
	Total Tested Positive CY16	Percent of Total Positives	Total Epi CY16	Percent of Total Epi	Total Unmet Need CY16	Percent of Unmet Need	Rank Compared to Totals	Percent Over Epi
Transmission								
MSM	88	65.67%	2745	55.8%	405	51.1%	1	-4.7%
High-Risk Heterosexual contact (HRH)	12	8.96%	864	17.6%	162	20.5%	2	-2.9%
Heterosexual contact (Non-HRH)	12	8.96%	0	0.0%	31	3.9%	6	3.9%
IDU	2	1.49%	440	8.9%	83	10.5%	3	1.6%
MSM/IDU	1	.746%	403	8.2%	69	8.7%	4	-0.5%
No Identified Risk	0	0.0%	0	0.0%	35	4.4%	5	4.0%
Other	19	14.17%	414	8.4%	2	0.3%	8	-8.1%
Perinatal	0	0.0%	52	1.1%	5	0.6%	7	-0.4%
Totals	134	100.0%	4918	100.0%	792	100.0%		
Race								
White	47	35.08%	2527	51.4%	380	48.0%	1	-3.4%

INDICATORS OF RISK Sacramento TGA Surveillance data, Unmet Need Data and Testing Data for 1/1/16-12/31/16								
	Total Tested Positive CY16	Percent of Total Positives	Total Epi CY16	Percent of Total Epi	Total Unmet Need CY16	Percent of Unmet Need	Rank Compared to Totals	Percent Over Epi
African American	39	29.10%	1123	22.8%	195	24.6%	2	1.8%
Hispanic	33	24.63%	895	18.2%	169	21.3%	3	3.1%
Asian	7	5.22%	191	3.9%	29	3.7%	4	-0.2%
Native Hawaiian Pacific Islanders	1	0.75%	0	0.0%	4	0.5%	7	0.5%
American Indian/Alaska Native	1	0.75%	27	0.5%	5	0.6%	6	0.1%
Other Race/ Multi Race	4	2.98%	131	2.7%	10	1.3%	5	-1.4%
Unknown/Unreported	2	1.49%	24	0.5%	0	0.0%		
Totals	134	100.0%	4918	100.0%	792	100.0%		
Age Diagnosis								
0-13	0	0.0%	51	1.0%	2	0.3%	3	-0.7%
13 – 19	1	0.75%	142	2.9%	1	0.1%	4	-2.8%
20-44	110	82.09%	3790	77.1%	280	35.4%	2	-41.7%
45+	23	17.16%	935	19.0%	509	64.3%	1	45.3%
Totals	134	100.0%	4918	100.0%	792	100.0%		
Gender								
Male	118	88.06%	4078	82.9%	646	82.0%	1	-0.9%
Female	15	11.19%	817	16.6%	141	18.0%	2	1.4%
Transgender: Male to Female	1	0.75%	21	0.4%	5	1.0%	3	0.6%
Transgender: Female to Male	0	0.0%	2	0.0%		0.0%		
Unknown/ Unreported	0	0.0%	0	0.0%		0.0%		
Totals	134	100.0%	4918	100.0%	792	100.0%		

Epi combines all Heterosexuals, includes Native Hawaiian, whereas the Unmet Need Data and Testing Data break down the age groups to identify the 13-24 year-old population and Pacific Islanders as "Asian," and identifies ages as 20-44 years, whereas the Unmet Need Data and Testing Data break down the age groups to identify the 13-24 year old population.
High-Risk Heterosexuals are defined by the State to include heterosexual intercourse with a person of the opposite sex who was HIV-positive or high risk for HIV infection (MSM, IDU). The TGA also includes those with Multiple Sexual Partners as HRH.

2.B.1) Planned Activities in TGA's FY18 EIIHA Plan

2.B.1)a) Primary Activities of EIIHA Strategy, Including System Level Interventions

The Program Manager, who oversees the newly integrated HIV Surveillance Units within the Sacramento Department of Public Health, also manages the recently established Sacramento Workgroup to Improve Sexual Health (SacWish). Sacramento County Public Health Division formed this community group, comprised of representatives from community medical clinics, testing agencies, school districts, public health departments, and non-profit agencies, to intensify the TGA's HIV/STD prevention, testing and

treatment efforts and to assist with determining best practices for tracking client retention and data sharing opportunities. The EIIHA Plan is disseminated to SacWISH to provide information on regional goals and objectives, and to elicit their support to provide the RW program with annual testing results. As a result of last year's presentation, Planned Parenthood, the largest tester in a three-county area, provided its testing results for the final FY17 EIIHA Plan. SacWISH also provides members with materials to increase awareness of free testing sites and referral locations for low-cost or free treatment; and provides technical assistance to guide HIV prevention efforts. So far in FY17, SacWISH has received in-depth presentations on PrEP, Partner Services, the importance of routine testing at their clinic sites, and has received promotional materials for their clients to encourage STD/HIV testing and linkage to care. Primary activities of the EIIHA Plan for 2017/18 are as follows:

- Provide HIV testing to high risk populations to make them aware of their HIV status
- Provide prevention and harm reduction education information, including PrEP information and referrals, to individuals at testing
- Increase percent of newly diagnosed HIV+ people linked to medical care within one month of diagnosis
- Educate medical providers on HIV testing and referral resources to increase testing of population at large
- Address the stigma found in some religious institutions that inhibits people from getting tested or seeking care by offering education, prevention messages and on-site testing at places of worship
- Educate and enlist the support of community leaders to encourage their continued support of maintaining the HV/AIDS epidemic as a continuing priority
- 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.
- 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.
- Provide Ora-Quick rapid testing to targeted populations to provide immediate knowledge of their HIV status and remove barriers that may prevent them from returning for test results.

Prevention for Negatives:

- Increase the number of TGA residents at high risk for HIV infection who are on PrEP by 500 individuals in CY17 to achieve a total goal of 3,100 persons by 2021
- The CARES Foundation, founded in 2013, has funded the following community organizations to implement targeted Prevention activities in 2016-2017:
  1. HIV/AIDS Local Outreach (HALO) Project, Parents, Families, Lesbians and Gays (PFLAG)
  2. Youth Street Education Project, Wind Youth Services
  3. Health Outreach Program, Lesbian, Gay, Bisexual, Transgender (LGBT) Center
  4. HIV Prevention Coalition, Cares Community Health
  5. Syringe Access Program, Safer Alternatives Networking and Exchange (SANE)
  6. Safe Points Syringe Exchange Program, Harm Reduction Services (HRS)
  7. Condom Finder, Cares Community Health
  8. Outreach, Education and Testing, Community Against Sexual Harm (CASH)
  9. Preventing HIV with PrEP, Cares Community Health.
  10. Overdose Prevention Program, Cares Community Health

11. Medication Assisted Treatment Program SANE
12. Project Reach, HRS
13. Heart to Heart Project, Life Enriching Communications
14. Addressing Sacramento's Youth STI Epidemic, Planned Parenthood Mar Monte

- Cares Community Health and the Sacramento County HIV/STD Prevention Program will collaboratively modify a PrEP Provider Toolkit and disseminate it widely among the TGA's medical providers
- Sacramento County Public Health Communicable Disease Investigators will provide Partner Services to all partners of HIV+ to get them tested. Those high-risk individuals testing negative will be educated on PrEP
- Sacramento County Public Health HIV/STD Prevention Program will continue to implement STD/HIV Prevention, education and testing activities in Sacramento County
- SacWISH will provide PrEP Toolkit to their providers and distribute Prevention materials to their clients
- Rural county RW providers will disseminate PrEP Toolkit and Prevention materials to rural county medical providers and clinics
- Rural county testers will provide Risk Reduction Counseling to their clients testing negative
- Ryan White providers will provide Risk Reduction Counseling to their clients with negative partners

2.B.1)b) Collaborations with Programs and Agencies Including HIV Prevention and Surveillance

A major achievement of the EIIHA Plan in the last two years has involved the integration of the STD and HIV Surveillance Units within the Sacramento County Department of Public Health, and all Communicable Disease and STD Investigators have been cross trained. These efforts have enhanced the TGA's efforts to identify HIV+ individuals, fast track them into care, and provide risk reduction counseling to those at highest risk. With the merger, the HIV and STD Surveillance, HIV/STD Prevention, and RW Care and Treatment Programs meet on a regular basis along with the County Epidemiology team to determine best practices for tracking client retention and data sharing opportunities. In addition, the County HIV/STD Program Manager is responsible for oversight of the SacWISH Group, as described above, which is comprised of representatives from community organizations working to intensify the HIV/STD prevention, testing and treatment efforts in the TGA.

EIIHA Plan Community Collaborations to Strengthen Outcomes Across HIV Care Continuum

In addition to the County integration efforts and the community stakeholder group, the HIV/AIDS Prevention Coalition, funded by the CARES Foundation, has spearheaded the "Zero New Infections Together" Initiative. This Coalition is comprised of community organizations actively participating in the campaign to end HIV in the TGA; and they meet monthly to provide critical feedback to the campaign on strategies that have proved effective in reaching their target audiences.

In the rural counties of the TGA, the Sierra Foothills AIDS Foundation (SFAF) has encouraged community clinics in El Dorado and Placer County to resume HIV testing at their sites. While three clients were positively diagnosed in CY15 by this provider, SFAF did not report any positive tests in CY16. SFAF also conducts HIV testing in Placer County using test kits provided by Cares. These test sites inform rural county residents of the availability of medical care and services at Cares and other providers in the TGA. As a result of RW Medical Case Managers who assist the clients in overcoming barriers to care, all newly diagnosed clients in the rural counties were transitioned into care in FY15, all are on medication and all are virally suppressed.

The TGA's EIIHA strategy has expanded its ability to obtain testing data from the TGA's few privately funded HIV testing sites. Since these providers are already members of the STD/HIV Stakeholder group (SacWISH), they have cooperated in the development of the EIIHA Plan. With years of community collaboration and coordination, the TGA has a solid framework for implementation of its EIIHA Plan by targeting demographic characteristics, specific needs, and limiting barriers to HIV testing and care for the TGA's most at risk populations.

In addition to these efforts, the CARES Foundation, a Sacramento Region private non-profit Foundation dedicated to HIV prevention and treatment, has expanded to providing over 1.3 million dollars in grants annually to nonprofit service providers throughout the TGA for services such as HIV testing, syringe exchange, HIV education, healthcare navigation, condom distribution, substance abuse treatment, health outreach, case management, transportation, overdose prevention, harm reduction services, mental health services, support groups, PrEP education activities, and other essential services for PLWH that strengthen outcomes across the HIV Care Continuum.

Further collaborations ensure that all Ryan White providers are equipped with information and referral agreements for partner counseling services, PrEP and harm reduction services that are shared with clients at every visit. In addition to all community efforts mentioned above, the RW Program will conduct an in-depth review to monitor the number of individuals prescribed PrEP by utilizing information from Sacramento County surveillance staff and pharmaceutical companies.

2.B.1)c) Anticipated Outcomes of EIIHA Strategy

The TGA's EIIHA Goals are identified in the first column of the table below; with the planned outcomes and CY2016 accomplishments in the final column. The EIIHA Plan can ***only include goals*** for the government funded agencies, as the private partner (Cares Community Health) does not have goals for the specific number of tests. Rather than have predetermined testing goals, Cares tests any individual who comes to the clinic, regardless of residence, income, insurance or immigration status. Planned Parenthood also provides opt-out testing to all of its clients but does not have individual goals. Thus, the actual number of tests performed in 2016 (14,771) far exceeded the stated goal (2,890 tests) because the region's two largest private agencies still participate in the TGA's EIIHA Plan and provide their testing results. The target population percentages were developed based on the total number of tests administered by government funded providers in 2016 (5,614) and Cares Community Health, which received some governmental funding during that reporting period.

FISCAL YEAR 2016 EIIHA PERFORMANCE INDICATORS Indicator/Monitoring Status	
Strategies to Improve EIIHA	Indicator/Monitoring Status 12/31/16 *
1. Conduct testing at 89 venues accessible and familiar to high risk populations to maximize number of high risk individuals who become aware of their status.	Indicator: Testing provided at 136 locations, 128% of goal of 106. Status: Standard met and exceeded.
2. Certify and train new testers on Ora-Quick Rapid HIV testing to expand the region's ability to administer a minimum of 1,100 tests and inform individuals of their HIV status.	Indicator: 2,270/2,890 tests were conducted by government agencies or 78.6% of goal of 2,890. Total of 14,771 tests were provided by government and private agencies combined. Status: Standard not met by government agencies alone
3. Provide community level and social network Ora-Quick rapid testing to the following risk populations to make them aware of their HIV status:	
▪ IDUs and other Substance Abusing Individuals: 10.1% of total tests will be administered to IDUs.	Indicator: 752/5,614 or 13.40% of clients tested were IDUs and other Substance-Abusing individuals. Status: 132.7% of goal achieved
▪ Men having Sex with men (MSMs): of 28.7% of total tests will be administered to MSM	Indicator: 1,500/5,614 tests or 26.8% of total tests were MSM Status: 98.1% of goal achieved, 1.9% under goal
▪ Men Who Have Sex with Men and are Injection Drug Users (MSM/IDU) 2% of total tests will be administered to MSM/IDU.	Indicator: 88/5,614 or 1.57% of total tests was MSM/IDU. Status: 78.5% of goal achieved, 21.5% under goal
▪ High-Risk Heterosexuals: 35% of total tests will be administered to High-Risk Heterosexuals: HIV+ Sex Partner; Sex Worker; IDU Partner; MSM Partner; Sex Worker Partner; Syphilis/Gonorrhea Diagnosis; Stimulant User; Heterosexual Multiple Partners.	Indicator: 1,512/5,614 or 27% of total tests were High-Risk Heterosexuals Status: 63.22% of goal achieved, 7.2% under goal
▪ Transgender: 1% of those tested will be transgender	Indicator: 78/5,614 tests or 1.4% of total tests were Transgender individuals. Status: 104% of goal achieved.
▪ Low and Moderate Risk Community: 4.7% of total tests will be administered to Low Risk, or Risk Not Reported individuals.	Indicator: 256/5,614 tests or 4.6% of total tests were Other/Unreported risk. Status: 97.4% of goal achieved, 2.6% under goal
Target Population Goals by Race: ▪ 53.6% of total clients tested will be White	Indicator: 2,246/5,614 or 40% of total clients tested were White Status: 74.7% of goal of 3,008 achieved.
▪ 23.3% of total clients tested will be African American	Indicator: 1,089/5,614 or 19.4% of total clients tested were African-American. Status: 83.3% of goal of 1,308 achieved.
	Indicator: 453/5,614 or 8.1% of total

FISCAL YEAR 2016 EIIHA PERFORMANCE INDICATORS Indicator/Monitoring Status	
Strategies to Improve EIIHA	Indicator/Monitoring Status 12/31/16 *
▪ 17.1% of total clients tested will be Hispanic	clients tested were Hispanic Status: 47.2% of goal of 960 achieved
▪ 3.7% of total clients tested will be Asian/Pacific Islander	Indicator: 100/5,614 or 1.8% of total clients tested was Asian/Pacific Islander. Status: 208% of goal of 208 achieved.
▪ .7% of total clients tested will be American Indian	Indicator: 87/5,614 or 1.6% of total clients tested was American Indian. Status: 223.1% of goal of 39 achieved.
▪ 1.5% of total clients tested will be Other/Undeclared	Indicator: 1,300/5,614 or 23.2% of total clients tested were Other/Undeclared. Status: 1,544% of goal of 84 achieved.

Note: Transmission figures are only available from government funded testers and Cares Community Health.

FISCAL YEAR 2016 EIIHA PERFORMANCE INDICATORS Responsible Parties/Timeframes	
Strategies to Improve EIIHA	Responsible Parties/Timeframes
1. Conduct testing at 89 venues accessible and familiar to high risk populations to maximize number of high risk individuals who become aware of their status.	Parties/Timeframes: Government-Funded Testing Providers 1/1/17-12/31/18
2. Certify and train new testers on Ora-Quick Rapid HIV testing to expand the region's ability to administer a minimum of 900 tests and inform individuals of their HIV status.	Parties/Timeframes: Government-Funded Testing Providers 1/1/17-12/31/18
3. Provide community level and social network Ora-Quick rapid testing to the following risk populations to make them aware of their HIV status: ▪ IDUs and other Substance Abusing Individuals: 10.1% of total tests will be administered to IDUs. ▪ Men having Sex with men (MSMs): of 28.7% of total tests will be administered to MSM. ▪ Men Who Have Sex with Men and are Injection Drug Users (MSM/IDU) 2% of total tests will be administered to MSM/IDU. ▪ High-Risk Heterosexuals: 35% of total tests will be administered to High-Risk Heterosexuals: HIV+ Sex Partner; Sex Worker; IDU Partner; MSM Partner; Sex Worker Partner; Syphilis/Gonorrhea Diagnosis; Stimulant User; Heterosexual Multiple Partners. ▪ Transgender: 1% of those tested will be transgender Low and Moderate Risk Community: 4.7% of total tests will be administered to Low Risk or Risk Not Reported individuals. Target Population Goals by Race: ▪ 53.6% of total clients tested will be White ▪ 23.3% of total clients tested will be African American ▪ 17.1% of total clients tested will be Hispanic ▪ 3.7% of total clients tested will be Asian/Pacific Islander ▪ .7% of total clients tested will be American Indian ▪ 1.5% of total clients tested will be Other/Undeclared	Parties/Timeframes: Government-funded Testing Providers and Cares Community Health. 1/1/17-12/31/18

Contribution of EIIHA Plan to Improvements in HIV Care Continuum Outcomes

The TGA's FY17 EIIHA goals correlate with the Goals of the White House Continuum of Care Initiative; with goals 1 through 6 designed to achieve the following National Continuum of Care Performance Indicators:

"Increase knowledge of HIV-positive status to 90%. Nationally, across age groups, young persons, 13-24 years, are most likely to be undiagnosed with fewer than half aware of their infection." The TGA's efforts target youth, in particular young gay men, to get tested. In CY16, 36.6% of tests administered through the TGA's EIIHA providers were for clients ages 24 years and younger, exceeding their 3.6% representation in the TGA's HIV epidemic as of 12/31/16. Further, 29.1% of positive tests were for those under age 25, a 7.3% increase in positive tests for this age group over CY15. The TGA offers a wide range of testing sites accessible to target populations through venues associated with their culture, geography, lifestyles, 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 populations for transmission of HIV: MSM and Intravenous Drug Users. The TGA's efforts of providing testing at needle exchange sites, and offering incentives to clients who get tested, are proving successful at increasing the number of IDUs in the TGA aware of their HIV status. Another finding in the TGA's analysis of HIV epidemiology, Unmet Need, Continuum of Care and HIV testing data show that the High-Risk (HR) Heterosexual category has surpassed, in absolute numbers and percentages, the IDU category across all demographic aspects. CY16 efforts to target this population proved successful with 22.1% of total tests administered to HR Heterosexual individuals compared to 19.8% of their representation in the HIV epidemic.

"Increase linkage of newly diagnosed persons to HIV medical care within three months to 85%." The TGA's service providers implementing the EIIHA Plan coordinate efforts to link each client to care when they test positive for HIV, ensuring they get a confirmatory test; and providing each client with access to Partner Services and Risk Reduction Counseling. Surveillance teams follow up with all positive tests to ensure that clients promptly access medical care, and are linked to a RW Case Manager to access services such as benefits counseling and transportation. The TGA's CY16 rate of 95.8% for linkage to HIV medical care within three months for newly diagnosed PLWH exceeds the 2020 NHAS goal and is 7.8% higher than the most recent CY15 reporting period.

Innovative EIIHA Plan Approaches to Address Access Barriers to Testing and Treatment

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 targeted 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. All government-funded testing agencies, Cares Community Health, and County testing sites throughout the TGA provide Ora-Quick rapid 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 targeted populations through venues associated with their culture, geography and lifestyles.

3. All TGA testing sites distribute HIV+ Care Packets to newly diagnosed clients; and provide HIV/AIDS resource and referral information. Cares provides newly diagnosed clients with free or low-cost confirmatory tests, Partner Services, and RW medical care and support services. All testing sites inform newly diagnosed clients of services at Cares and provide linkage to care.

Use of EIIHA Data to Address Gaps Along the HIV Care Continuum

Analysis of 2016 California SOA surveillance data allows the TGA to determine which subpopulations are less likely to be linked to care within 12 months (Hispanic Male IDU, Hispanic and White Heterosexual Females); less likely to be retained in care (White, Hispanic and African American MSM, Hispanic Male and Female Heterosexuals, and White MSM/IDUs); and less likely to be virally suppressed (ages 13-24, 26.7%), and Hispanic Male (60.3%) White Male (60%) compared to the viral load suppression rate of 68.9% for the three-county TGA rate overall. Follows are examples of innovative TGA approaches to address these HIV Care Continuum gaps:

- Expanded "field-based" case management which allows medical case management (MCM) to be offered in settings of the client's choice, rather than only at an office site. This model was first employed with the Minority AIDS Initiative (MAI) program in 2003, and the health outcomes improved so substantially that the Council increased the allocations for field-based MCM from 30% to 86.1% between 2003 and 2017. In addition, the RW Program allocates funding to outreach workers specific to the growing target populations, such as youth MSM who are persons of color.

- All RW agencies, regardless of services provided, are required to track each client's progress related to that service's linkage to the Continuum of Care (i.e., ambulatory care providers must track all NHAS Performance Indicators, while transportation providers must track their clients' linkage to care). All RW sub-recipients must document each client's viral load suppression regardless of the service provided.

The TGA maintains its own client-level database, the Sacramento HIV/AIDS Reporting Engine (SHARE), formerly called the Sacramento Eligible Metropolitan Area System (SEMAS), and collects intake information from all RW clients. Through this sophisticated database, the TGA has developed Performance Indicator reports that document, by service, agency, and demographics, the percent of clients in each stage of NHAS Continuum of Care. An additional report, "Clients Not in Medical Care," is provided monthly to RW agencies, identifying clients not-in-care, allowing agencies to follow up on clients and get them back in care. The reports also identify clients who are not virally suppressed so that agencies are better able to provide immediate assistance to address barriers clients may be experiencing.

For example, the CARES Foundation currently funds the HIV Prevention Coalition administered by Cares Community Health. Through the first year of this HIV Testing and Linkage to Care initiative, 397 out-of-Care HIV+ people were identified; 205 were returned to care; and 51 out of 79 newly diagnosed individuals were linked to care within three months. Additionally, in 2015 the CARES Foundation funded the Condom Finder program which enlisted 216 sites for condom distribution; had 3,026,187 online impressions; and 52,000 click-throughs with social medical advertising. The CARES Foundation funded a PrEP media campaign which includes Spanish and English ads on websites viewed by gay men in the TGA, reaching 1,317,140 persons and having 65,542 "clicks" from May - September 2015, documenting that the social media campaign is effectively reaching target audiences. The CARES Foundation has continued funding these efforts in 2016 and 2017.

Relationship of Unmet Need Estimate and Activities to EIIHA Plan

The Unmet Need Population closely follows the TGA's HIV/AIDS epidemiology data for CY16. Comparing Epidemiology, Unmet Need, and EIIHA data for 2016, the FY17/18 EIIHA Plan indicates that the MSM population continues to rank the highest at-risk population in the TGA; the High-Risk Heterosexual population continues to rank second and the IDU population ranks third. These findings mirror the surprising shift in 2015 where High-Risk Heterosexuals overtook IDUs as the second highest at-risk population in the TGA. The Unmet Need data stratifies these transmission populations even further, identifying the most at risk by gender and race. This breakdown is not fully available for HIV testing data in the TGA, as only government funded testing providers and Cares maintain client transmission information. Therefore, the Unmet Need data is used to presume similar demographics of the unaware population.

Influence of FY16 EIIHA Plan Processes, Activities and Outcomes on FY17/18 EIIHA Plan

The TGA has established its FY17/18 EIIHA Plan to incorporate NHAS Continuum of Care performance indicators. The RW Program, County Public Health Divisions, as well as participating government and private testing providers, have agreed to common data elements that must be tracked to monitor the impact of the EIIHA Plan. With new data available from the current FY16 Unmet Need Estimate and the most recent TGA-wide epidemiology, the FY17/18 EIIHA plan targets those populations overrepresented in the local HIV/AIDS epidemic, those with Unmet Need, and those populations with the highest positivity rates in the previous year. While the government funded test sites, and those in the RW system of care, have a coordinated approach to testing the highest risk populations, data collection from private testers continues to be challenging. Data collection efforts often are costly processes, and despite their willingness to cooperate, private testing agencies have limited resources to generate the data that would provide a more expansive picture of the TGA's success in reaching high risk populations. The TGA's private testers do, however, cooperate very well with the RW Program to get HIV+ clients into medical care; and provide clients with outreach materials to get free or low-cost care. Most HIV testing providers in the Sacramento TGA make immediate contact with Cares or the County Public Health Surveillance Team for Partner Services, confirmatory tests, and access to HIV medical providers.

2.B.2) Efforts to Remove Legal Barriers to Routine HIV Testing

In California, routine testing has not yet become law; and many state and local legislators have worked collaboratively with the Cares Community Health's former "*Strategic Initiative to End HIV*" to continue to move this effort forward. Further, the State Office of AIDS is a strong advocate for California's HIV/AIDS providers. It's anticipated that legislation will be introduced in the near future to mandate routine HIV testing in California. Although routine HIV testing has not yet become law, California has been successful in passing two significant laws that have eliminated barriers to testing. As of January 1, 2008, Assembly Bill 682 added a California Health and Safety Code Section which eliminated the requirement for written consent for an HIV test when ordered by a medical care provider; although tests provided in non-medical settings still require written consent. As of January 1, 2009, AB 1894 was successful at requiring individual and group health service plans and insurers to provide coverage for HIV testing in medical settings regardless of whether the testing is related to the primary diagnosis. These laws have been instrumental in expanding the TGA's ability to expand routine testing among providers and to reduce financial barriers.

2.B.3) Three Selected Target Populations for FY17/18 EIIHA Plan

- Men who have Sex with Men (MSM)
- High Risk Heterosexuals
- Injection Drug Users (IDU)

2.B.3)a) All Target Groups in the EIIHA Plan and Justification for Each Group
Data Used to Determine Target Populations

Through the coordinated efforts of the TGA's EIIHA organizations described above, the TGA's target populations were selected using the following data: 1) the California State Office of AIDS (SOA) data identifying the highest risk populations in California; 2) the RW Unmet Need Estimates outlining the TGA's target Out-of-Care populations; 3) the RW Planning Council Needs Assessments; 4) the State of California TGA epidemiological data; the 5) California Integrated HIV Surveillance, Prevention and Care Plan; Plan; 6) the RW service utilization and demographic data; and 7) testing data provided by participating local government-funded and private testing sites. Based on each HIV/AIDS risk group's representation in the local epidemic, as well as in the unmet need data, the populations determined to be most disproportionately represented were selected as target populations.

The Target Groups in the TGA's 17/18 EIIHA Plan include the following populations most likely to be unaware of their HIV status, in need of referral to support services, and in need of linkage to medical care:

Men who have Sex with Men (MSM)	*High-Risk (HR) Heterosexuals*	*Intravenous Drug Users (IDU) (Includes MSM/IDU)*
• White MSM • African American MSM • Hispanic MSM • Youth MSM	• African American Females • Female and Male • Caucasians • Hispanic Males	• Male White IDUs • Male African American IDUs • White Female IDUs • Male Hispanic IDUs • White MSM/IDU • African American MSM/IDU

Men who Have Sex with Men (MSM). MSM continue to represent the highest percentage of PLWH (55.8%) in the TGA as of 12/31/16. Among MSMs, Caucasian MSMs are the largest population at 1,564 (or 31.8% of total PLWH) followed by Hispanic MSM (525) 10.7% and African American MSM (433), or 8.8% for each of these racial groups. The MSM population also represented the highest percentage of PLWH with Unmet Need (51.1%), and the greatest number and percent of newly diagnosed (65.7%) in 2016.

High Risk Heterosexuals. This category includes those Heterosexuals who are in one or more of the following risk groups: Partners of HIV+; Sex Workers; Partners of IDU; Partners of MSM; Partners of Sex Workers; Heterosexuals with a Syphilis/Gonorrhea Diagnosis; Stimulant Users; and/or Heterosexuals with Multiple Partners. The High-Risk Heterosexual category represents the second largest percentage of PLWH in the TGA (17.6%) as of 12/31/16; the second highest population of PLWH with Unmet Need (20.5%) in calendar year 2016; and the second highest category of newly diagnosed PLWH (8.96%). African American women (25%) and White women (18.1%) represent the highest percentage of HR Heterosexuals followed by White men and African American men (17.1% and 14.4% respectively). Within the Unmet Need population, African Americans were 43.9% of the men out of care and 56.2% of women out of care.

African American Women are one of the target populations within the High Risk Heterosexual risk group. In FY16, 34.9% of the female RW clients were African American (up from 49.7% in FY15) vs. 63.5% of the male clients. Notably, the 34.9% of females who were African American was much higher than the 22.8% of the total RW population and 7.5% of the TGA's population who were African American. Within the High-Risk Heterosexual transmission category (second highest category of PLWH in 2016),

African American men and women are the most represented. Further, African American women represented 41.8% of all women Out of Care in the CY16 Unmet Need data.

Injection Drug Users (IDU). AIDS Incidence among IDUs in CY16 was nearly the same as the previous three-year reporting period (6.3%). AIDS Prevalence among IDUs increased 18.3% (from 246 to 291) and HIV Prevalence increased from 133 to 149 cases, a 12.1% increase since 13-15. CY16 data indicates that IDUs rank third among all PLWH in terms of percentages not only in the epidemic for the TGA (8.9%), but in the Out of Care population (10.5%) and fifth in the newly diagnosed population (1.49%). While their positivity rate among the newly diagnosed was only.3% compared to 5.8% for MSM and 4.3% for HR Heterosexuals, this population's AIDS incidence shows they are more likely to be diagnosed with Stage 3 at the time of diagnosis.

Men who Have Sex with Men and Inject Drugs (MSM/IDU) is a target group in the TGA's EIIHA plan that is included as a subgroup under Injection Drug Users. Regarding AIDS Incidence among the MSM/IDU population in the TGA, there was a decrease from 13 or 6.3% to 3 or 2.4% between 13-15 and 14-16; AIDS Prevalence increased slightly from 10% to 10.4% while HIV Prevalence decreased slightly, from 6.6% to 6.3%. The MSM/IDU exposure category ranked the fourth highest population Out of Care in CY 2016 (8.7%) a .2% increase over CY15.

2.B.3)b) Challenges for Working with Each Target Population

Men who have Sex with Men (MSM). The challenges for working with the MSM population include issues such as: stigma regarding homosexuality, particularly within the African American, Hispanic, and Asian/Pacific Islander populations, including homophobia by religious communities that leads to isolation of MSM of color. These issues result in many MSM staying "closeted" which inhibits their ability to reach out for care and treatment services due the fear of others finding out about their sexuality.

High-Risk Heterosexuals. This population includes those Heterosexuals who are in one or more of the following risk groups: Partners of HIV+; Partners of MSM; Partners of IDU; Stimulant Users; Heterosexuals with a Syphilis/Gonorrhea Diagnosis; Partners of Sex Industry Workers; Sex Industry Workers; and /or Heterosexuals with Multiple Partners. Challenges in working with High-Risk Heterosexuals mirrors those of other risk categories: stigma regarding homosexuality and bisexuality; limited trusting relationships due to fear of arrest and incarceration; addiction focused behaviors challenging concern for personal health and well-being; and other high-risk behaviors including unprotected sex with multiple partners.

Injection Drug Users (IDU). The challenges in working with the IDU population include issues such as: limited ability to form trusting relationships due to fear of arrest and incarceration; mental health issues leading to substance use and self-medication; addiction behaviors that challenge concern for personal health and well-being; use of infected syringes; being under-the influence of drugs which limits follow through with appointments and medication regimens; unprotected sex and other high-risk behaviors.

2.B.3)c) EIIHA Activities for Each Target Population

Although most of the activities for each objective of EIIHA are implemented across all target populations, many are tailored to each specific population, with the following examples of tailored activities:

MSM. Promote opportunities for anonymous Partner Referral Services to HIV+ clients. Provide Risk Reduction counseling to all clients at least once a year; and to all newly diagnosed clients immediately after

diagnosis. Continue broad-based media campaign to encourage individuals to get free HIV/STD testing. Use ads on Craigslist in the "men-seeking-men" personal advertising section promoting free HIV and STD testing. Continue utilizing targeted marketing campaign on social networking venues such as Facebook, Twitter, Grindr, Scruff, and others. Outreach to selected venues favored by gay youth. Conduct outreach through partners of gay youth. Provide free testing and testing referral information at gay youth events. Utilize social marketing to expand outreach services to youth and their social networks using Facebook ads.

High-Risk Heterosexuals. Promote testing of HIV+ and STD Partners at all testing sites; and promote opportunities for anonymous Partner Referral Services to HIV+ and STD+ clients. Provide risk reduction counseling to all clients at least once a year, and to all newly diagnosed clients immediately after diagnosis. Encourage high-risk clients to bring partners in for testing on a frequent basis. Continue broad-based media campaign encouraging individuals to get free HIV/STD testing. Utilize targeted marketing campaigns on social networking venues such as Facebook and Twitter. Conduct testing venues accessible and familiar to high risk populations to maximize the number of people in the Sacramento TGA aware of HIV status.

Injection Drug Users. Promote testing at Safer Alternative thru Networking and Education (SANE) and Harm Reduction Services (HRS), agencies that provide syringe exchange and support services to the IDU community. Provide mobile testing on street corners and homeless camps in neighborhoods where IDUs congregate. Provide incentives (food vouchers, etc.) to promote testing to target population. Provide free testing at social venues frequented by African American IDUs. Disseminate culturally appropriate and multilingual printed materials for Hispanic IDUs. Provide outreach to selected venues and sites favored by Hispanic IDUs, such as HRS and SANE, and the local methadone clinics. Provide culturally appropriate, multilingual free testing at residential substance abuse treatment centers and methadone clinics.

Objectives for Each Component of EIIHA for Target Populations. For each target population, several EIIHA activities are implemented by the TGA's private and public partners. Since each subgroup has advisory committees and peer advisory groups, the list of strategies for each target population are extensive, and can't be provided within this application's page limitations. Follows are examples of EIIHA strategies in the TGA, which are customized for each target population:

Activities to Identify Individuals Unaware of HIV Status. Since Sacramento County's integration of HIV/STD prevention, surveillance, care and treatment programs, many additional efforts have been implemented to identify individuals unaware of their HIV status, and to ensure that they are immediately referred to and provided care and treatment. All individuals receive an Ora-Quick rapid HIV test and are provided test results within 25 minutes. This HIV testing process involves both pre- and post-test counseling, incorporating both assessment and discussion of HIV risk factors. Clients who test negative receive risk reduction counseling and educational materials, and referrals to agencies providing testing, free condoms, PrEP (Pre-Exposure Prophylaxis), PEP (Post-Exposure Prophylaxis), and other support services. In addition to HIV/STD testing, all TGA programs have contractual language requiring providers to refer all newly diagnosed individuals to the HIV Counseling, Testing and Referral Service (Partner Services Program). This service solicits the names of sex and/or needle-sharing partners from clients testing positive for HIV, and follows up with partners to notify them of their exposure; and to provide them with free testing.

In addition to HIV/STD testing through public entities, the TGA has a broad range of private

organizations conducting activities to identify individuals unaware of their HIV status. The variety of private agencies involved in HIV testing allows for multi-level strategies targeting various high risk populations. For example, Cares Community Health is a RW sub-recipient for Part A and B, and receives direct Part C and Part D grants. Cares shares information and coordinates outreach, education, testing and data sharing with Sacramento DHHS, RW Fiscal Agent and EPT program. Using the same models as the publicly-funded programs, all strategies to identify individuals unaware of their HIV status are coordinated through these funding sources.

In 2013, Cares went further in its efforts to assist the community with HIV prevention and treatment efforts and created the CARES Foundation, a private foundation that has distributed over $1.3 million dollars annually throughout the TGA in the last three years. The Foundation provides grants to nonprofit agencies that work to identify individuals unaware of their HIV status, and work with various subpopulations, such as homeless youth, IDUs, people involved in the sex trade industry, the LGBT community, and specific racial/ethnic groups, such as Hispanics, African Americans and Native Americans.

Activities to Inform Individuals Unaware of HIV Status. All activities to inform individuals of their HIV status are implemented by public and private test sites. All individuals are tested for HIV using an Ora-Quick test and are informed of their results within 25 minutes. Those people testing negative are given post-test counseling and risk reduction education, as well as referrals for future testing and support services. Individuals who test positive or inconclusive, including all subpopulations identified above, receive a more extensive counseling session along with resource and referral information for medical care. For clients who consent, a Partner Service session also allows them to anonymously contact their sex and/or needle sharing partners to inform them of their risk, and encourage them to get tested. All clients are transitioned immediately to Cares or the County Public Health lab to receive a confirmatory blood test.

The Sacramento County HIV/STD Prevention programs are an integral part of the TGA's plan to inform individuals of their HIV status and works cooperatively with government-funded programs and private testing organizations to develop coordinated strategies, plans and activities. The Prevention and Disease Control branches of the TGA's two rural counties both subcontract services through the Sierra Foothills AIDS Foundation (SFAF), which is headquartered in Placer County, and participates in all of the TGA's activities related to informing individuals of their HIV Status. Although severe state and county budget reductions have forced the rural counties to eliminate their government-funded testing sites, the SFAF has entered into a contractual agreement with Sacramento County testing providers to continue testing in the TGA's rural counties.

Activities to Refer Individuals to HIV Care. Since Sacramento County's integration of the prevention, surveillance, care and treatment programs, many additional efforts have been implemented throughout the TGA to identify individuals unaware of their HIV status, and to ensure that they are immediately referred to care. In addition to HIV/STD testing, both programs have contractual language requiring providers to refer all newly diagnosed individuals to the Partner Services Program. This service solicits the names of sex and/or needle-sharing partners from those testing HIV+ and follows up to notify them of their exposure; and to provide them with free testing. This service also makes immediate referrals to treatment providers, most often linking them up with RW case managers. All individuals who test positive, or have an inconclusive test through public sources, are immediately referred to care. In addition to receiving resource and referral information, testers are trained to provide immediate services to clients to assist them in accessing care. While the TGA covers a large geographic area for HIV testing, HIV specialty providers are relatively limited. All testers are familiar with the private providers, such as Cares,

Sierra Foothills and Planned Parenthood, and government funded testing sites. Cares is the only Ryan White funded HIV medical care provider in the TGA for the adult population. All public HIV testing sites are currently referring 100% of newly diagnosed clients to medical care, as are the few privately funded testing sites.

Persons receiving a preliminary HIV+ test result are provided more extensive counseling and are immediately referred to medical care and psychosocial support services. All sites send clients to their respective care providers for confirmatory tests, or if uninsured, to Cares Community Health. Cares provides free or low cost confirmatory testing to all individuals regardless of their insurance, county of residence, immigration or income status. All of the testing sites distribute resource and referral information to all clients who are first diagnosed with HIV, or if results are inconclusive. The resource and referral information identifies sources for treatment and care, as well as educational materials for HIV+ individuals. The Sacramento HIV/STD Prevention program is an integral part of the TGA's plan to refer individuals to appropriate services, and both HIV+ and HIV- individuals receive referrals that are custom designed to meet their specific needs.

Activities to Link Individuals to HIV Care. Several RW funded agencies operate a "field-based medical case management model" in which case managers go directly to the clients to provide services, rather than requiring clients to go to a service site. Public testing sites are familiar with these agencies, and arrange for a medical case manager to meet with each newly diagnosed person. The case managers assist the individual with making their first appointment, and ensuring that their confirmatory tests are conducted to verify the accuracy of the Ora-Quick test.

In addition to providing referral information, each publicly funded site has an ongoing relationship with Cares Community Health, which operates an Outreach Program employing outreach workers who transport clients from their test site to the Cares clinic to get a confirmatory test; and ensure that clients go to follow-up medical appointments. For clients tested at Cares testing sites, all preliminary positive Ora-Quick tests are sent for confirmatory follow-up testing and medical appointments are scheduled at the post-test interview. Clients are contacted no later than 3 days prior to remind them of the follow-up appointment. In addition, the Sacramento County HIV/STD Prevention is an integral part of the TGA's plan to link individuals to treatment. SFAF also carries out these activities for the TGA's two rural counties.

The TGAs client-level database (SHARE) tracks whether clients are "in medical care" or have "dropped out of" care. Each RW sub-recipient, regardless of services provided, is given a monthly report of their clients who are not in medical care and agencies are contractually obligated to follow-up with out-of-care clients and help get them back into care. At the time of intake, RW clients are encouraged to sign the Universal Release of Information Form, so that RW agencies unable to locate their out-of-care client can refer that client's name to the Cares Community Health's Outreach team; who uses resources necessary to locate out-of-care clients and provide them with the assistance necessary to return to medical care.

While the field-based case management system is more expensive than office-based case management, client health outcomes demonstrate this model's effectiveness in linking and retaining clients in care. In FY16, 4,098 or 83.4% of TGA clients met the minimum definition of "In Care" by receiving a minimum of one medical visit in 2016, including a CD4 count, viral load test and/or on anti-retroviral therapy; and 68.5% (3,368 out of 4,918) achieved viral suppression. Outcomes for clients receiving RW medical care exceeded the TGA outcomes: 76.2% of clients receiving medical care from the Ryan White system of care met the more stringent definition of two visits per year at least three months apart

(1503/1972), and 82.7% (1630/1972) achieved viral suppression.

Organizations Responsible for Implementation of EIIHA Activities. Cares Community Health, Golden Rule Services, Safer Alternatives through Networking and Education (SANE), Gender Health Center (GHC), Harm Reduction Services (HRS), Sacramento Lesbian, Gay, Bisexual, and Transgender Center, Wind Youth Services (Wind), Community Against Sexual Harm (CASH), Sacramento Native American Health Center, Sacramento County DHHS HIV/STD Prevention Program, El Dorado County Department of Public Health, Placer County Department of Public Health, Planned Parenthood, WellSpace Health, Sierra Foothills AIDS Foundation (SFAF), Strategies for Change, and Molina Health Centers are entities responsible for ensuring that activities to identify individuals are implemented. Cares Community Health used funding from a prior CDC grant for implementation of EIIHA activities in 2014, but that funding ended and was replaced by CARES Foundation funding for CY 2016 and 2017. Additional funding has been provided by RW Part C funds (test kits only), and private funds for its testing efforts (CARES Foundation). Golden Rule Services, HRS and the Sacramento County DHHS HIV/STD Prevention Program use federal CDC funds through a SOA grant; Cares and Molina Health Centers are federally qualified health centers and utilize some federal funds for testing, and Planned Parenthood uses State and private funds for testing and reproductive health services.

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. Each of these providers has one of the TGA's three target populations as part of its contract with the County HIV/STD Prevention Program. As the designated STD testing site for Sacramento County Public Health, Cares has access to high risk individuals and their partners who come for free or low-cost STD testing and treatment. HRS targets the IDU and substance using community, and conducts free HIV and Hep C testing and a syringe exchange program, offering clients' case management services, food, clean syringes, overdose prevention medications and transportation. Golden Rule Services targets African American MSM, offering free HIV testing, case management and social support services. SANE targets the IDU and substance using community and provides IDUs with clean syringes, risk reduction counseling, referral to partner services and medication assisted substance abuse treatment. The Sacramento County HIV/STD Prevention Program targets MSM by providing testing at venues such as gay bars, the LGBT Community Center, the Gender Health Center, gay pride events and communitywide health fairs. All of these organizations work closely with County Public Health to coordinate efforts to target the high-risk populations throughout the TGA.

Planned Outcomes of EIIHA Plan for Each Target Population. The S.M.A.R.T. (Specific, Measurable, Achievable, Realistic and Time phased) objectives for the TGA's EIIHA Plan are identified in the EIIHA Work Plan Goals and Objectives table that provides the goals, responsible parties, time frame and desired outcomes. Since the 2018 EIIHA Plan is still being developed, proposed goals, objectives and time frames may change after dissemination of the proposed EIIHA Plan to community coalition partners and government funded testing providers, and new contracts are negotiated. Planned FY17 EIIHA Plan outcomes follow:

1. Conduct HIV testing at 89 testing venues accessible and familiar to high risk populations to maximize the number of high risk individuals who become aware of their status.
2. Certify and train new testers on Ora-Quick Rapid HIV testing to expand the region's ability to test more individuals and inform them of their HIV status.

3. Prove social network Ora-Quick rapid testing to the following risk populations: Men having Sex with men (MSMs): 28.7% of tests; High-Risk Heterosexuals: 35% of tests; IDUs: 10.1% of tests; MSM/IDUs: 2% of tests; Transgender: 1% of tests; All Other Categories: 22.8% of tests
4. Target Population Goals by Race: White: 53.6% of clients tested; African American: 23.3%; Hispanic: 17.1%; Asian/Pacific Islander: 3.7%; .7%; Other/Undeclared: 1.5% of total clients tested.
5. Ensure that government funded testing agencies provide community outreach identifying free testing and treatment sites to improve private referrals for testing.
6. Enlist a minimum of one African American community leader to provide outreach messages and on-site testing to his/her community to expand the number of persons in African American community that get tested.
7. Enlist State and community leaders to advocate for routine HIV testing statewide.

2.C. Local Pharmaceutical Assistance Program (LPAP) – not applicable to Sacramento TGA

SECTION 3: METHODOLOGY

3.IMPACT OF THE CHANGING HEALTH CARE LANDSCAPE

3.A.1) Description of Health Care Coverage Options Available to PLWH in TGA

There was continued success in outreach and enrollment to expand insurance coverage for PLWH in the TGA in FY16. Since the majority of FY16 RW clients (97%) fell below 400% of Federal Poverty Level (FPL), these clients were eligible for some form of assistance under the Affordable Care Act (ACA), known in California as "Covered California." Between FY14 and FY15, there was a reduction from 13.3% to 8.5% of RW clients without another source of health insurance, and this fell further in FY16 to 7.8%. The fact that a fewer number of RW clients were uninsured in 2016 than the general population of the TGA (7.8% vs. 10.8%) shows that the RW Program is making solid progress in maximizing other sources of health care coverage for PLWH in the TGA. The following table provides the health care coverage status of FY16 Ryan White Part A clients as compared to the health care coverage status of the TGA's general population in 2016:

Healthcare Coverage	Ryan White Part A Clients 2016		TGA General Population 2016	
	#	%	#	%
Medi-Cal	1,231	46.5%	583,860	28.5%
Medicare	787	29.8%	362,014	17.4%
Medi/Medi (Medi-Cal/ Medicare)	31	1.2%	71,887	3.5%
Other Insurance	391	14.8%	828,285	39.8%
Uninsured (RW included here)	205	7.8%	224,570	10.8%
	2,645	100%	2,080,616	100%

As can be seen in the table above, there is a disproportionately higher percentage of RW clients on Medi-Cal than the TGA's general population (46.5% vs. 28.5%), as well as Medicare (29.8% vs. 17.4%). In terms of other health care insurance coverage, such as private insurance or other public insurance, there is a 2 ½ times lower percentage of RW clients with these coverage options as compared to the TGA's general population (14.8% vs. 39.8%). In FY16, the TGA had 1,967 (75.0%) RW clients who were at or below 138% of poverty. Of these PLWH, 1,262 (64.2%) were enrolled in Medi-Cal or Medi-Medi. The balance of those clients (minus approximately 5% of undocumented RW clients) are eligible to enroll in a private Covered California insurance plan with tax subsidy assistance, ADAP drug co-pays and a California SOA Health Insurance Premium Payment Program (OA-HIPP).

At the end of FY16, 7.8% of the RW population had no insurance, which is a promising decline over the past few years due to ACA implementation. In FY15, 10.8% of RW clients had no insurance, in FY14, 11.8%, and in FY13 that figure was 15.5%. The RW Program has consistently determined that between 4.5% and 5.0% of RW clients with no insurance are undocumented, and therefore ineligible for public health insurance benefits.

In FY16, 97.0% of RW clients had annual incomes at or below 400% of the FPL, and 62% had annual incomes at or below 100% of the FPL. These figures show poverty rates dramatically higher among RW clients than the 16.1% of the TGA's general population, as reported by the 2014 California Department of Finance Population Estimates and 2014 US Census Bureau Survey. Further, 20.0% of FY16 RW clients reported no income at all, which is over 5 times higher than the 3.8% of FY13 RW clients with no income.

Coordination of Health Insurance Enrollment Efforts

CARE/Health Insurance Premium Payment Program (CARE/HIPP), formerly funded through the California Department of Public Health, State Office of AIDS (SOA), is designed to provide payment of health insurance premiums for clients who have lost their employment and are losing their private health insurance coverage. CARE/HIPP transitioned to a federally funded OA-HIPP program in January of 2014. Cares Community Health has staff who are OA-HIPP certified to assist PLWH in maintaining their private health insurance coverage by directly enrolling eligible clients in the State's insurance premium assistance program. With the new ACA, low-income clients who are dually enrolled in both ADAP and the Health Insurance Premium Assistance Program get assistance paying their private insurance premiums and medication co-payments. Generally, this assistance is available to clients who fall between 139% and 250% of poverty.

The efficiency of these direct enrollments by Cares will continue to significantly improve client access to third-party reimbursement. In addition, it will continue to reduce RW ambulatory medical care expenditures for new clients who would otherwise be at risk of losing their insurance. The TGA's rural counties also have certified Health Insurance Premium Assistance enrollment workers and this assistance has been a critical factor in maintaining RW rural county residents in ongoing HIV/AIDS care and treatment.

The federally financed Office of AIDS Health Insurance Premium Program (OA-HIPP) has experienced significant increases since FY15 for clients who purchased insurance through California's Health Insurance Exchange, Covered California, and enrolled in private insurance plans. While RW programs were formally the only assistance available to clients who needed assistance with *medical* co-payments and deductibles, the SOA has informed California RW recipients that State assistance became available in 2016 for medical co-payments and deductibles for clients with a Modified Adjusted Gross Income that does not exceed 500% Federal Poverty level based on household size. Clients enrolled in Medicare, or Full-Scope Medic-Cal or Medi-Cal Expansion are not eligible for this program. Estimates for these ACA enhancements are not available in terms of dollar amounts at this time. While this new program should reduce the need for Ryan White dollars for medical co-pays and deductibles, the RW program still experiences the need to assist clients with the first month of insurance premiums until their OA-HIPP application is approved and processed. Reimbursements that clients receive for that first month of service are returned to the RW program and utilized as program income for RW services.

3.A.1)a) Impact of Health Care Coverage Options on Access to Care and Health Outcomes

In FY16, 75.4% of RW clients who reported an income source were receiving that income through some form of public assistance (General Assistance, Social Security Disability, Temporary Assistance to Needy Families, Supplemental Security Income, etc.). There are vast needs for PLWH living in poverty, and their average cost of care is significantly higher than the population of PLWH not living in poverty. For FY16 RW clients, the average cost of care to the RW system for PLWH on public assistance was 37.6% higher than those employed or with private retirement ($1,897 vs. $1,379). Poverty limits individuals' abilities to acquire basic needs, such as food, housing, and transportation, and if these survival needs are not met, few PLWH prioritize medical care until they are extremely sick. It is proven that clients who enter the RW system with progressed level of HIV disease are costlier than those who enter care in less advanced stages.

The RW program in Sacramento continues to serve PLWH who have ACA coverage. Medical and non-medical case management (Benefits and Enrollment counseling) are services most frequently in demand by these clients, as these services are not covered for clients with ACA coverage. The RW Program Benefits and Enrollment staff has been increased over the last several years from 4 to 7 positions to assist clients with re-enrollment in their health plans, ADAP and the State's OA-HIPP program. The RW medical case management services are a critical link in assisting clients overcome barriers and access to care, and this type of service is not avaialble under ACA covered plans.

In addition, the TGA's RW program continues to assist PLWH with some core RW services such as mental health and outpatient substance abuse treatment, both of which are in high demand for RW clients, and both of of which have limited coverage under ACA plans. The RW oral healthcare services also have expanded significanlty since ACA implementation, largely because Medi-Cal dental providers are extremely limited in the Sacramento TGA, and California's Medi-Cal program offers very limited procedures. RW clients with private insurance through the ACA don't have dental coverage, and RW services remain their only option for oral heatlh care. Since low income clients represent the largest percentage of PLWH throughout the TGA, the support services offered by the RW program are in high demand for this population.

While the Planning Council envisioned that the RW program would realize some cost savings as a result of ACA implementation, it will take several more years of additional data to analyze any significant cost savings in approved RW service categories. Comparing FY15 year-end expenditures to the most recent FY16 figures, decreases in RW cost per client were only found in 4 of 16 RW service categories as follows: medical case management decreased by 3.6%; mental health services decreased by 1.8%; outpatient medical care decreased by 11.9%; and outpatient substance abuse treatment decreased by 2.4%. However, increases were found in 12 of 16 RW service categories between FY15 and FY16, off-setting the savings in the other 4 service categories. For example: non-medical case management cost per client increased by 6.0%; housing cost per client increased by 55.9%; oral health care increased by 17.3%; mental health services increased by 8.8%; outreach services increased by 142%; and residential substance abuse treatment increased by 65.1%. In addition, in FY14 a new service category was added, Health Insurance Premium and Cost Sharing, which increased from $5,156 in FY14 to $6,460 in FY15, to $26,782 in FY16. The cost per RW client for Health Insurance Premium and Cost Sharing increased 146% (from $248 to $609) between FY15 and FY16.

There is additional concern in the TGA that the ACA will have some negative impact on the number of HIV/AIDS service providers in the TGA due to the low reimbursement rates for Medi-Cal through Covered

California. As background, in FY13, 224 RW clients were enrolled in the Low-Income Health Program in the TGA and reimbursements from that program totaled approximately $1,502 per client. During that same time, 1,048 RW clients were on Medi-Cal with reimbursements totaling only $371 per client. Because the Low-Income Health Program no longer exists in the TGA, and the majority of RW clients are now eligible for Medi-Cal through Covered California, there is concern that these low Medi-Cal reimbursement rates will negatively affect the limited number of HIV/AIDS service providers in the TGA.

Affect of Marketplace Plans on Provider Accessibility

The TGA has been very successful in transitioning PLWH to health insurance coverage through the ACA for which they are eligible, notwithstanding the lengthy wait time for Medi-Cal approval. In the TGA's discussions with other California RW recipients, it is widely accepted that the best practices for enrolling clients in ACA coverage is the one-stop shop approach where Benefits and Enrollment Counselors are certified as Covered California counselors, OA-HIPP counselors and ADAP Enrollment workers, limiting the time and confusion that occurs when clients must schedule appointments at different locations to complete their application processes. Throughout the Sacramento TGA, all RW Enrollment counselors use standardized assessment tools to determine client eligibility, assess available plans that would most closely meet the individual needs of clients, and obtain documentation needed for clients to maximize insurance coverage.

In the TGA, four health plans are offered through the ACA insurance marketplace exchange or Covered California, and only one plan (other than Medi-Cal managed care plans) contracts with the TGA's RW Clinic, Cares Community Heath, which provided medical care to 63.7% of PLWH in the TGA in FY16 (3,137 Cares HIV patients in FY16 out of 4,918 PLWH in the TGA as of 12/31/16). Kaiser Permanente, the second largest provider of HIV care in the TGA, is a Covered California plan. The other two Covered California plans do not list any HIV specialists as members of their "network." Since only two other clinics in Sacramento provide HIV specialty care, UC Davis and Sutter Health (neither are taking new HIV patients), RW clients have been advised to select one of the two Covered California plans that will provide them with HIV/AIDS care continuity, and the RW Program has not yet identified problems with accessibility for care or medications for RW clients enrolled in those Covered California Plans.

The TGA has experienced several cases of RW clients who signed up for Covered California plans that were not contracted with HIV specialty care physicians. Through its efforts, the RW Enrollment and Benefits counselors have succeeded in getting those clients into HIV specialty care under their Covered California Plans to resolve their need for HIV specialty care.

Although the ADAP program has recognized the serious backlog of Medi-Cal approvals, and extended the grace period for medication assistance, the TGA was grateful that it had the following unique system in place to assist clients with continued ADAP coverage. As the TGA's ADAP Coordinator in FY16, the RW Program staff could access the State MEDS (Medi-Cal Database) system to identify whether a client has submitted a Medi-Cal application. ADAP agreed to expand the individual grace period for clients after receiving confirmation letters from the RW Program that the client's Medi-Cal application was "pending." While this unique response is labor intensive, clients were able to get their medications filled without missing any doses. In July of 2017, the State Office of AIDS contracted directly with sub-recipient agencies to provide ADAP Enrollment Services, and ADAP Coordinators are now stationed directly at the State Office of AIDS' ADAP Program, where access to Medi-Cal is available system wide.

The TGA has a limited availability of HIV specialty physicians. In 2016 Cares Community Health, a RW

funded comprehensive health center, saw the vast majority of PLWH in the region (3,137 Cares HIV patients of 4,918 PLWH in the TGA or 63.7%), followed by Northern California Kaiser Permanente. The Sutter Healthcare system and U.C. Davis (UCD) Adult Infectious Disease have combined only about 5% of the PLWH in the TGA. All HIV+ children are seen at the UCD Pediatric Infectious Disease center (a RW sub-recipient) and they serve all of Northern California's Pediatric HIV+ patients. Within this regional system of care for PLWH, less than .07% of PLWH in the greater Sacramento area experienced interrupted HIV/AIDS care due changes in health care coverage. The TGA had only a few cases of clients whose new ACA covered Plan would not provide HIV Specialty care, but those cases were resolved through RW patient advocacy.

In the rural counties, however, there is only one Covered California private plan, and clients have had difficulty maintaining coordinated care and receiving HIV specialty medical care. Medical Case Managers in the rural county area have found this a challenging problem with few options. The number of clients impacted by this, however, is still minimal, as the greatest percentage of rural county clients qualify for Medi-Cal and are able to receive their care in Sacramento at Cares Community Health Clinic.

Challenges to Heatlh Insurance Enrollment Efforts

Follows are examples of issues that have challenged outreach and enrollment effort in the TGA: (1) Statewide Backlog of Medi-Cal expansion. California has had one of the highest response rates in the nation to ACA coverage applications. As a result, the State's Medi-Cal system was overwhelmed with applications to be approved; and the State's ADAP grace period for Medi-Cal Expansion eligibility determination was increased from 45 to 90 days after the ACA implementation. (2) Limited Financial Resources for HIV Patients. The number of RW clients newly enrolled under the Covered California insurance plans have increased the demand for RW Emergency Financial Assistance and Health Insurance Premium Assistance to pay for medical co-payments and deductibles. This demand for RW funding has increased because State and Federal assistance has not covered medical co-payments until recently and still does not cover deductibles. Further, OA-HIPP premium assistance is only available to clients whose incomes are 139% up to 250% of poverty. (3) Limited HIV Specialty Providers in Rural Counties of TGA. While the majority of RW clients from the rural counties of the TGA receive care at Cares Community Health in Sacramento County, and signed up for the ACA's Anthem Blue Cross plan which contracts with Cares, several HIV patients signed up for the only other private Covered California option in the rural counties (the California Health and Wellness Plan). Although ensuring access to medical care and medications have continued to be addressed by RW Medical Case Managers, the limited access to HIV specialty care in the rural counties of the TGA remains a challenge.

3.A.2) Impact of Health Care Landscape on Part A Program and PLWH in TGA
3.A.2)a) Impact on Service Provision and Complexity of Providing Care for PLWH
Factors that Contributed to Funding Changes within Services Categories

Medicaid expansion and implementation of the ACA were factors that contributed to recent changes in funding within the TGA's service categories. In anticipation of the ACA implementation, the Council added health insurance premium assistance to the slate of RW funded service categories. They also increased the emergency financial assistance, emergency housing assistance and medical transportation service categories in response to the demographics and needs of the Out-of-Care population.

The allocation for outpatient ambulatory care was moderately reduced to accommodate these increases in health insurance premium, emergency financial assistance, etc., as the Council believed some additional

revenue from third party payers would provide a resource shift. As service demands decreased in some service categories, the Council made mid-year adjustments to the oral health service category, as RW provides the only full service oral health care for HIV+ clients in the TGA. Additional funding also was received from RW Part B, so Part A was able to redirect some funds to increase funding for the benefits and enrollment counseling and medical case management that has been experiencing waiting lists. The expansion of these service categories was critical to assist clients not only in enrolling in new health care plans, but in maintaining policies during re-enrollment periods. The Benefits Counseling (non-Medical Case Management) service category also provides clients with assistance in applying for the state's OA-HIPP, as well as ADAP programs.

While some ACA plans have "Medical Case Management," this is only limited to a referral coordinator who assists with the cumbersome process of getting a client an authorization to see a specialist. The RW Medical Case Management program offers a full range of services to clients, including medication adherence services, advocacy, and assistance with a broad range of barriers to care. Medical Case Managers often case confrence with the PLWH's physicians to ensure that their medical issues are being addressed. The non-medical case management services (benefits and enrollment counseling) not only assist the clients with initial enrollment and re-enrollment in health plans, but determine eligibility for public assistance programs and assist clients with those application processes as well. The RW program also provides critical support services such as transportation, emergency financial assistance, emergency housing assistance, premium payment assistance services, pediatric treatment adherence, risk reduction counseling, nutritional counseling, residential substance abuse (detox only) and child care services.

In addition, the RW program continues to assist PLWH with Core Services such as mental health and outpatient substance abuse services which have limited coverage under ACA plans. These Covered California Plans, including Medi-Cal, also require that Mental Health Counselors be Licensed Clinical Social Workers (LCSWs), and clients are on waiting lists due to shortages of these professionals. The RW Program has counseling professionals with alternative licensure (MFCCs, MSWs, ACSWs) who continue to proivde mental health counseling to RW clients while on ACA waiting lists.

Expanding its efforts towards health insurance expansion, which began in late 2013, the TGA continues to participate in numerous outreach events to inform PLWH of expanded insurance coverage options through Covered California. The RW program funded four "Benefits and Enrollment" Counselors at Cares Community Health in 2013, but expanded the number of counselors to seven beginning in 2014 and has maintained that through 2017. The Benefits and Enrollment Counselors are certified as ADAP Enrollment Counselors, Covered California Counselors, and OA-HIPP counselors. Because the Benefits and Enrollment Counselors have certifications to enroll clients in these three insurance coverage programs, clients are able to complete their application processes and obtain all of the assistance for which they are eligible. The Enrollment Counselors also assist RW clients in completing all required Medi-Cal applications, and assist them in obtaining the documentation required to have those applications approved. Cares also has installed new software that reviews a client's active insurance status prior to their scheduled medical visit. If a client has no insurance or their insurance status has changed, the client is contacted and scheduled for an appointment with the Benefits and Enrollment Counselors to assist them in obtaining new medical insurance or updating their current insurance status.

All new clients at Cares also are required to complete a Benefits and Enrollment Counseling session to determine eligibility for all sources of insurance assistance. The "Benefits" appointments are scheduled

immediately after the "Intake" appointment to minimize client challenges in attending appointments. With this system, RW ensures that all clients receive comprehensive assistance in identifying and completing applications for all services and benefits for which they are eligible to assure that RW is payer of last resort.

Affect of Marketplace Plans on Medications for PLWH

Effective January 1, 2014, the State passed SB 249, legislation that authorizes the Office of AIDS and its contractors, including ADAP Enrollment workers, to share RW client data with "qualified entities" solely for the purpose of facilitating enrollment and maintaining access to Medi-Cal Expansion and Covered California health coverage. The ADAP Enrollment workers at Cares may share ADAP client information with the following entities: Department of Health Care Services; the California Health Benefit Exchange (Covered California); the Medi-Cal Managed Care Plans; Covered California health plans; and County health departments or their contractors that deliver HIV or AIDS health care services. This new State law has expanded the TGA's ability to coordinate enrollment efforts with other agencies and community partners.

3.A.2)b) Impact on Part A Alllocations, Health Insurance Premium and Cost Sharing Assistance

The RW Program has nearly tripled its allocations and funding support for Benefits and Enrollment Counselors between FY13 and FY15 to ensure that clients receive assistance enrolling in any public benefits for which they may be eligible, including Covered California (ACA). Enrollment Counselors are co-located at the same site as the RW outpatient / ambulatory care clinic, and new clients are immediately scheduled for an appointment with the Benefits Counselors to ensure that they obtain enrollment assistance in various programs available in California; such as Medi-Cal, Covered California Health Plans, State Insurance Premium Assistance Programs, the AIDS Drug Assistance Program, and others. Enrollment Counselors also perform this function at the TGA's rural county sites.

A large challenge for PLWH is that assistance under a Covered California plan is not available for co-payments or deductibles for medical expenses. This creates a significant barrier to care for clients whose incomes range from 139% to 400% of poverty; which affected 580 clients who made up 22.1% who made up 22.1% of the RW caseload in FY16 (up from 21.6% in FY15 and 18.9% in FY14). The resource shifts resulting from ACA has allowed the RW Planning Council to increase allocations to the Insurance Premium Assistance Program, assisting clients who have financial need for premiums, deductibles and medical co-payments. The Health Insurance Premium and Cost Sharing Assistance Program (HIPP) service category was added to the TGA's funded priority services beginning in FY14. The Council has developed and adopted service directives and service standards for the HIPP service category, and administrative regulations have been established and put into place for this service category.

During the first years of the ACA, this service also paid for client's first month of their share of premiums while waiting for the State OA-HIPP program to process their applications. Now that the State program has been operating for more than two years, those applications are being approved much more timely, and the Insurance Payment and Premium assistance service has seen more clients needing help with their medical visit co-pays. The resource shifts in the TGA allowed the Council to allocate more funding to transportation, emergency financial assistance, child care and emergency housing, although client needs continue to far outpace the TGA's ability to respond. In addition, the case management service category has continued to have increased costs due to increases in Patient Navigators working to enroll all eligible PLWH in a Covered California plan or another public health insurance plan. In mid-2016, the State of California implemented a program for assistance with medical co-pays and insurance

deductibles for clients who are ADAP eligible (up to 500% of the poverty level).

Increase in Part A Funding for Benefits Counselors

In addition, the TGA's RW program has tripled its allocations for Benefits and Enrollment Counselors since FY13 to ensure that RW clients receive assistance enrolling in public benefits, including Covered California (ACA coverage). In Sacramento County, only two or three clients have experienced disruption in care due to changes in their health care coverage under the ACA. These clients were assisted by Benefits Counselors who acted as advocates with Covered California to assist them in changing plans to maintain continuity of care.

3.B. PLANNING RESPONSIBILITIES
3.B.1) Planning and Resource Allocation
3.B.1)a) Description of Community Input Process
3.B.1)a)i. Involvement of PLWH in Priority Setting and Allocation Process

PLWH, who account for 50% of the Council's Priorities and Allocations Committee (PAC's) membership, represent the issues that are of most concern to PLWH throughout the TGA. In addition, PLWH community input is extensively solicited through the following tools used by the PAC (explained in more detail above): the TGA's Needs Assessments, Out-of-Care Needs Assessment, Annual Client Satisfaction Survey, Annual Unmet Need Estimates, Comprehensive Plan, and client-level SHARE database service utilization and cost data, cross referenced by client demographic and exposure categories. The most recent Needs Assessment and Out-of-Care Needs Assessments are explained in more detail in the previous two sections. In addition, targeted Needs Assessments, such as the Housing Needs Assessment, are conducted to get targeted input from specific subpopulations. Participants surveyed for all of the TGA's Needs Assessments are sampled to ensure that all surveyed populations are reflective of the overall HIV/AIDS population, as well as the RW client population, in terms of age, race, sex, mode of HIV/AIDS transmission, and geographic locations.

PLWH also are actively involved in the TGA's Consumer Forums that garner community feedback on service gaps, changing needs and barriers to care. The PAC uses the forum's anecdotal discussions to coordinate with the FA and service providers to determine how to more effectively and efficiently spend RW funds to meet consumer needs across all subpopulations. The PAC also receives regular feedback from the Council's Affected Communities Committee (ACC), which is comprised exclusively of PLWH who are consumers of RW services. The ACC begins each monthly meeting with an open forum for consumers to express challenges they've encountered and discussion points are forwarded to appropriate committees of the Council for consideration. Similar to the annual Consumer Forum, ACC reports provide verification of quantitative findings found in the Needs Assessments, and identify areas in need of further investigation.

The TGA takes a methodical approach to the priority setting and allocation processes – both involving extensive data review and input from a wide variety of stakeholders throughout the TGA. The Priorities and Allocations Committee (PAC) of the Council started working on the FY18 priority setting and allocations process well before FY16 ended. PAC followed the policy and procedure document (PAC 01) that clearly outlines the processes for setting priorities and calculating allocations for direct services in Sacramento County, while allowing local control over these processes in the TGA's rural Counties. These clearly outlined steps are crucial to ensuring a process that is explicit, and open to all involved stakeholders. The TGA's Priority Setting and Allocation process includes input from all PLWH: from those who are aware of their HIV status and in care, to those who are out of care, to those who are unaware of their HIV status. In addition to relying on a detailed action plan for the use of a wide variety of data sources, PAC relies on its

formally adopted core values, which direct the Council to do the following: 1) maximize access to RW services across a broad number of people; 2) reduce disparities between subpopulations; and 3) ensure that the Council does not fund services that benefit only a small segment of PLWH in the TGA.

The broad efforts of gathering information from consumers throughout the TGA are used by the Planning Council during the priority setting and allocations process to contribute to positive health outcomes along the HIV Care Continuum. PLWH and RW service providers are actively involved in the TGA's Consumer Forums that garner community feedback on service gaps, quality of care, challenges, and changing needs. In addition, as the TGA's most recent Needs Assessment survey solicited input from Affected Community Committee members who represent the various perspectives and needs of PLWH. Input also is received from the RW Council's Executive Committee which is comprised of the Chair of each of the Council's Committees, all of which have heavy consumer representation.

To take into consideration the needs of all PLWH throughout the TGA, the Council not only analyzes trends in HIV/AIDS epidemiological data, and RW client cost and utilization data for those PLWH in care, the Council also analyzes the demographics and HIV/AIDS status of those persons identified as being "Out of Care." The findings from the Unmet Needs Assessment were used by the PAC in to describe the demographics and location of persons who know their HIV status but are not in care, including disparities in access and services among affected subpopulations. Through this analysis, the PAC then determined the priorities, resource allocations and made revisions to the Continuum of Care for FY18.

The TGA also conducted its biannual comprehensive Needs Assessment in 2013, which surveyed 232 PLWH throughout the TGA, which was a 28.9% increase over the number of PLWH surveyed in FY11. The Needs Assessment provides feedback to the Council, service providers and other stakeholders regarding the strengths and weaknesses of the current Continuum of Care, and provides feedback from consumers regarding service needs, service gaps, and barriers to accessing the Care Continuum. This extensive input from PLWH is imperative to the Council as it establishes priorities and determines allocations across the care continuum. The Council receives input to make improvements at all levels of the Care Continuum; from the consumer level (increasing consumer knowledge); to the service provider level (decreasing waiting lists); to the overall service delivery system level (improving referral systems). In addition, the Needs Assessments assist the Council and Fiscal Agent to analyze input from PLWH by various demographic groups (i.e., race, age, gender and mode of HIV/AIDS transmission) to understand the unique service needs, gaps, and barriers to care for each subpopulation in the TGA.

On a broader scale of community input processes, the TGA's RW Program has been involved in the development of California's 2016 Integrated HIV Surveillance, Prevention and Care Plan, "Laying a Foundation for Getting to Zero," in collaboration with California Department of Public Health, Center for Infectious Diseases and Office of AIDS. In addition, the TGA's RW Program was involved in development of California's 2016 Needs assessment for HIV in collaboration with the California SOA.

Although the Council was awaiting the release of the Comprehensive Plan Guidance which was expected to drive the direction of the assessment, the Council's Needs Assessment Committee proceeded with updating its survey tool and made significant changes to the data collection and structure of the survey tool itself; also incorporating a number of questions surrounding prevention and partner counseling services. This new Needs Assessment survey tool is currently being used as the Council has initiated its Needs Assessment process with a final report expected in FY17.

Consideration of Historically Underserved Populations in Priority Setting and Allocations

The involvement and views of PLWH are central to the priorities and allocations processes, and the influence of comprehensive input from PLWH is visible in the Council's FY 2017 Service Category Plan, as well as the TGA's 2012-2014 Comprehensive Plan for HIV/AIDS Services. The needs of PLWH are continuously expressed to the Council, either through verbal or written mechanisms (as documented by Community Needs Assessments, Client Satisfaction Surveys, Consumer Forums, Council members and Affected Communities Committee members) and through consumer action (service utilization). The analysis of service utilization data, when compared to epidemiological and demographic data, informs the PAC as to which subpopulations are being underserved and in which service categories.

3.B.1.a)ii. Consideration of Community Input in Priority Setting and Allocations Process

In addition to the funding requested in this Part A Application, the Council developed alternate funding scenarios in case the actual award is less than requested. By adopting several funding scenarios, the RW system, its service providers, and its clients, can plan for potential funding decreases in the TGA while minimizing health risks. For example, when previously faced with funding reductions leading to service eliminations, expansion of waiting lists, or tightening of disability acuity scales and financial eligibility criteria, the Council authorized transitional grants to affected RW providers so patients could be transitioned out of the programs taking the brunt of the reduction, instead of being cut off instantaneously. In addition, every fiscal year, regardless of funding increases or decreases, the Council and Fiscal Agent implement a mid-year reallocation process which identifies which service categories are overspending and which are under spending at mid-year, to determine why, and – if needed – to transfer funds between service categories to the areas of greatest need.

3.B.1)a)iii. Consideration of Minority AIDS Initiative (MAI) Funding in Planning Process

The Planning Council reviews all RW funding sources available during its allocation process, including Part A, Part B, and MAI funding, which the Fiscal Agent receives directly, and Parts C and D, which go directly to the service provider. The Fiscal Agent tracks all expenditures by service, and assigns individual "service codes" for MAI funded activities. These up-to-date service utilization expenditures are provided to the Council so it can project the needs of MAI funded services. Since the inception of the program, the MAI programs have overspent their federal MAI allocations, so the RW Program's Part A funds have been allocated by the Council to MAI funded sub-recipients to maintain essential MAI programs.

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; formerly or about to be incarcerated; and women who are pregnant or at risk of dropping out of care. In FY16, 523 clients (up from 464 clients in FY15) received medical case management services under the MAI grant, and the TGA was successful in reaching the program's target populations. Of the 523 clients served through the MAI grant in FY16, 59.3% were African American; 33.1% Hispanic; 3.0% American Indian; 3.3% Asian, and 1.3% Native Hawaiian/Pacific Islander.

3.B).1)a)iv. Use of Data in Planning Process to Increase Access and Reduce Disparities

The Council's Priorities and Allocations Committee (PAC) reviews and evaluates the following data during its regularly scheduled monthly meetings throughout the year: the TGA's Comprehensive HIV/AIDS Services Plans; Needs Assessments; Client Satisfaction Surveys; Unmet Need framework findings; reports from consumer and provider forums; 10-year epidemiology, client utilization and cost trends; 10-year RW

client demographic trends; performance indicators; changes in legislative policies; and changes in availability of other funding sources. The end product of PAC's work is a logical priority service category list, with corresponding funding allocations for both core medical and support services. PAC's proposal for Priorities and Allocations was presented to the Council for review and approval.

One key element in this process is the analysis of RW client service utilization and cost trends, both annually and over a ten-year period. The TGA's RW client-level database collects extensive data detailing each service category by number of clients accessing service, broken down by race, age, gender, race, geographic location, transmission category, insurance status, income, housing status, vital enrollment, incarceration status, HIV/AIDS status, viral load, and other variables. The Council and Fiscal Agent have gone further in their client-level data analysis by developing a series of reports, the Ryan White Annual Statistical Summary Project (RASSP), that include sophisticated queries analyzing the database from 1996 (the inception of the TGA's RW Program) to the present, and provide detailed cross tabulations, such as cost per client by race by transmission by service category, and many other combinations as requested by the Council or Fiscal Agent to make programmatic or funding allocation decisions. In this most recent year, there were over 200 pages of reports, generated from over 80 queries and 70 spreadsheet files.

PAC also analyzes waiting list figures, with focus on those core services that meet urgent client needs, that must be addressed before the client's health status deteriorates and the cost of care increases. Further, PAC reviews service outcomes to determine the efficacy of each RW funded service. The indicators set benchmarks for service accessibility, improvement in health status, service quality, and linkages to primary care. The Council also analyzes the availability of services through other funding sources, including a service capacity assessment of low to no cost health and social service agencies in the TGA, to determine which RW-fundable services are provided by each agency, and each agency's ability to provide services to new referrals.

Use of HIV/AIDS Epidemiology Trends in Priority Setting and Allocations

Since the RW Program's inception in the TGA in 1996, the TGA's epidemiological profile has continued to disproportionately affect specific subpopulations, and is a critical piece in the Council's decision-making processes to determine service priorities, allocations and the Service Category Plan. For example, people of color comprised only 27% of the new AIDS cases in 1994-1995 when the RW Part A Program first started in the TGA. Since then, the percentage of AIDS cases among non-whites has almost doubled, with people of color comprising 54.0% of new AIDS cases between 1/1/14-12/31/16. During the same time, the proportion of new AIDS cases that are Hispanic increased from 6% to 26.2%; and new AIDS cases among African Americans increased from 18% to 19.8%. This disproportionate representation necessitates Part A resources being targeted to the African American and Hispanic communities, in addition to MAI grant funding, in the FY18 Service Category Plan. The proportion of female HIV and AIDS cases also has steadily increased, with women comprising over 16.6% of HIV/AIDS prevalence in the TGA as of 12/31/16, which is almost twice their percentage in 1995.

To decrease the epidemic's impact in the TGA, the FY18 Service Category Plan addresses the critical needs of disproportionately affected populations, such as women, by prioritizing and allocating resources for support services that are key access points for this high-risk populations; such as medical and social case management, emergency financial assistance, child care and transportation.

Use of Unmet Need Data in Priority Setting and Allocations

The TGA's Unmet Needs data was used by the Priorities and Allocations Committee (PAC) to conduct a more extensive analysis of the data to trend the demographic details of the various subpopulations. For example, the PAC was able to breakdown the Unmet Needs Estimate by race, gender, age, transmission category and residential zip code, and to calculate potential costs to the RW program for clients who would likely be new to the care system. To establish priorities and allocations for FY18, PAC applied the percentage of its Unmet Needs Estimate to the average cost of care per client for FY16 to project the potential need in the TGA for all clients needing care. This analysis shows that the RW program served 53.3% of the TGA's People Living with HIV/AIDS in FY16 (2,622 RW clients out of 4,918 PLWH. Applying this FY16 percentage of 53.3% to the out-of-care population in the TGA in FY16 (792 PLWH out-of-care), an additional 422 persons could potentially need access to the RW system of care in FY18 at a potential cost of $300,586 for ambulatory care alone - which averaged $712 per client in FY16. Since the average cost of care per client for *all* services within the RW system was $1,768 in FY16, the potential need rises to as much as $746,096 annually if 53.3% of the anticipated out-of-care clients access the RW system of care in FY18.

Use of EIIHA Data in Priority Setting and Allocations

The Council comprehensively considers the needs and costs of the aware but out-of-care (Unmet Needs population), as well as the unaware population (EIIHA), in determining its priorities and allocations. The Council uses the demographics of the aware but out-of-care population to presume similar demographics of the unaware population and its corresponding needs. Further, the PAC analyzes the EIIHA findings to trend the probable increase in newly diagnosed HIV+ clients in order to provide appropriate allocations for core and support services. Demographic information on newly diagnosed individuals also assists in determining the success of selected outreach efforts to determine if additional funding is needed to expand efforts to reach each target population.

Tracking the annual goals of the EIIHA Strategy and Plan, the Council has updated the demographics of the targeted high-risk populations for testing, as well as the linkage and clinical Continuum of Care outcomes of newly diagnosed populations. This information is incorporated into the Council's Priorities and Allocations process to ensure that the RW services are designed to meet the needs of newly diagnosed and targeted high-risk populations that are overrepresented in the TGA's HIV epidemic.

Use of Women, Infants, Children and Youth (WICY) Data

The State Department of Healthcare Service (DHS), Children's Medical Services Branch, administers the California Children's Services (CCS) HIV Children's program and funds all health care services for each child's HIV disease and complications. The UC Davis Pediatric Infectious Disease Department is the TGA's CCS service provider, and contracts with RW to provide necessary pediatric medical case management and medication adherence, which are services not covered by CCS.

Proportional Allocations to Women, Infants, Children and Youth (WICY) Percentages

As directed by the FY18 Service Category Plan, the "percent of clients accessing services will be reflective of the TGA's proportion of WICY living with HIV/AIDS." This objective assures the ongoing monitoring of allocations and client-level service utilization to verify that WICY are able to access services, and that their service needs are addressed in adequate quantities. To further target WICY, the TGA allocates funding for services exclusively available to women and/or youth (i.e., pediatric treatment adherence, child psychological sessions, family mental health counseling, a female-specific medical case management program, a women's HIV support group, and a field-based child care case management

service). During FY16, the TGA was required to spend a minimum of 19.9% of the total Part A and Part A MAI direct service grant award to target Women, Infants, children and Youth (WICY), which is their representation in the HIV/AIDS epidemic in the TGA. By year-end FY16, WICY expenditures were $998,721, which represented 35.5% of Part A and Part A MAI direct service allocations on Women, Infants, Children and Youth, which exceeded their representation in the epidemic by 15.6%.

Use of Cost Data in Funding Allocation Decisions

Cost data are a necessary tool for the Council's projections of funding needs each fiscal year. The RW Program's client-level database monitors all expenditures by client, service and provider regardless of the type of reimbursement contract. These cost figures are analyzed to provide current and past utilization data for the Council to use in its allocation decision-making process. The Priorities and Allocations Committee (PAC) analyzes the number of unduplicated clients, units of service, total cost and average cost per client over a ten-year trend as a starting point for projected allocation needs. This data is available by service code, which breaks down unique service delivery options *within* a service category and allocation decisions are made at the subcategory level. Used in combination with epidemiological trends, and changes in the availability of other funding sources, these figures provide a close estimate of how much funding will be needed annually for each service category to meet changing service needs.

The Council also analyzes cost data to systematically assess each program's benefit relative to its cost. Due to the TGA's many years of overall funding declines, increasing RW client caseloads, and increasing expenditures for core services, the Council had, in years past, determined that home health care, companion services, hospice, food voucher, utility assistance and psychosocial support categories were no longer feasible. Of the services still funded locally by RW, the Council does not feel that any can be considered discretionary. All funded services are either core services, or support services that are essential to facilitating entry into or maintenance in primary medical care.

Use of Data from other Federally Funded HIV/AIDS Programs

See Attachment 5 for Coordination of Services and Funding Streams Table which details the other sources for HIV/AIDS Care in the TGA. During its Priority Setting and Allocations process, the Council uses these figures to ensure that RW Part A funds are allocated as a last resort for each client and for each service.

3.B.1)a)v. Impact of Changing Healthcare Landscape on Priority Setting and Allocations

During the FY17 priority setting and allocations process, The Council took into consideration the implications of the continuing implementation of the Affordable Care Act (ACA). Estimates of the number of current RW clients eligible for transition into Medicaid and low-cost insurance programs was considered, and the services not covered by new State Insurance Exchange plans was reviewed. For example, the State Exchange plans offer what is labeled as "Medical Case Management," but this is merely a service to refer clients to specialty medical care services. Thus, Council decided that the greatest need for the RW program has become social service case management services, since the services needed by RW clients goes well beyond referral to specialty medical care services, and increased funding was allocated.

Another example of the impact of changing healthcare landscape on priority setting and allocations, is that the Council recognized that oral health care, which is critical to the medical care of HIV+ clients, is not adequately available through other programs, and continued to rate this service category as one of the highest priorities. The Council further determined that, in its aggressive efforts to get eligible clients enrolled in third party insurance, the RW program needed to enhance the emergency financial assistance

service to help clients with medical copayments and deductibles. The Council will continue to monitor changes as they occur with the ACA enrollment process to identify further actions necessary.

How Integrated Prevention and Care Plan Informs Planning Processes

In 2010, there was a consolidation of HIV/AIDS prevention, care and treatment planning bodies to further coordinate efforts within the TGA. Prior to 2010, all testing sites in Sacramento County had been members of the Sacramento Alliance to Prevent AIDS (SAPA), a broad based community planning body integrated with the State of California's HIV Prevention Plan process. The RW CARE Program staff (Parts A and B) and its Planning Council were active members in SAPA and worked together to incorporate prevention policy and plans into its HIV/AIDS care and treatment services. In 2010, these two planning bodies were consolidated and now operate under the RW HIV Health Services Planning Council.

During 2014 and 2015, the TGA went much further in its efforts to integrate prevention and care planning at the RW Part A level, and merged the STD and HIV Surveillance, Prevention and Care and Treatment Units within the Sacramento Division of Public Health. The merger of these units has enhanced the TGA's efforts to identify HIV+ individuals and to provide risk reduction counseling to those at risk of contracting HIV. All Communicable Disease and STD Investigators with Sacramento County Public Health have been cross trained to determine both the HIV and STD status of anyone who has tested positive for either an HIV or STD reportable condition. With the merger, an STD/HIV Stakeholder Group (SacWish) was developed with the goal of intensifying the TGA's HIV and STD prevention, testing and treatment efforts.

3.B.2) Administrative Assessment

3.B.2)a) Assessment of Grant Recipient Activities

The Council, through its Administrative Assessment Committee (AdAC), utilizes an Administrative Assessment Tool to analyze how well a series of 76 standards, within ten rating categories, are met by the FA each year. Twelve standards were not reviewed in FY16, as they relate to procurement activities that only occur in years where a Request for Proposal (RFP) is issued. A semi-annual monitoring process is used to assess progress made towards meeting standards, implementing recommendations, and implementing corrective actions throughout the year. A documentation log tracks all the documentation needed to complete the Annual Administrative Assessment.

The results of the FY16 Administrative Assessment Review Panel showed an overall improvement over FY15. In FY16, 96.2% of the 79 standards reviewed consistently met or exceeded the intent of the standard; 3.8% primarily met the intent of the standard, but left room for improvement; and there were no standards that were not met. Comparatively in FY15, 96.1% of 76 outcomes reviewed consistently met or exceeded the intent of the standard; 2.6% primarily met the intent of the standard but left room for improvement; and 1.3% showed the standard was not met.

The standard that showed the most improvement between FY15 and FY16 was the requirement that the FA complete written corrective action reports to RW service providers in a timely manner. The FA conducted quality management, program and fiscal site visits during FY16, and completed written reports to sub-recipients within 90 days as required.

3.B.2)b) Deficiencies Noted and Status of Grant Recipient Response

In FY16, the Administrative Assessment review panel found that the Fiscal Agent's administrative mechanisms are strong with NO standards not met. The panel determined that Fiscal Agent staff continues

to provide consistently exemplary work, with attention to detail despite FY16 being a particularly challenging year for program reporting requirements and obligations. The review committee did find one area on the Administrative Assessment Review Tool, under Timeliness, that needed clarification and updating, and determined that the indicator needed to be re-worded prior to the FY17 Annual Assessment.

3.B.3) Letter of Assurance from Planning Council Chair (Attachment 6)

3.B.4) Resource Inventory
3.B.4)a) Coordination of Services and Funding Streams
3.B.4)a)i. Public and Private Sources for HIV Care Continuum in TGA (Attachment 5)

See Attachment 5 (Coordination of Services and Funding Streams) for public funding in the TGA for PLWH for FY17, including other Ryan White HIV/AIDS Program funding and Federal, state and local sources of public funding.

3.B.4)a)ii. Gaps in HIV Resources and Services and Actions to Secure them in TGA

Substance Abuse and Mental Heatlh Adminstration (SAMHSA) funding to Sacramento County was significantly reduced in FY 2007, and as a result, outpatient substance abuse treatment, which was formerly funded entirely by the DHHS Alcohol and Drug Division, is now partially funded through RW Part A. In FY16, SAMHSA set-aside funds for HIV programs has been denied in California, and the local health jurisdiction has lost an additional $600,000 in HIV testing funds. The TGA's HIV Prevention Coalition prepared a grant request to the CARES Foundation for prevention funding to help offset this community funding loss, and the Foundation awarded $375,000 to Cares Community Health and its subcontractors for the current year's *Zero New HIV Infections* Initiative. In addition, the CARES Foundation funded prevention efforts of several other local non-profit agencies in the greater Sacramento Region.

To further address gaps in HIV resources in the Sacramento TGA, several non-profit agencies who work to address the HIV epidemic in the region applied to and received funding from the CARES Foundation in 2016 and 2017. Several examples of funding provided by the CARES Foundation follows:

- Cares Community Health received $200K in 2016 and $200K in 2017 for its "Condom Finder Program"
- Planned Parenthood received $82,165 in 2017 for its "Addressing Sacramento Youth's STI Epidemic"
- Life Enriching Communications received $35,000 for its "Heart to Heart Project"
- Safer Alternatives thru Netwroking and Education (SANE) received $56K in 2016 and $56K in 2017 for its "HIV Prevention throgh Expanded Syringe Services" Program and $150K in 2017 for its Medication Assisted Treatment Program
- Community Against Sexual Harm (CASH) recevied $25K in 2016 and $20K in 2017 for its "Testing, Education and Outreach" Program
- Parents, Families of Lesbians and Gays (PFLAG) received $10K in 2016 and 2017 for its "HIVAIDS Local Outreach" program
- Harm Reduction Services (HRS) received $113K in 2016 and $65K in 2017 for its "Safe Points Syringe Access" Program and $113K for its "Project Reach" Outreach Program in 2017
- Cares Community Health received $150K in 2016 and $75K in 20177 for its PrEP Program
- Wind Youth Services received $132K in 2016 and $160K in 2017 for its HIV/STI Street Education Program
- Cares Community Health recvied $9K in 2017 for its Overdose Prevention and Increased Naloxone Access Program in 2017

- Sacramento LGBT Center received $75K in 2017 for its HIV Preventioni and LGBT Health Equity Program

Funding for transportation, housing, residential substance abuse services and emergency financial assistance is significantly short of demand in this community. The Ryan White Part B program for the first time applied for and was awarded Supplemental Part B funds for a fiscal year covering September 30, 2016 through September of 2018. The Sacramento TGA applied for and received this one-time funding to provide housing, food, transportation and residential substance abuse services to its PLWH through September 29, 2018. This supplemental funding is targeting the 7.7% of the TGA's current PLWH who are homeless or in unstable housing.

In the June 2014 local Needs Asessment, Oral Health care ranked high in both service Need (#3) and Service Need/Receive Gap (#2). Given these findings, the HIV Health Services Planning Council increased RW funding for Oral Health Care from $276,580 in 2013 to $416,117 in 2017. With the additional funding allocations, the RW Dental clinic has been able to expand its capacity by purchasing a dental van to accommodate more dental chairs, and dental technicians were hired to provide routine care while dental staff concentrated on more serious dental procedures. Insufficient provider capacity continues, but the wait time for dental services has been substantially decreased as a result of these efforts. The Dental Clinic is currently in the process of an expansion, and expects to have six additional chairs available by the Spring of 2018. With additional funding from Part A, it would then be possible to reduce the current significant waiting list for routine dental services.

SECTION 4: WORKPLAN

4.A. HIV CARE CONTINUUM TABLE AND NARRATIVE

4.A.1) HIV Care Continuum Table (Attachment 7)

See Attachment 7 for the Ryan White Part A Implementation Plan: HIV Care Continuum Table which is comprised of the HIV care continuum, baseline indicators for each stage, the desired target outcome to be achieved during the FY18 project period, and the Ryan White Part A funded service categories to help support achieving the desired outcomes.

4.A.2) HIV Care Continuum Narrative

4.A.2)a) Use of HIV Care Continuum in Planning, Prioritizing, Targeting and Monitoring Resources

The detailed analysis of the HIV Care Continuum, with examples noted above, is currently used in planning, prioritizing, targeting and monitoring available resources in response to needs of PLWH in the TGA. Not surprisingly, most of the same demographic groups that are less likely to be linked to and retained in care in the HIV Care Continuum analysis, also were identified as more highly represented in the TGA's out of care population in its Unmet Need Estimate; Newly Diagnosed Testing data in the Early Identification of Individuals with HIV/AIDS (EIIHA) analysis; and its most recent TGA-wide Needs Assessment as discussed throughout this application. Analysis of CQM data at the RW funded Cares Clinic also has identified several other health disparities among demographic groups within the TGA's HIV Care Continuum.

The RW Council addresses these disparities by allocating funds to services identified as having the greatest unmet needs for the populations with the greatest health disparities. For example, beginning in FY14 the Council increased by five times the amount of funding for emergency financial assistance, housing assistance, and expanded the funding for child care. Enrollment and benefits counseling funds more than doubled, and field-based case management funds were increased. Expansions in funding for

these services were again maintained by the Council for FY18, as these services are most effective at increasing access along the continuum of care, and are more highly utilized by minority demographic groups within the TGA. The Council will continue to monitor service utilization and implement mechanisms to ensure that RW funding continues to reduce identified health disparities among demographic groups.

4.A.2)b) Evaluation of Efforts to Impact HIV Care Continuum in TGA

The HIV Care Continuum is used to improve engagement of PLWH, and to improve outcomes at each stage of the continuum throughout the TGA. By utilizing the HIV care continuum in planning, prioritizing, targeting and monitoring available resources in response to the needs of PLWH in the TGA, the region has had numerous and continual successes in linking and retaining clients in care. These successes are documented by the RW Program's current baseline rates compared not only to the National and California rates, but to the TGA's general HIV+ population rates for the five HHS measures that comprise the NHAS Continuum. The Sacramento Region's RW program exceeds the current national, California, and local TGA HIV general population rates of linking clients to care, retaining clients in care, prescribing ART and achieving viral suppression.

The Planning Council believes that much of the RW Program's success is due in part to the cooperative approach and aggressive outreach conducted by Cares Community Health, the government funded testing agencies in the TGA, and numerous nonprofit agencies dedicated to HIV prevention, treatment and services for PLWH. In addition, the local County Department of Health and Human Services has made major contributions to linking and retaining clients in care. Follows are examples of several of these efforts, and the collaborative approaches used by many organizations, both public and private throughout the TGA, to improve outcomes along the HIV Care Continuum across the TGA:

Diagnosis of HIV Infection. The RW Program and the Sacramento County DHHS Education, Prevention and Testing (EPT) programs operate under the same DHHS Division, and work cooperatively to integrate prevention and treatment for persons living with, or at risk for, HIV/AIDS in the TGA. Planning bodies for these programs were consolidated in FY10 by merging the Sacramento Alliance to Prevent AIDS (SAPA) into the RW HIV Health Services Planning Council (the Council). With the RW CARE Program operating as Fiscal Agent for both Part A and B funding, all services, plans and strategies are coordinated.

In addition to various hospitals and private labs, the TGA has historically had numerous HIV testing, education and prevention sites. Unfortunately, as of July 1, 2009, more than 66% of state funds for testing were eliminated and many county testing sites were closed. Both rural counties of the TGA, El Dorado and Placer Counties, also experienced testing site closures. To ensure that HIV testing and education in the TGA continued, Cares Community Health (Cares) expanded its HIV testing and education services and has been conducting HIV testing using private funding. Cares, which was established as the Center for AIDS Research, Education and Services (CARES) in 1989, transitioned from a Community Health Center to become a Federally Qualified Heath Center (FQHC) in 2015. Through this transition, Cares has maintained itself as the largest provider of services to PLWH in the Sacramento Region and is the primary RW service provider in the three county TGA. Part of Cares Community Health's strategy to maintain its HIV testing and education services has included entering into cooperative agreements with the Sierra Foothills AIDS Foundation (SFAF) to provide testing kits for the TGA's rural counties, and the SFAF has obtained private funding for testing staff. Government-funded testing sites, including Cares Community Health that relies primarily on private funding, are responsible for ensuring that activities to identify HIV+ individuals throughout the TGA are implemented.

The TGA's current strategy, which will continue to be implemented in the TGA's FY18 Service Category Plan, includes enlisting the support of the few private testing providers to cooperate with Cares in its testing efforts. Private testing agencies have strong working relationships with government-funded entities. All public and private testing providers distribute HIV+ Care Packets to newly diagnosed clients; provide or refer clients to post-test counseling; and facilitate the immediate transition of newly diagnosed preliminary positive clients to their private provider if insured, or to Cares or the Sacramento County Public Health Lab for confirmatory tests if uninsured.

Linkage of HIV Clients to Care and Retention in HIV Care. The Council has established, and continues to refine, mechanisms in its Implementation and Service Category Plan that enable newly infected and underserved persons, and disproportionately impacted communities of color, to access and remain in medical care. The TGA's care providers that do HIV testing (noted above) work closely with the Sacramento County DHHS HIV Prevention and Testing outreach providers to work with communities located in those zip codes with the highest number of clients with "unmet need." When clients are newly diagnosed with HIV, many care providers, as well as testing sites, refer clients to Cares where they are screened for eligibility for RW medical services and receive Partner Services and Risk Reduction Counseling, a program which provides immediate access to resource referrals. Due to the TGA's successes in bringing high-risk HIV+ clients into care using a field-based Medical Case Management (MCM) model, the Council has steadily adjusted its Implementation Plan to increase the percentage of MCM funds directed to this model from 30% in FY 2003, to 86.1% in FY18.

These efforts have proven successful in increasing the number of new RW clients in care over the years, especially among historically underserved communities. In the TGA's RW Program, the proportion of people of color (non-Whites) clients has risen from 38% to 50.6% of the total caseload between FY97 and FY16. The FY17 Service Category Plan builds on the TGA's successes over the years: 97.5% of newly diagnosed RW clients met the minimum definition of "Linked to Care" in CY16 by receiving a minimum of one medical visit within three months of diagnosis, a figure that is 45.5% over the State rate for CY14 and 24.9% over the national rate for CY12. (the most recent years with complete data). During CY16, 76.2% of RW clients receiving RW ambulatory care outpatient services in the TGA met the definition of "Retained in Care" by having at least 2 visits per year at least three months apart. This retention in care rate exceeded the State rate by 26.2% and exceeded the national rate by 22.4%. RW funding also has supported linkage to care by hiring additional Enrollment and Benefits Counselors to assist clients in applying for health care coverage through the ACA healthcare reform initiative (Covered California).

Access to Antiretroviral Therapy and Viral Load Suppression. The RW Council continues to prioritize HIV Primary Care, Medical Case Management and HIV/AIDS Prescription Medications to ensure that RW clients not only access HIV care, but remain in care and maintain access to antiretroviral therapy. The TGA's web-based system (SHARE) collects basic medical service utilization data from RW providers. This system tracks clients who receive a service, but are not in ongoing primary medical care, and each provider receives a monthly report with the unique client identifier for all clients out of medical care. Providers are contractually obligated to follow up with these clients to ensure that they overcome barriers and receive primary medical care for their HIV/AIDS. This integrated service model has been achieving successful health outcomes throughout the TGA. For example, in FY16, 82.7% of RW medical care patients had an HIV viral load of less than 200 copies/ML, compared to 81.7% in FY15.

The most common challenge in the TGA's development of its Continuum of Care roadmap has been in identifying and obtaining the data sources required to monitor the TGA's successes or to identify areas

needing improvement. While the TGA has its own client-level database that provides the TGA with current data, it is limited to monitoring RW clients only. National data is available for CY12, and State of California data is available for CY14, the TGA data is available for CY15, and RW data is available for CY16 (with the exception of Linked to Care RW data which was available for CY15). Therefore, comparisons for the Continuum of Care are not covering the same time period and are therefore limited in their analysis.

Another data issue surrounds State surveillance data reporting unknown/unreported viral load counts. The SOA has been cooperative in supplying as much data as is available from State systems, but that data is restrained by backlogs that occur at state and local health jurisdiction levels. It also takes State surveillance systems more than a year to mature, so real-time progress is not always possible to monitor. Statewide systems also may not collect all of the data monitored for the RW Continuum of Care (i.e., the SOA was not able to provide the RW Program with TGA data on the number and percent of persons on ART).

The RW Council continues to analyze numerous relevant data sources and performance indicators of the Continuum of Care to assess changes in client utilization, emerging high-risk populations, the specific needs of these populations, as well as new best practices at the national and state level to improve the TGA's Care Continuum.

For example, beginning in 2015, the TGA coordinated efforts with the California Department of Public Health, Center for Infectious Diseases, Office of AIDS, on two large scale projects: California's Needs Assessment for HIV, and California's Integrated HIV Surveillance, Prevention and Care Plan "Laying a Foundation for Getting to Zero," both of which were just completed in September 2016. This Integrated HIV Surveillance, Prevention and Care Plan not only incorporates the NHAS Continuum of Care Indicators, but assesses the needs identified by the most high-risk populations in California's Needs Assessment for HIV and develops statewide plans and TGA level strategies to overcome barriers to care. The most recent TGA Needs Assessment was completed in 2014, the updated Needs Assessment tool for the TGA was approved in September 2016, and the TGA Needs Assessment will be completed by the end of the current Fiscal Year (February 28, 2018).

4.B. FUNDING FOR CORE AND SUPPORT SERVICES

4.B.1) FY 2018 Service Category Plan

4.B.1)a) FY 2018 Service Category Plan Table (Attachment 8)

The TGA's FY2018 Service Category Plan (Attachment 8), lists the TGA's seven core medical services and nine support services, covering all of Part A funded services for FY18. For each service, the Plan describes one or more service goals with time-limited and measurable program objectives which define service units; number of persons to be served; units of service to be delivered; and estimated cost of meeting each objective. The FY18 Service Category Plan also lists separately the MAI funded service category of Medical Case Management, the only Core Service funded with MAI funds. The MAI Service Category table provides a breakdown of the category by target populations.

4.B.1) b) Service Category Plan Narrative

The TGA's 2018 Service Category Plan includes Minority AIDS (MAI) Initiatives that impact positive health outcomes along the HIV Care Continuum for populations experiencing health inequities. Since the inception of the program, the MAI programs have overspent their federal MAI allocations, so the RW Program's Part A funds have been allocated by the Council to MAI funded sub-recipients to maintain essential MAI programs.

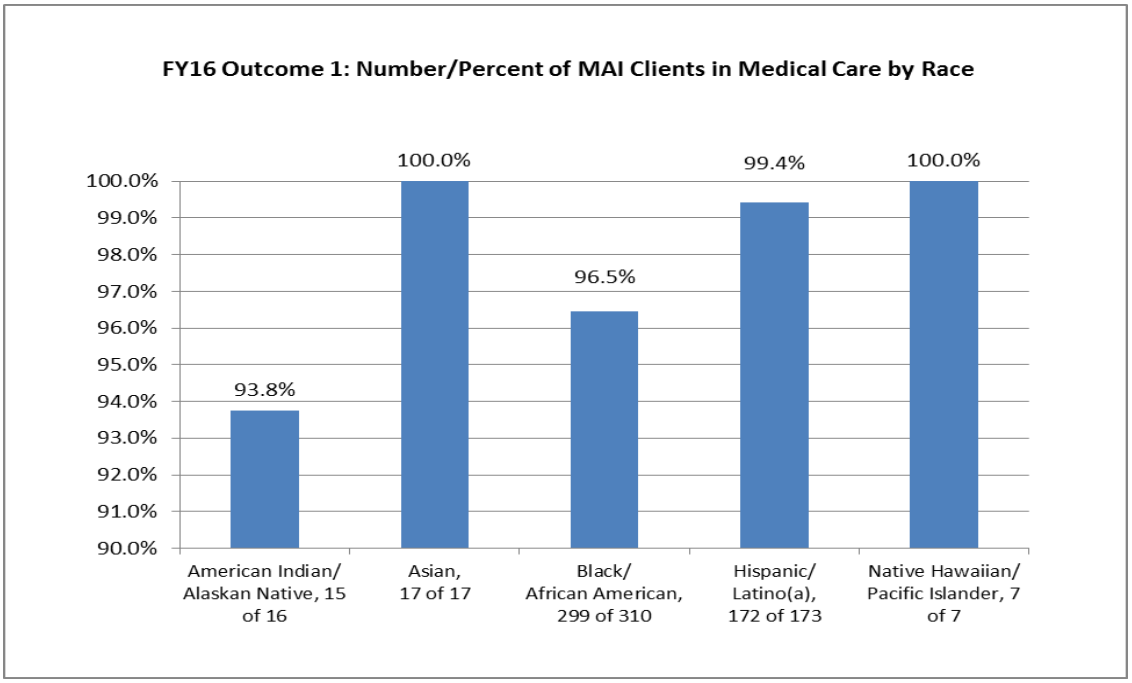
The primary goal of the Sacramento TGA's Minority AIDS Initiative Plan is to enhance access to ambulatory medical care and provide ongoing assistance to keep high risk clients in medical care. A secondary goal of the TGA's MAI Plan is to provide assistance to clients in the area of medication adherence where appropriate for clients on ART. This goal is achieved by providing "field-based" Medical Case Managers who act as a client advocate to fast-track clients into specialty care and other intensive support services provided at the TGA's primary HIV clinic, Cares Community Health. Cares Community Health provides a full range of HIV specialty and primary care services including medical, dental, mental health, outpatient and residential substance abuse, clinical trials, medications, and other supportive services. Follow-up with patients occurs on a regular basis through the Medical Case Management system and continuous quality assurance tracking system. All means are used to ensure that the client's access to medical care is not jeopardized by their social or emotional health. The Medical Case Managers (MCM) throughout the RW system of care follow each client closely for a minimum of six months or until such time the client successfully demonstrates consistent independence.

The HIV Health Services Planning Council allocated MAI funds according to the overall HIV Services Plan based on documented needs as identified throughout this 2018 Application. In the Sacramento TGA's Ryan White system, 19.2% of youth between the ages of 13-24 are out of care compared to the 16.2% of the TGA's overall population of out of care. Therefore, during Fiscal Year 2017-18, one of the MAI contracted agencies transitioned its former MAI clients into regular medical case management and the program is now utilizing the field-based medical case management service to target youth of color between the ages of 13-24, with a special emphasis on youth newly diagnosed within the most recent twelve months.

In the State of California's 2016 HIV Integrated Plan, the Sacramento TGA identified the following populations as those with the highest risk for HIV/AIDS: African Americans, Hispanics, ages 19-24 years old, High-Risk Heterosexuals, and Men who have Sex with Men. The MAI programs currently in place throughout the TGA, and the emphasis of the newly structured components of the MAI program, will address the TGA's Integrated Plan goals for each of these target populations.

African Americans continue to be over-represented in the HIV epidemic in the Sacramento TGA, followed by Hispanics. As of December 2016, the combined number of African Americans and Hispanics accounted for 40.2% of AIDS Prevalence and 42% of HIV Prevalence in the TGA, while their prevalence in the general population represented 7.5% and 20%, respectively.

Since the inception of the MAI program in the Sacramento TGA, the "field-based" model has demonstrated its effectiveness in keeping clients in care and improving their health outcomes. The following chart identifies the health outcomes of the MAI clients at the end of Fiscal Year 2016.



The health outcomes of the clients in the Sacramento RW Minority AIDS Initiative Program continue to exceed the outcomes of their racial counterparts in the RW Program's overall client population. Of the 523 clients receiving MAI Medical Case Management services, 512 or (97.9%) were on ART during the FY16 reporting period.

In addition to the MAI program that targets high-risk communities of color, all service standards developed and adopted by the Council include mechanisms to assure parity of services across subpopulations of PLWH throughout the TGA. These service standards ensure that comprehensive, geographically feasible, culturally appropriate and high quality services are consistently provided by all RW sub-recipients to all eligible PLWH. The RW Program's FY18 Service Category Plan calls for "100% of all RW sub-recipients to comply with the adopted service standards." Compliance with adopted service standards also is required in all provider contracts. To ensure geographic parity of HIV services, the Plan mandates that all services be delivered in the TGA's rural counties. In addition, the rural counties may apply RW allocations to any Council-approved service categories to meet client needs. To ensure parity of services across all demographic categories, objectives are included in every service category that state that the "percentage of clients accessing services will be reflective of TGA's PLWH population in terms of race/ethnicity."

The TGA's sub-recipient contracts also include requirements that require all services be culturally and linguistically appropriate to the TGA's various populations. RW providers that target high risk women through field-based MCM have bilingual staff to address the needs of Spanish speaking clients, and African American and bilingual staff has been added to all levels of service provision. In addition, the RW Fiscal Agent provides RW sub-recipients with free and low-cost cultural competency training opportunities.

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; formerly or about to be incarcerated; and women who are pregnant or at risk of dropping out of care. In FY16, 523 clients (up from 464 clients in FY15) received medical case management services under the MAI grant, and the TGA was successful in reaching the program's target populations. Of the 523 clients served through the MAI grant in FY16, 59.3% were African American; 33.1% Hispanic; 3.0% American Indian; 3.3% Asian, and 1.3% Native Hawaiian/Pacific Islander.

All service standards developed and adopted by the Council include mechanisms to assure parity of services across subpopulations of PLWH throughout the TGA. These service standards ensure that comprehensive, geographically feasible, culturally appropriate and high-quality services are consistently provided by all RW sub-recipients to all eligible PLWH. The FY18 Plan calls for "100% of all RW sub-recipients to comply with the adopted service standards." Compliance with adopted service standards also is required in all provider contracts. To ensure geographic parity of HIV services, the Plan mandates that all services be delivered in the TGA's rural counties. In addition, the rural counties may apply RW allocations to any Council-approved service categories to meet client needs. To ensure parity of services across all demographic categories, objectives are included in every service category that state that the "percentage of clients accessing services will be reflective of TGA's PLWH population in terms of race/ethnicity."

The TGA's sub-recipient contracts also include requirements that require all services be culturally and linguistically appropriate to the TGA's various populations. RW providers that target high risk women through field-based MCM have bilingual staff to address the needs of Spanish speaking clients, and African American and bilingual staff has been added to all levels of service provision. In addition, the RW Fiscal Agent provides RW sub-recipients with free and low-cost cultural competency training opportunities.

There are several Core Medical Services that are prioritized by the RW Council, but are not funded with RW funds because they funded by other Federal, State and local sources. Analysis of these other funding sources is used by the Planning Council to develop the TGA's Continuum of Care; Annual Priorities and Allocations; and the Service Category Plan. To ensure that CARE Act funds are used as the payer of last resort, to eliminate any duplication of services, and to ensure that Part A funds are most effective used to fill service gaps not funded by other sources, the Council voted ***not*** to prioritize or fund the following RW Care Act Core Medical Services:

AIDS Pharmaceutical Assistance (local). California does not have a "state-run" Pharmaceutical Assistance program; rather, it makes the AIDS Drug Assistance Program (ADAP) available to all California counties. Certified ADAP enrollment specialists work on-site at the Cares Community Health, which also operates as a 340B Local Pharmacy Assistance program.

Early Intervention Services (EIS). The TGA had received funding for EIS from the SOA's general fund dollars until 7/1/09, when funding was eliminated. In its place, the State DHS combined the EIS and RW Part B contract into a "Single Allocation Method" contract for Sacramento County DHHS, which was given the authority to use these funds for the TGA's most pressing HIV needs. The EIS program's vital components have remained intact; although other funding sources in the TGA are used for HIV testing.

Home Health Care. Home Health Care is provided by two California State-funded programs: the In-Home Supportive Services Program (IHSS) and the Medi-Cal AIDS Waiver Program. Medicare funds also are provided for home hospice services in the TGA.

Medical Nutrition Therapy. Funded through RW Part B and C funding, this service is offered at Cares. Should Part B and C funds be reduced; Part A would pick up a portion of this service.

4.B.1)c) Core Medical Services Waiver (not applicable to Sacramento TGA)

SECTION 5: RESOLUTION OF CHALLENGES

The following table summarizes the approaches used throughout the TGA to resolve the challenges and barriers identified throughout this application in the larger context of implementing the RW Part Program; and challenges encountered in integrating the HIV Care Continuum into the RW Part A Program:

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	**Resolutions**	**Outcomes**	**Current Status**
Continuum of Care Data Submission and Retrieval			
Changes at the national level in the definitions of "in care" have created costly revisions to the local tracking and database systems. In FY13 "retained in care" was considered one visit per year with a viral load or CD4 count test; but in FY15 the HHS measure for "retained in care" changed to two visits, at least three months apart within 24 months, and CDC revised its definition to >=2 visits 3 months apart in 12 months.	Determining a consistent definition of what constituted a visit (a viral load or CD4 count, a medical visit with an HIV specialist but with no viral load taken on that visit, etc.) has taken time, but the TGA has been successful in its efforts in revising local tracking and database systems.	All local tracking system reports were re-coded to track the Continuum of Care according to HRSA and CDC guidelines.	The TGA has put their new reports into production. Continuum of Care reports are provided to each RW provider monthly and reported to the HIV Health Services Planning Council on a quarterly basis.
Continuum of Care Data Sharing with Community Partners			
In FY14 and FY15, the RW Planning Council identified its Continuum of Care template to specify data sources to be tracked each year, as these needed to be consistent with Continuum of Care Performance Indicators. Targeted efforts have been necessary to obtain agreements with community partners	Once the data sources were finalized, the TGA's FY16 Implementation Plan Performance Outcomes were updated to reflect the changes adopted by the Council and the Fiscal Agent, and were incorporated into all Performance Indicators included in RW provider contracts.	The FY15 and FY16 Performance Indicators had to be adjusted several times due to release of the updated National HIV Aids Strategy (NHAS) indicators which provided updated target goals. The reports provide multiple levels of evaluation as they report on the five key NHAS Continuum of Care indicators for clients by race, age, gender,	RW Providers receive monthly reports showing the progress of their clients along the continuum of care. Included with each indicator is a list of unique client identifiers for clients from their agency, so providers have the means to follow up on clients whose indicators are less than desirable. These reports will continue to be monitored and improved to

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	**Resolutions**	**Outcomes**	**Current Status**
regarding tracking, timing and sharing of data.		transmission and provider.	be most useful to RW providers and the TGA.
Integration of Continuum of Care at State Level			
The process of integrating the full Continuum of Care into the Part A program has been challenging not so much as the TGA level, but at the State level.	California has worked hard to reach a point where the State and local health jurisdictions will all be using the same surveillance data and NHAS indicators to track the Continuum.	The RW Program has the additional benefit of having a quarterly client level data import, so the RW client health information is much more current than State data.	Full integration of the Continuum of Care into the Part A program will continue to be modeled at the TGA level and integrated at the State level.
Integration of Continuum of Care at the Ryan White level			
Tracking the "Diagnosed" Continuum of Care at the local level is challenging because RW doesn't fund HIV testing. The private testing agencies, while cooperative, don't always have resources to track demographic data on HIV testing clients and State surveillance data has reporting delays.	TGA's RW Program has established cooperation and coordination among government funded testers and two of the largest HIV private testers in the area (Cares Community Health and Planned Parenthood).	Through the newly created STD Stakeholders group, the TGA is gaining access to more data from private HIV testers.	The RW Fiscal Agent and Planning Council will continue their outreach efforts to obtain HIV testing data from private testers in the TGA.
Tracking the "Linkage to Care at the RW local level is challenging because State surveillance data is one year behind current RW data. Confirmation of diagnoses within the current year often requires delayed responses from surveillance data. Therefore, the counts of newly diagnosed RW clients are often incomplete.	TGA's RW Program has established cooperation among government funded testers and two of the largest HIV private testers in TGA (Cares and Planned Parenthood). Using data from the testers, the TGA has identified that all but one client newly diagnosed have been linked to care. TGA testing data compared to State surveillance data has identified reporting delays at the State.	Through the newly created STD Stakeholders group (SacWISH), the TGA is gaining access to more data from private HIV testers. Our internal client-level data system has also been revised to capture more accurate "date of diagnosis" data from Ryan White providers.	The RW Fiscal Agent and Planning Council will continue their outreach efforts to obtain HIV testing data from private testers in the TGA.
Resolution of Barriers to Care			

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	Resolutions	Outcomes	Current Status
The impact of overall budget cuts in HIV Related Services during the Recession has a continued impact on PLWH throughout the TGA.	Recent Needs Assessments have identified Transportation as a major barrier to care for PLWH in the Tri-County TGA	The TGA recently applied for and received one-time funding from RW Part B Supplemental funds to provide a Transportation Coordinator position and additional transportation services to clients.	Funding for these services has been provided on a one-time basis for ten months. Additional funding from Part A is requested in this application in order to continue these service enhancements.
The impact of overall budget cuts in HIV Related Services during the Recession has a continued impact on PLWH throughout the TGA.	Recent Needs Assessments have identified Housing as a major barrier to care for PLWH in the Tri-County TGA	The TGA recently applied for and received one-time funding from RW Part B to provide a Model Housing Demonstration program targeting homeless HIV+ clients.	Funding for these additional services has been provided for ten months only. Additional Part A funding from Part A is requested with this application to continue this service.
The impact of overall budget cuts in HIV Related Services during the Recession has a continued impact on PLWH throughout the TGA.	Recent TGA Needs Assessments have identified Residential Substance Abuse treatment as a major barrier to care for PLWH. The RW program hasn't been able to provide this service since experiencing a 22% reduction in Part A in 2007.	The TGA recently applied for and received one-time funding from RW Part B Supplemental funds to provide Residential Substance Abuse Treatment services targeting homeless and out of care HIV+ clients.	Funding for this additional service has been provided on a one-time basis for ten months. Additional funding from Part A is requested with this application in order to continue this service.
The impact of overall budget cuts in HIV Related Services during the Recession has a continued impact on PLWH throughout the TGA.	Recent TGA Needs Assessments have identified Food and Nutrition treatment as a major barrier to care for PLWH. The RW program hasn't been able to provide this service since it experienced a 22% reduction in Part A in 2007.	The TGA recently applied for and received one-time funding from RW Part B Supplemental funds to provide Food and Nutrition services targeting homeless and out of care HIV+ clients.	Funding for this additional service has been provided on a one-time basis for a ten-month period of time. Additional funding from Part A is being requested with this application in order to continue this service expansion.
The Office of AIDS Health Insurance Premium Cost Sharing Assistance Program (OA-HIPP) has been experiencing backlogs in determining client eligibility and allocating premium payments.	The Sacramento Region RW Program added the HIPP and cost sharing service category to its funded priorities beginning in 2015 and expanded the allocations in FY17.	RW clients in the Sacramento TGA who enroll in Affordable Care Act (ACA) have been provided assistance by the RW program for the first month of eligibility as needed.	Funding for this service category has been expanded in FY17 through the reallocation process as a result of increased client demand and need. The Planning Council will evaluate expansion of this service for FY18 after final

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	Resolutions	Outcomes	Current Status
			service utilization figures are obtained for the current fiscal year (FY17).

SECTION 6: EVALUATION AND TECHNICAL SUPPORT CAPACITY

6.A. CLINICAL QUALITY MANAGEMENT(CQM)

6.A.1) Analysis of Performance Measure Data to Evaluate and Address Disparities

The RW Program's SHARE database is a sophisticated system that stores RW client-level data at the service category and point-of-service levels. This data, along with data from the Electronic Medical Record / Client Chart Reviews and on-site sub-recipient reviews, is thoroughly analyzed by the Fiscal Agent and Planning Council, and is compared to State and National benchmark data. These ongoing data measurement and analysis processes assist the Fiscal Agent and RW Planning Council in evaluating disparities in care within the TGA, and assist them with developing strategies, programs and coordination efforts with other service providers in the TGA to reduce and eliminate these disparities.

Minority AIDS Initiative (MAI) funding has been instrumental in the development of models of care which bring the services to the people, rather than requiring the people to seek out the services and overcome barriers to care on their own. When MAI funds first became available, the TGA developed the following medical case management model programs: "Street-Side," "In-Home Visitation;" and "Pre-and Post-Incarcerated Medical Case Management Program." Because the MAI programs were so successful in meeting their goals of reaching the target communities and reducing disparities, these field-based models have been adopted, implemented and expanded into the TGA's overall Medical Case Management system. The RW Program's MAI outcome data was used to continue to improve access to clinical care and to address disparities among PLWH in the TGA. For example, in FY16, the percentage of MAI clients that were in medical care (a minimum of one medical visit per year including a CD4 count, Viral Load test or on ART) follows: 99.4% of Hispanics; 93.8% of African Americans, 93.8% of American Indian/Alaskan Native, 100% Native Hawaiian/Pacific Islander and 100% Asian.

6.A.2) CQM Data to Improve Service Delivery in TGA and Long-Range Service Delivery Planning

CQM and client level data are the cornerstones of strategic and long-range service delivery planning for the TGA. The Fiscal Agent has been ahead of the curve in data collection and analysis of client level data since its RW Program was implemented in 1996, when it developed the Sacramento Eligible Metropolitan Area System (SEMAS - recently renamed the Sacramento HIV/AIDS Reporting Engine - SHARE). During FY08, the Fiscal Agent went further in its analysis of its client-level data, and developed a series of data analysis reports identified as the RW Annual Statistical Summary Project (RASSP). These comprehensive statistical reports provide multi-level cross-tabulations of the TGA's client-level data to determine cost and service utilization by multiple fields (gender, race, transmission, age, income, insurance, housing, co-morbidities, etc.) which are updated annually with additional queries.

The RASSP reports include analyses of client-level outcomes and performance indicators over

extended periods of time, providing analysis of progress in achieving goals since the inception of the TGA's RW Program, and identifying where improvements can be made. This data provided input for the TGA's most recent 2012-2014 Comprehensive Plan, as well as the State of California's 2016 Integrated HIV Surveillance, Prevention and Plan which includes strategic long-range service delivery planning.

In FY16, there were 94 quality of care performance indicators across 155 service categories; setting benchmarks for service accessibility, health status improvement, service quality and linkages to primary medical across the TGA. The FA reviews annual "Medical Performance Indicator Reports" for each RW service provider to identify successes and challenges in achieving CQM at the provider level. This process is effective in continually improving health outcomes for RW clients. The RW Program's CQM service indicator measurements ensure than every service category, whether a core service or support service, has service outcomes that are linked to outpatient medical care health indicators.

The TGA's RW Program has performance measures for all currently funded service categories, and all performance measure data is collected from RW service providers annually; with the exception of Cares Community Health which provides CQM reports to the RW Fiscal Agent on a quarterly basis. The following examples provide CQM service indicators and collection strategies for the TGA, with FY16 aggregate performance noted across services providers:

Medical Case Management. Due to the TGA's successes in bringing high-risk clients into care using a field-based Medical Case Management (MCM) model, the Council has increased the percentage of MCM funds directed to this model from 30% in FY 2003 to 86.1% in 2017, a level which represents 51.1% more than the minimum allocation of 35% established by the Council. While field-based MCM is significantly more expensive than office-based services, it has proven to be a cost- effective method of getting the TGA's most at-risk and underserved clients into care, retaining them in care, and ensuring that they have full access to care continuum.

Outpatient Medical Care. The percent of clients accessing primary medical care was reflective of the TGA's proportion of PLWH by race/ethnicity for African Americans, Hispanics, American Indian/Alaskan Natives and Native Hawaiian/Pacific Islanders in FY16. The mortality rate for RW clients has decreased over the last three reporting periods, from 1.2% in FY14, to 0.5% in FY15 to 0.3% in FY16. The mortality rate of 0.3% is a substantial decrease from the RW Program's FY02 rate of 3.4%, when it was at its highest.

SECTION 7: ORGANIZATIONAL INFORMATION

7.A. GRANT ADMINISTRATION

7.A.1) Program Organization

7.A.1)a) Administration of Part A and MAI Funds within TGA (Attachment 10)

The Chair of the Sacramento County Board of Supervisors, as the Chief Elected Official (CEO) for Ryan White (RW) Part A funds, has delegated authority to Dr. Sherri Heller, Director of the Sacramento County Department of Health and Human Services (DHHS), to administer the RW CARE Program as the Recipient / Fiscal Agent (FA). The STD/HIV Program Manager, Staci Syas, M.P.H., directly supervises the program (*see Attachment 11 for Organizational Chart*). Adrienne Rogers, the RW CARE Program Coordinator and AIDS Director, runs the day-to-day operations of the program. Ms. Rogers has a voting seat on the HIV Health Services Planning Council (Council). Ms. Rogers, an experienced RW Program Coordinator for over eighteen years, has received HRSA training on all the major responsibilities of the CARE Act including RSR reporting, Unmet Need estimates, Clinical Quality Management (CQM),

Performance Outcomes and Indicators, and Fiscal and Programmatic Monitoring. Due to the high quality of her RW CARE Program administration over the years, Ms. Rogers was recognized by HRSA at the 2008 RW All Titles national conference to receive the Hank Carde award for Metropolitan Areas, a high level recognition for leadership and outstanding service. Ms. Rogers and the Human Services Program Planner, Paula Gammell, M.P.A., attend all Committee and Council meetings, providing epidemiological, demographic, needs assessment, financial and service utilization data. FA staff administers the TGA's CQM program, and contracts with consultants as needed to monitor ongoing quality management activities.

Staff vacancies are filled through an established civil service system, or filled by contracts with temporary employment agencies during the recruitment process when expediency is necessary.

7.A.1)b) Administration of Part A Funds by Contractor

The Sacramento TGA does not utilize contractors to administer the Part A funds.

7.A.2) Grant Recipient Accountability

7.A.2)a) Monitoring

Program Monitoring Process

The Fiscal Agent's ongoing fiscal and programmatic monitoring protocol includes both off-site monitoring procedures, conducted at the FA office; and on-site monitoring visits, conducted at each RW sub-recipient's facility, to review all fiscal policies and procedures, audits, and to review completeness and accuracy of financial records. Using a standard Contract Analysis Report, the FA compares financial performance indicators to each sub-recipient's actual performance measures on a monthly basis. The protocols for off-site monitoring of programmatic performance are similar to those for fiscal monitoring, with additional protocol reports that assess quality of care data collected through SHARE. Subrecipienets also are required to submit semi-annual program narratives to the FA, with a cumulative year-end report.

7.A.2)a)i. FY17 Sub-recipient Monitoring, FY17 Findings, Corrective Action Processes and Timeline

In addition to ongoing processes conducted at the FA offices, the FA performs a full fiscal, programmatic and quality management on-site monitoring visit of each sub-recipient every fiscal year. The FA's annual on-site programmatic monitoring includes investigations of CQM through client chart reviews, agency policies and procedures, and agency evaluation systems. Annual performance outcomes are reviewed by the FA to determine if service quality is within acceptable ranges.

The Fiscal Agents' monitoring tools have been revised and incorporate the new CQM activities, as well as the new processes that were available through the data collection system. Additional changes in the monitoring tools also were added to incorporate the new areas identified by HRSA's National Monitoring Standards.

Corrective Action Procedures for Sub-recipients and Summary of Findings for FY17

If significant fiscal or programmatic deficiencies are noted for any sub-recipient based on the Fiscal Agent's monitoring procedures, the FA notifies the sub-recipient and requires, within two weeks, a written Corrective Action Plan that describes: 1) specific activities the contractor will take to remedy the deficiencies; 2) a timeline for completing all activities of correction; and 3) a request for technical assistance as needed. If the Corrective Action Plan sufficiently addresses the Fiscal Agent's concerns, the FA provides follow-up contact with the sub-recipient to monitor progress, and to provide any necessary technical assistance until all deficiencies are corrected. Contract language allows the FA to terminate services within 30 days if corrections are not made for any serious fiscal or programmatic concerns that

would result in an audit exception. Where appropriate, the FA provides TA to assist the sub-recipient with corrective action.

Currently, four out of eight (50%) of full site visits have been conducted in 2017. Each of these site visits resulted in corrective action plans but no major deficiencies were found. The three most common deficiencies noted were: 1) delays in entering client six-month updates into the TGA's electronic database (SHARE); 2) client six-month eligibility updates were scheduled but not yet completed; and 3) sub-recipients were not "inactivating" the clients in the electronic database when clients were no longer in their care. The sub-recipients are provided a detailed corrective action plan listing each client by unique identifier along with the documentation or activity required to be addressed and requested to provide a timeline for the corrective action within two weeks of receipt of the notice. All sub-recipients completed the corrective actions within a two-week period and the corrective action was verified by the RW Program Coordinator. One sub-recipient was identified as needing technical assistance with their Continuous Quality Management Plan and program, and that technical assistance has been scheduled.

Technical Assistance (TA) to Sub-recipients for FY17

As part of its Annual Administrative Assessment process, the FA maintains a Technical Assistance (TA) log to document all TA provided throughout the program year. The FA's TA tracking log for FY16 documented 462 instances of individual TA to providers, averaging 38.5 instances of TA per month. The FY17 TA tracking log documents 261 instances of individual TA to providers, averaging 37 instances of TA per month. The individual TA for FY16, and to date in FY17, involved a wide range of detail, but primarily consisted of responding to inquiries about entries into the web-based data system, either on client intake forms or invoice data entry; interpretation of updated Council approved service standards and CQM issues; HAB information and AAHIV National advocacy updates; authorization of funds allowed under the "other critical need" category; assistance in identifying client resources, medication co-payments and specialty medical care; contract document related issues and requests; SHARE issues; service inquiries; provision of information regarding ADAP; and assistance in developing revised budgets.

Additional TA was provided by the FA to all sub-recipients through the Service Providers Caucus, a mandatory monthly RW sub-recipient meeting. Updates regarding HRSA Policy Guidelines, TGA Service Directives, Poverty Guidelines, and Provider Orientation Manual updates were explained to all RW sub-recipients. The Provider Orientation Manual contains instructions for completing all contractual requirements, as well as documents related to quality and access to care. The FA also sponsored a mandatory training on recent revisions to the Client Intake Form and RSR required fields, documentation of the client eligibility for the Affordable Care Act (ACA), the Continuum of Care and its implications on the TGA. During FY16, the providers received training from the FA on the updated Federal Poverty Guidelines; information on the SHARE database access and password changes; California Department of Public Health (CDPH) training on new Intake Forms; ADAP updates; SHARE invoicing updates; updates on the NHAS, the "Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan" which was co-authored by the Sacramento TGA's local health jurisdiction; and ongoing updates on the ACA.

The RW Fiscal Agent also arranged training sessions for the HIV Health Services Planning Council, which included training sessions on the mechanics of the Planning Council; an update on the All Titles National RW Conference; and a presentation on the Goals and Objectives of the "Zero Together: Integrated Surveillance, Prevention and Care and Treatment Plan." Presentations were provided by six local community non-profit organizations regarding their services and eligibility requirements, and the Planning

Council staff assisted the Council in their sponsorship of several community forums on HIV related topics.

7.A.2)a)ii. Sub-recipient Compliance with Audit Requirements

All sub-recipients must submit financial audits to the RW Coordinator and the DHHS Fiscal Services within sixty days of the end of the Fiscal Year. Notices are sent out by the Department's contract unit reminding each sub-recipient of their audit due date. If audits are not received on a timely basis, the County discontinues payment to the contractor until they are in compliance with the audit submission requirement. Six of the eight (75%) FY17 sub-recipients receive enough Federal funding to fall under the OMB Circular A-133 requirements. Audits first are reviewed by the RW Coordinator and then by the Sacramento County DHHS' Chief Financial Services Officer to ensure that no audit exceptions or serious audit concerns exist. To date, five sub-recipients that were required to have an A-133 compliant audit have submitted their current audits showing no audit exceptions or serious financial disclosures. One sub-recipient has an approved request for an audit submission extension; and that audit will be submitted by 10/31/17. The two sub-recipients not required to have an audit are required by the County to submit audited financial statements; and both sub-recipients also have complied with the County requirement and submitted acceptable audited financial statements. All current sub-recipients also had rigorous financial testing at the time of the RFP review process prior to contract awards.

7.A.2)a)iii. Corrective Actions Taken for Audit Findings

If major audit exceptions are noted, the Sacramento County Auditor-Controller conducts its own audit of sub-recipients, and makes recommendations to the Department Director. If the problem appears to be correctable, the County requires a corrective action plan within a specific time frame. If the problem appears beyond the sub-recipient's ability for correction, the Department's contract language allows the County to immediately terminate the sub-recipient's RW contract.

7.A.2)b) Third Party Reimbursement

7.A.2)b)i. Processes to Ensure Monitoring of Third Party Reimbursement by Sub-recipients

Contract language between the FA and each sub-recipient includes requirements for screening for payer of last resort and application of the TGA's Eligibility standards. In addition, all sub-recipients are required to attend a comprehensive training on Benefits Eligibility Determination at the start of their three-year contract term. The FA sends out updated eligibility information on Federal and State programs as they change throughout the year, including annual updated poverty guidelines. TA sessions also are provided at mandatory monthly RW Service Provider Caucus meetings when those changes require more in-depth training. A RW 6-Month Eligibility Checklist was distributed to all sub-recipients to assist them in identifying all RW eligibility documentation required for client files and documentation of identifying payer of last resort efforts.

7.A.2)b)ii. Eligibility Documentation to Ensure RW is Payer of Last Resort

At intake into the RW system of care, all clients must present HIV verification, proof of TGA residency, and document annual income. The service standard for determining eligibility and share of cost requires that clients up to 300% of poverty are eligible for RW services at a schedule of charges that conforms to HRSA National Monitoring Standards. Six-month updates are required for each client to ensure eligibility. During sub-recipient site visits conducted by the FA, client charts are pulled randomly to verify appropriate documentation of RW eligibility. To provide RW funded services to clients, case files must include denials from the other funding sources, and/or documentation of the lack of an alternative provider. Through the SHARE database, the FA provides quarterly reports to sub-recipients indicating the Client Intake Forms that require updating, allowing the FA to monitor sub-recipient adherence to eligibility updates on a regular

basis.

7.A.2)b)iii. Monitoring and Tracking of Program Income at Recipient and Sub-recipient Levels

To monitor appropriate tracking and use of program income, the FA reviews sub-recipient program income records during on-site visits to ensure that schedule of charges systems are in place and conform to HRSA guidelines; and program fees also are taken into consideration during contract negotiations.

7.A.2)c) Fiscal Oversight

7.A.2c)i. Fiscal Staff Coordination and Accountability

The RW Program Coordinator has responsibility for reporting, reconciling and tracking program expenditures; and the County DHHS' systems have cross check methods to ensure accurate payment and claiming of expenditures. The County's accounting system, COMPASS, records and tracks all expenditures by order number (i.e., Part A has order numbers for administrative, quality management, and direct service expenses). Each service category has an order number for formula, supplemental, MAI and carryover funds. The RW Coordinator reviews each claim to ensure that appropriate order numbers are entered into the County's COMPASS system. Direct Services are reconciled against the SHARE database to ensure accuracy of provider claims. While Sacramento County DHHS has its own Fiscal Department, all reconciliations and tracking of expenditures are the RW Program Coordinator's responsibility, using the RW program's database (SHARE) which includes tracking of direct service expenditures. The Final Financial Report (FFR) is prepared by the RW Coordinator; and the County's Fiscal Manager must review and authorize the final FFR after ensuring that it matches the County's Payment Management system figures.

7.A.2)c)ii. Tracking of Formula, Supplemental, MAI and Carryover Funds

Sacramento County DHHS maintains a coding system that charges expenditures to each specific program and grant. Order numbers are assigned to separately track formula, supplemental, unobligated and carryover funds for each grant, as well as programs within those grants. The RW Coordinator assigns order numbers to each grant's budget; and reviews provider invoices and grant claims to verify accuracy of order number assignment for all expenditures. The database system, COMPASS, provides a clear and up-to-date audit trail of all grant-funded expenditures. In addition, the TGA has procedures in place to ensure that funds are redirected to service categories most in need throughout the year. The FA has authority to transfer funds between service categories during the year, up to 10% or $70,000, whichever is less, as long as the transfer does not substantially change the intent of the Council's Annual Service Category Plan. In addition to the fund transfer, the TGA employs a "Rapid Reallocation" process. At the end of the fifth month of service, the FA notifies sub-recipients that all funds invoiced below 5% of budget will be redirected unless the affected sub-recipients can substantiate the anticipated expenditure of all allocated funds by fiscal year end. The Council's Priorities and Allocations Committee (PAC) reviews reports from the FA to identify funds available for reallocation by service category, as well as justification for additional funds requests. The FA makes adjustments to sub-recipient contracts based on the identified needs and allocations adopted by the Council. This process has been highly effective in reducing carryover at the end of each fiscal year.

7.A.2)c)iii. Sub-recipient Reimbursement Process

The TGA's SHARE database supports online submission of sub-recipient invoices. Each sub-recipient's annual budget is entered into the database with approved allocations for service codes as stipulated in their contract. On a monthly basis, sub-recipients enter data which includes a client's unique identifier, service date, service code and number of units served. The system generates an invoice for the sub-recipient based on the monthly service cost as approved by the FA. The system has several built-in

monitoring protocols which generate error reports and prohibit sub-recipients from submitting invoices that do not comply with contractual requirements or service maximums set by the Planning Council. Once the sub-recipient submits signed invoices, the FA reviews and approves payment, indicating the order number to be charged. All invoices are processed within ten days of receipt of a signed approved invoice and paid within 30 days. The RW Coordinator maintains a log of all invoices sent to the County's Fiscal Department for payment where a record of the check number is maintained along with the date the checks were cashed. Before claims are submitted to the funding sources, the RW FA reconciles the logs and the SHARE database, ensuring that checks have been issued for correct amounts.

7.B. MAINTENANCE OF EFFORT (MOE) and MOE BUDGET ELEMENTS (Attachment 11)