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 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/AIDS (PLWH) in the Part A service area. The impact of the HIV epidemic on the Sacramento TGA continues to grow. Just over the last five years, the number of PLWH in the TGA grew 23.2%, from 4,078 to 5,024 cases of HIV and AIDS. This growth in HIV/AIDS cases was 4 times the growth in the TGA's general population during that same time, 5.9%, from 1,987,834 to 2,105,768, between 2012 and 2017.

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 Management (CQM) 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 72.7% of the TGA's population and 89.1% of the PLWH in the TGA as of 12/31/17. The rural county of Placer accounted for 18.3% of the TGA's general population and 6.9% of PLWH in the TGA and the rural county of El Dorado accounted for 9.0% of the TGA's general population and 3.9% of PLWH in the TGA as of 12/31/17.

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 (2010-2017).

Analysis of the overall trends in HIV/AIDS epidemiology for the three County TGA between the current reporting period (1/1/15-12/31/17) and past reporting periods is skewed by the fact that the reporting methodology for the Sacramento TGA has changed and become more rigorous since previous reporting periods making year over year comparisons challenging. Beginning with the most recent reporting period ending 12/31/16, the TGA is now reporting "diagnosed" data which is more accurate than "reported" data which was used in prior Ryan White Part A Grant Applications. Starting with the 1/1/116-12/31/16 data, the TGA will use "diagnosed" HIV/AIDS incidence and prevalence data only. Beginning with the 2020 Part A Grant Application, the epidemiological trend analysis will be more informative as the TGA's HIV/AIDS epidemiology data for the 1/1/16-12/31/18 reporting period will include only "diagnosed" data.

"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 described above, the analysis throughout the Needs Assessment of this 2019 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.

With these caveats in mind, as can be seen in the first table below, the number of new HIV/AIDS infections (HIV/AIDS Incidence) increased by 4.3% during the last eight years with 2017 having the largest number of new HIV/AIDS cases in the TGA since 2010. Sacramento County, the TGA's urban county, had a small increase of .52% (from 194 to 195 new infections) while the rural county of Placer County had an increase of 90% (10 to 19 new infections). Newly diagnosed HIV/AIDS in the rural county of El Dorado decreased slightly from 4 to 3 cases over the same timeframe.

HIV/AIDS Incidence (New Cases)

HIV/AIDS Incidence	CY10	CY11	CY12	CY12	CY14	CY15	CY16	CY17	% Change CY10-17
El Dorado	4	8	3	4	4	7	5	3	-25%
Placer	10	14	16	14	14	12	17	19	+90%
Sacramento	194	183	190	171	184	155	187	195	+.52%
TGA Total	208	205	209	189	202	174	209	217	+4.3%

As noted in the following table regarding HIV/AIDS Prevalence (total living cases of HIV and AIDS) in the TGA overall, the number of PLWH rose 35.9% between 2010 and 2017, from 3,696 to 5,024 total living cases of HIV and AIDS. The rise in PLWH was experienced throughout the TGA, in the large urban County of Sacramento (+35.6%), as well as two rural counties of Placer (+37.5%) and El Dorado (+25.5%).

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

PLWH Prevalence	CY10	CY11	CY12	CY13	CY14	CY15	CY16	CY17	% Change CY10-17
El Dorado	157	170	174	178	182	185	194	197	+25.5%
Placer	236	249	256	278	296	309	330	348	+37.5%
Sacramento	3,303	3,465	3,648	3,833	4,016	4,188	4,394	4,479	+35.6%
TGA Total	3,696	3,884	4,078	4,289	4,494	4,682	4,918	5,024	+35.9%

Overall, these statistics show that the number of PLWH, as well as the number of new HIV/AIDS diagnoses, continue to rise throughout the Sacramento TGA. These increases have been continuous since the Sacramento Region became eligible for Ryan White CARE Act funds in 1996 when there were only 2,025 People Living with AIDS in the three counties (HIV cases were not tracked at that time).

2.A.1)b) Socio-Demographic Characteristics of HIV Epidemic in TGA
2.A.1)b)i. HIV/AIDS Epidemic: 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 (1/1/15 – 12/31/17 for the TGA, as reported by the California State Electronic HIV/AIDS Reporting System (E-HARS).

As described above, the analysis of overall trends in HIV/AIDS epidemiology for the TGA overtime are skewed by the fact that reporting methodology has become more rigorous, making year-over-year comparisons challenging. The HIV/AIDS epidemiological analysis, comparing the current two-year reporting period ending 12/31/17, to the former reporting period ending 12/31/16 found that HIV and AIDS prevalence in the TGA increased 2.2% since the last reporting period (from 4,918 to 5,024 cases). Specifically, AIDS prevalence increased .07% (from 2,673 to 2,675) and HIV prevalence increased 4.6% (from 2,245 to 2,349 cases). Regarding HIV incidence (number of new HIV cases) the TGA experienced a decrease of 0.7% (from 442 to 439 new HIV cases) and AIDS incidence (new AIDS cases) decreased 15.9% (from 126 to 106 new AIDS cases).

By conducting a more detailed analysis of available data for over the last five year period from the Sacramento County Department of Health Services (DHS) 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 2017 US Census; and 2016 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 7.3% of the TGA's general population in 2016, they were 23.0% of PLWH, 21.4% of new HIV cases (HIV incidence) and 18.9% of AIDS incidence during the current reporting period (1/1/15 – 12/31/17). Although there was virtually no growth among African Americans in the TGA's general population between 2012 and 2016 (0.8) there was a 35.4% increase in the number of African American PLWH from 855 to 1,158 cases. Comparison of the current reporting period ending 12/31/17 to the period ending 12/31/16 found a 3% increase among African Americans in AIDS Prevalence (from 617 to 641 cases). Thankfully, new cases of HIV and AIDS both decreased between the last two reporting periods, by 10% for HIV (from 105 to 94 cases) and 20% for AIDS (from 25 to 20 cases).

Hispanics. Hispanics were the racial group most disproportionately represented among new HIV cases as compared to their representation in total PLWH in in the TGA in 2017: 28.8% of new HIV cases and 19.2% of total PLWH. Over the last five years, between 2012 and 2017, 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 6 times that rate (68.1%, from 573 to 963 cases). This rate of increase in Hispanic PLWH over the last five years was two times the rate of increase in HIV/AIDS prevalence in the TGA overall (68.1% and 32.6%, respectively). Just since the most recent reporting period there was a 14.1% increase in HIV incidence, 2.6% increase in AIDS prevalence and 12.8% increase in HIV prevalence among the Hispanic

population. The increase of 14.1% in new cases of HIV among the Hispanic population is the highest of any racial group in the TGA since the last reporting period.

Whites. As of 12/31/17, Whites were underrepresented among PLWH in the TGA (50.1%) as compared to their representation in the TGA's 2016 general population (54.5%). Since the last reporting period ending 12/31/16, HIV incidence among Whites decreased by 9.3%, AIDS incidence decreased by 13.7%, and total PLWH decreased by .35% (from 2,727 to 2,518 People Living with HIV or AIDS).

Youth and Young Adults. Young adults ages 20-24 were the age group most disproportionately represented among new HIV cases as compared to their representation in total PLWH in the TGA in 2017: 19.2% of new HIV cases and 13.1% of total PLWH. Among youth ages 0-19, HIV prevalence increased by 56.5% (from 69 to 108 HIV cases) between the 2012 and 2017 reporting periods compared to a 46.6% increase in HIV prevalence in the TGA overall during the same timeframe (from 1,602 to 2,349 HIV cases). During the same 5-year period, there was an alarming increase in AIDS prevalence in this age group which grew by 1.6 times (from 34 to 89 AIDS cases), compared to a 22.4% increase in AIDS prevalence in the TGA overall (from 2,186 to 2,675 AIDS cases).

Older Adults. Among adults 45 and older, HIV prevalence increased 40.9% (from 342 to 482 cases) between 2012 and 2017 and the total number of PLWH over age 45 increased 2.8% (from 929 to 955 cases). AIDS prevalence, on the other hand, decreased 19.4% (from 587 to 473 cases). Since the last reporting period ending 12/31/16, PLWH ages 45 and over increased 2.1% (from 935 to 955).

Men who Have Sex with Men (MSM). HIV (not AIDS) prevalence among the MSM transmission category increased 54.1% over the last five years between 2012 and 2017 (from 901 to 1,388 cases). AIDS Prevalence among MSMs increased 21.9% during the same timeframe (from 1,182 to 1,441 cases). The total number of PLWH among the MSM population increased 35.8% (from 2,083 to 2,829 cases). Since the most recent reporting period the number of PLWH among the MSM population has increased by only 4.5% (from 2,745 to 2,829).

Injection Drug Users (IDU). AIDS prevalence among the IDU transmission category increased 4.5% between 2012 and 2017 (from 248 to 287 cases). HIV prevalence increased 8.1% during the same five-year period (from 135 to 146 cases). Thankfully, these figures decreased between the most recent reporting period ending 12/31/16 as compared to the current reporting period ending 12/31/17. AIDS prevalence decreased 1.4% and HIV prevalence decreased 2%, with total PLWH decreasing 1.6% (from 440 to 433). IDUs represented 8.9% of PLWH in the TGA, and MSM/IDUs represented an additional 7.9% of PLWH, as of 12/31/17. Among the TGA's general population, however, the Centers for Disease Control (CDC) estimates that only .3% of the population were injection drug users in 2016,

Men who Have Sex with Men and Inject Drugs (MSM/IDU). AIDS prevalence among MSM/IDUs increased 17.8% between 2012 and 2017 (from 219 to 258), and HIV prevalence increased 12.3% (from 122 to 137 cases) during the same five-year period. The total number of PLWH among the MSM/IDU population increased 15.8% (from 341 to 395 cases) over the last five years. Over the last year, however, total HIV/AIDS Prevalence among MSM/IDUs decreased by 2% (from 403 to 395).

Heterosexuals. AIDS prevalence among heterosexuals increased 21.0% between 2012 and 2017 (from 433 to 524 cases), and HIV prevalence increased 14.2% (from 323 to 369 cases) during the same five-year period. The total number of PLWH among the heterosexual population increased 18.1% (from

756 to 893 cases) over the last five years. Over the last year these increases in HIV/AIDS prevalence continued among Heterosexuals which increased by 3.4% (from 864 to 893).

2.A.1)b)ii. HIV/AIDS Epidemic: Socioeconomic Data

See Attachment 4: Co-occurring Conditions Table for socioeconomic data for the Sacramento TGA's general population as compared to 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. 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. 6.9% of FY17 RW clients (up from 4.8% in FY15) reported themselves as either homeless (5.6%) or in unstable housing (1.2%), as compared to a 2016 homeless/unstable housing rate of 0.22% of the Sacramento TGA's general population. African Americans continued to be significantly overrepresented among homeless FY17 RW clients (32.8%) as compared to a 25.1% homeless rate among RW clients overall.

Poverty. In FY17, 96.6% of RW clients had annual incomes at or below 300% of the FPL, and 74% had annual incomes at or below 100% of the FPL, as compared to 62% of FY16 RW clients with annual incomes at or below 100% of the FPL. These figures show poverty rates dramatically higher among RW clients in FY17 than the TGA's general population of 15.8%. Further, 34.5% of FY17 RW clients reported no income at all, which is higher than the 20.0% of FY16 RW clients with no income and is 9 times higher than the 3.8% of FY13 RW clients with no income.

Insurance Status. In 2017 there continued to be a much higher percentage of RW clients on Medi-Cal than the TGA's general population (60.9% vs. 32.0%). In terms of other health care insurance coverage, such as private insurance or other public insurance, RW clients had these coverage options at a rate ten times lower than the TGA's general population (6.8% vs. 67%).

2.A.1)c) New and Emerging Subpopulations of PLWH

2.A.1)c)i. Identifying New and Emerging Subpopulations, 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 Surveillance Data to Identify New and Emerging Subpopulations

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 54.2%, in the current (1/1/15 - 12/31/17) reporting period, and total HIV and AIDS Prevalence (PLWH) increased from 29% to 49.9% among people of color. Regarding gender, there has been a large increase in the proportion of female PLWH, which has increased from 10% to 16.5% of all PLWH in the TGA between 1995 and 2017. Regarding HIV transmission risk, the percent of new AIDS cases from heterosexual contact more than doubled, from 7% in 1995 to 12.3% in 2017. The MSM transmission category has dropped from 61% of new AIDS cases in 1995 to 50.0% of new AIDS cases in 2017.

In addition to the most recent HIV Surveillance data for 1/1/15 -12/31/17 (see Table 1 in Appendix),

detailed Surveillance data from the California State Office of AIDS (SOA) is provided below for the most recent year of 2017 for newly diagnosed HIV cases. This data is stratified by age, race, gender and HIV transmission category. Regarding HIV transmission categories, the High Risk Heterosexual (HRH) category is defined by California Department of Public Health (CDPH) as including "persons who reported engaging in heterosexual intercourse with a person of the opposite sex of their sex-at-birth, and that partner was known to be HIV positive or engage in an activity that put them at high risk for HIV (e.g., MSM, IDU)." The Sacramento TGA also includes Heterosexuals with Multiple Partners in its definition for High-Risk Heterosexuals.

In addition to stratifying the 2017 data for newly diagnosed HIV cases by various demographic categories, the data below provides the percentage of newly diagnosed HIV cases that were linked to care within one month of diagnosis and the percentage of newly diagnosed HIV cases that were virally suppressed within 1 year of diagnosis. An analysis also is provided to assist with understanding the most current state of the HIV epidemic in the TGA for each subpopulation.

California State Office of AIDS (SOA) 2017 HIV Surveillance Data			
Demographic Exposure Group	Epidemiology New HIV Cases	Linked in 1 month	Virally Suppressed 1 year
TGA Total	n/a	85%	70%
Transmission			
MSM	56%	89%	74%
High-Risk Heterosexual (HRH)	14%	86%	57%
Heterosexual (non-HRH)	8%	83%	88%
IDU	5%	78%	56%
MSM/IDU	5%	86%	44%
White	38%	82%	68%
African American	22%	82%	71%
Hispanic	29%	90%	71%
Gender			
Male	82%	85%	69%
Female	14%	88%	72%
Transgender	3%	100%	83%
Age at Diagnosis			
13-24	25%	82%	70%
25-44	49%	87%	71%
45-64	22%	82%	61%
>65	3%	100%	100%

Mode of HIV Transmission. Among new HIV cases in the TGA, MSMs are the largest group (56%), followed by High Risk Heterosexuals (14%), non-High Risk Heterosexuals (8%) and IDUs (5%).

Linkage to Care by Mode of HIV Transmission. Of the risk groups, Heterosexuals (non-HRH) are least likely to be linked to care in 1 month (83%) followed by High Risk Heterosexuals (86%) and MSM/IDUs (86%). MSM were the most likely to be linked to care in 1 month (89%). All of these rates, with the exception of Heterosexuals (non-HRH), are higher than the TGA's 2017 rate for all risk groups combined (85%).

Viral suppression by Mode of Transmission. MSM/IDUs are least likely to be virally suppressed

within 1 year of diagnosis (44%), followed by IDUs (56%), High Risk Heterosexuals (57%) and MSMs (74%). Heterosexuals are the most likely to be virally suppressed (88%).

Linkage to Care by Race. African Americans and Whites were less likely to be linked to care in 1 month (both 82%) compared to Hispanics (90%) and the TGA overall (85%).

Linkage to Care and Viral Suppression by Gender. Males were less likely than females to linked to care within 1 month (85% vs. 88%).

Linkage to Care and Viral Suppression by Age. PLWH ages 25-44 accounted for the greatest percentage of new HIV cases (49%) and were the most likely to be linked to care (87%) and virally suppressed (71%). PLWH ages 13-24 accounted for the next highest percentage of new HIV cases (25%) with 82% linked to care and 70% virally suppressed. PLWH ages 45-64 were a smaller percentage of new HIV cases (22%) and least likely to be virally suppressed (61%).

Ryan White HIV/AIDS Program (RWHAP) Data to Identify New and Emerging Subpopulations

Comparison of the demographics of the Ryan White client population in relation to the TGA's HIV Epidemiological Surveillance Data is important in helping the RW HIV Health Services Planning Council in identifying new and emerging subpopulations of PLWH. Some highlights of this analysis follow:

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 FY17. People of color rose from 37.7% to 51.2% of RW caseload between FY97 and FY17.

Gender Trends. The total number of RW females increased 78.1% between FY97 to FY17, from 270 to 481 clients.

Mode of HIV Transmission Trends. RW clients reporting heterosexual contact increased nearly 3 times between FY95 and FY17, from 220 to 628 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 23.8% over the most recent 10 years (from 713 to 883) between 2007 and 2017. The number of RW clients ages 13-24 increased by 57.2% from 1997 to 2007 and increased 42.2% between 2008 to 2017 (from 71 to 101).

Unmet Need Data to Identify New and Emerging Subpopulations

Using the Current Method Unmet Need Framework, the TGA identified the three highest out-of-care populations in 2016 as MSMs (51.1%), High-Risk (HR) Heterosexuals (20.5%) and IDUs (10.5%). These three risk groups also ranked the highest among PLWH in the 2017 HIV surveillance data; and ranked as the top three newly diagnosed populations as identified by the 2017 EIIHA data. Unmet Need Data also provides a breakdown of each of these top three out-of-care transmission categories by race, gender and age to gain a greater understanding of the subpopulations of PLWH most likely to be out of care in the TGA and to assist with identifying new and emerging subpopulations as follows:

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%), an age group that represents only 19% of PWLH in the TGA. The remaining 2.8% of out-of-care population were below the age of 19.

New and Emerging Subpopulations of PLWH Identified by TGA

The Sacramento TGA has identified three emerging subpopulations most disproportionately impacted by HIV that require special attention in FY18 and FY19, as described below. These subpopulations were identified through analysis of data from the following sources: a) TGA's 2018 HIV Needs Assessment; b) TGA's HIV/AIDS epidemiological trends; c) data from the California SOA electronic HIV/AIDS Reporting System (e-HARS); d) RW SHARE service utilization and cost data; National HIV/AIDS Strategy data from SOA; e) TGA's 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 Heterosexuals (HRH). The High-Risk Heterosexual category represents the second largest percentage of PLWH in the TGA (17.8%) as of 12/31/17; the second highest population of PLWH with Unmet Need (20.5%) in 2016; and the second highest category of newly diagnosed HIV and AIDS cases (9.6%). Among PLWH in the TGA, High-Risk Heterosexuals have surpassed Injection Drug Users in terms of mode of HIV transmission. As of December 31, 2017, there were close to twice as many High-Risk Heterosexuals living with HIV (893 – up from 864 as of 12/31/16) as compared to Injection Drug Users (433). This gap continued to widen just since the last reporting period ending 12/31/16 when High-Risk Heterosexual PLWH increased by 3.5% and IDU PLWH decreased by 1.6%.

African American Women are one of the target populations within the High-Risk Heterosexual risk group. There were 224 High-Risk Heterosexuals who were African American Females, which represents 26% of High-Risk Heterosexuals in the TGA as of 12/31/16, as compared to African American Females

being only 7.5% of PLWH in the TGA during the same timeframe. African American women represented 41.8% of all women Out of Care in the CY16 Unmet Need data. 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%).

To estimate the size of the heterosexual adult population in California, the State Office of AIDS used California Health Interview (CHIS) data, conducted through the University of California, Los Angeles (UCLA), 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 High-Risk Heterosexuals in the TGA in 2016.

In the RW Program there continues to be an increase in the number of clients reporting heterosexual contact as their HIV mode of transmission. 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 2017 (7% vs. 17.8%). The High-Risk Heterosexual category represents the second largest percentage of PLWH in the TGA as of 12/31/17. 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 racial group among FY17 RW clients was African American at 40.9% which is much higher than the 23.0% of African American PLWH in the TGA as of 12/31/17. The second largest racial group among FY17 RW clients with heterosexual contact as mode of HIV transmission was Whites (38.4%) which is lower than their representation among PLWH in the TGA overall (50.1%). Hispanics were only slightly underrepresented among heterosexual RW clients (16.1%) as compared to their representation among PLWH in the TGA (19.2%) as of 12/31/17. Asian/Pacific Islander heterosexuals are closely represented among FY17 RW clients as compared to PLWH in the TGA overall (3.5% vs. 4.0%). In FY17, 331 females in the RW system of care were infected with HIV via heterosexual contact (representing 52.7% of all RW clients infected by heterosexual contact), which is higher than their representation among PLWH in the TGA as of 12/31/17 (16.5%). The 44.3% of female FY17 RW clients who were African American was much higher than the 25.0% of the total RW population who were African American and the 7.3% of the TGA's population who were African American.

In FY17 there were several RW service categories in which the High-Risk Heterosexual transmission category had higher cost per client that the cost per RW client overall, as follows: mental health services ($827 vs. $662), housing services ($5,784 vs. $5,106), health education/risk reduction ($341 vs. $296), and non-medical case management services ($178 vs. $163). In FY17, 44.3% of the female RW clients were African American (up from 34.9% in FY16) vs. 19.8% of the male clients. Notably, the 44.3% of females who were African American was much higher than the 25.0% of the total RW population and 7.3% of the TGA's population who were African American in 2017.

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. Most challenging is the fact that there is not a consistent understanding as to what is considered high-risk sexual behavior and more education among the general population is needed regarding this important issue.

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. Regarding youth ages 0-19 years old, HIV prevalence increased by 56.5% (from 69 to 108 HIV cases) between the 2012 and 2017 reporting periods compared to a 46.6% increase in HIV prevalence in the TGA overall (from 1,602 to 2,349 HIV cases). During the same 5-year period, there was an alarming increase in the number in AIDS prevalence in this age group. The number of AIDS cases among youth ages 0-19 grew by 1.6 times (from 34 to 89 AIDS cases), compared to a 22.4% increase in AIDS prevalence in the TGA overall (from 2,186 to 2,675 cases).

Although this trend is occurring throughout the entire youth and young adult population, there is a disproportionate impact on Hispanic and African Americans ages 13-24. For example, in FY17, 40% of RW clients ages 13-24 were African American (40 out of 101) compared to 25% of RW clients being African American overall (623 of 2,495). Hispanic youth also are disproportionately impacted. In FY17, 30% of RW clients ages 13-24 were Hispanic (30 out of 101) compared to Hispanics being 20.7% of RW clients overall (517 of 2,495).

Within the youth and young adult population, the target group for the Sacramento TGA is youth ages 13-24 years old, as TGA data show that, regardless of mode of HIV transmission and regardless of race, PLWH ages 13-24 are less likely to be virally suppressed and are less likely to be retained in care than older populations of PLWH across the TGA. Data from the California State Office of AIDS shows that for 2017 PLWH ages 13-24 were less likely to be virally suppressed (73%) than PLWH ages 25-44 (82%), PLWH ages 45-64 (91%) and PLWH ages 65+ (97%). Further, PLWH ages 13-24 were less likely to be retained in care (56%) than PLWH ages 25-44 (64%), PLWH ages 45-64 (74%) or PLWH ages 65+ (83%)

Moreover, PLWH ages 13-24 in the Ryan White system of care had several outcomes along the HIV Care Continuum that were worse than those outcomes for RW clients overall in 2017. For example, RW clients ages 13-24 were less likely to be virally suppressed (70.3%) compared to RW clients overall (85.7%). Further, in the FY17 RW system of care, only 27.5% of clients ages 20-24 years old were retained in care compared to 70.3% of the RW population overall. There clearly is more work to be done throughout the TGA to ensure that youth between the ages of 13-24 who were out of HIV medical care in 2017 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 age groups, the RW Program found that youth ages 13-24 utilized almost half of all RW service categories at rates higher than RW clients overall. For example, in FY17 RW clients ages 13-24 had higher average service expenditures per client ($2,870) compared to RW clients overall ($2,148). These increased costs per RW clients ages 13-24 were found in the following service categories where the average cost per client ages 13-24 was higher than RW clients overall: medical case management ($2,353 vs. $974), outpatient medical care ($1,200 vs. $531) mental health services ($813 vs. $662), oral health care ($1,907 vs. $1,113), residential substance abuse services ($6,263 vs. $5,398), emergency financial assistance ($779 vs. $306) and health education ($344 vs. $296), showing increased service demand and

increased access to care for this high-risk population. In FY17, 44.6% of RW clients ages 13-24 accessed mental health services (45/101) compared to 29.6% of RW clients overall (738/2495). 49.5% of clients ages 13-24 accessed medical case management services (50/101) compared to 46.1% of RW clients.

Men who Have Sex with Men (MSM). MSM continued to represent the highest percentage of PLWH (56.3%) in the TGA as of 12/31/17. HIV (not AIDS) prevalence among the MSM transmission category increased 54.1% over the last five years between 2012 and 2017 (from 901 to 1,388 cases). AIDS Prevalence among MSMs increased 21.9% during the same timeframe (from 1,182 to 1,441 cases). The total number of PLWH among the MSM population increased 35.8% (from 2,083 to 2,829 cases). Over the last year, since the most recent reporting period ending 12/31/16, the total number of PLWH among the MSM population has increased another 4.5% (from 2,745 to 2,829 PLWH).

In addition to PLWH with MSM as HIV mode of transmission, the MSM/IDU risk group, which continues to emerge as a disproportionately affected population, also needs to be included in the analysis of MSMs. AIDS prevalence among MSM/IDUs increased 17.8% between 2012 and 2017 (from 219 to 258 cases), and HIV prevalence increased 12.3% (from 122 to 137 cases) during the same five-year period. The total number of PLWH among the MSM/IDU population increased 15.8% (from 341 to 395 cases) over the last five years. Over the last year, however, total HIV/AIDS Prevalence among MSM/IDUs decreased by 2% (from 403 to 395) cases.

In addition to representing the highest percentage of PLWH in the TGA, the MSM population represented the highest percentage of PLWH with Unmet Need (51.1% in 2016), and the greatest number and percent of newly diagnosed (56.0%) in 2017. Continuum of Care data for the TGA shows that MSM/IDUs, a subset of MSMs, were less likely to be linked to care (78.0%) than MSMs (89%) in 2017. In addition, among newly diagnosed PLWH in the TGA, MSM/IDUs (44%) and MSM (74%) were less likely to be virally suppressed within 12 months of diagnosis than Heterosexuals (88%). Within the FY17 RW Program, MSMs were less likely to be retained in care (65.1%) than IDUs (87.3%).

Although the retention in medical care rate for MSMs in the FY17 RW program is in need of improvement, there were several RW service categories in which the MSM transmission category had higher cost per client that the cost per RW client overall, as follows: residential substance abuse services ($6,348 vs. $5,398), outpatient substance abuse services ($831 vs. $720), housing services ($5,207 vs. $5,106), oral health care ($1,125 vs. $1,113), health insurance premium assistance ($714 vs. $674) and emergency financial assistance ($341 vs. $306).

In addition, there were several RW service categories in which the MSM/IDU transmission category had higher costs per client than RW clients overall, as follows: emergency financial assistance ($354 vs. $306), health insurance premium assistance ($915 vs. $609) and oral health care ($1,295 vs. $1,113).

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

HIV/AIDS Prevalence rose 35.5% in the TGA between 2012 and 2017, from 3,708 to 5,024 PLWH.

The rise in People Living with HIV (PLWH) is occurring throughout the TGA, in the large urban County of Sacramento (+28.5%) from 3,484 to 4,479 PLWH, with even larger increases in the rural counties of El Dorado and Placer (+79.0%) from 304 to 545 PLWH over the last five years.

Regarding new AIDS infections (AIDS incidence) in the rural counties of the TGA (El Dorado and Placer Counties) there has been a significant 183% increase, from 6 to 17 new AIDS cases. In the urban county of Sacramento, however, there have been decreases in AIDS incidence over the last five years, from 301 down to 89 new AIDS cases between 2012 and 2017 reporting periods. Overall, these statistics show that while there is some success in reducing the spread of new HIV/AIDS cases in Sacramento County, that has not yet happened in the rural counties of the TGA.

The Sacramento TGA's Ryan White Program experienced an increase of 240 new (never been served in the TGA) clients in the RW Program during FY17. This is a decrease from the 345 new RW clients in FY16, but very close to the number of new clients seen by the RW program in 2015 (218 new clients). It will be important for the RW program to keep a close watch on the number of new clients continuing to enter the RW program in FY18 and FY19.

These increases in the RW client population in the Sacramento TGA over the last five years, including the more 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 (ACA). Due to the limited availability of HIV specialists in the health care plans under the ACA, 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 PLWH 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 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 and which subpopulations have increased needs for outreach efforts and services related to Diagnosis, Linkage to Care, Retention in Care and 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 Sacramento TGA.

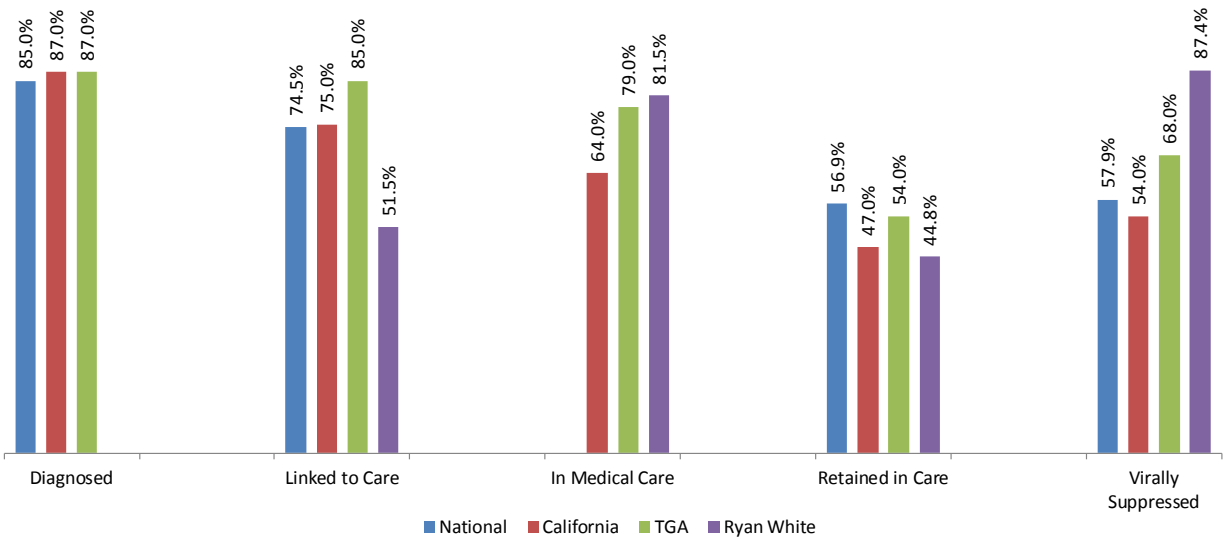
2.A.2) HIV Care Continuum

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) In Medical Care; 4) Retention in Care; and 5) Viral Suppression. The TGA's RW Program's successes and challenges are 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). Data sources used for the following graph includes many data sources and definitions as follows:

- 2014 national figures: National HIV/AIDS Strategy 2020, released May 2018
- "Diagnosed" for the TGA is calculated estimate based the actual CY17 rate for California
- CY17 California and TGA: E-Hars Surveillance System, California State Office of AIDS, August 2018
- RW clients in Medical Care (defined as having at least one viral load or CD4 test within 12 months): Sacramento TGA SHARE Client level database FY 2017 as of August 2018
- "Linked to Care" is defined as newly diagnosed with at least one CD4, viral load or HIV-1 genotype test within 30 days of diagnosis
- "Retained in Care" had =>2 visits per year at least three months apart during the 12-month reporting period
- RW Programs do not Fund Testing, and therefore cannot report "Diagnosed"

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



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 smaller proportion of PLWH with a new HIV diagnosis were linked to HIV care within one month following diagnosis in the RW program in FY17 (51.5%) than in California in CY17 (75.0%), the nation in CY14 (74.5%) or TGA in in CY17 (85.0%). This data has been used by the outpatient medical care clinic currently funded by the RW program to change their operating systems to provide for an on-call

physician to be available each day for immediate appointments for newly diagnosed clients. As a result, the number of newly diagnosed clients linked to care within 30 days has substantially increased during the FY18 RW program.

- RW clients were more likely to be in medical care in FY17 (81.5%) than PLWH in the TGA during FY17 (79.0%) or in the State of California (64.0%) during CY17.
- RW clients were less likely to be retained in care in FY17 (44.8%) than PLWH in the TGA during CY17 (54.0%). The Retained in Care statistics are skewed by the fact that the RW program has not yet finalized its reporting methodology to capture a RW client's second visit in the retention in care report if it falls outside a 12-month reporting period. Programmers are currently working on this effort and expect it to be corrected during 2018. Evidence that the low retention in care figures are a reporting problem, rather than a service provision problem, is demonstrated by the high viral load suppression rates of RW clients (87.4%), higher than National, State and TGA viral suppression rates.
- A smaller proportion of RW clients were retained in care than were nationwide in CY14 (56.9%) and in California in CY17 (47.0%) (see bullet above for explanation).
- A greater proportion of RW clients in FY17 were virally suppressed (87.4%) than PLWH nationwide during CY14 (57.9%).
- PLWH in the TGA were more likely to be virally suppressed (68.0%) than in California (54.0%) in CY17.

The data show the following disparities among HIV transmission, age, and race among TGA. PLWH and RW clients in FY17:

Age Disparities

- Younger RW clients are less likely to be virally suppressed than older clients. Clients aged 13-19 and 20-24 had viral suppression rates of 73.7% and 68.6% respectively, while clients aged 45-59 and 60+ had viral suppression rates of 86.6% and 90.1% respectively.
- In the TGA, newly diagnosed PLWH age 45-64 (61%) were less likely to be virally suppressed within 12 months of diagnosis than all other age groups (70-100%).
- In the TGA, PLWH age 13-24 (73%) and 25-44 (82%) were less likely to be virally suppressed than those age 45-64 (91%) and 65+ (97%).
- In the TGA, PLWH age 13-24 (56%) and 25-44 (64%) were less likely to be retained in care than those age 45-64 (74%) or 65+ (83%).

Racial Disparities

- Hispanic RW clients were more likely to be virally suppressed (85.4%) than African-Americans (53.6%) or Whites (50.1%).

Transmission Disparities

- RW IDUs were more likely to be retained in care (87.3%) than MSM (65.1%) or Heterosexuals (63.2%).
- In the TGA, IDUs (60%), MSM IDUs (78%) and Non-HRHs (79%) were less likely to be linked to care than MSMs (89%).
- In the TGA, newly diagnosed PLWH IDUs (56%), MSM IDUs (44%), MSM (74%) and HRHs (57%) were less likely to be virally suppressed within 12 months of diagnosis than non-HRHs (88%).

Viral Suppression Rates for Disproportionately Impacted Minority Populations

Follows is a more in-depth analysis of the Continuum of Care data for Sacramento County, which accounted for 89.1% of PLWH in the Sacramento TGA as of 12/31/17 and is the county with the most detailed data currently available. The three most disproportionately impacted minority populations that have experienced the greatest health disparities among PLWH in 2017 include High Risk Heterosexuals; Youth and Young Adults (ages 13-24); and Men who have Sex with Men (MSM).

High Risk Heterosexuals (HRH)

- Newly diagnosed HRH's (57%) were less likely to be virally suppressed within 12 months of diagnosis than non-HRHs (88%)
- Female Asian HRHs (82%) were more likely to be retained in care than male Asian HRHs (69%)

Youth and Young Adults (ages 13-24)

- PLWH ages 13-24 (73%) were less likely to be virally suppressed than those ages 45-64 (91%) and 65+ (97%)
- PLWH age 13-24 (56%) were less likely to be retained in care than those age 45-64 (74%) or 65+ (83%)
- African American MSM ages 13-24 (80%) were less likely to be linked to care in the first month after diagnosis than White MSM ages 13-24 (100%)

Men who have Sex with Men (MSM)

- African American MSM were less likely to be virally suppressed (80%) than White MSM (91%)
- Asian MSM (63%) and African American MSM (64%) were less likely to be retained in care than White MSM (73%)
- African American MSM (88%) were less likely to be linked to care than Asian MSM (100%)

2.A.3) 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, Table 2: Co-Occurring Conditions Table. The Co-Occurring Conditions Table provides a quantitative profile of FY17 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. Follows is an analysis of HIV epidemiology data, RW client data and TGA population data shows the disproportionate impact of comorbidities on PLWH served through the RW program, as compared to the TGA's general population:

2.A.3)a) Hepatitis C Virus

The Hepatitis C rate among FY17 RW clients was significantly higher than the TGA's general population in 2017 (13.4% vs. 1.01%). Moreover, 16.9% of the TGA's 2018 Needs Assessment 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 FY17 RW clients and 2018 Needs Assessment respondents 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 ($2,600 vs. $2,148)

2.A.3)b) Sexually Transmitted Infections (STIs)

Data from the California Department of Public Health show that the TGA's general population has

some of the highest STI rates in California. In 2016, 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 81.5% of the FY17 RW caseload became infected with HIV through sexual contact.

Chlamydia. New Chlamydia cases in the TGA's general population increased by 67.6% (from 6,765 to 11,339 cases) between 2009 and 2016. Just in the last year, between 2016 and 2017, new Chlamydia cases increased 14%, from 9,951 to 11,339 cases in the TGA. 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 FY17 RW clients, the number of cases of Chlamydia was almost 3 times the number of Chlamydia cases in FY15 (42 vs. 15 cases).

In Sacramento County (where over 90% of the TGA population lives), STDs disproportionately impact teens and young adults, especially females. For example, the Sacramento County-wide Chlamydia rate in 2017 was 645 per 100,000, but among teen females aged 15-19 it was 3,383 per 100,000. Among young adult females aged 20-24, the Chlamydia infection rate was 3,864 per 100,000. African American females also were disproportionately impacted – their Chlamydia infection rate was 1,848 per 100,000 the highest among all ethnic groups.

Gonorrhea. Gonorrhea had similar patterns of disproportionate impact among youth, females and African Americans. The number of Gonorrhea cases in the TGA increased 69.8% between 2010 and 2016 (from 1,969 to 3,344 cases). Just in the last year, between 2016 and 2017, there was a 4.3% increase (from 3,205 to 3,344 cases). Among RW clients the number of Gonorrhea cases increased from 30 to 53 (76.7%) between 2015 and 2017 (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 FY17 was much higher than the rate in the TGA's general population (2.12% vs. 0.18%). 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 with procedures performed by a gynecologist.

Syphilis. The number of new Syphilis cases in Sacramento County increased over 3 ½ times between 2012 and 2017 (from 147 to 517 cases). In FY17, the number of RW clients treated for Syphilis was 71.7% higher than in FY15 (237 vs. 138 cases). The 237 reported Syphilis cases among FY17 RW clients is an alarming 45.8% of all reported Syphilis cases in the Sacramento TGA, and 9.5% of the total FY17 RW caseload, which is well above the rate in the TGA's general population (0.025%) as reported by California Department of Public Health, STD Control Branch 2017. A most disturbing trend in the TGA is the increasing number of cases of congenital Syphilis, which increased from 3-fold between 2013 and 2017, from 2 cases in 2013 to 6 cases in 2017. In the TGA's 2018 Needs Assessment, 11.3% of respondents reported a new diagnosis of Syphilis, which is over 2 times the rate of reported Syphilis among 2013 Needs Assessment respondents (5%). 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.3)c) Mental Illness

There is an extremely high rate of mental illness among RW clients, at 29.6% in FY17, as compared to

a 19.4% rate of mental illness in the TGA's general population in 2016 as documented by the Substance Abuse and Mental Health Services Administration (SAMHSA) 2016. In FY17, 29.6% of RW clients accessed mental health services These 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 FY17, the average annual cost per RW client ages 13-19 for mental health care services was over 18.4% higher than the cost per RW client overall ($813 vs. $662) and 29.4% higher for females than for males ($868 vs. $613).

2.A.3)d) 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 0.3% based on the national IDU rate (CDC 2014). Injection drug use alone, or in combination with other risk factors, accounted for 7.8% of HIV incidence (new HIV infections), 8.5% of AIDS incidence, 20.5% of AIDS prevalence, 12.2% of HIV prevalence, for a total of 16.5% of PLWH in the TGA as of 12/31/17. In comparison, the RW program served a smaller proportion of clients with IDU as mode of HIV transmission in FY17 (12.6%) as compared to the TGA's HIV/AIDS epidemiology data (10.8% RW clients were infected with HIV through IDU alone, 1.8% were infected through IDU and MSM risk factor). These figures demonstrate 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 FY17, the average cost of care for the RW IDU population was 29.3 % higher than that of the overall RW population ($2,503 vs. $2,148), 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)e) Homeless/Unstably Housed

6.9% of FY17 RW clients (up from 4.8% in FY15) reported themselves as either homeless (5.7%), or in unstable housing (1.2%), 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 36.0% of the RW clients who were homeless, 25.0% of the overall RW population, and 7.3% of the TGA's general population in FY17. In addition, PLWH in the TGA's 2018 HIV Needs Assessment survey were asked about their current living arrangements. 18.7% of survey respondents reported that they were currently homeless or in unstable housing (living on the street, in a car or in a shelter) during the last two years. Homeless Needs Assessment survey respondents reported unmet needs for several Ryan White service categories as compared to survey respondents overall. For example, 34% of homeless survey respondents reported an Unmet Need for AIDS Drug Assistance Program (ADAP) vs. 21% of survey respondents overall. 63% of homeless respondents indicated an Unmet Need for community-based health Services vs. 50% of respondents overall. Other service categories in which homeless survey respondents had greater Unmet Needs than overall respondents include housing (59% vs. 48%), medical case management (41% vs. 29%), medical transportation (47% vs. 37%), oral health care (47% vs. 27%), referral for healthcare/supportive services (34% vs. 21%), and inpatient substance abuse treatment (41% vs. 31%).

Given the high service need for the homeless population living with HIV/AIDS, the impact on the costs of care for the RW CARE Program is significant. In FY17, the average cost per RW client who was homeless was 52.4% higher than the average cost per RW client who was in stable or permanent housing ($3,182 vs. $2,088). Further, RW clients who were in unstable housing had an average annual cost per

client of $4,124, which is over two times the annual cost of care for RW client in stable housing ($2,088). These cost figures show that the outreach efforts to the homeless population living with HIV/AIDS have been more effective over the last year.

2.A.3)f) Former Incarceration

The most recent data from the Bureau of Justice Statistics (2015) shows that 0.8% of California prison inmates were living with HIV. In FY17, 16 RW clients (0.6%) indicated on their intake form that they had been released from a correctional facility within the past 12 months (up from 11 RW clients in FY16). Although the number of recently released RW clients is not high, the cost implications to the RW Program in FY17 were high. The average cost of care for recently released RW clients was over twice as high as the average cost per RW client overall in FY17 ($5,382 vs. $2,148). 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 and receives direct referrals as PLWH are released in the TGA.

The TGA conducted a targeted Needs Assessment (NA) for the recently released HIV+ population to identify the service needs and gaps of twenty-one incarcerated PLWH in the TGA in 2012. 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 often available for this population.

2.A.3)g) 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) and decreased again to 69 cases in 2017 which is still above its 2012 rate. Within the FY17 RW program, there were 12 clients treated for latent or active TB (0.48% of RW clients) which is exponentially higher than the 2017 TB rate in the TGA's general population of .003%.

2.A.4) Complexities of Providing Care

2.A.4)a) Impact and Response to RW Part A Funding Changes

2.A.4)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 70.6%, from 1,462 to 2,495 clients. These increases in RW client caseload, coupled with flat 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 average 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 (15 days for appointments); child care medical case management (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); HOPWA (7 days); Medical Nutritional Therapy (1 – 2 days); Health Insurance Premium and Co-pay Assistance (1 -5 days) and outpatient substance abuse treatment services (7 days).

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 and more recent availability of one-time RW Part B Supplemental funds.

2.A.4)a)ii. Response to Funding Changes: Cost Containment and Transitional Planning

Regarding transitional planning, the Council prepares several funding 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 directives annually to determine adjustments as necessary.

2.A.4)b) Poverty and Healthcare Coverage Among PLWH

The following table provides the TGA's current data on poverty and health care coverage for Ryan White clients in the Sacramento TGA as compared to the TGA's General Population:

HEALTH INSURANCE AND INCOME STATUS Sacramento Region RW Clients and TGA General Population 2017			
Ryan White Clients			*TGA General Population*
HEALTH INSURANCE STATUS			
Medicaid	1,514	60.9%	32.0%
Medicare	445	17.9%	18.2%
Medicare and Medicaid	45	1.8%	3.6%
No insurance (RW included)	121	4.9%	9.5%
Private insurance	344	13.8%	66.7%
Other insurance	47	1.9%	0.3%

HEALTH INSURANCE AND INCOME STATUS Sacramento Region RW Clients and TGA General Population 2017			
INCOME STATUS			
No Income	860	34.5%	NA
100% of Poverty	986	39.5%	14.0%*
101-138% of Poverty	223	8.9%	6.8%
139-250% of Poverty	294	11.8%	17.2%
251-300% of Poverty	48	1.9%	7.1%
Over 300% of Poverty	85	3.4%	54.8%

*includes general population with no income

The percentage of 2017 Federal Poverty Level used to determine RW eligibility in the 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.).

As can be seen in the chart above, very few RW clients have private healthcare insurance. Only 13.8% of FY17 RW clients had any form of private insurance, as compared to 66.7% in the TGA's general population in 2017. 86.2% of FY17 RW clients had only public health insurance or had no other form of insurance and relied solely on the RW CARE Program for HIV/AIDS care and treatment services. 80.6% of RW clients had public insurance (Medicaid, Medicare or Medi/Medi) as compared to 53.8% of the TGA's general population.

Regarding income status, as shown in the chart above, the vast majority of FY17 Ryan White clients were living in poverty. 74% of RW clients either had no income (34.5%) or were living at 100% of poverty (39.5%) as compared to 14.0% of the TGA's general population with no income or living at 100% of poverty. Only 3.5% of RW clients were living above 300% of poverty as compared to 54.8% of the TGA's general population.

2.A.4)c) Factors Limiting Healthcare Access and Use of Part A Funds to Address Factors
2.A.4)c)i. Unmet Need, Service Gaps and Barriers to Care
Unmet Need for PLWH

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 Demand, Unmet Need/Service Gaps and Barriers to Care for PLWH to assist the Council with effective planning for both service funding and service delivery. Service demand, unmet need 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-occurring conditions such as homelessness, previous incarceration, other STIs, and other co-morbidities, to gain an understanding of the unique needs of each subpopulation throughout the TGA. This analysis is done at the aggregate level as well as by Ryan White Service Category to fully understand what service categories are not able to be received by what groups of PLWH, and what barriers to care are more of an issue for which RW service categories.

The most important section of the TGA's Needs Assessments is the "Unmet Need" section. Unmet Need is defined, by each RW service category, as the number of survey respondents who reported that the were not able to receive the service due to at least one Barrier to Care that they confronted for that service category. The Unmet Need for each service category is further analyzed by client demographics such as race, age, gender and mode of HIV transmission to further understand which subpopulations of PLWH have higher Unmet Needs for which service categories. In addition, the demographic breakdown provides information about which Barriers to Care are confronted most by which subpopulations of PLWH throughout the TGA. In addition, the Needs Assessment provides recommendations for improvements to the RW Continuum of Care, at both the service provider level and system-wide level, to continue to further improve access to care for each subpopulation.

The 2018 Needs Assessment further analyzed each RW service category to determine which RW services had disparate Unmet Needs for which demographic categories. The following service categories had a demographic cohort that reported an Unmet Need of >10% than the overall survey average:

Ryan White Service Category	2018 Needs Assessment Unmet Need: Demographic Disparities
ADAP	34% of homeless had an unmet need vs. 21% of overall respondents
AIDS Pharmaceutical Assistance	47% of rural respondents had an unmet need vs. 36% overall
Health Insurance Assistance	41% of respondents age 65+ had an unmet need vs. 30% overall
HIV Medical Care	29% of respondents age 65+ had an unmet need vs. 15% overall
Home/Community Based Health Services	63% of homeless respondents indicated an unmet need vs. 50% overall
Housing	59% of homeless respondents indicated an unmet need vs. 48% overall
Linguistic Services	53% of respondents age 65+ and 56% of IDU respondents indicated an unmet need vs. 41% overall
Medical Case Management	41% of homeless and 41% or rural respondents indicated an unmet need vs. 29% overall
Medical Transportation	47% of homeless respondents and 47% of rural respondents indicated an unmet need vs. 37% overall
Nutritional Supplements	53% of rural respondents indicated an unmet need vs. 41% overall
Mental Health Services	28% of IDU respondents and 28% of homeless respondents indicated an unmet need vs. 18% overall
Oral Health Care	47% of homeless respondents indicated an unmet need vs. 27% overall
Psychosocial Support	35% of rural respondents indicated an unmet need vs. 24% overall
Referral for Healthcare / Supportive Services	34% of homeless respondents indicated an unmet need vs. 21% overall
Substance Abuse Treatment (Inpatient)	41% of homeless respondents indicated an unmet need vs. 31% overall

Service Gaps for PLWH

In addition to the 2018 TGA-wide HIV/AIDS Needs Assessment, service gaps are identified through an annual analysis of trends in RW client service utilization in terms of mode of HIV transmission, gender, race and age, to determine subpopulations facing additional factors that limit access to care and create service gaps. For example, the examination of service utilization trends among various racial groups found that language barriers continue to exist among the Hispanic community, which continues to be underutilizing RW services. In FY17, Hispanic RW clients had the lowest cost per client as compared to any other race and compared to the cost per RW client overall. Findings from the 2018 Needs Assessment also found Unmet Needs reported at higher rates among Hispanics than other racial groups. For example, more Hispanics (31%) indicated unmet need for psychological support services compared to Whites (18%). More Hispanics (41%) indicated unmet need for medical transportation compared to African Americans (25%), and more Hispanics indicated unmet need for medical case management compared to African Americans.

In terms of geographic variation in needs across the TGA 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 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 out-of-care analysis, 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 as of 12/31/17 (89.1% PLWH reside in Sacramento County, 3.9% El Dorado County and 6.9% Placer County) the rural county of El Dorado has a slightly higher percentage of PLWH out-of-care compared to their representation in the TGA's HIV/AIDS epidemic.

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 two hours, 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. 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.

In addition to the TGA-wide Needs Assessments, Service Gaps are identified by the RW Planning Council annually by conducting a detailed analysis of service utilization trends among RW clients to examine which demographic subpopulations were underutilizing services compared to other groups and compared to their representation in the TGA's HIV epidemic. Follows are several findings:

- PLWH ages 20-44 were significantly underrepresented among RW clients in FY17 (35.4%) as compared to their representation among PLWH in the TGA (76.8%)
- MSM/IDUs were significantly underrepresented among RW clients in FY17 (1.8%) as compared to their representation among PLWH in the TGA (7.9%)
- MSM/IDU RW clients had 25% lower cost per client than RW clients overall ($1,611 vs. $2,148)
- MSM RW clients had 10% lower cost per client than RW clients overall ($1,931 vs. $2,148)
- Hispanic RW clients had 11.5% lower cost per client than non-Hispanic RW clients ($1,948 vs. $2,200)
- Male RW clients had 33.4% lower cost per client than female RW clients ($1,949 vs. $2,928)

Barriers to Care for PLWH

In addition to identification of Unmet Needs and Service Gaps descried above, the TGA-wide Needs Assessment goes deeper in trying to understand what is driving these issues. Service gaps or Unmet Need may be caused by decreased consumer awareness and demand for services; however, it 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). In the 2018 Needs Assessment, Barriers to Care were classified into three general categories of "Access," "Financial," and "Personal" Barriers to Care. To help the TGA gain a better understanding about which level of the service system the Barriers to Care exist, these categories go from examining broad-based TGA-wide "Access Barriers" and "Financial Barriers" to more and client-based "Personal Barriers," as follows:

- Access Barriers include issues regarding the overall structure of the TGA's system of care and includes barriers such as "Didn't know how to get," Location not convenient," "Wait times too long."

- Financial Barriers include issues such as "Didn't think I was eligible," "Was told I wasn't eligible," "Services cost too much," "No insurance coverage," or "Co-pay was too high."

- Personal Barriers include issues such as "Treated with disrespect," "Jail/Prison history," or "Concerns about privacy of HIV status."

The primary goal of the Needs Assessment survey process was to identify strategies to reduce Barriers to Care so that Service Demand and Unmet Need can be met for the majority of service categories across all demographic groups. As can be noted below, of the top 10 Barriers to Care, 50% were Access Barriers, 30% were Financial and 20% were Personal Barriers.

Rank	2018 HIV/AIDS NEEDS ASSESSMENT TOP 10 BARRIERS TO CARE	Cumulative Responses*
1	Didn't know this was available *(Access)*	735
2	Didn't think I was eligible *(Financial)*	706
3	Didn't know how to get *(Access)*	585
4	Privacy of HIV status concerns *(Personal)*	413
5	Didn't know where to go *(Access)*	323
6	Wait times too long *(Access)*	251
7	Treated with Disrespect *(Personal)*	167
8	Was told I wasn't eligible *(Financial)*	156
9	Appointment times not convenient *(Access)*	126
10	Co-pay was too high *(Financial)*	98

**Respondents were asked to indicate all applicable barrier types for all service categories*

2.A.4)c)ii. Use of Part A Funds to Address Factors Limiting Healthcare Access

Once the service needs, gaps and barriers to care 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 FY19. The FY17 RW caseload represents 49.7% of the TGA's PLWH as of 12/31/17.

Applying the 49.7% to the out-of-care population (792 PLWH out-of-care), an additional 394 persons could need access to the RW system of care at a potential cost of $846,312 annually if 49.7% of the anticipated out-of-care clients accessed the RW system of care in FY19. This potential increased dollar figure is based on FY17 RW cost figures and does not take into consideration the rising cost of living in California, which would increase this figure further. The increased FY19 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).

In addition, by using data from the Unmet Needs Estimate, the TGA's RW care providers work closely with Sacramento County DHS 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 One Community Health to be screened for RW eligibility and to receive free Partnership Services, which provides immediate access to counseling and resource referral, as well as health education/risk reduction counseling. The Partner Services 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. All RW Medical Case Management sub-recipients are contractually required to document referrals to Partner Services.

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.

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 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. 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 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 (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 FY19 to allow these programs to continue beyond the expiration date of the one-year Part B Supplemental funding ending September 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 1/1/17 – 12/31/17 as follows:

INDICATORS OF RISK Sacramento TGA Surveillance data, Unmet Need Data and Testing Data for 1/1/16-12/31/16								
	Total Newly Diagnosed CY17	Percent of Total Positives CY17	Total Epi CY17	Percent Total Epi CY17	Total Unmet Need CY16	Percent Unmet Need CY 16	Rank Compared to Totals	Percent Unmet Need Over Epi
Transmission								
MSM	101	57.06%	2,829	56.31%	405	51.1%	1	-5.21
High-Risk Heterosexual contact (HRH)	NA	NA	NA	NA	162	20.5%		NA
Heterosexual contact (Non-HRH) and HRH	19	10.73%	893	17.77%	31	3.9%	2	-13.87
IDU	9	5.08%	433	8.62%	83	10.5%	3	+1.88
MSM/IDU	9	5.08%	395	7.86%	69	8.7%		+0.84
No Identified Risk/Unknown	38	21.46%	415	8.26%	35	4.4%		-3.86
Other	0	0%	17	.34%	2	.3%		-0.04
Perinatal	1	.56%	42	.84%	5	.6%		-0.24
Totals	177	100%	5,024	100%	792	100%		
Race								
White	65	36.7%	2,518	50.12%	380	48.0%	1	-2.12
African American	37	20.9%	1,158	23.05%	195	24.6%	3	+1.55
Hispanic	51	28.8%	963	19.17%	29	21.3%	2	+2.13
Asian	14	7.91%	157	3.13%	4	3.7%		-0.57
Native Hawaiian Pacific Islanders	0	0%	42	.84%	5	0.5%		-o.34
American Indian/Alaska	1	.56%	22	.44%	10	0.6%		+0.16

INDICATORS OF RISK Sacramento TGA Surveillance data, Unmet Need Data and Testing Data for 1/1/16-12/31/16								
	Total Newly Diagnosed CY17	Percent of Total Positives CY17	Total Epi CY17	Percent Total Epi CY17	Total Unmet Need CY16	Percent Unmet Need CY 16	Rank Compared to Totals	Percent Unmet Need Over Epi
Native								
Other Race/ Multi Race	4	2.26%	142	2.83%	10	1.3%		-1.53
Unknown/ Unreported	5	2.82%	22	.44%	0	0%		-.44
Totals	177	100%	5,024	100%	792	100%		
Age Diagnosis								
0-12	1	.56%	51	1.02%	2	0.26%		-0.72
13 – 19	9	5.08%	160	3.18%	1	0.13%		-3.08
20-24	34	19.21%	657	13.08%	18	2.3%	4	-10.78
25-34	55	31.07%	1,733	34.49%	106	13.4%	2	-21.09
35-44	32	18.08%	1,468	29.22%	155	19.6%	3	-9.62
45+	46	25.99%	955	19.01%	510	64.3%	1	+45.29
Totals	177	100%	5,024	100%	792	100%		
Gender								
Male	145	81.92%	4,168	82.96%	646	82.0%	1	-0.96
Female	26	14.69%	828	16.49%	141	18.0%	2	+1.51
Transgender: Male to Female	5	2.82%	26	.52%	5	1.0%	3	+0.48
Transgender: Female to Male	1	.56%	2	.04%	0	0%		-0.04
Unknown/ Unreported	0	0%	0	0%	0	0%		
Totals	177	100%	5,024	100%	792	100%		

TGA Epidemiology Data combines all Heterosexuals (HR and non-HR), includes Native Hawaiian. Unmet Need Data and Testing Data include 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.

1) Planned Activities in TGA's FY18 EIIHA Plan

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 Division 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 FY18, 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 2018/19 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 Rapid HIV 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 600 individuals in CY18 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 2017 through 2018:
  1. HIV/AIDS Local Outreach (HALO) Project, Parents, Families, Lesbians and Gays (PFLAG)
  2. Youth Street Education Project, Wind Youth Services
  3. HIV Prevention and Health Equity Program, Lesbian, Gay, Bisexual, Transgender (LGBT) Center
  4. HIV Prevention Coalition, One 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, One Community Health
  8. Outreach, Education and Testing, Community Against Sexual Harm (CASH)
  9. Preventing HIV with PrEP, One Community Health.
  10. Overdose Prevention Program, One Community Health
  11. Medication Assisted Treatment Program, SANE
  12. Project Reach, Harm Reduction Services

13. Heart to Heart Project, Life Enriching Communications
14. Addressing Sacramento's Youth STI Epidemic, Planned Parenthood Mar Monte
15. Enhancing the Sacramento HIV Care Continuum, Central Valley AIDS Education & Training Center (AETC)
16. HIV Prevention, Intervention, Education and Linkage to Care, Gender Health Center (GHC)

- One Community Health and the Sacramento County HIV/STD Prevention Program have collaboratively modified a PrEP Provider Toolkit and disseminated it widely among the TGA's medical providers.
- Sacramento County Public Health Communicable Disease Investigators provides 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 the PrEP Toolkit to their providers and distribute Prevention materials to their clients.
- Rural county RW providers will disseminate the 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.

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 or CY17. SFAF also conducts HIV testing in Placer County using test kits provided by One Community Health. These test sites inform rural county residents of the availability of medical care and services at One

Community Health and other TGA providers. RW Medical Case Managers assist the clients in overcoming barriers to care and ensure all newly diagnosed clients receive a warm hand-off to medical care.

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 one 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.

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 CY2017 accomplishments in the final column. The EIIHA Plan can ***only include goals*** for the government funded agencies, as the private partner (One Community Health) does not have goals for the specific number of tests. Rather than have predetermined testing goals, One Community Health 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 clients but does not have individual goals. Despite the limitation of being able to report only on the progress of the government-funded testing sites at this time, the actual number of tests performed in 2017 (1,551) exceeded the stated goal (1,100 tests). The target population percentages were developed based on the total number of tests administered by government funded providers in 2017.

FISCAL YEAR 2018 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 Finger Stick 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 Rapid HIV testing to the following risk populations to make them aware of their HIV status:	Parties/Timeframes: Government-funded Testing Providers and One Community Health. 1/1/17-12/31/18

FISCAL YEAR 2018 EIIHA PERFORMANCE INDICATORS Responsible Parties/Timeframes	
Strategies to Improve EIIHA	Responsible Parties/Timeframes
▪ 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. <u>Target Population Goals by Race:</u> ▪ 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	

Contribution of EIIHA Plan to Improvements in HIV Care Continuum Outcomes

The TGA's FY18 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:

"<u>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.</u>" The TGA's efforts target youth, in particular young gay men, to get tested. In CY17, 17.4% of tests administered through the TGA's EIIHA providers were for clients ages 24 years and younger, exceeding their 4.2% representation in the TGA's HIV epidemic as of 12/31/17. Further, 24.8% of positive tests in CY17 were for those under age 25, as compared to 21.9% positivity rate for those under age 25 in 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. CY17 efforts to target the HR Heterosexual population proved successful with 24.4% of total tests administered to HR Heterosexual individuals compared to 17.8% 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 CY17 rate of 85% for linkage to HIV medical care within 30-days for newly diagnosed PLWH exceeds the 2020 NHAS goal.

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 targeting substance using individuals. SANE and HRS have developed and sustained strong trust relationships with the IDU and substance using communities; provide mobile testing on street corners and homeless camps in neighborhoods where IDUs congregate; and provide incentives (i.e., food vouchers) to promote testing for their target populations.

2. All government-funded testing agencies, One Community Health, and County testing sites throughout the TGA provide Finger Stick 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 provide HIV/AIDS resource and referral information to newly diagnosed clients, and risk reduction referrals for those testing negative. One Community Health 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 One Community Health and provide linkage to care.

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

Analysis of 2017 California SOA surveillance data allows the TGA to determine which subpopulations are less likely to be linked to care within one month of diagnosis - IDUs (60%) MSM/IDUs (78%) and non-HRH (79%) than overall TGA rate of 85%; less likely to be retained in care - ages 13-24 (56%) than ages 45-64 (74%); and less likely to be virally suppressed – African Americans (53.6%), IDUs (56%), MSM/IDUs (44%) and HRH (57%) compared to the viral load suppression rate of 68.0% for the TGA 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), 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, beginning in 2015, The CARES Foundation funded the HIV Prevention Coalition administered by One Community Health in coordination with Sacramento County DHS, Sierra Foothills AIDS Foundation (SFAF) and numerous non-profit agencies throughout the TGA. Between 2015 and 2017 this HIV Testing and Linkage to Care initiative, 986 out-of-Care HIV+ people were identified and returned to HIV medical care and 8,598 HIV tests were conducted. Additionally, between 2015 and 2017 The CARES Foundation funded the Condom Finder program which distributed 6,395,002 condoms throughout the TGA and enlisted 243 sites for condom distribution. The CARES Foundation also funded a PrEP media campaign including Spanish and English ads on websites viewed by gay men in the TGA. Prescriptions for PrEP at One Community Health increased to 278 patients prescribed PrEP during 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, CY16 Unmet Need, and Newly Diagnosed data for 2017, the FY18/19 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 One Community Health maintain client transmission information. Therefore, the Unmet Need data is used to presume similar demographics of the unaware population.

Influence of FY17 EIIHA Plan Processes, Activities and Outcomes on FY18 EIIHA Plan

The TGA has established its FY18/19 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 most current FY16 Unmet Need Estimate and the most recent CY17 TGA-wide epidemiology, the FY18/19 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 One Community Heath or the County Public Health Surveillance Team for Partner Services, confirmatory tests, and access to HIV medical providers.

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 One 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 offer routine testing among providers and to reduce financial barriers.

3) Three Selected Target Populations for FY18/19 EIIHA Plan

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

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 2017 California State Office of AIDS (SOA) data identifying the highest risk populations in California; 2) the RW CY16 Unmet Need Estimates outlining the TGA's target Out-of-Care populations; 3) the 2018 RW Planning Council HIV/AIDS Needs Assessment; 4) the State of California TGA CY17 epidemiological data; the 5) the California CY16 Integrated HIV Surveillance, Prevention and Care Plan; 6) the FY17 RW service utilization and demographic data; and 7) testing data provided by participating local government-funded 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 18/19 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 (56.3%) in the TGA as of 12/31/17. Among MSMs, Caucasian MSMs are the largest population followed by Hispanic MSM and African American MSM. The MSM population also represented the highest percentage of PLWH with Unmet Need in CY16 (51.1%), and the greatest number and percent of newly diagnosed (57.06%) in 2017.

HIV (not AIDS) prevalence among the MSM transmission category increased 54.1% over the last five years between 2012 and 2017 (from 901 to 1,388 cases). AIDS Prevalence among MSMs increased 21.9% during the same timeframe (from 1,182 to 1,441 cases). The total number of PLWH among the MSM population increased 35.8% (from 2,083 to 2,829 cases). Since the most recent reporting period ending 12/31/16, the total number of PLWH among the MSM population has increased another 4.5% (from 2,745 to 2,829). In addition, 2017 Continuum of Care data found that newly diagnosed MSMs (74%) were less likely to be virally suppressed within 12 months of diagnosis than non-HRHs (88%).

High Risk Heterosexuals. Regarding HIV transmission categories, the High Risk Heterosexual (HRH) category is defined by California Department of Public Health (CDPH) as including "persons who reported engaging in heterosexual intercourse with a person of the opposite sex of their sex-at-birth, and that partner was known to be HIV positive or engage in an activity that put them at high risk for HIV (e.g., MSM, IDU)." The Sacramento TGA also includes Heterosexuals with Multiple Partners in its definition for High-Risk Heterosexuals. High Risk (HR) Heterosexuals ranked as the second highest out of care category, with males representing 53% and females 47%. The High-Risk Heterosexual category represents the second largest percentage of PLWH in the TGA (17.8%) as of 12/31/17; the second highest population of PLWH with Unmet Need (20.5%) in calendar year 2016; and the second highest category of newly diagnosed PLWH in CY17 (. African American women and White women represent the highest percentage of HR Heterosexuals followed by White men and African American men. 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 FY17, 44.3% of the female RW clients were African American (up from 34.9% in FY16) vs. 19.8% of the male clients. Notably, the 44.3% of females who were African American was much higher than the 25.0% of the total RW population and 7.3% of the TGA's population who were African American in 2017. Further, African American women represented 41.8% of all women Out of Care in the CY16 Unmet Need data. 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%). In addition, 2017 Continuum of Care data found that newly diagnosed High Risk Heterosexuals were less likely to be virally suppressed within 12 months of diagnosis than non-HRHs (57% vs. 88%).

Injection Drug Users (IDU). AIDS prevalence among the IDU transmission category increased 4.5% between 2012 and 2017 reporting periods (from 248 to 287 cases). HIV prevalence increased 8.1% during the same five-year period (from 135 to 146 cases). Thankfully, these figures decreased between the period ending 12/31/16 as compared to the current reporting period ending 12/31/17. AIDS prevalence decreased 1.4% and HIV prevalence decreased 2%, with total PLWH decreasing 1.6% (from 440 to 433). The Centers for Disease Control (CDC) estimates that only .3% of the TGA's general population were Injection Drug Users in 2016, but IDUs represented 8.9% of PLWH in the TGA, and MSM/IDUs represented an additional 7.9% of PLWH, as of 12/31/17.

Unmet Needs data for CY16 indicates that IDUs rank third among all PLWH in terms of percentages in the Out of Care population (10.5%). While their positivity rate among the newly diagnosed in CY16 was only.3% compared to 5.8% for MSM and 4.3% for HR Heterosexuals, the IDU population's AIDS incidence shows they are more likely to be diagnosed with Stage 3 at the time of diagnosis. In addition, 2017 Continuum of Care data for the TGA found that IDUs (60%) were less likely to be linked to care than MSMs (89%).

Men who Have Sex with Men and Inject Drugs (MSM/IDU). AIDS prevalence among MSM/IDUs increased 17.8% between 2012 and 2017 (from 219 to 258), and HIV prevalence increased 12.3% (from 122 to 137 cases) during the same five-year period. The total number of PLWH among the MSM/IDU population increased 15.8% (from 341 to 395 cases) over the last five years. Over the last year, however, total HIV/AIDS Prevalence among MSM/IDUs decreased by 2% (from 403 to 395).

2017 Continuum of Care data for the TGA found that MSM/IDUs (78%) were less likely to be linked to care than MSMs (89%). Further, newly diagnosed MSM/IDUs were less likely to be virally suppressed within 12 months of diagnosis than non-HRHs (44% vs. 88%). In addition, the MSM/IDU exposure category ranked the fourth highest population Out of Care in CY 2016 (8.7%) a .2% increase over CY15.

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 (HRH. 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.

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.

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 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 a Finger Stick Rapid HIV test and are provided test results within 20 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 the County surveillance team to notify partners of their exposure; and 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, One Community Health is a RW sub-recipient for Part A and B and receives direct Part C and Part D grants. One Community Health shares information and coordinates outreach, education, testing and data sharing with Sacramento DHS, 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, One Community Health 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 $6.4 million dollars throughout the TGA since its inception. The CARES 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 a Finger Stick Rapid HIV test and are informed of their results within 20 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 One Community Health 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 TGA 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 One, Sierra Foothills and Planned Parenthood, and government funded testing sites. One Community Health is the only RW funded HIV medical care provider for adults in the TGA. All public HIV testing sites currently refer 100% of newly diagnosed clients to medical care, as are the 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 One Community Health. One Community Health provides low cost confirmatory testing to all individuals regardless of their insurance, county of residence, immigration or income status. All 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 Rapid HIV test.

In addition to providing referral information, each publicly funded site has an ongoing relationship with One Community Health, which operates an Outreach Program employing outreach workers who transport clients from their test site to One Community Health to get a confirmatory test; and ensure that clients go to follow-up medical appointments. For clients tested at One Community Health testing sites, all preliminary positive Rapid HIV 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 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 One 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 clients to medical care and achieving viral suppression. In 2017, 79.0% of TGA clients met the minimum definition of "In Medical Care" by receiving a minimum of one medical visit in 2017 including a CD4 count or viral load test; and 68.0% achieved viral suppression. Outcomes for FY17 Ryan White clients exceeded the 2017 TGA outcomes: 81.5% of RW clients met the definition of "In Medical Care" and 87.4% achieved viral suppression.

Organizations Responsible for Implementation of EIIHA Activities. One 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 DHS 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), and Strategies for Change are entities responsible for ensuring that activities to identify individuals are implemented. One Community Health used funding from a prior CDC grant for implementation of EIIHA activities in 2014, but that funding ended and was replaced by the CARES Foundation funding from CY 2016 to the present. 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 DHS HIV/STD Prevention Program use federal CDC funds through a SOA grant; One Community Health is a FQHC and utilizes 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. One Community Health has access to high risk individuals and their partners who come for 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. These organizations all 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 2019 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 FY18 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%; American Indian: .7%; Other/Undeclared: 1.5% of 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 their community to expand the number of African American persons that get tested.
7. Enlist State and community leaders to advocate for routine HIV testing statewide.

2.C. LOCAL PHARMACEUTICAL ASSISTANCE PROGRAM (LPAP) – N/A to Sacramento TGA

SECTION 3: METHODOLOGY

3.A. IMPACT OF 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 FY17. Because 96.6% of FY17 RW clients fell below 300% 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 FY13, FY14 and FY15, there was a reduction from 15.5%, to 13.3% to 8.5% of RW clients without another source of health insurance, and this fell further in FY16 to 7.8%, stabilizing at 7.8% in FY17. This shows a very promising decline over the past several years due to the implementation of the ACA.

The fact that a fewer number of FY17 RW clients were uninsured than in the TGA's general population in 2016 (7.8% vs. 9.5%) 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 FY17 Ryan White clients as compared to the health care coverage status of the TGA's general population in 2017:

Healthcare Coverage	Ryan White Part A Clients 2017		TGA General Population 2016	
	#	%	#	%
Medi-Cal	1,514	60.9%	649,883	32.0%
Medicare	445	17.9%	369,399	18.2%
Medi/Medi (Medi-Cal/ Medicare)	45	1.8%	72,418	3.6%
Other Insurance	47	1.9%	6,177	0.3%
No Insurance (RW included here)	121	4.8%	193,894	9.5%
Private Insurance	344	13.8%	1356,059	66.7%
Total	2,485	100%	2,032,871	100.0%

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 (60.9% vs. 32.0%). In terms of other health care insurance coverage, such as private insurance, RW clients are 5 times less likely to have private insurance as compared to the TGA's general population (13.8% vs. 66.7%). In FY17, 78.8% of RW clients were enrolled in Medi-Cal or Medi-Cal and Medicare (Medi/Medi), as compared to 64.2% of RW clients in FY16. 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).

The level of poverty among RW clients continues to worsen in the TGA. In FY17, 82.9% of RW clients were at or below 138% of Federal Poverty Level (FPL), as compared to 75.0% in FY16. In FY17, 96.6% of RW clients had annual incomes at or below 300% of the FPL, and 74% had annual incomes at or below 100% of the FPL, as compared to FY16 when 62% of RW clients had annual incomes at or below 100% of the FPL. These figures show poverty rates dramatically higher among RW clients than the 15.5% of the

TGA's general population under 100% of FPL as reported by the 2016 US Census Bureau. Further, 34.5% of FY17 RW clients reported no income at all, which is higher than the 20.0% of FY16 RW clients with no income and is 9 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. One 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 Affordable Care Act (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 One Community Health 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 ADAP and 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. While this 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

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 FY17 RW clients, the average cost of care per RW client with an income under $20K was 39.3% higher than RW clients with incomes over $20K ($2,268 vs. $1,628). Given that 46% of FY17 RW clients had incomes under $10K, and there were over 4 times as many RW clients with incomes under $20K than over $20K, the costs of care to the RW in poverty continues to be quite apparent. 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.

In addition, limited health care coverage for people living in poverty has a negative impact on health outcomes for patients who require intense health care intervention once they get coverage and access to care. For example, in FY17, the average cost of care per RW client on Medi-Cal was over two times the average cost of care for clients with private insurance ($2,501 vs. $1,102). The RW program serves a large percentage of PLWH who have ACA medical insurance coverage. Medical case management 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, 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 FY16 year-end expenditures to the FY17 year-end figures, decreases in RW cost per client were only found in 4 of 15 RW service categories as follows: outpatient medical care decreased from $712 to $531, medical nutrition therapy ($286 to $120), health education/risk reduction ($347 to $296) and child care services ($1,020 to $964). However, increases were found in 11 of 15 RW service categories between FY16 and FY17, off-setting the savings in the other 5 service categories. For example, mental health services increased from $496 to $662), medical case management increased from $820 to $979 per RW client, medical transportation increased from $189 to $367 per client, outreach services ($419 to $548), oral health care ($1,062 to $1,113), residential substance abuse treatment ($3,036 to $5,398) and outpatient substance abuse treatment increased from $644 to $720 per RW client between FY16 and FY17. In addition, in FY14 a new service category was added, Health Insurance Premium and Cost Sharing, which increased from $248 per RW client in FY15 to $609 in FY16 to $674 per RW client in FY17.

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 continue to 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 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 comprehensive HIV Specialty Medical Care Clinic, One Community Heath (a Federally Qualified Health Center (FQHC) formerly doing business as Cares Community Health). One Community Health provided medical care to 51.5% of PLWH in the TGA in FY16 (2,587 One Community Health HIV patients in FY17 out of 5,024 PLWH in the TGA as of 12/31/17). 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 Medical Center and Sutter Health, 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 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.

The TGA has a limited availability of HIV specialty physicians. In FY17 One Community Health, a sub-recipient of RW funds, continued to see the vast majority of PLWH in the region, followed by Northern California Kaiser Permanente. The Sutter Healthcare system and U.C. Davis (UCD) Adult Infectious Disease have been serving close to 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 the majority of Northern California's Pediatric HIV+ patients. Within this regional system of care for PLWH in the greater Sacramento area very few patients experienced interruptions in their HIV/AIDS care due to changes or lapses 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 efforts.

In the TGA's rural counties of El Dorado County and Placer County, however, there is only one Covered California private health care insurance plan (the California Health and Wellness Plan), and rural clients have had some difficulty receiving HIV specialty medical care and maintaining coordinated medical and support services in their respective county. Medical Case Managers in the rural county areas have found this a challenging problem with few options. The total number of clients impacted by these issues remains small, however, as the majority of rural county RW clients qualify for Medi-Cal and are able to receive their care in Sacramento at One 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 and Cost-Sharing 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 One Community Health in Sacramento County, and signed up for the ACA's Anthem Blue Cross plan which contracts with One Community Health, 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 over the last several years. For example, the Council increased emergency financial assistance, emergency housing assistance and medical transportation allocations in response to the demographics and needs of the Out-of-Care population.

The allocation for outpatient ambulatory care was moderately reduced over the last several years to accommodate for these increases in emergency financial assistance, and other support services, as the Council believed some additional revenue from third party payers would provide a resource shift. As service demands decreased in some service categories with ACA implementation, the Council increased funding for the oral health service category, as RW provides the only full-service oral health care for HIV+ clients in the TGA. Further, additional funding was received from RW Part B, so Part A was able to redirect some funds to service categories that had client waiting lists. For example, funds were redirected to medical case management and to non-medical case management, including benefits and enrollment counseling which also provides clients with assistance in applying for the State Office of AIDS Health Insurance Premium Program (OA-HIPP) and AIDS Drug Assistance Program (ADAP). The expansion of these service categories was critical to assist clients not only in enrolling in new health care plans, but in maintaining coverage during re-enrollment periods.

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, however, offers a full range of services to clients, including medication adherence services, advocacy, and assistance with a broad range of barriers to care. RW Medical Case Managers often case conference with the PLWH's physicians to ensure that their medical issues are being addressed. The benefits and enrollment counselors 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 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.

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 One Community Health are authorized to 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 Allocations, Health Insurance Premium and Cost Sharing Assistance

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). A large challenge for PLWH is that assistance under a Covered California plan is not available for co-payments or deductibles for medical expenses. The Office of AIDS HIV Insurance Premium Program (OA-HIPP) provides premium assistance, but it is only available to clients whose incomes are 139% up to 250% of poverty. This creates an additional barrier to care for clients whose incomes range from 251% to 300% of poverty; which affected 13.7% of the RW caseload in FY17.

The resource shifts resulting from ACA has allowed the RW Planning Council to increase allocations to the Health Insurance Premium Assistance Program (HIPP), assisting clients who have financial need for premiums, deductibles and medical co-payments. The 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 three years, those applications are being approved in a timely manner, and the Insurance Payment and Premium assistance service has seen more clients requiring help with their medical visit co-pays. In 2016 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).

These 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.

Increase in Part A Funding for Benefits Counselors

The TGA's RW Program nearly tripled its allocations and funding support for Benefits and Enrollment Counselors between FY13 and FY17 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 One Community Health 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.

All new RW clients 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.

The RW Program continues to participate in numerous outreach events across the TGA to inform PLWH of expanded insurance coverage options through Covered California. The RW Program's Benefits and Enrollment Counselors are certified as ADAP Enrollment Counselors, Covered California Counselors, and OA-HIPP counselors. Because these professionals have certifications to enroll clients in these three insurance coverage programs, they can assist clients in completing their application processes and obtaining all assistance for which they are eligible. The Benefits 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. One Community Health also has installed new upgraded 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.

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: 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 TGA's most recent 2018 HIV/AIDS Needs Assessment and Out-of-Care Needs Assessments are explained in more detail throughout this grant application narrative. Participants surveyed for all TGA 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 changes in unmet service needs, service gaps 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 consumers of RW services. The ACC begins each monthly meeting with an open forum for consumers to express challenges that they have 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 FY19 priority setting and allocations process well before FY17 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. 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 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 revised the Continuum of Care for FY19.

The TGA also conducted its biannual comprehensive HIV/AIDS Needs Assessment in 2018, which surveyed 177 PLWH throughout the TGA. 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 detailed quantitative data and qualitative feedback from consumers regarding Service Demand, Unmet Need and Barriers to Care for accessing the TGA's HIV/AIDS Care Continuum. This extensive input from PLWH is imperative to the Council as it establishes priorities and

determines allocations across the HIV 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 by analyzing input from PLWH by various demographic groups (i.e., race, age, gender and mode of HIV/AIDS transmission) to understand the unique Service Demands, Unmet Needs 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, 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.

The RW Planning Council's Needs Assessment Committee revamped its HIV/AIDS survey tool in 2017 and made significant changes to the data collection and structure of the survey tool. The updated survey tool incorporated several new questions surrounding HIV prevention and partner counseling services. The findings of the Needs Assessments are important for use by the Council in the Priority Setting and Allocations Process, as well as in its Continuous Quality Management Program.

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 2018 Service Category Plan, as well as the TGA's 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. The needs of PLWH also are continuously expressed to the Council through its review of RW client 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 RW 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 Ryan White Part A, Part B, and MAI funding, which the Fiscal Agent receives directly, and Ryan White

Parts C and D, which go directly to the service provider. The Fiscal Agent tracks all expenditures by service category and assigns individual "service codes" for MAI funded activities. These up-to-date service utilization expenditures are provided to the RW Planning Council so that 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 additional 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; and formerly or about to be incarcerated clients. In FY17, 309 clients received medical case management services under the MAI grant, and the TGA was successful in reaching the program's target populations. Of the 309 clients served through the MAI grant in FY17, 59.9% were African American; 30.5% Hispanic; 3.6% American Indian/Alaskan Native; 4.8% Asian, and 1.3% Native Hawaiian/Pacific Islander. There was a slight decrease in percentage of Hispanics and a slight increase in percentage of Asians MIA clients as compared to FY16 figures (33.1% and 3.3%, respectively).

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 which occur 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 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 are 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.

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 analysis of this epidemiological profile 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 51.9% of new AIDS cases between 1/1/15-12/31/17. During this twenty-year period, the largest increase was in the proportion of new AIDS cases among Hispanics which increased from 6% to 27.4% between 1995 and 2017. New AIDS cases among African Americans increased as well, but at a much lower rate, from 18% to 18.9% over the same timeframe. This disproportionate representation necessitates Part A resources being targeted to the African American and Hispanic communities, in addition to MAI grant funding, in the FY19 Service Category Plan. The proportion of female HIV and AIDS cases also has steadily increased, with women comprising over 16.5% of HIV/AIDS prevalence in the TGA as of 12/31/17, which is almost twice their percentage in 1995.

To decrease the epidemic's impact in the TGA, the FY19 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 FY19, PAC applied the percentage of its Unmet Needs Estimate to the average cost of care per client for FY17 to project the potential need in the TGA for all clients needing care. This analysis shows that the RW program served 49.5% of the TGA's People Living with HIV/AIDS in FY17 (2,485 RW clients out of 5,024 PLWH). Applying this FY17 percentage of 49.5% to the out-of-care population in the TGA in FY17 (792 PLWH out-of-care), an additional 392 PLWH could potentially need access to the RW system of care in FY19 at a potential cost of $208,152 for ambulatory care alone - which averaged $531 per client in FY17. Since the average cost of care per client for *all* services within the RW system was $2,148 in FY17 (up from $1,768 in FY16) the potential need rises to as much as $842,016 annually if 49.5% of the anticipated out-of-care clients access the RW system of care in FY19.

Use of TGA Needs Assessment Data in Priority Setting and Allocations

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 2017 the Sacramento TGA's Needs Assessment Committee of the HIV Health Services Planning Council (HHSPC) voted to revamp the Needs Assessment Survey Tool based on feedback from survey

participants that it was quite lengthy and had several skip patterns that were confusing to survey participants. The tool was also updated to include all current RW service categories. The TGA-wide HIV/AIDS Needs Assessment survey was conducted in 2017/18 and the 2018 Needs Assessment Report of Findings was used throughout this grant application. The findings of the 2018 HIV/AIDS Needs Assessment Survey are critical in helping the RW Program determine what services are needed by PLWH, the unmet needs (or service gaps) and the barriers to care across all RW service categories.

The most important section of the TGA's 2018 HIV/AIDS Needs Assessment is the "Unmet Need" section. Unmet Need is defined, by each RW service category, as the number of survey respondents who reported that they were not able to receive the service due to at least one Barrier to Care that they confronted for that service category. The Unmet Need for each service category is further analyzed by RW client demographics such as race, age, gender and mode of HIV transmission to further understand which subpopulations of PLWH have higher Unmet Needs for which service categories. In addition, the Needs Assessment provides recommendations for improvements to the RW Continuum of Care, at both the service provider level and system-wide level, to continue to further improve access to care for each subpopulation.

In addition to the TGA-wide Needs Assessments, Service Gaps are identified by the RW Planning Council annually by conducting a detailed analysis of service utilization trends among RW clients. The Council is aware that service gaps or service underutilization may be caused by decreased consumer awareness and demand for services as well as a 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 had substantial waiting lists). Therefore, a more detailed analysis of Barriers to Care is conducted during the TGA-wide HIV/AIDS Needs Assessment, including a demographic analysis of which Barriers to Care are confronted most by which subpopulations of PLWH throughout the TGA.

In the Needs Assessment Survey Tool, Barriers to Care are classified into three general categories of "Access", "Financial", and "Personal" Barriers to Care to help the Council gain a better understanding about which level of the service system the Barriers to Care exist. Access Barriers include issues regarding the overall structure of the TGA's system of care and includes barriers such as "Didn't know how to get," "Didn't know where to go", "Location not convenient", "Appointment times not convenient", and, "Wait times too long". Access Barriers were the most common type of Barrier to Care reported. Financial Barriers include issues such as "Didn't think I was eligible," "Was told I wasn't eligible", "Services cost too much", "No insurance coverage", or, "Co-pay was too high", Personal Barriers include issues such as "Treated with disrespect", "Jail/Prison history", or, "Concerns about privacy of HIV status".

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 its effort to provide appropriate allocations for core and support services. Demographic information on newly diagnosed individuals also aids 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 FY19 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 can 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 FY17, the TGA was required to spend a minimum of 18.9% of the total Part A and Part A MAI direct service grant award to target Women, Infants, children and Youth (WICY), equal to their representation among PLWH as of 12/31/16. By year-end FY17, WICY expenditures were $1,046,785, which represented 36.0% of Part A and Part A MAI direct service allocations on Women, Infants, Children and Youth, which exceeded their representation in the epidemic by 17.1%.

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 all sources of funding 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 FY19 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 comprehensive medical 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 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 an STD reportable condition and provide appropriate testing for all of these conditions. Intensive follow-up is conducted to ensure that all clients access medical care as soon as possible. The RW CARE Program continues to work closely with the surveillance staff and STD/CDI staff to share information to determine a client's status of care.

With the merger, the Sacramento County Public Health Division developed and continues to host an STD/HIV Stakeholder Group, the Sacramento Workgroup to Improve Sexual Health (SacWish), with the

goal of intensifying the TGA's HIV and STD prevention, testing and treatment efforts on behalf of the Sacramento Region's community. The goal of SacWish is to reduce new HIV and STD infections and increase the percentage of persons who know their sero-status and are linked to and receive care. The Coalition is comprised of a broad range of community partners including medical clinics, testing agencies, school districts, public health representatives and non-profit agencies that work closely with high-risk populations.

Additionally, the ZERO New HIV Infections TOGETHER campaign, initiated in FY17 by the One Community Health FQHC clinic, continues its collaborative community-wide campaign to advance information and activities to reduce new HIV infections including the distribution of Provider Tool Kits and client information on the availability of Pre-Exposure Prophylaxis PrEP) in the Sacramento Region.

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 86 standards, within 10 rating categories, are met by the FA each year. Six standards were not reviewed in FY17/18, as they relate to procurement activities that only occur in years where a Request for Proposal (RFP) is issued. The Fiscal Agent has, however, been providing the RW Planning Council with regular updates regarding the release of the RFP for FY19. 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 FY17 Administrative Assessment Review found that the Fiscal Agent is doing exemplary work. 100% of the 80 standards reviewed consistently met or exceeded the intent of the standard. No outcomes primarily met the intent of the standard, but left room for improvement; and there were no standards that were not met. Comparatively in FY16, 96.2% of 79 outcomes 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 no standards were not met.

The standard that showed the most improvement 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 FY17, and submitted written reports to sub-recipients by the time of the final Administrative Assessment.

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

In FY17, the Administrative Assessment review panel found that the Fiscal Agent's administrative mechanisms are strong with 100% of the standards reviewed consistently met or exceeded the intent of the standard and NO standards were not met. The panel determined that Fiscal Agent staff continues to consistently achieve a high standard of work, with attention to detail despite FY17 being a particularly challenging year for program reporting requirements and obligations.

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 FY18, 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 DHS 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. To help offet this community funding loss for HIV prevention efforts, the TGA's HIV Prevention Coalition prepared a grant request to The CARES Foundation, a private Foundation founded in 2014 to provide grants for HIV Prevention and Treatment services in the Sacramento Region. The CARES Foundation awarded $375,000 per year to One Community Health and its subcontractors for the the 2016 through 2018 *Zero New HIV Infections* Initiative.

To further address gaps in HIV resources in the Sacramento TGA, numerous other non-profit agencies who work to address the HIV epidemic in the region applied to and received grant funding from the CARES Foundation over the last several years. In 2017, the CARES Foundaiton was pleased to provide grant funding to 9 nonprofit service organizations for 14 unique programs aimed at meeting the Foundation's priorities, which was a substantial increase from 2016 when 6 organizations were funded for 9 programs.

Several examples of funding provided by The CARES Foundation to address the Sacramento Region's HIV/AIDS epidemic follows:

- One Community Health received $200K in 2016 and $200K in 2017 for its "Condom Finder Program"
- Planned Parenthood Mar Monte (PPMM) received $82,165 in 2017 and $90,216 in 2018 for its "Addressing Sacramento Youth's STI Epidemic"
- Life Enriching Communications (LEC) received $35,000 in 2017 for its "Heart to Heart Project"
- Safer Alternatives thru Networking and Education (SANE) received $56K in 2017 and $73,000 in 2018 for its "HIV Prevention through Expanded Syringe Services" Program; and $150K in 2017 for its Medication Assisted Treatment Program
- Community Against Sexual Harm (CASH) received $25K in 2016, $20K in 2017 and $30K in 2018 for its "Testing, Education and Outreach" Program
- Parents, Families of Lesbians and Gays (PFLAG) received $10K in 2016, $10K in 2017 and $15K in 2018 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 in 2017 and $199,589 in 2018 for its "Project Reach" Outreach Program
- One Community Health received $150K in 2016 and $75K in 2017 for its PrEP Program
- Wind Youth Services received $132K in 2016, $160K in 2017 and $170,492 in 2018 for its HIV/STI Street Education Program
- One Community Health received $9,430 in 2017 for its Overdose Prevention and Increased Naloxone Access Program
- Sacramento LGBT Center received $75,063 in 2017 and $125K in 2018 for its HIV Prevention and LGBT Health Equity Program
- Gender Health Center (GH) received $150K in 2018 for its HIV Prevention, Intervention, Education and

Linkage to Care Program

- The Central Valley AIDS Education and Training Center (AETC) received $102,430 for its Enhancing the Sacramento HIV Care Continuum Program

Even with new funding from The CARES Foundation for HIV/AIDS specific services over the last couple of years, funding for transportation, housing, residential substance abuse services and emergency financial assistance continues to be in high demand and under funded in the Sacramento Region. Due to these shortages, the RW program, for the first time, applied for and was awarded Supplemental Part B funds for September 2016-September 2018. This supplemental funding request is being used for the 6.9% of the TGA's RW clients who are homeless or in unstable housing. The TGA received this one-time funding to provide housing, food, transportation and residential substance abuse services to PLWH through September 29, 2018. Unfortunately, it is unclear if that funding will be available to the TGA in FY19, and additional funding from Part A maybe necessary to continue funding those services in the TGA in 2019.

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 FY19 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 TGA's HIV Care Continuum is currently used in planning, prioritizing, targeting and monitoring available resources throughout the Sacramento TGA to maximize the impact on health outcomes in response to service needs, service utilization and health outcomes of PLWH in each stage of the Care Continuum. 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 have been 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 2018 TGA-wide Needs Assessment as discussed throughout this application. Analysis of CQM data at the RW funded One Community Health 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 FY19, as these services are most effective at increasing access along the HIV 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) Impact of Changes in TGA's HIV Care Continuum 2015-2018

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 2017 RW program exceeded the national, California, and local TGA rates of getting clients in medical care and achieving viral suppression. However, more work is needed to improve the rates of linkage to care and retention in care for RW clients, which decreased between FY16 and FY17.

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. The most recent National data is available only for CY14. Therefore, comparisons for the Continuum of Care are not covering the same timeframe and are somewhat 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 data monitored for the RW Continuum of Care.

Another data issue has to do with the Continuum of Care definitions which have changed from year to year which make analysis and consistency of reporting difficult. For example, Linked to Care had been defined up until FY16 as "newly diagnosed with at least one CD4, viral load or HIV-1 genotype test within 3 months of diagnosis." This Continuum of Care indicator was changed to the current definition (used in FY17 for RW program) of "newly diagnosed with at least one CD4, viral load or HIV-1 genotype test within 30 days of diagnosis."

The RW Council continues to analyze numerous relevant data sources and Continuum of Care performance indicators to assess changes in client utilization, emerging high-risk populations and the specific needs of each subpopulation. In addition, the RW Council analyzes known best practices at the national and state level that are being used to improve the TGA's Care Continuum and works to integrate those findings in the Sacramento TGA.

For example, beginning in 2015, the TGA coordinated efforts with the California Department of Public Health, 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 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.

In 2018, the TGA's Ryan White Program embarked on a comprehensive HIV/AIDS Needs Assessment for the Sacramento Region, using an updated Needs Assessment tool which was approved in September 2016. The findings of the 2018 Needs Assessment have been analyzed and used throughout this grant

application for Ryan White Part A funding and assist with development of programmatic changes across the TGA's Continuum of Care to improve services for each subpopulation of PLWH across the region.

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 numerous nonprofit agencies dedicated to HIV prevention, treatment and services for PLWH across the Sacramento Region as well as government funded testing agencies across the TGA. In addition, the local County Department of Health Services has made major contributions to linking HIV clients to care and retaining them in care. Follows are examples of several of these efforts, and the collaborative approaches used by many organizations, both public and private, to improve the outcomes along the HIV Care Continuum throughout the TGA:

Diagnosis of HIV Infection. The RW Program and the Sacramento County DHS Education, Prevention and Testing (EPT) programs operate under the same division and work cooperatively to integrate prevention and treatment for persons living with, or at risk for, HIV/AIDS in the TGA. In efforts to streamline and coordinate efforts, planning bodies for these programs were successfully consolidated in 2010 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 now well coordinated and more efficient.

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, One Community Health, the largest FQHC in the region specializing in HIV/AIDS prevention and treatment, expanded its HIV testing and education services and has been conducting HIV testing using private funding.

One Community Health, which was established as the Center for AIDS Research, Education and Services (CARES) in 1989, transitioned from a Cares Community Health to One Community Health, an FQHC, in 2015. Through this transition, One Community Health 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 One Community Health's strategy to maintain its HIV testing and education services includes entering into cooperative agreements with the Sierra Foothills AIDS Foundation (SFAF) to provide testing kits for the TGA's rural counties, and SFAF has obtained private funding for testing staff. Government-funded testing sites and One Community Health, that relies primarily on private funding, ensure that activities to identify HIV positive individuals throughout the TGA are implemented.

The TGA's current strategy, which will continue to be implemented in the TGA's FY19 Service Category Plan, includes enlisting the support of the few private testing providers to cooperate with One Community Health in its testing efforts. Private testing agencies have strong working relationships with government-funded entities. All public and private testing providers distribute HIV+ service information 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 One Community Health 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 DHS 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 One Community Health where they are screened for eligibility for RW medical services and receive Partner Services and Risk Reduction Counseling (PRCS), 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 66.5% in FY19.

These efforts are proving successful in increasing the number of new RW clients in care over the years, especially among historically underserved communities, however, more work continues to be needed across the Continuum of Care for all subpopulations of PLWH. The FY19 Service Category Plan builds on the TGA's successes over the years and focuses efforts in those areas most in need of improvement. In two of four Continuum of Care indicators, the RW program exceeded National, California and TGA rates. RW clients were more likely to be in medical care in FY17 (81.5%) than PLWH in the TGA during FY17 (79.0%) or in California (64.0%) in CY17. A greater proportion of RW clients in FY17 were virally suppressed (87.4%) than PLWH nationwide during CY14 (57.9%).

However, in two of four Continuum of Care indicators, the RW program had outcomes that were lower than National, State and TGA rates. For example, a smaller proportion of PLWH with a new HIV diagnosis were linked to HIV within one month following diagnosis in the RW program in FY17 (51.5%) than in the state in CY17 (75.0%), the nation in CY14 (74.5%) or TGA in CY17 (85.0%). Although RW funding has increased support for 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), there clearly is more work to be done in this area.

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 (Sacramento HIV/AIDS Reporting Engine), 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. This percentage increased further in FY17 when 87.4% of RW clients were virally suppressed, which is much higher than PLWH nationwide during CY14 (57.9%).

4.B. FUNDING FOR CORE AND SUPPORT SERVICES
4.B.1) FY 2019 Service Category Plan
4.B.1)a) FY 2019 Service Category Plan Table (Attachment 8)

The TGA's FY2019 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 FY19. 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 FY19 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) MAI Service Category Plan Narrative

The TGA's 2019 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. 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 the California 2016 HIV Integrated Plan, the Sacramento TGA identified the following populations as those with the highest risk for HIV/AIDS: African Americans, Hispanics, Youth and Young Adults ages 19-24 years old, High-Risk Heterosexuals, and Men who have Sex with Men. African Americans continue to be over-represented in the HIV epidemic in the TGA, followed by Hispanics. As of 12/31/17, the combined number of African Americans and Hispanics accounted for 42.6% of AIDS Prevalence and 43% of HIV Prevalence in the TGA, while their prevalence in the general population represented 7.3% and 20.0%.

A secondary goal of the TGA's MAI Plan is to help 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 One Community Health. One Community Health provides a full range of HIV specialty and primary care services including medical, dental, mental health, outpatient substance abuse, medical case management, social service case management, clinical trials, pharmacy, and other supportive services. Follow-up with patients occurs on a regular basis through the Medical Case Management system using an electronic medical record combined with a continuous quality improvement tracking system. Numerous strategies and services 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 throughout the RW system of care follow each client closely for a minimum of six months or until the client successfully demonstrates consistent independence and is compliant with their medical care regimen.

The HIV Health Services Planning Council allocated MAI funds according to the overall HIV Services Plan based on documented needs for various sub-populations of PLWH as described throughout this 2019 RW Grant Application. For example, in the Sacramento TGA's FY17 RW system of care, younger RW clients were less likely to be virally suppressed than older clients. Clients ages 13-19 and 20-24 had viral suppression rates of 73.7% and 68.6%, respectively, while clients ages 45-59 and 60+ had viral suppression rates of 86.6% and 90.1% respectively. One strategy to address this issue of out-of-care youth is that one of the RW Minority AIDS Initiative contracted agencies transitioned its former MAI clients into the field-based medical case management program targeting youth of color between the ages of 13-24, with a special emphasis on youth newly diagnosed within the most recent twelve months.

Since the inception of the MAI program in the Sacramento TGA, the field-based medical case management model has demonstrated its effectiveness in keeping clients in care and improving their health outcomes. The health outcomes of the MAI clients at the end of FY17, as compared to FY16 show that the percentage of RW MAI clients that achieved viral load suppression increased from 69.0% in FY16 to 74.8% in FY17. These FY17 viral suppression rates among RW MAI clients are well above the most recent National rate (57.9%) and State rate (54.0%) of viral suppression. The following chart shows the viral suppression rates for RW MAI program by racial categories, showing the improvement between FY16 and FY17 for all racial groups except American Indian/Alaskan Native:

Ryan White Minority AIDS Initiative (MAI) Clients Viral Suppression Rates		
	FY16	FY17
American Indian/Alaskan Native	75%	55%
Asian	71%	73%
African American	74%	67%
Hispanic	70%	79%
Native Hawaiian/ Pacific Islander	100%	100%
Total	69%	75%

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 provided by all RW sub-recipients to all eligible PLWH. The RW Program's FY18 Service Category Plan calls for "100% of all RW subrecipients to comply with the adopted service standards." 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 demographics, objectives are included in each service category that "the percentage of clients accessing services will be reflective of TGA's PLWH population for 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.

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.

There are several Core Medical Services that are prioritized by the RW Council but are not funded with RW funds because they are 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 effectively 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 One 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 DHS, 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 One Community Health. 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	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	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.

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	**Resolutions**	**Outcomes**	**Current Status**
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.	systems.		
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 regarding tracking, timing and sharing of data.	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. Annually, these Indicators are evaluated and adjusted as needed.	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, transmission and provider.	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 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 (One 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.

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	**Resolutions**	**Outcomes**	**Current Status**
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 (One Community Heath 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			
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 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 to continue this service.
The impact of overall budget cuts in HIV	Recent TGA Needs Assessments have	The TGA recently applied for and received one-time	Funding for this additional service has been provided

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Challenges	Resolutions	Outcomes	Current Status
Related Services during the Recession has a continued impact on PLWH throughout the TGA.	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.	funding from RW Part B Supplemental funds to provide Food and Nutrition services targeting homeless and out of care HIV+ clients.	on a one-time basis for a ten-month period. Additional funding from Part A is being requested with this application to continue this service expansion.

SECTION 6: EVALUATION AND TECHNICAL SUPPORT CAPACITY

6.A. CLINCAL QUALITY MANAGEMENT(CQM)

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

To support the RW Program's CQI efforts, the RW Program's Sacramento HIV/AIDS Reporting Engine (SHARE) database has been implemented over the last several years which is a sophisticated system that stores RW client-level data at the service category and point-of-service levels. This data, along with 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 disparities.

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 FY 2008, 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-occurring conditions, 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 2018 HIV/AIDS Needs Assessment, the TGA's 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 at the State level as well as the local TGA level.

To provide an example of the extensive Clinical Quality Management activities that the Sacramento TGA has been undertaking, the following provides information about the CQM efforts for the Minority AIDS Initiative (MAI) aspect of the RW Program. MAI funding has been instrumental in the development of models of care which bring the services to those people in greatest need, rather than requiring the people to seek out the services and overcome barriers to care on their own. The RW Program's MAI outcome

data demonstrates that the TGA continues to improve access to clinical care and to address disparities among PLWH in the TGA. For example, in FY17, 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: 100% of Native Hawaiian/Pacific Islanders; 88.7% of African Americans, 84.0% of Hispanics, 72.7% of American Indian/Alaskan Native, and 86.7% of Asians. The chart below provides a summary of each minority race category served through the MAI program in FY17 and the results of the HIV Care Continuum Performance Measures.

As can be noted, Viral Load Suppression and Utilization of Antiretroviral Drug Therapy (HAART) were two of the Sacramento TGA's Planned CQM Outcome measures for FY 17. The HAART outcome measure was exceeded (97.7% on HAART, 90% goal) while the Viral Load Suppression target was not met (74.8% Virally Suppressed, 85% goal) and has room for improvement in FY18.

FY17 HIV Care Continuum Outcomes
Minority AIDS Initiative (MAI)

	American Indian/Alaskan Native	Asian	African American	Hispanic / Latino(a)	Native Hawaiian / Pacific Islander	Total	TGA Outcome Goal
MAI Clients	11	15	185	94	4	309	
Linked to Care*	n/a	n/a	n/a	n/a	n/a	n/a	n/a
In Medical Care	72.7% 8	86.7% 13	88.6% 164	84.0% 79	100% 4	86.7% 268	n/a
Retained in Medical Care**	54.6% 6	66.7% 10	70.8% 131	67.0% 63	100% 4	69.3% 214	n/a
Virally Suppressed***	54.5% 6	73.3% 11	73.5% 136	78.7% 74	100% 4	74.8% 231	85%
On HAART****	90.9% 10	93.3% 14	98.9% 183	96.8% 91	100% 4	97.7% 302	90%

**There were no newly diagnosed MAI clients receiving MAI Medical Case Management services in FY17.*

*** "Retained in Medical Care" criteria is at least two viral load tests at least three months apart within a 12 month period.*

**** HIV viral load less than 200 copies/ML at last viral load test during measurement year.*

Further analysis of FY17 Continuum of Care data shows that all racial minority groups noted an improvement in the outcomes for percentage of clients retained in care as compared to FY16. Across all MAI clients, the percent Retained in Care increased from 50.3% in FY16 to 69.3% in FY17.

Regarding Viral Load Suppression, there was an improvement in outcomes for all minority races between FY16 and FY17 except for American Indians/Alaskan Natives, which dropped from 75% virally suppressed in FY16 to 55% in FY17. In addition, there was a 43% decrease in the number of American Indian/Alaskan Native clients served in FY17 (4 clients) as compared to FY16 (7 clients).

Regarding HAART, only African Americans achieved an increase in the percent of MAI clients on

HAART between FY17 (98.9%) as compared to FY16 (97.4%).

6.A.2) CQM Data to Improve Patient Care, Outcomes, Service Delivery and Long-Range Planning

CQM and client level data are the cornerstones of strategic and long-range service delivery planning for the TGA. CQM data is used by the Ryan White Program to improve patient care, health outcomes, and patient satisfaction throughout the TGA. In addition, CQM data is used to improve the service delivery system in the TGA, including long-range service delivery planning. During FY17, the Sacramento Ryan White CARE Program continued to work tirelessly on its CQM efforts to continue to assure conditions for optimal health for people living with HIV across the TGA. Additional efforts were dedicated to developing a Continuous Quality Improvement (CQI) Plan which was completed in July 2018 and is effective through March 2021. The purpose of the CQI Plan is to systematically plan for, measure, evaluate and improve the quality of RW funded services delivered to PLWH. The plan is a "living" document designed to be updated as part of the continuous quality improvement process and will be reviewed annually as needed.

As part of the CQI Program, Performance Indicators were established for the RW Program as a whole, and include the following targets for 2021, with FY17 RW Program baseline measures for comparison:

RW CARE Program Continuous Quality Improvement Indicators
FY17 Baseline and 2021 Targets

Indicator	Performance Measure	Data Source	RW Program Baseline (FY17)	2021 Target
Linkage to HIV Medical Care	% of newly diagnosed clients who attend a routine HIV medical care visit within 1 month of diagnosis	SHARE	58.5%	85%
Prescribed ART	% of still active clients prescribed antiretroviral therapy (ART) for treatment of HIV	SHARE	95.1%	90%
In Medical Care	% of still active clients with at least one medical visit during 12-month period (one CD4 count or Viral Load Test)	SHARE	79.3%	90%
Retained in Medical Care	% of still active clients with at least two medical visits at least 3 months apart in 12-month period (visit include CD4 or Viral Load Test)	SHARE	41.7%	82.5%
Viral Load Suppression	% of still active clients with viral load < 200 copies/ml with viral load test recorded in 12-month period	SHARE	85.7%	90%
Housing	% of still active clients with HIV who were stably housed in 12-month measurement period	SHARE	38.4%	54%

HIV Care Program Performance Measures have also been established by Service Category in the CQI Plan so that each RW funded service category continues to have a measurable health outcome target and process for measurement. In FY17, there were 94 quality of care performance indictors across 15 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 that every service category, whether a core service or support service, has service outcomes linked to outpatient medical care health indicators.

The TGA's RW Program has performance measures for all currently funded service categories, and performance measure data is collected annually; with the exception of One Community Health which

provides CQM reports to the RW Fiscal Agent on a quarterly basis. The following provides Continuum of Care CQM service indicators and collection strategies for the TGA, with FY17 aggregate performance noted across services providers for Medical Case Management and Outpatient Medical Care as examples:

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 39.6% 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 clients into care, retaining them in care, and ensuring that they have full access to care continuum. The TGA needs to continue implementing these programmatic changes to continue to improve its Continuum of Care outcomes. As can be seen in the chart below, the HIV Viral Load Suppression rate for the FY17 RW Medical Care Management clients (78.7%) exceeds the National rate (50.1%):

FY17 RW Medical Case Management Clients CQM Measurements and Outcomes		
Outcome Measure	Definition	FY17 Outcome
HHS Measure: Retention in HIV Medical Care	#/% of HIV patients with at least two medical visits at least three months apart in FY17	513/1138 45.1%
HAB Core Measure: HIV Viral Load Suppression	#/% of HIV patients with HIV viral load <200 copies/ML	895/1138 78.7% NOTE: National Rate 50.1%

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 FY17, as follows, with Whites being slightly underrepresented in the RW population for primary medical care:

Racial Reflectiveness of RW Outpatient Medical Care Patients FY17		
Race	Percent of Ambulatory Care Clients	Percent of TGA's HIV/AIDS Prevalence as of 12/31/16
White	49.4%	51.4%
African American	25.5%	22.8%
Hispanic	20.3%	18.2%
Asian/Pacific Islander	3.7%	3.9%
American Indian/Alaskan Native	1.3%	.5%
Multi-Race/Other/Not Specified	0%	3.2%

As can be seen in the chart below, the HIV Viral Load Suppression rate for the FY17 RW Outpatient Medical Care patients (84.5%) exceeds the National rate (50.1%).

FY17 RW Medical Case Management Clients CQM Measurements and Outcomes		
Outcome Measure	Definition	FY17 Outcome
HHS Measure: Retention in	#/% of HIV patients with at	947/1932

FY17 RW Medical Case Management Clients CQM Measurements and Outcomes		
Outcome Measure	Definition	FY17 Outcome
HIV Medical Care	least two medical visits at least three months apart	49.0%
HAB Core Measure: Prescription of HIV Antiretroviral Therapy	#/% of HIV patients prescribed HIV antiretroviral therapy	1833/1932 97.5%
HAB Core Measure: HIV Viral Load Suppression	#/% of HIV patients with HIV viral load <200 copies/ML	1632/1932 84.5% NOTE: National Rate 50.1%
HHS Measure: Housing Status	#/% of RW clients with permanent housing	765/1932 39.6%

One CQM measure that improved significantly between the last two years is the mortality rate for RW clients. The mortality rate has decreased over the most recent three reporting periods, from 1.2% in FY14, to 0.5% in FY15 to 0.3% in FY16 to 0.1% in FY17.

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

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 Services (DHS), to administer the RW CARE Program as the Recipient / Fiscal Agent (FA). See Attachment 1 for Staffing Plan, Job Descriptions and Biographical Sketches for key personnel for the administration of RWHAP Part A funds within the Sacramento TGA and Attachment 10 for Organization Chart.

The STD/HIV Program Manager, Staci Syas, M.P.H., directly supervises the Sr. Health Program Coordinator and AIDS Director who runs the day-to-day operations of the program and oversees all RWHAP sub-recipient grant awards and program implementation. The Sr. Health Program Coordinator position is currently listed in the budget as vacant, as the current Sr. Health Program Coordinator, Adrienne Rogers, plans to retire at the end of February 2019. The DHS Division of Public Health is in the process of recruitment for this position and expects it to be filled by November of 2018. The Sr. Health Program Coordinator position. The Sr. Health Program Coordinator position is allocated to Part A RW program 56.01% as follows: Part A Administration (32.4%), CQM (20.9), and MAI Administration (2.71%). The RW Program Coordinator has a voting seat on the HIV Health Services Planing Council. The RW Program Coordinator and Human Services Program Planner, Paula Gammell, attend all Committee and Council meetings, providing epidemiological, demographic, needs assessment, financial and service utilization data to Council members. Fiscal Agent staff also administers the TGA's CQM program, and contracts with consultants as needed to monitor on-going quality management activities, prepare final Needs Assessment Reports and assist in the development of grant applications.

Ms. Rogers is included in the budget as a "Retired Annuant" as she will return to work a total of 960 hours in 2019 to provide on-going training and technical assistance to the newly appointed Program Coordinator. Ms. Rogers, the RW Program Coordinator for over twenty years, has received HRSA training

on all the major responsibilities of the CARE Act including RSR reporting, Clinical Quality Management (CQM), Performance Outcomes and Indicators, and Fiscal and Programmatic Monitoring. Her extensive experience in the administration of the RW Program will continue to be available to the program through 2019.

Paula Gammell is the CQM Program Manager and Planning Council support staff with 77.6% FTE allocated to Part A as follows: Administration (10.6%), Part A CQM (39%), Part A MAI Admin (2.9%), Part A MAI CQM (5.1%) and Planning Council (20%). Alden Hunter, ASO II, is allocated 39.7% FTE to provide contract preparation, claims processing and sub-recipient compliance oversight with (16.8%) FTE allocated to Part A Admin and (22.9%) FTE to Part A CQM. Helen Zheng, Epidemiologist, provides epidemiological reporting and data analysis at (10.2%) FTE to CQM. Jan Resler, Dental Program Coordinator, provides oversight of the RW Oral Health Preauthorization Program with (7%) FTE allocation to the Part A Administration program. Emitai Bishop, Office Assistant II, provides data entry services at (28.6%) FTE to Part A Administration, and Yian Saechao, Office Assistant II, provides clerical support and claims processing at (14.8%) FTE allocation to Part A Administration. 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) Subrecipient Monitoring
7.A.2)a)i) Program and Fiscal Monitoring, Subrecipeint Findings and Corrective Actions
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 (CAR), the Fisal Agent 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 Sacramento HIV/AIDS Reporting Engine (SHARE). Subrecipienets also are required to submit semi-annual program narratives to the FA, with a cumulative year-end report.

FY17 Site Visits Conducted

In addition to ongoing processes conducted at the Fiscal Agent 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 Fiscal Agent to determine if service quality is within acceptable ranges.

The Fiscal Agents' monitoring tools have been revised to incorporate the new CQM activities, as well as the new processes that are available through the updated data collection system. Additional changes in the monitoring tools have also been 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 describing: 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 provides any necessary technical assistance until all deficiencies are corrected. Contract language allows the FA to terminate services within 30 days if corrections aren't made for any 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.

During FY17, the Fiscal Agent conducted Site Visits for all Part A Sub-recipients. Each of these site visits resulted in corrective action plans but no major deficiencies were found. During the site visits, 563 RW client charts were pulled for Part A site visits and 11.2% of the charts required corrective action which was completed by providers within the required timeframes.

The three most common deficiencies noted during FY17 site visits 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 CQM 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 FY17 documented 467 instances of individual TA to RW service providers, averaging 39 instances of TA per month. RW Consumers received 31 instances of TA, Governmental Agencies received 15, and other Community Agencies 35 instances of TA from the RW Program Administration.

The Technical Assistance provided in FY17 involved a wide range of issues. The most common need for TA consisted of responding to inquiries about entries into the web-based data system (SHARE), either on client intake forms invoice data entry, or inquiries related to access user requests and password updates. TA was also needed for interpretation of updated Council approved service standards and CQM issues, as well as HAB information and AAHIV National advocacy updates. There were also inquiries and TA needed regarding subrecipient contract documentation; 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; HIV/AIDS statistics and health outcome 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 ACA, the Continuum of Care and its implications on the TGA.

During FY17, 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 DHS 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 DHS' Chief Financial Services Officer to ensure that no audit exceptions or serious audit concerns exist. To date, six 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. 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 Fiscal Agent 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, 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 Client Intake Forms that require updating, allowing the FA to regularly monitor sub-recipient adherence to eligibility updates.

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 Fiscal Agent reviews sub-recipient program income records during site visits to ensure that schedule of charges systems are in place, 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 DHS' 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 DHS 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 DHS 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 Priorities and Allocations Committee (PAC) reviews FA reports 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

See Attachment 11 for the Maintenance of Effort (MOE) Table that identifies the baseline aggregate for the Sacramento TGA expenditures for HIV-related core medical and support services during FY17, as well as an estimate of these expenditures for FY18. In addition, the process and elements used to determine the expenditure amounts in the MOE table calculations are discussed in Attachment 11.