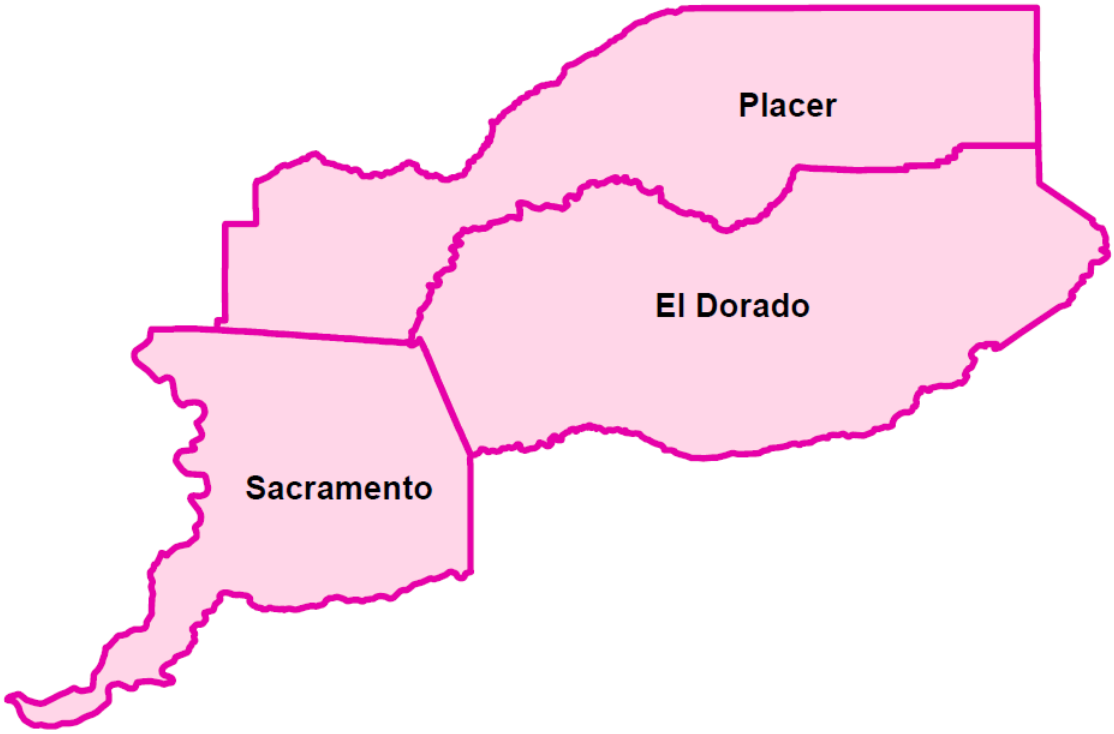
RYAN WHITE C.A.R.E. ACT

SACRAMENTO REGION
PART A APPLICATION
2022 – 2023



SUBMITTED OCTOBER 5, 2021

Fiscal/Administrative Agent
County of Sacramento
Department of Health Services
Division of Public Health
Ryan White C.A.R.E. Program
7001-A East Parkway, Suite 600B
Sacramento CA, 95823

Contact: Chelle Gossett
Office: (916) 875-2776
Confidential Fax: (916) 854-9459
Email: gossettm@saccounty.net

FY 2022 RYAN WHITE PART A GRANT APPLICATION
TABLE OF CONTENTS

EXECUTIVE SUMMARY i
APPLICATION FACE PAGE xi
KEY CONTACTS xiv
PROJECT/PERFORMANCE SITE LOCATION xv
CERTIFICATE REGARDING LOBBYING xvi
BUDGET SUMMARY xvi
BUDGET NARRATIVE xxiv
PROJECT ABSTRACT 1

PROJECT NARRATIVE 2

SECTION 1: INTRODUCTION 2

SECTION 2: NEEDS ASSESSMENT 2
2.A. DEMONSTRATED NEED 2
2.A.1) Epidemiologic Overview 2
2.A.1)a) Summary of HIV Epidemic in Sacramento TGA 2
2.A.1)b) Socio-Demographic Characteristics of HIV Epidemic in TGA 4
2.A.1)b)i. HIV/AIDS Epidemic: Demographic Data Analysis (Attachment 3) 4
2.A.1)b)ii. HIV/AIDS Epidemic and Socioeconomic Data Analysis: TGA and RW Clients 7
2.A.1)c) New and Emerging Subpopulations of PLWH 7
2.A.1)c)i. Identifying New and Emerging Subpopulations, Challenges and Costs 7
2.A.1)c)ii. Increasing HIV/AIDS Cases and Need for HIV Related Services 11
2.A.2) HIV Care Continuum 12
2.A.2)a) Graphic Depiction of HIV Care Continuum 12
2.A.2)b) Care Contiuun Analysis Across Jurisdictions 12
2.A.3) Unmet Need (Attachment 4) 16
2.A.3)a) Unmet Needs Estimate Method and Issues 16
2.A.3)b) Service Needs of PLWH Based on Unmet Need Estimate 17
2.A.3)b)i. Service Needs of Late Diagnosed PLWH 17
2.A.3)b)ii. Service Needs of PLWH with Unmet Need 17
2.A.3)b)iii. Service Needs of PLWH In Care Without Viral Suppression 18
2.A.4) Co-Occurring Conditions (Attachment 5) 18
2.A.4)a) Hepatitis C 19
2.A.4)b) Sexually Transmitted Infections (STIs) 19
2.A.4)c) Mental Illness 20
2.A.4)d) Substance Use Disorders 20
2.A.4)e) Homeless/Unstably Housed 21
2.A.4)f) Former Incarceration 21
2.A.4)g) Tuberculosis 22
2.A.5) Complexities of Providing Care 22
2.A.5)a) Impact and Response to RW Part A Formula Funding Reductions 22
2.A.5)a)i. Impact of Funding Reductions 22
2A.5)a)ii. Response to Funding Reductions: Cost Containment and Transtional Planning 22
2.A.5)b) Healthcare Coverage Among PLWH 23
2.A.5)b)i. Impact of Healthcare Coverage on Services and Health Outcomes 24
2.A.5)c) Factors Limiting Healthcare Access 27
2.A.5)c)i TGA HIV Needs Assessments Findings and Healthcare Access 28

2.A.5)c)ii. Social Determinants of Health and Healthcare Access 31
2.B. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA) EIIHA 32
2.B.1) Planned Activities in TGA's EIIHA Plan for 2022-2024 Period of Performance 32
2.B.1)a) Primary Activities of EIIHA Plan and System Level Interventions 32
2.B.1)b) Collaborations with HIV Prevention, Survellience and Ending HIV Epidemic Programs 36
2.B.1)c) Anticipated Outcomes of EIIHA Strategy 39
2.B.2) Efforts to Remove Barriers and Expand Implementation of Routine HIV Testing 42
2.C. SUBPOULATIONS OF FOCUS 43
2.C.1) Three Subpopulations with Health Outcome Disparities and Unique Service Needs 43
2.C.1)a). Men who have Sex with Men (MSM) – African Americans, Latinx, Youth and Young Adults 44
2.C.1)b). Hetorsexuals – African American Women, Youth and Young Adults 45
2.C.1)c). Injection Drug Users – African Americans, Youth and Young Adults 46
2.C.2) Unmet Need Framework Data and Subpopulations of Focus 46
2.C.3) Continuum of Care Data and Subpopulations of Focus 47
2.C.4) EIIHA Data, Activities and Subpopulations of Focus 49
2.D. Local Pharmaceutical Assistance Program (LPAP) – N/A for Sacramento TGA

SECTION 3: METHODOLOGY 50
3.A. PLANNING RESPONSIBILITIES 50
3.A.1) Letter of Assurance from Planning Council Chair (Attachment 6) 50
3.A.2) Resource Inventory 50
3.A.2)a) Coordination of Services and Funding Streams (Attachment 7) 52

SECTION 4: WORKPLAN 52
4.A. HIV CARE CONTINUUM TABLE AND NARRATIVE 52
4.A.1) HIV Care Continuum Serivices Table (Attachment 8) 52
4.A.2) HIV Care Continuum Narrative 52
4.A.2)a) HIV Care Continuum Changes, Impact and Response 52
4.B. FUNDING FOR CORE AND SUPPORT SERVICES 56
4.B.1) FY2022 Service Category Plan 56
4.B.1)a) Service Category Plan Table (Attachment 9) 56
4.B.1)b) MAI Service Category Plan Narrative **56**
4.B.1)b)i. MAI Implmenentation to Address Subpopulations of Focus 56
4.B.1)b)ii. MAI Implementation to Decrease Health Disparities and New HIV Infections 57
4.B.1)c) Unmet Need 59
4.B.1)c)i Interventions to Improve Outcomes for PLWH with Unmet Need 59
4.B.1)c)ii Activities to Re-engage in Care PLWH with Unmet Need 59
4.B.1)d) Core Medical Services Waiver (not applicable to Sacramento TGA) 60

SECTION 5: RESOLUTION OF CHALLENGES 60

SECTION 6: EVALUATION AND TECHNICAL SUPPORT CAPACITY 63
6.A. CLINICAL QUALITY IMPROVEMENT (CQI) 63
6.A.1) Changes to CQI Program Based on Past Outcomes and Experiences 63
6.A.2) CQI Data to Improve Patient Care, Outcomes, and Long-Range Planning 64

SECTION 7: ORGANIZATIONAL INFORMATION 67
7.A. GRANT ADMINISTRATION 67
7.A.1) Program Organization 67
7.A.1)a) Administration of Part A and MAI Funds within TGA (Attachments 1, 2, 11) 67

7.A.1)b) Administration of Part A Funds by Contractor 69
7.A.2) Grant Recipient Accountability 69
7.A.2)a) Subrecipient Monitoring 69
7.A.2)a)i. Program and Fiscal Monitoring, Subrecipient Findings, and Corrective Actions 69
7.A.2)a)ii. Subrecipient Compliance with Audit Requirements 71
7.A.2)a)iii. Corrective Actions Taken for Audit Findings 71
7.A.2)b) Third Party Reimbursement 72
7.A.2)b)i. Processes to Ensure Monitoring of Third Party Reimbursement by Subrecipients 72
7.A.2)b)ii. Eligibility Documentation to Ensure RW is Payer of Last Resort 72
7.A.2)b)iii. Monitoring and Tracking of Program Income at Recipient and Subrecipient Levels 72
7.A.2)c) Fiscal Oversight 73
7.A.2)c)i. Fiscal Staff Coordination and Accountability 73
7.A.2)c)ii. Tracking of Formula, Supplemental, MAI and Carryover Funds 73
7.A.2)c)iii. Subrecipient Reimbursement Process 73
7.B. MAINTENANCE OF EFFORT (MOE) and MOE BUDGET ELEMENTS (Attachment 12) 74

ATTACHMENTS

Attachment 1: Staffing Plan, Job Descriptions and Biographical Sketches for Key Personnel
Attachment 2: FY 2022 Agreements and Compliance Assurances, Certifications
Attachment 3: HIV/AIDS Demographic Table
Attachment 4: Unmet Need Framework
Attachment 5: Co-occuring Conditions Table
Attachment 6: Letter of Assurance from Planning Council Chair
Attachment 7: Coordination of Services and Funding Streams Table
Attachment 8: HIV Care Continuum Services Table
Attachment 9: Service Category Plan Table
Attachment 10: Core Medical Services Waiver Request (Not Applicable)
Attachment 11: Program Organizational Chart
Attachment 12: Maintenance of Effort (MOE) Documentation
Attachment 13: Federally Negotiated Indirect Cost Rate Agreement (Not Applicable)

This page intentionally blank

SACRAMENTO REGION RYAN WHITE (RW) HIV/AIDS PROGRAM
PART A GRANT APPLICATION FY 2022
EXECUTIVE SUMMARY

RW HIV Part A grant application is submitted to the U.S. Department of Health and Human Services, HIV/AIDS Bureau, to compete for funding for the Sacramento Transitional Grant Area (TGA) of Sacramento, El Dorado, and Placer Counties. The TGA became eligible to apply for RW Part A funds in 1995 when it reached the threshold of 2,000 residents with AIDS (Acquired Immune Deficiency Syndrome). AIDS is caused by the human immunodeficiency virus (HIV) which damages the immune system if not treated. RW Part A funds are used to provide HIV medical care and support services for People Living with HIV or AIDS (PLWH) who have no other source of funding. The 2022 grant application for this funding includes the following sections:

SECTION 1: INTRODUCTION

RW Program's intended use of Part A grant funds to support a comprehensive continuum of high-quality care for PLWH in the TGA who rely on these funds as a payor of last resort.

SECTION 2: NEEDS ASSESSMENT

- Analysis of TGA's HIV epidemic, co-occurring conditions; RW service utilization and costs; Unmet Need (PLWH who know their HIV status but are not in care); Early Identification of PLWH; Minority AIDS Initiative (MAI); and HIV Care Continuum outcomes for the TGA's RW clients compared to all PLWH in the TGA, State and Nation.

- Identification of subpopulations of TGA's RW clients with disproportionately poor health outcomes and inequitable access to care with disparities compared to overall TGA, State and National outcomes for PLWH.

SECTION 3: METHODOLOGY

Description of HIV Health Services Planning Council (Council) functions: priority setting; resource allocation; needs assessment; membership training; administrative assessment; and service and funding stream coordination.

SECTION 4: WORKPLAN

RW HIV Care Continuum Table, including Part A and MAI funding by core medical and support service; projected number of clients; service units; and subpopulations of focus; including interventions to decrease health disparities; HIV infections; and improve outcomes for PLWH not in ongoing medical care (unmet need).

SECTION 5: RESOLUTION OF CHALLENGES

Summary of workplan implementation challenges, including new and ongoing strategies to resolve issues.

SECTION 6: EVALUATION AND TECHNICAL SUPPORT CAPACITY

Description of Clinical Quality Improvement (CQI) program structure; projects; performance measures; data management systems; and utilization of CQI results to improve service delivery.

SECTION 7: ORGANIZATIONAL INFORMATION

Description of RW Part A funds administration, including Fiscal Agent staffing; provision of technical assistance; site visits; and subrecipient contract monitoring to confirm program and fiscal compliance and oversight of third-party reimbursement to ensure RW is payor of last resort.

NEEDS ASSESSMENT SECTION SUMMARY

The needs assessment section is used by the TGA's HIV Health Services Planning Council for priority setting and resource allocation to improve HIV care and expand access to critical services for PLWH who rely on the RW Part A Program as payor of last resort for their HIV medical care and support services. Due to its importance and potential use as a roadmap for those working towards ending the HIV epidemic in the TGA, the rest of the Executive Summary focuses on the needs assessment section.

Trends in the TGA's HIV/AIDS epidemiology; RW client demographics: co-occurring conditions, service utilization, costs; and outcomes along the HIV Care Continuum are summarized with specific attention to subpopulations of focus with unique service needs. Unmet Need data, which includes PLWH who know their HIV status but are not in care; late diagnosed PLWH, and PLWH in care but not virally suppressed, also is summarized.

It must be noted that several variables create discrepancies in figures when conducting direct comparative analyses across jurisdictions (TGA, RW Program, California and the Nation). For example, the data requirements for HIV/AIDS Epidemiology, HIV Care Continuum and Unmet Needs Framework do not match exactly due to differences in date ranges, definitions, and formats of each database and jurisdiction. Given this caveat, the RW Program remains diligent in in efforts to conduct a data driven process to understand the state of the TGA's HIV/AIDS epidemic, and the needs of its clients.

OVERALL TRENDS IN SACRAMENTO TGA'S HIV EPIDEMIOLOGY

- There has been a 23% increase in the number of people living with AIDS in the TGA over the last 25 years, from 2,215 to 2,723 cases, between 1995 and 2020.

- Beginning in 2010, HIV began being tracked separately from AIDS. Over the last 10 years, between 2010 and 2020, there was a 45% increase in the number of People Living with HIV or AIDS (PLWH) in the TGA, from 2,696 to 5,347 cases of HIV or AIDS.

- The rise in PLWH has occurred throughout the TGA, in the large urban County of Sacramento (+36%), and the two rural counties of Placer (+58%) and El Dorado (+38%) since 2010.

- There has been a 79% increase in the number of RW clients between 1997 and 2020 (from 1,359 to 2,436).

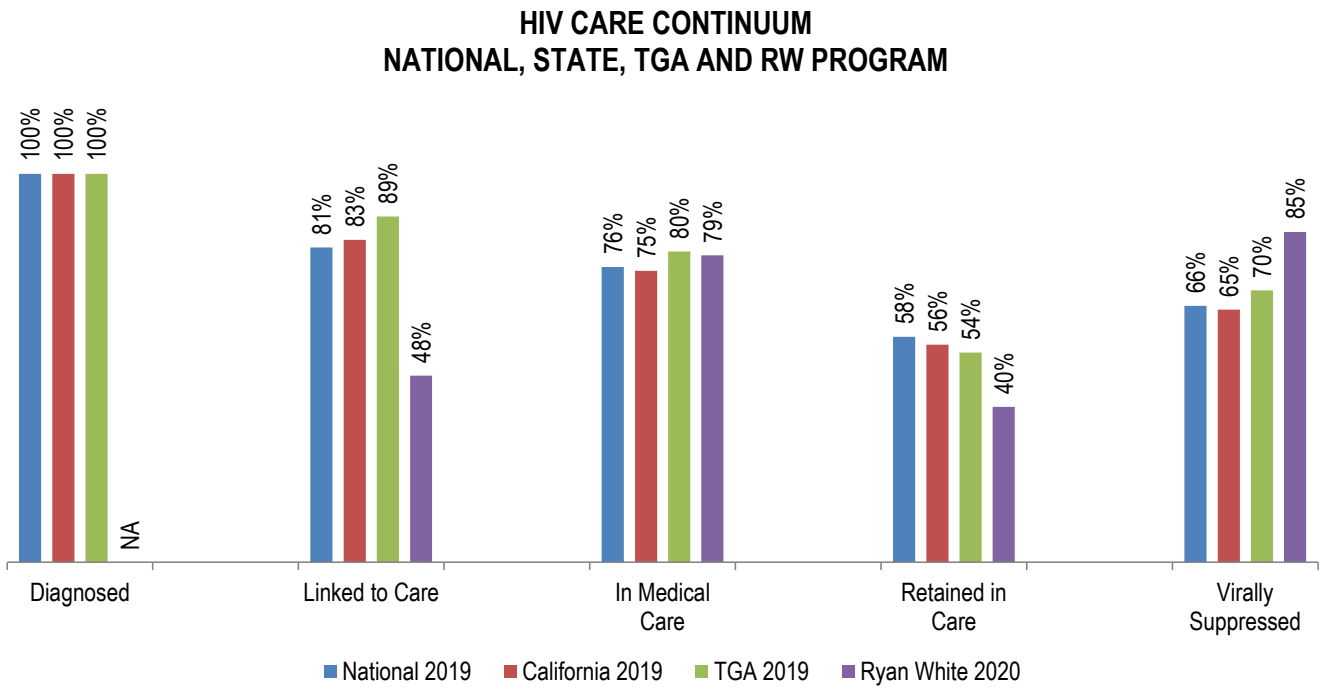
STATUS OF HIV CARE CONTINUUM

The TGA's RW Program's successes and challenges are documented in the following bar graph where baseline rates of RW clients are compared not only to the National and California rates, but to the TGA's total population of PLWH for five measures that comprise the National HIV/AIDS Strategy (NHAS).

HIV Care Continuum Definitions:

- *Diagnosed HIV Infection:* number of persons aged > 13 years with diagnosed HIV infection at end of calendar year.
- *Linked to HIV Medical Care:* newly diagnosed with HIV in year w/ CD4 or viral load test within one month of diagnosis.
- *In Medical Care:* * RW and Nation ≥1 viral load or CD4 test within year. TGA and CA ≥CD4, viral load or HIV-1genotype test
- *Retained in Care:** RW and TGA ≥2 visits ≥3 months apart in year; for CA ≥2 CD4, viral load, or HIV-1 genotype tests ≥3 months apart in year; for Nation, ≥2 tests (CD4 or VL) ≥3 months apart in year.
- *Viral Suppression:* most recent HIV viral load test result in year ≤ 200 copies/ml.

**Note:* Definitions vary slightly between jurisdictions and must be considered when comparing outcome data.



HIV CONTINUUM OF CARE ANALYSIS ACROSS JURISDICTIONS

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

Diagnosed HIV Infection:

- The diagnosed-based HIV Care Continuum includes all PLWH who have been diagnosed with HIV, so all jurisdictions that conduct HIV testing are at 100%. The RW Part A Program does not conduct HIV testing.

Linked to HIV Medical Care:

- A smaller proportion of PLWH with a new HIV diagnosis were linked to HIV care within 30 days of diagnosis in the TGA's RW program in FY20 (48%) than in the TGA (89%), California (83%), or the Nation (81%) in CY19.

- African Americans had the lowest Linkage to Care in California (80%) and the Nation (78%), while Hispanics had the lowest linkage to care rate for the TGA (87%).

In Medical Care:

- RW clients were more likely to be in medical care in FY20 (79%) than PLWH in California (75%), the Nation (76%) and slightly less likely than the TGA in CY19 (80%).

- African Americans had the lower "In Medical Care" rates than all other racial groups across all jurisdictions (RW, TGA, California and the Nation).

- MSMs (78.9%) and Heterosexuals (85.9%) were less likely than IDUs (88.5%) to be in RW medical care.

Retained in Care:

- RW clients were less likely to be retained in care in FY20 (40%) than PLWH in the TGA (54%), California (56%) and the Nation (58%).

- African Americans had the lowest rates of "Retained in Care" for RW, the TGA, California and the Nation.

Virally Suppressed:

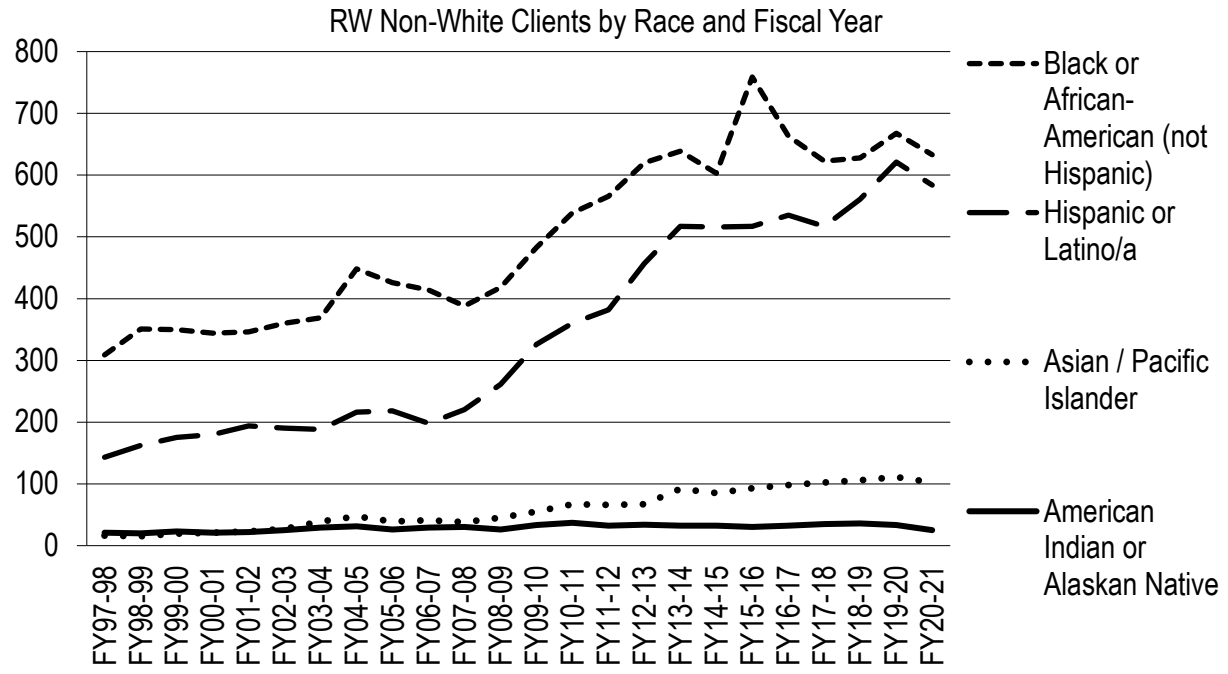
- RW client viral suppression rates in FY20 (85%) were once again higher than all other jurisdictions: the TGA (70%), California (65%) and the Nation (66%) in CY19. This is evidence that the low retention in care figures likely are a RW reporting problem, rather than a service provision problem.

- Both African Americans and Hispanics had lower rates of viral suppression than the average across the HIV Care Continuum (RW, TGA, CA and Nation).

- African Americans (74%) and Hispanics (81%) were virally suppressed at rates lower than FY20 RW clients 85% overall (85%).

TRENDS AMONG SACRAMENTO TGA'S RW PROGRAM SUBPOPULATIONS OF FOCUS

RACE TRENDS



Trends in the TGA since the RW Program began in the TGA in 1997 underscore the disproportionate spread of HIV/AIDS among People of Color (African Americans, Hispanics, Asian/Pacific Islanders and American Indian / Alaska Natives), and low RW service utilization for People of Color (POC) in many service categories, as follows:

People of Color:

- When the TGA's RW Program began in 1995, POC comprised 27% of AIDS incidence (new cases of AIDS). Since then, AIDS incidence among POC more than doubled to 65% by 12/31/20.

- In FY13, people of color became the majority of RW clients and have stayed the majority through FY20 (from 38% to 55%).

- Hispanic RW clients increased over 4 times (from 143 to 584); African Americans more than doubled (309 to 633); and Asian/Pacific Islanders increased over 6 times (from 16 to 102) between 1996 and 2020.

African Americans:

- Although African Americans made up only 7% of the TGA's general population in 2019, they were 22% of PLWH (HIV/AIDS prevalence), 22% of new HIV cases (HIV incidence) and 25% of AIDS incidence during the most recent reporting period through 12/31/20.

- African Americans increased from 15.0% to 24.9% of new AIDS cases between 1995 and 2020.

- There was a 32.8% increase in the number of African American PLWH (855 to 1,175) and only a 1% growth in African Americans in the TGA's general population between 2012 and 2020.

- African Americans (78.2%) were less likely to be in RW medical care than Hispanics (79.1%) or Whites (78.7%).

- African Americans were the largest racial group among heterosexual RW clients in FY20 (40.4%), much higher than the 26% of FY20 African American RW clients or 22.0 % of PLWH in the TGA as of 12/31/20.

Hispanics:

- Hispanics has the greatest increase of all racial groups, from 6.0% to 29.6% of all new AIDS cases between 1995 and 2020.

- The increase in Hispanic PLWH was more than 7 times the rate of Hispanics in the TGA's general population (61.6% vs. 7.9%) over the last five years.

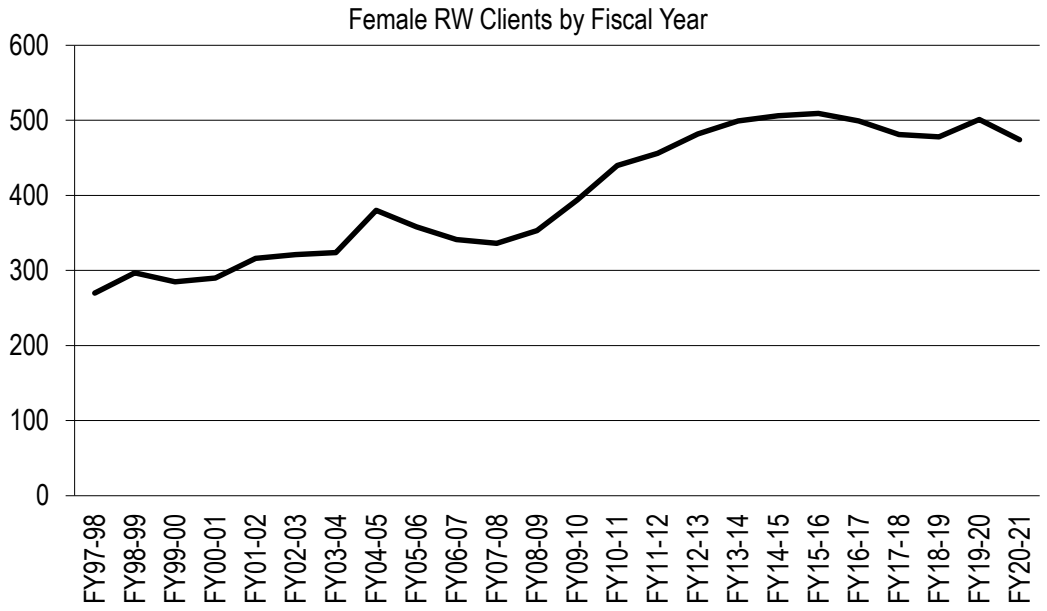
- Hispanic PLWH increased at almost twice the rate of PLWH in the TGA overall (8.3% and 5.2%, respectively) between 2019 and 2020.

- 69.3% of Hispanic RW clients in FY20 reported MSM as their HIV mode of transmission.

- Hispanics were disproportionately represented among youth ages 20-24 (33.3%) vs. RW clients overall (24%).

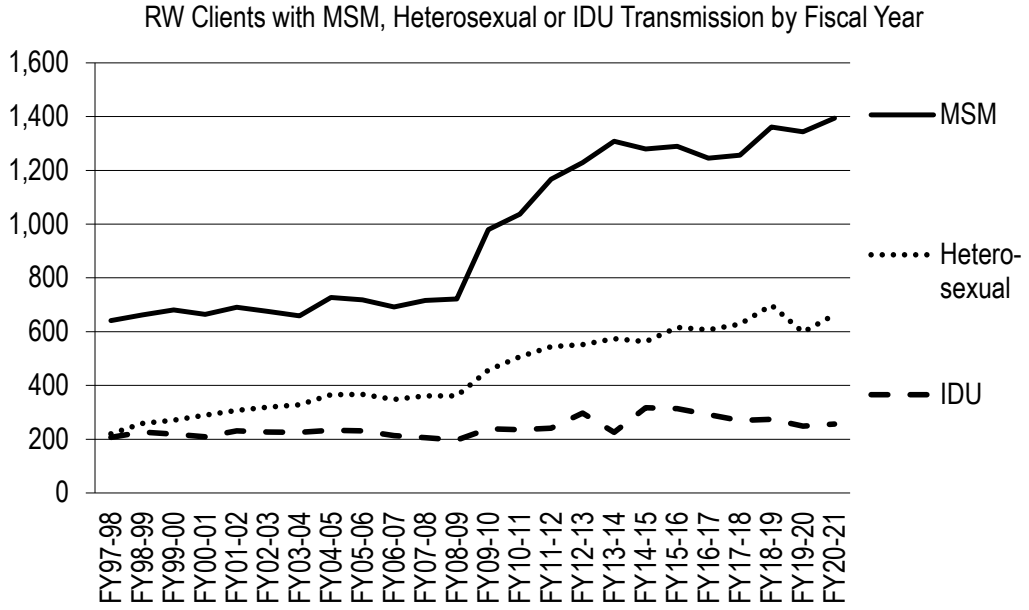
- Hispanics had the lowest RW service utilization and cost per client ($1,344) compared to all other races in FY20: African Americans ($1,582), Whites ($1,584), and Asian/Pacific Islanders ($1,785).

GENDER TRENDS:



- RW females increased 75.6% between FY1997 to FY2020, from 270 to 474 clients.
- 44.9% of female FY20 RW clients were African American, which is much higher than the 25.9% of RW clients; and 7.2% of African Americans in the TGA's 2019 general population.
- RW transgender clients were 2.2% of FY20 RW clients (54 clients), up from 1.8% of FY19 RW clients (50 clients).

HIV TRANSMISSION TRENDS



Men who have Sex with Men (MSM):

- MSM transmission decreased from 65.0% of new AIDS cases to 46.2% between 1995 and 2020.
- Between 2019 and 2020, AIDS incidence among MSMs increased 61.5% (52 to 84 new cases); AIDS prevalence increased 1.0% (1,435 to 1,449) and HIV prevalence increased by 3% (from 1,446 to 1,491).
- HIV incidence decreased by 14.2% (247 to 212 new HIV cases) between 2019 and 2020.
- MSMs (78.9%) and Heterosexuals (85.9%) were less likely than IDUs (88.5%) to be in RW medical care in FY20.
- MSM RW clients ages 20-24 were under half the average cost per RW client overall ($732 vs. $1,528) in FY20.
- 41.4% of African American RW clients were MSMs and had a 79.8% lower cost per client than RW clients overall.

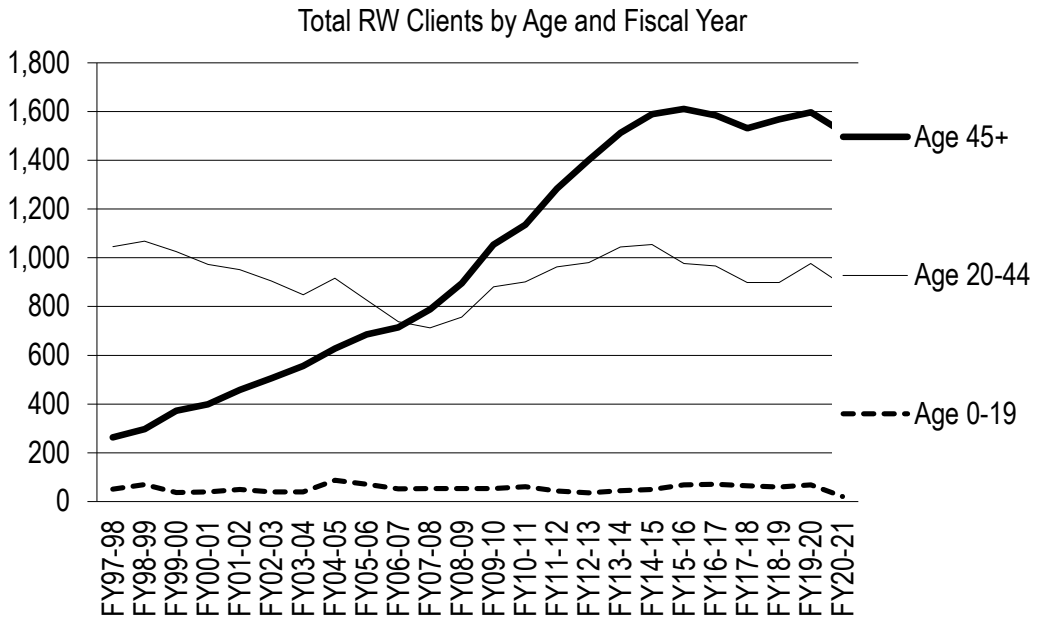
Heterosexuals:

- A steady increase in the number of PLWH reporting heterosexual contact as their HIV mode of transmission has occurred since the beginning of TGA's RW Program (7% vs. 15.8% of PLWH).
- Heterosexuals, which includes High Risk Heterosexuals, was the second largest percent of PLWH in the TGA (15.8%); and the second highest among newly diagnosed HIV (7.6%) and AIDS cases (14.3%) as of 12/31/20.
- Among PLWH in the TGA, there were almost twice as many Heterosexuals than IDUs (843 vs. 425) as of 12/31/20.
- Within the RW Program, clients reporting heterosexual transmission (High Risk and non-HR combined) tripled between 1997 and 2020 (from 220 to 663 clients).
- 27.2% of FY20 RW clients reported heterosexual transmission, compared to 15.8% of PLWH in TGA.
- African Americans were 40.4% of Heterosexual RW clients, compared to 26.0% of RW clients overall in FY20.

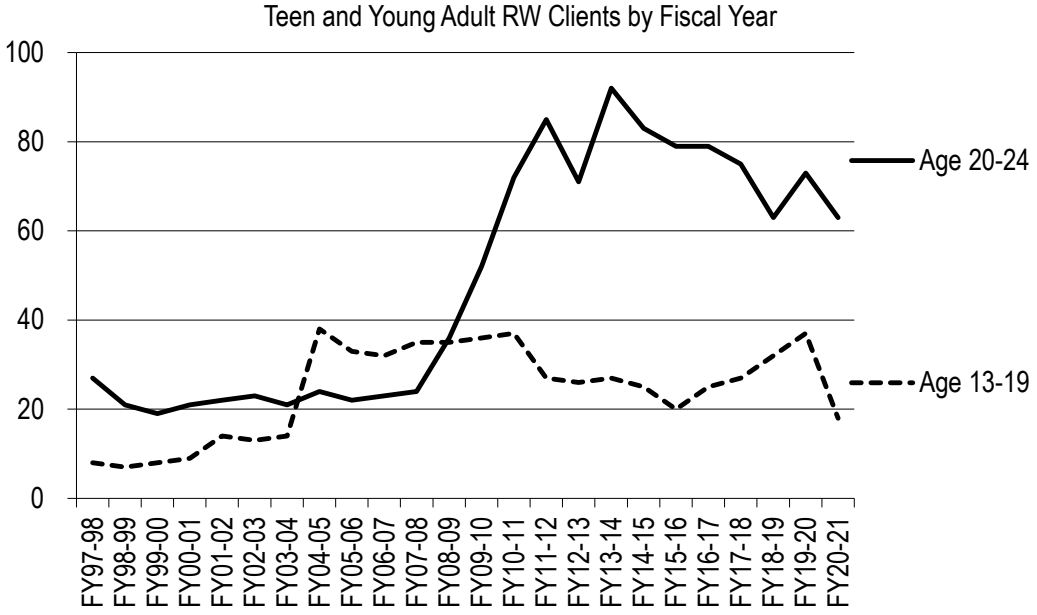
Injection Drug Users (IDUs):

- IDU transmission accounted for 12.7% of HIV incidence; 14.3% of AIDS incidence; 19.5% of AIDS prevalence; 11.1% of HIV prevalence; and 15.3% of PLWH in the TGA as of 12/31/20.
- AIDS incidence among IDU transmission increased by 125% (from 8 to 18); AIDS prevalence increased by 2.9% (276 to 284) and HIV prevalence increased by 3.7% (136 to 141) between 12/31/19 and 12/31/20.
- IDUs were underrepresented among FY20 RW clients (10.5%) compared to their representation in the HIV/AIDS epidemic overall (15.3%) as of 12/31/20.
- African American IDUs were overrepresented among FY20 RW clients in the MAI Program (48.9%).

AGE TRENDS AMONG RW CLIENTS



- The number of RW clients 19 and younger decreased 61% between FY 1997 and FY 2020.
- The number of RW clients between the ages of 20-44 decreased 15% between FY 1997 and FY 2020.
- The number of RW clients aged 45 and older has increased more than 5-fold between FY 1997 and FY 2020.



Teen and Young Adults:

- The HIV epidemic has continued to have an increasing impact on youth and young adults across the TGA, including an increase in the number of youth and young adult RW clients over time.

- Youth and young adult RW clients have continued to climb since the inception of the TGA's RW Program in 1997. RW clients ages 13-24 increased by 131% from 1997 to 2020.

- Hispanics were 33.3% of RW clients ages 20-24 compared to 24.0% of RW clients overall in FY20.

- 60.5% RW clients ages 13-24 reported MSM as their mode of HIV transmission compared to 57.2% of RW clients overall in FY20.

TRENDS AMONG RW CLIENTS: CO-OCCURRING CONDITIONS AND SOCIAL DETERMINANTS OF HEALTH

RW Client Housing, Poverty, Insurance and Mortality Trends

Homeless/Unstably Housed:

- 10.9% of RW clients were either homeless or unstably housed in FY20, (up from 8.5% in FY19 and 6.6% in FY18) compared to a 2019 homeless rate of 0.32% in the TGA's general population. An additional 5.8% of RW clients were in temporary housing.
- Alarmingly, 18.2 % of *new* FY20 RW clients were homeless or unstably housed; which is higher than the already high 14.0% of new FY19 RW clients that were homeless or unstably housed.

- African Americans are increasingly overrepresented among homeless or unstably housed FY20 RW clients (34.9%) compared to African American representation in the TGA overall (7.3%).

- 18.7% of PLWH in the TGA's 2018 Needs Assessment survey reported that they were currently homeless or in unstable housing (living on the street, in a car or in a shelter) in the previous two years.

Poverty:

- 63.0% of FY20 RW clients had no income or were living at or under 100% of poverty as compared to 11.0% of the TGA's 2019 general population.

- Only 7.2% of FY20 RW clients were living above 300% of poverty as compared to 60.0% of the TGA's 2018 general population.

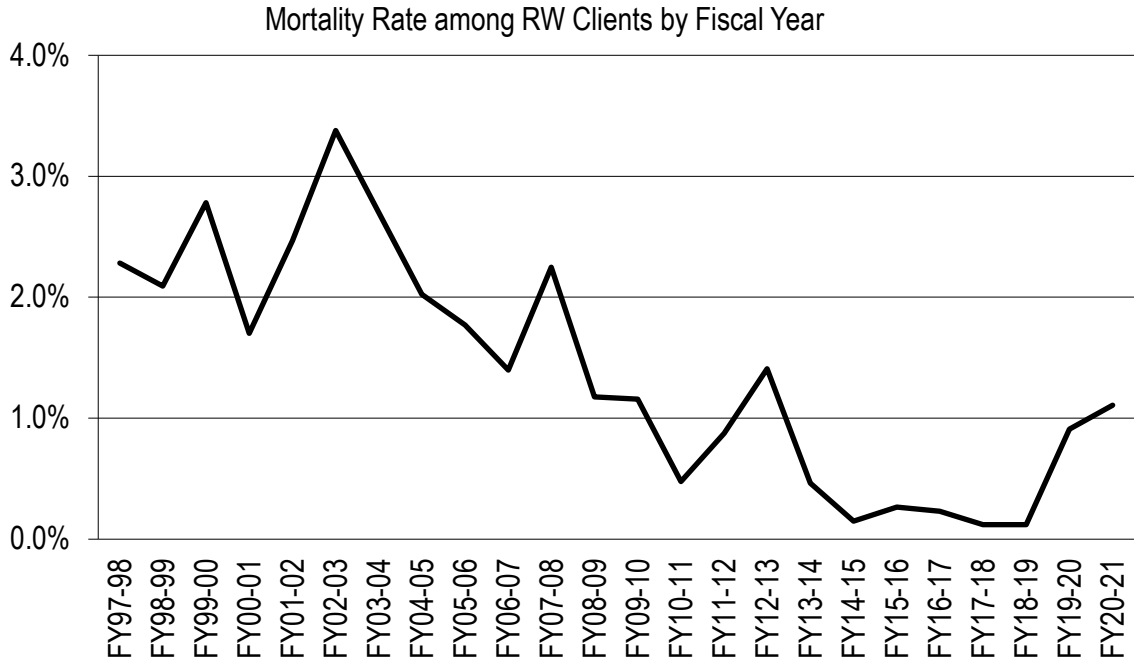
Insurance Status:

- Only 14.6% of FY20 RW clients had any form of private healthcare insurance, as compared to 68.3% of the TGA's general population in 2019.

- 75.1% of FY20 RW clients had Medicaid or Medicare insurance vs. 45.2% of the TGA's 2019 general population.

RW Client Mortality Trends

- After peaking at 3.4% in FY2002, RW client mortality had since dropped to a low of 0.1% in FY17 and remained there until FY19. With 24 RW client deaths in FY19 and 27 in FY20, the mortality rate has jumped to 0.9% in FY19 and 1.1% in FY 20, the highest rates since FY12. This upward trend in FY19 and FY20 may be due to the impact of COVID-19, as the RW fiscal year runs from March through February.



OMB Number: 4040-0004
Expiration Date: 12/31/2022

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 10/05/2021

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier: H89HA00048

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: County of Sacramento

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6000529

* c. Organizational DUNS: 1371337030000

d. Address:

* Street1: 7001A East Parkway, Suite 600A
Street2:
* City: Sacramento
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 95823-2501

e. Organizational Unit:

Department Name: Department of Health Services

Division Name: Public Health

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Michelle
Middle Name:
* Last Name: Gossett
Suffix:

Title: Senior Health Program Coordinator

Organizational Affiliation:

* Telephone Number: 916-875-2776
Fax Number: 916-854-9459

* Email: gossettm@saccounty.net

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-22-018

* Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

HRSA-22-018

Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Sacramento Transitional Grant area including Sacramento, El Dorado and Placer Counties.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: Fifth

* b. Program/Project: 3,4,5

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2022

* b. End Date: 02/28/2023

18. Estimated Funding ($):

* a. Federal	3,764,772.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	3,764,772.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☒ a. This application was made available to the State under the Executive Order 12372 Process for review on 10/06/2021.

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:

* First Name: Paula

Middle Name:

* Last Name: Gammell

Suffix:

* Title: Human Services Program Planner

* Telephone Number: 916-876-5548

Fax Number: 916-854-9459

* Email: gammellp@saccounty.net

* Signature of Authorized Representative: Paula Gammell

* Date Signed: 10/05/2021

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**

County of Sacramento

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Ryan White CARE Program Coordinator

Prefix:

* First Name: Michelle

Middle Name:

* Last Name: Gossett

Suffix:

Title: Senior Health Program Coordinator

Organizational Affiliation:

County of Sacramento-Dept of Health Svcs-Div. of Pub. Health

* Street1: 9616 Micron Avenue, Suite 930

Street2:

* City: Sacramento

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 95827-2625

* Telephone Number: 916-875-2776

Fax: 916-854-9459

* Email: gossettm@saccounty.net

Next Person

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: County of Sacramento

DUNS Number: 1371337030000

* Street1: 7001A East Pkwy, Suite 600

Street2:

* City: Sacramento

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 95823-2501

* Project/ Performance Site Congressional District: CA-005

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code:

* Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION

County of Sacramento

* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE

Prefix: | * First Name: Paula | Middle Name:

* Last Name: Gammell | Suffix:

* Title: Human Services Program Planner

* SIGNATURE: Paula Gammell | * DATE: 10/05/2021

Tracking Number:GRANT13479968 Funding Opportunity Number:HRSA-22-018 Received Date:Oct 05, 2021 04:47:46 PM EDT

RWHAP PART A BUDGET SUMMARY
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

	Part A			Minority AIDS Initiative (MAI)			Total
Object Class Categories	**Administration**	**CQM**	**HIV Services**	**Administration**	**CQM**	**HIV Services**	
a. Personnel	$ 122,799	$ 88,974		$ 11,928	$ 5,921		**$ 229,622**
b. Fringe Benefits	$ 75,379	$ 48,773	$ -	$ 6,828	$ 3,459	$ -	**$ 134,439**
c. Travel	$ 2,958	$ -	$ -	$ -	$ -	$ -	**$ 2,958**
d. Equipment	$ 2,500	$ -	$ -	$ -	$ -	$ -	**$ 2,500**
e. Supplies	$ 5,800	$ 200	$ -	$ -	$ -	$ -	**$ 6,000**
f. Contractual	$ 44,000	$ -	$ 2,832,962	$ -	$ -	$ 183,549	**$ 3,060,511**
g. Other	$ 49,554	$ 13,548	$ -	$ 874	$ 435	$ -	**$ 64,411**
Direct Charges	**$ 302,990**	**$ 151,495**	**$ 2,832,962**	**$ 19,630**	**$ 9,815**	**$ 183,549**	**$ 3,500,441**
Indirect Charges	**$ 30,299**	**$ 15,150**		**$ 1,963**	**$ 981**		**$ 48,393**
TOTALS	**$ 333,289**	**$ 166,645**	**$ 2,832,962**	**$ 21,593**	**$ 10,796**	**$ 183,549**	**$ 3,548,834**
Program Income							**$ -**

FY2022 Funding Ceiling:	
Part A Funding	$ 3,332,896
MAI Funding	$ 215,938
Total:	**$3,548,834.00**

Administrative Budget 10%
Part A and MAI Within Limit

CQM Budget 5%
Part A and MAI Within Limit

PART A ADMINISTRATIVE BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Personnel

Salary	FTE	Name, Position	Budget Impact Justification	Amount
$ 122,096	0.25	Sr. Health Program Coordinator (Gossett) 12 mos	Oversees daily operations of Part A. Monitors contractual obligations of contractors, MOU's with participating counties; Monitors expenditure rate and reallocation process, Negotiates yearly contract rates with contractors, Provides technical assistance, Coordinates functions of Part A program with other AIDS programs, including Part B, C and D program, AIDS Drug Assistance Program, and County STD, Public Health Surveillance and Prevention. Engage Planning Council in long-range planning. Keep Council apprised of strategic issues and trends in health and human services in the region. Facilitate collaboration in carrying out Planning Council activities. Develop performance improvement plans and monitor and report on Performance Outcomes. Identify and pursue opportunities for program enhancement.	$ 30,524
$ 124,386	0.01	Human Services Program Planner, (Gammell) 12 mos	Assists the Sr. Health Program Coordinator in overseeing daily operations of Part A and Part A MAI Programs and contract monitoring as well as expenditure and utilization monitoring. Disseminates program changes and program reports to sub-recipients. prepares various mandatory program reports and Conditions of Award. Assists sub-recipients in accessing SHARE database and database issues and provides Technical Assistance on various issues.	$ 1,244
$ 59,778	0.53	Account Technician, (Chang) 12 mos	Supports program by keeping track of sub-recipient expenditures with the SHARE data base, processes invoices for Sr. Health Program Coordinator to review, reconciles program spreadsheets, keeps program files accurate and in order, prepares and runs reports for the program as needed, works with sub-recipients who have program invoicing questions, takes minutes at committee meetings.	$ 31,682
$ 110,918	0.07	Dental Program Coordinator (Resler) 12 mos	Oversees pre-authorizations for Dental Project services to assure compliance with Dental Rate Schedule and Eligible Dental Procedures.	$ 7,764
$ 99,109	0.08	Admin. Services Officer II (Hunter) 12 mos	Supports program through preparing direct services contracts and amendments, tracking their expenditures and related required documentation. Assist in the Ryan White claims process, drafts Board Letters, implements sub-recipient contract changes; and provides routine clerical support to Ryan White program staff; Run specialized data reports from Report Manager and Access queries for Quality Management reviews, special studies, and contractor monitoring visits.	$ 7,929
$ 108,788	0.10	Epidemiologist (Zheng) 12 mos	Provides epidemiology data to program for grant writing and other reporting purposes. Assists program with HIV cluster and other relevant programmatic information.	$ 10,879
$ 78,999	0.10	Admin. Services Officer I (Thomasson) 12 mos	Liaison with Information Technology (IT), travel and mileage claims, and Planning Council Member reimbursement expenses. Supports program through routine clerical assistance.	$ 7,900
			Personnel Total	**$ 97,922**

Fringe Benefits

Percentage	Components	Amount
21.61%	Retirement	$ 21,157
3.49%	Retirement Health Savings Account	$ 3,417
3.73%	401K Match	$ 3,652
7.66%	FICA/SSI	$ 7,501
25.65%	Health insurance	$ 25,119
	Fringe Benefit Total	**$ 60,846**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
0.575	72.46/mo	Sr. Health Program Coordinator, Gossett	Local mileage - Conduct site sub-recipient site visits; attend HIV Planning Council committee meetings; provide TA to sub-recipients; attend off-site Training opportunities; participate in community continuum of care meetings and events.	$ 500
0.575	72.46/mo	Human Services Program Planner, Gammell	Local mileage - Conduct site sub-recipient site visits; attend HIV Planning Council committee meetings; provide TA to sub-recipients; attend off-site Training opportunities; participate in community continuum of care meetings and events.	$ 500
			Local Travel Sub-Total	**$ 1,000**

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
Air	Sr. Health Program Coordinator, Gossett	Airfare = $550, Hotel = $189 +20% taxes and fees x 4 nights = $907, meals at per diem rates $71 x 5 days = $355; parking = $18/day x 5 days = $90, transportation to and from airport = $31, incidentals $5/day x 5 days = $25; Attend US Conference on HIV/AIDS to obtain current information and best practices for administering HIV/AIDS programs x 1 staff	$ 1,958
		Long Distance Travel Sub-Total	**$ 1,958**
		Travel Total	**$ 2,958**

PART A ADMINISTRATIVE BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Equipment

List of Equipment	Budget Impact Justification	Amount
Copy machine maintenance	Copy machine lease and maintenance agreements. Software license fees;	$ 2,200
	Equipment Total	**$ 2,200**

Supplies

List of Supplies	Budget Impact Justification	Amount
Copy Paper, Printer Cartridges, Pens, Highlighters, Pencils, Erasers, Post It Notes, Paper Clips, Pens, Flash Drives, Highlighters, Pencils, Erasers, Ink Refill, etc.	General consumable office supplies necessary to perform the work of administering the Ryan White Care Act funds.	$ 2,700
	Supplies Total	**$ 2,700**

Contractual

List of Contract	Deliverables	Budget Impact Justification	Amount
Lili Joy Consulting Company	Part A Grant Application guidance review, original writing of application	Consultant for grant application; analyzes drafts of the application comparing to the Guidance to identify any missing components, and original writing. (235.87 hrs x $101.75/hr) Costs estimated based on previous years total hours for this project.	$ 24,000
		Contracts Total	**$ 24,000**

Other

List of Other	Budget Impact Justification	Amount
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals.	$ 8,507
Training	Cost of mandatory supervisory County training sessions for Sr. Health program Coordinator and Program Planner; training on new software for staff.	$ 2,000
OCIT-Data Processing/SHARE/MIS	SHARE is the unique client-level database for the Sacramento TGA. This expense includes data Processing for the RSR; Development and on-going maintenance of the data import program from sub-recipients; update of SHARE database reports; (IT programming $100 per hour x 330 hours)	$ 28,080
Lease	Cost of rent per person for building. All rent charges are applied on a per FTE basis.	$ 2,110
Postage	Routine postage, share of postage machine equipment and maintenance and federal Express charges.	$ 1,500
Printing/Duplicating	Printing of routine administrative documents.	$ 1,800
	Other Costs Total	**$ 43,997**

Total Direct Cost

	$ 234,623

Indirect Cost

Type of Indirect Cost	Rate	Insert Base	Total
Provisional	**10% de minimis**	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.	**$ 23,462**

Part A Administrative Total

	$ 258,085

PART A PLANNING COUNCIL BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Personnel

Salary	FTE	Name, Position	Budget Impact Justification	Amount
$ 124,386	0.20	Human Services Program Planner, (Gammell)	Manage operational support and assist the HHSPC in meeting its obligations which include adequate structure and governance, diverse and representative membership; annual priorities and allocations process; administrative assessment of the grantee; development of a comprehensive HIV Services Plan for the Sacramento TGA; increase access to services; Assessment of need for HIV services; assist the Sr. Health Program Coordinator with operations of Part A.	$ 24,877
			Personnel Total	**$ 24,877**

PART A PLANNING COUNCIL BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Fringe Benefits

Percentage	Components	Amount
20.53%	Retirement	$ 5,107
1.49%	Retirement Health Savings Account	$ 371
4.00%	401K Match	$ 995
7.65%	FICA/SSI	$ 1,903
24.75%	Health insurance	$ 6,157
	Fringe Benefit Total	**$ 14,533**

Travel

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
		Long Distance Travel Sub-Total	**$ -**
		Travel Total	**$ -**

Equipment

List of Equipment	Budget Impact Justification	Amount
Copy Machine Lease and maintenance agreements	Provide HHSPC with required documentation for Council meetings ($25/mo. x 12/mos.)	$ 300
	Equipment Total	**$ 300**

Supplies

List of Supplies	Budget Impact Justification	Amount
Refreshments for Council meetings and annual retreat ($25/mo. x 12; $300 x 1 retreat meeting)	Provide non-aligned Council members with refreshments during Council meetings to help maintain their energy during long meetings.	$ 600
General office supplies: paper; staples; writing pads; pens; paper clips; printer cartridges; stickie notes; rubber bands; Large Binders for Council Governance manual; etc.	General consumable office supplies to support the work of the HIV Health Services Council.	$ 2,500
	Supplies Total	**$ 3,100**

Contractual

List of Contracts	Deliverables	Budget Impact Justification	Amount
Lili Joy Consulting Company	Ryan White Statistical Analysis reports; Needs Assessment data analysis. Prepare Client Needs Assessment Tools.	Consultant for needs assessment tools for clients; evaluations of data research; prepares summaries of data reports; analyzes needs assessment data and quality measurement outcome data. (196.56 hrs x $101.75/hr.)	$ 20,000
		Contracts Total	**$ 20,000**

Other

List of Other	Budget Impact Justification	Amount
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals.	$ 2,143
Leases	Cost of rent per person for building. All rent charges are applied on a per FTE basis. Additional charges are included for Planning Council Outreach event fees to participate in community events (table rentals, etc.) in order to promote the Council and recruit new members.	$ 414
Postage	Routine postage, share of postage machine equipment and maintenance and Federal Express charges in order to send Council and Committee monthly packets to Council members prior to meetings.	$ 1,000
Printing/Duplicating	Printing/duplicating of routine Council documents; printing of Council publications such as Needs Assessments, Comprehensive Plans, special studies.	$ 2,000
	Other Costs Total	**$ 5,557**

Total Direct Cost

$ 68,367

PART A PLANNING COUNCIL BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Indirect Cost

Type of Indirect Cost	Rate	Insert Base	Total
Provisional	10% de minimis	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.	6,837
Part A Planning Council Total			
			$ 75,204

PART A CLINICAL QUALITY MANAGEMENT BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Personnel

Salary	FTE	Name, Position	Budget Impact Justification	Amount
$ 122,096	0.15	Sr. Health Program Coordinator, (Gossett)	Coordinates outcome measures of Part A CQM program with other RW CQM programs; Assist as the CQM Program Manager with the on-going recruitment of the CQM Committee, development of CQM Performance measures, and provision of technical assistance to sub-recipients on CQI activities and site visits.	$ 18,314
$ 124,386	0.33	Human Services Program Planner, (Gammell)	Oversees daily operation of the CQM program by providing leadership to guide, plan, implement and evaluate the Continuous Quality Improvement Plan; tracks client-level and contractor level data; provides technical assistance to sub-recipients on CQI Performance measures; assists the CQM Committee with the development and analysis of Performance measures and outcomes; standards and expectations; performs fiscal and programmatic CQM site visits to improve patient care health outcomes and client satisfaction.	$ 41,047
$ 99,109	0.20	Admin. Services Officer II (Hunter)	Supports CQM program through tracking required CQI documentation from sub-recipient to ensure they are meeting performance/outcome measures, assist Program Coordinator and Planner with evaluation of Continuous Quality Improvement Plan measures, runs specialized data reports from Report Manager to track to plan outcome measures. Assists in identifying areas of improvement using the quality data.	$ 19,822
$ 108,788	0.09	Epidemiologist, (Zheng)	Supports the CQM program by preparing Epidemiological reports, studies and tracking systems. Codes and prepares Access queries designed and developed by the CQM Committee to track new Performance measures. Downloads and analyzes statewide and national epidemiological data for local comparison on selected CQM Performance Measures.	$ 9,791
			Personnel Total	**$ 88,974**

Fringe Benefits

Percentage	Components	Amount
18.50%	Retirement	$ 16,456
1.49%	Retirement Health Savings Account	$ 1,326
2.50%	401K Match	$ 2,224
7.65%	FICA/SSI	$ 6,807
24.68%	Health insurance	$ 21,960
	Fringe Benefit Total	**$ 48,773**

Travel

Local

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
			Local Travel Sub-Total	**$ -**
			Travel Total	**$ -**

Supplies

List of Supplies	Budget Impact Justification	Amount
General Consumable office supplies	Supplies necessary to provide quarterly reports to the CQM committee; file folders for CQI documentation; Refreshments for quarterly CQM Committee meetings.	$ 200
	Supplies Total	**$ 200**

PART A CLINICAL QUALITY MANAGEMENT BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Other

List of Other	Budget Impact Justification	Amount
Office Lease	Cost of rent per person for building. All rent charges are applied on a per FTE basis.	$ 1,456
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals.	$ 6,141
Postage	Routine postage, share of postage machine equipment and maintenance and federal Express charges for CQM activities.	$ 1,050
Printing/Duplication	Printing of routine CQM documents and special reports.	$ 701
OCIT-Data Processing/SHARE/MIS	Maintenance of Sacramento HIV/AIDS Reporting Engine (SHARE) to provide CQI committee with on-going progress in achieving selected Performance Indicators. Costs to update and maintain SHARE.	$ 2,500
Copy machine maintenance	Copy machine lease and maintenance agreements. Software license fees.	$ 1,700
	Other Costs Total	**$ 13,548**

Total Direct Cost

	$ 151,495

Indirect Cost

Type of Indirect Cost	Rate	Insert Base	Total
Provisional	**10% de minimis**	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.	**$ 15,150**

Part A Clinical Quality Management Total

$ 166,645

PART A HIV SERVICES BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Contractual

List of Contracts	Deliverables	Budget Impact Justification	Amount
Golden Rule Services	Non-Medical Case Management	Direct client services. Costs estimated based on comparable community rates and actual expenses.	$ 52,500
Sexual Health Clinic County of Sacramento	Outpatient Amb Care, Health Education/Risk Reduction, Medical Transportation, Medical Case Management	Direct client services. Costs estimated based on comparable community rates and actual expenses.	$ 72,000
Harm Reduction Services	Medical CM; Transportation	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 240,000
One Community Health	Outpatient Amb Care; Oral Health; Medical CM and non-medical CMgt; Mental Health; Substance Abuse-Outpatient; Transportation; Housing; EFA; Health Ed/Risk Reduction; Outreach.	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 1,120,747
Sierra Foothills AIDS Foundation-El Dorado County	Outpatient Amb Care; Oral Health Care; Medical CM; Mental Health; Substance Abuse-Outpatient; EFA; Transportation	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 187,440
Sierra Foothills AIDS Foundation-Placer County	Outpatient Amb Care; Oral Health Care; Medical CM; Mental Health; Substance Abuse-Outpatient; EFA; Transportation	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 201,515
Sunburst Projects	Mental Health; Medical CM; Child Care, EFA, Transportation	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 808,500

PART A HIV SERVICES BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

U.C. Davis Pediatric Infectious Disease	Outpatient Pediatric Ambulatory Care; Medical CM; Transportation	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 138,500
Volunteers of America	Housing, EFA	Direct client services. Costs estimated based on comparable community rates and actual expenses.	$ 11,760
		Contracts Total	**$ 2,832,962**
Part A HIV Services Budget Total			
			$ 2,832,962

MAI ADMINISTRATIVE BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Personnel

Salary	FTE	Name, Position	Budget Impact Justification	Amount
$ 122,096	0.06	Sr. Health Program Coordinator, (Gossett)	Oversees daily operations of Part A MAI Program. Monitors contractual obligations of contractors, MOU's with participating counties. Monitors expenditure rate and reallocation process. Monitors programmatic functions of MAI program and sub-recipient adherence to MAI requirements; Negotiates yearly contract rates with contractors; Provides technical assistance; Coordinates functions of Part A MAI program with other AIDS programs, including Ryan White Parts B, C, D; HIV AIDS Education and Testing programs, and county Surveillance programs.	$ 7,326
$ 124,386	0.04	Human Services Program Planner, (Gammell)	Assists the Sr. Health Program Coordinator in overseeing daily operations of Part A MAI Program. Continuous improvement/development of Quality Plan, tracking of individual and contractor data, provides technical assistance, develops with HIV Health Services Planning Council outcomes measures and standards/expectations for MAI program; monitors monthly charges to MAI program and prepares annual MAI program reporting functions.	$ 4,602
			Personnel Total	**$ 11,928**

Fringe Benefits

Percentage	Components	Amount
19.86%	Retirement	$ 2,369
1.49%	Retirement Health Savings Account	$ 178
3.50%	401K Match	$ 417
7.65%	FICA/SSI	$ 912
24.75%	Health insurance	$ 2,952
	Fringe Benefit Total	**$ 6,828**

Other

List of Other	Budget Impact Justification	Amount
Office Lease	Cost of rent per person for building. All rent charges are applied on a per FTE basis.	$ 184
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals.	$ 690
	Other Costs Total	**$ 874**

Total Direct Cost

$ 19,630

Indirect Cost

Type of Indirect Cost	Rate	Insert Base	Total [Insert Indirect]
Provisional	**10% de minimis**	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.	**$ 1,963**

MAI Administrative Total

$ 21,593

MAI CLINICAL QUALITY MANAGEMENT BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Personnel

Salary	FTE	Name, Position	Budget Impact Justification	Amount
$ 124,386	0.05	Human Services Program Planner, (Gammell)	Oversees daily operation of the MAI CQM program by providing leadership to guide, plan, implement and evaluate the Continuous Quality Improvement Plan; tracks client-level and contractor level data; provides technical assistance to sub-recipients on MAI CQM Performance measures; assists the CQM Committee with the development and analysis of MAI Performance measures and outcomes; standards and expectations; performs fiscal and programmatic MAI CQM site visits to improve patient care health outcomes and client satisfaction.	$ 5,921
			Personnel Total	**$ 5,921**

Fringe Benefits

Percentage	Components	Amount
20.53%	Retirement	$ 1,216
1.49%	Retirement Health Savings Account	$ 88
4.00%	401K Match	$ 237
7.65%	FICA/SSI	$ 453
24.75%	Health insurance	$ 1,465
	Fringe Benefit Total	**$ 3,459**

Other

List of Other	Budget Impact Justification	Amount
Office Lease	Cost of rent per person for building. All rent charges are applied on a per FTE basis.	$ 90
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals.	$ 345
	Other Costs Total	**$ 435**

Total Direct Cost

$ 9,815

Indirect Cost

Type of Indirect Cost	Rate	Insert Base	Total
Provisional	**10% de minimis**	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.	**$ 981.00**

MAI Clinical Quality Management Total

$ 10,796

MAI HIV SERVICES BUDGET
APPLICANT: SACRAMENTO TGA
FISCAL YEAR: 2022

Contractual

List of Contracts	Deliverables	Budget Impact Justification	Amount
Harm Reduction Services	Medical Case Management	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 99,000
One Community Health	Medical Case Management	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 45,000
Sunburst Projects	Medical Case Management	Direct client services. Costs estimated based on prior utilization figures and comparable community rates.	$ 39,549
		Contracts Total	**$ 183,549**

MAI HIV Services Total

$ 183,549

Project Abstract

Project Title: Ryan White (RW) CARE Act Part A Grant Application - FY 2022
Applicant Name: Sacramento Transitional Grant Area (TGA) **HRSA Grant #:** H89HA00048
Address: County of Sacramento Department of Health Services
7001 A. East Parkway, Suite 600B, Sacramento, CA 95823-2501
Contact Phone #s: 916.875.6211 (voice); 916.875-5888 (fax)
E-Mail: GossettM@SacCounty.net **Web:** www.sacramento-tga.com

a) HIV Epidemic in Sacramento TGA: The Sacramento TGA is a large three-county area of 4,287 square miles, with a geography that presents unique challenges to efficient delivery of health care to PLWH. As of 12/31/20, Sacramento County accounted for 88.4% of the PLWH in the TGA, and the rural counties of El Dorado and Placer accounted for 4.3% and 7.4%, respectively. In the last 10 years, the number of People Living with HIV (PLWH) in the TGA rose 44.7%, from 3,696 to 5,347 as of 12/31/20 with increases in the large urban County of Sacramento (+36.4%) and the two rural counties of Placer (+58.2%) and El Dorado (+34.1%). The HIV epidemic has had an increasingly disproportionate impact on People of Color with the proportion of new AIDS cases more than doubling, from 27.0% to 53.5%, since 1997 when the TGA's RW Program began. Hispanics have had the largest increase in new AIDS cases, 6.0% to 28.0%. African Americans experienced the most disproportionate impact of HIV overall. African Americans comprise only 7.2% of the TGA's general population, but were 22.9% of AIDS prevalence, 21.0% of HIV prevalence, and 22.0% of HIV Incidence as of 12/31/20. Heterosexuals have had a disproportionate increase since 1997, from 6% of PLWH to 15.8% as of 12/31/20. Men who have Sex with Men (MSM) continue to be the majority at 55% of PLWH, and Injection Drug Users (IDUs) were 7.9% as of 12/31/20. Regarding age groups, total PLWH increased by 11.9% among youth under age 13; by 4.1% among ages 13-19; by 2.6% among ages 20-24; 5.2% among ages 25-44; 7.4% among ages 45-64; and 1.7% among ages 65 and older between 12/31/19 and 12/31/20. The number of RW clients ages 13-24 increased by 57.2% during the first 20 years of the TGA's RW program and another 14.1% over the last three years.

b) System of HIV Care in TGA: Since 1996, RW Part A funding has been a major contributor to the successes of the HIV Care Continuum for PLWH across the TGA and is used as a payor of last resort by coordinating closely with other funding sources. The TGA has received RW Minority AIDS Initiative (MAI) funding since 2003 to ensure that targeted services are provided to disproportionately impacted subpopulations. Most specialized HIV medical services are located in Sacramento County, although the TGA's rural counties participate in telemedicine clinical consultation. The comprehensive system of HIV care includes both core and support services across the region. Core services include services such as primary medical care; medical case management; oral healthcare; mental healthcare; and substance abuse treatment. Support services, designed to enhance PLWH's ability to access core services and remain in care, include services such as transportation, social service case management, childcare, housing support, emergency financial assistance, outreach, and substance use disorder services.

c) Overall HIV Viral Suppression Rate for TGA: The RW Program's 2020 viral suppression rate (85%) was higher than the 2019 rate in other jurisdictions: TGA (70%); California (65%), and National (66%). Among FY20 RW clients, Heterosexuals were less likely to be virally suppressed (83%) than Injection Drug Users (84%) or MSMs (86%). African Americans were less likely to be virally suppressed (74%) than Whites (79%), Hispanics (81%), Asians (86%) and American Indians/Alaska Natives (77%). Female RW clients were less likely to be virally suppressed (82%) than males (85%). RW clients ages 13-24 were less likely to be virally suppressed (60%) than those ages 20-44 years (67%), ages 25-44 (75%); 45-59 (82%) or 65+ (90%), ages 13-19 (81%) or ages <13 (100%).

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. Over the last five years, from 2015-2021, there has been a 29.4% growth in the number of Persons Living with HIV/AIDS (PLWH) in the TGA, from 4,132 to 5,347. This growth in HIV/AIDS cases is over 7 times the growth of the TGA's general population, 4.0%, over the same five-year period, from 2,061,178 to 2,143,230 people.

This growth in the Sacramento region's HIV epidemic continues to impact the RW Part A Comprehensive AIDS Resources Emergency (CARE) Act Program. In the RW Part A 2020 Fiscal Year (FY20), which runs from 3/1/20 to 2/28/21, there were 170 new clients, who had never been served by the TGA's RW Part A Program. Not only has there been growth in both the number of PLWH in the TGA and the RW Program over the years, but there also have been changes in the sociodemographic composition of the HIV/AIDS epidemic since the RW Part A Program began in the TGA 25 years ago.

In response to these changes, the HIV Continuum of Care has evolved to meet the increasing and divergent needs of newly emerging subpopulations of PLWH. The TGA has a strong base of service providers in the region that are dedicated to making a difference in the efforts to end the HIV epidemic. The RW Program, together with regional service providers, are committed to providing high quality services that meet the needs of PLWH at all levels of the Care Continuum.

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

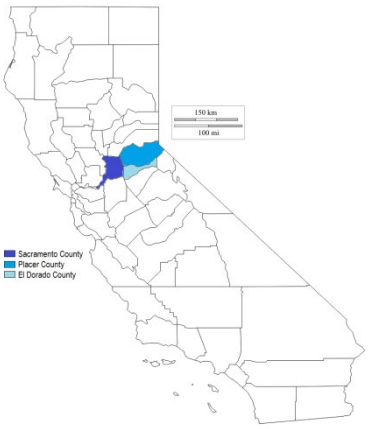
By having a thorough understanding of the needs of PLWH in the TGA, as well as the resources available to them, the RW CARE Program maximizes its use of RW Part A grant funds and makes certain that these funds are used as the payer of last resort. These funds are essential to support the TGA's comprehensive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

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 72.4% of the TGA's population and 88.4% of the PLWH in the TGA as of 12/31/20. The rural county of Placer accounted for 18.6% of the TGA's general population and 7.4% of PLWH in the TGA and the rural county of El Dorado accounted for 9.0% of the TGA's general population and 4.3% of PLWH in the TGA as of 12/31/20. In terms of geographical breakdowns of HIV/AIDS across the TGA's three counties, the table below provides trend data from the California Department of Public Health (CDPH) HIV Surveillance Report for each county (2011-2020).

Changes in the TGA's HIV/AIDS reporting methodology overtime has made long term trend reporting of the TGA's HIV/AIDS epidemic challenging. Analysis of the TGA's HIV/AIDS epidemiology between the current reporting period (1/1/18-12/31/20) and past reporting periods are skewed because the reporting methodology has become more rigorous. Starting with the 12/31/16 reporting period, the TGA began using "diagnosed" rather than "reported" HIV/AIDS data for incidence (new cases) and prevalence (existing cases).

"Diagnosed" HIV/AIDS data is more accurate than "reported" data because it goes through a more rigorous verification process to confirm that each newly "reported" HIV or AIDS case was truly new for the Sacramento Region and had not been previously reported outside of the TGA. Given the use of this more rigorous "diagnosed" methodology, the analysis throughout the Needs Assessment Section of this 2022 grant application is skewed toward a lower number of HIV/AIDS cases in the current reporting period as compared to reporting periods prior to 12/31/16.

In addition to changes in data definitions overtime, there are data variations that skew some of the data comparisons throughout this application. For example, the California State Office of AIDS (SOA) supplies the data sets used for Attachment 3, Table 1: HIV and AIDS Incidence (new cases) and Prevalence (existing cases) which is used throughout the application. The SOA also provides the data used for the HIV Care Continuum and the Unmet Needs table. The data requirements for these various analytic tools do not match exactly due to differences in the date ranges, definitions, and formats used for each database and jurisdiction. These differences have created some discrepancies in figures when conducting direct comparative analyses across measurement and reporting tools.

Given these caveats, the TGA remains diligent in in efforts to conduct and data driven process to understand the state of the HIV/AIDS epidemic in the Sacramento Region overtime. As can be seen in the first table below, the number of *new* HIV/AIDS infections (incidence) decreased from 205 to 91 cases (54.7% decrease) over the last ten years. The highest number of new HIV/AIDS cases was 217, which occurred in 2017. Over the ten-year period (2011-2020) the urban county of Sacramento had a decrease of 58.7% (from 183 to 74 new infections); the rural county of Placer had an increase of 7.1% (14 to 15 new infections); and the rural county of El Dorado had a decrease of 75% (from 8 to 2 newly diagnosed HIV/AIDS cases).

HIV/AIDS Incidence (New Cases)

	CY11	CY12	CY13	CY14	CY15	CY16	CY17	CY18	CY19	CY20	% Change
El Dorado	8	3	4	4	7	5	3	6	1	2	-75%
Placer	14	16	14	14	12	17	19	10	9	15	7.1%
Sacramento	183	190	171	184	155	187	195	161	102	74	-58.7%
TGA Total	**205**	**209**	**189**	**202**	**174**	**209**	**217**	**177**	**112**	**91**	**-54.7%**

As noted in the following table regarding total HIV/AIDS prevalence (People Living with HIV), cases of HIV and AIDS in the TGA overall rose 34.1% between 2011 and 2020, from 3,884 to 5,347. The rise in PLWH was experienced throughout the TGA, in the large urban County of Sacramento (+36.4%), as well as two rural counties of Placer (+58.2%) and El Dorado (+37.7%).

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

	CY11	CY12	CY13	CY14	CY15	CY16	CY17	CY18	CY19	CY20	% Change
El Dorado	170	174	178	182	185	194	197	210	211	228	+34.1%
Placer	249	256	278	296	309	330	348	350	362	394	+58.2%
Sacramento	3,465	3,648	3,833	4,016	4,188	4,394	4,479	4,397	4,508	4,725	+36.4%
TGA	**3,884**	**4,078**	**4,289**	**4,494**	**4,682**	**4,918**	**5,024**	**4,957**	**5,081**	**5,347**	**+37.7%**

Overall, these statistics show that the number of PLWH continue to rise throughout the Sacramento TGA. Although new HIV/AIDS cases are trending downward, the total number of PLWH has risen throughout the TGA. This upward trend in the number of PLWH has occurred since the Sacramento TGA became eligible for Ryan White Part A 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 Analysis (Attachment 3)

See Attachment 3, Table 1, for HIV and AIDS Incidence (newly reported cases), as well as HIV and AIDS Prevalence (existing cases) in the TGA, detailed by demographics, over the past three-year reporting period (1/1/18 – 12/31/20), as reported by the California State Electronic HIV/AIDS Reporting System (E-HARS). As described above, the analysis of trends in the TGA's HIV/AIDS epidemiology is skewed by the fact that reporting methodology has become more rigorous, making year-over-year comparisons challenging.

The HIV/AIDS epidemiological analysis, comparing the most recent three-year reporting period (1/1/17-12/31/19) to the current period (1/1/18-12/31/20), found that total HIV and AIDS Prevalence, the number of People Living with HIV (PLWH) increased 5.2% (from 5,081 to 5,347 PLWH). Specifically, AIDS prevalence increased 3.3% (from 2,636 to 2,723) and HIV prevalence increased 7.3% (from 2,445 to 2,624 cases).

Regarding HIV incidence (number of *new* HIV cases), the TGA experienced a decrease of 6.9% (from 493 to 459 new HIV cases) since the last reporting period. This decrease in new HIV cases is promising and points to continued success of the TGA's HIV prevention efforts, including successes in increasing viral load suppression among PLWH.

The TGA, however, experienced an increase of 57.5% in AIDS incidence (*new* AIDS cases, from 120 to 189) since the three-year reporting period ending 12/31/19. This increase in AIDS incidence is disconcerting and highlights the increased need for all PLWH to receive and be engaged in ongoing HIV medical care to achieve viral suppression.

To determine any disproportionate impacts of the HIV/AIDS epidemic on the various subpopulations in the Sacramento TGA, a more detailed analysis was conducted of the most recently available data from the following sources: 1) Sacramento County Department of Health Services (DHS) Epidemiology Division (through 12/31/20); 2) California State Electronic HIV/AIDS Reporting System, e-HARS, (through 12/31/20); 3) TGA's RW Database, Sacramento HIV/AIDS Reporting Engine – SHARE, (through 2/28/21); 4) Ryan White Annual Statistical Summary Project, RASSP, (through 2/28/21); 5) 2019 US Census Bureau; 6) 2020 California Department of Public Health; Centers for Disease Control and Prevention; and 7) California Department of Finance. Based on this thorough analysis, the RW Part A Program found that there was a disproportionate impact of HIV/AIDS on the following subpopulations in the TGA:

Racial Disparities in TGA's HIV Epidemic

African Americans. Although African Americans made up only 7.2% of the TGA's general population in 2019, they were 22.0% of PLWH (HIV/AIDS prevalence), 22.0% of new HIV cases (HIV incidence) and 24.9% of AIDS incidence during the most recent reporting period (1/1/18 – 12/31/20). The disproportionate impact of the HIV epidemic on African Americans, especially for AIDS incidence, is clear when comparing the current reporting period ending 12/31/20 to the most recent period ending 12/31/19. There was a 161% increase in AIDS incidence (new AIDS cases) among African Americans since the last reporting period. There was a 5.0% increase in HIV Prevalence and 2.1% increase in number of African American PLWH over the same time period. Longer term trends in the TGA's HIV epidemic further highlight the disproportionate impact among African Americans. There was a 37.4% increase in the number of African American PLWH even though there was only a 1.0% increase in the number of African Americans in the TGA's general population between 2012 and 2020.

Hispanics. The number of Hispanic PLWH in the TGA grew by 61.6% over the last five years which was almost 10 times higher than the growth in Hispanics among the TGA's general population 7.9% (from 416,753 to 449,523) during the same timeframe. Hispanics were the racial group most disproportionately represented among new AIDS cases and new HIV cases as compared to their representation among total PLWH in the TGA during the most recent reporting period of 1/1/18-12/31/20. Hispanics were 29.6% of new AIDS cases and 28.0% of new HIV cases compared to 21.3% of total PLWH.

Among the Hispanic population over the last two reporting periods (1/1/17-12/31/19 and 1/1/18-12/31/20) there was an 8.8% increase in HIV prevalence; 7.8% increase in AIDS prevalence; and a 20.5% increase in AIDS incidence. The only HIV indicator that decreased among Hispanics over the last two reporting periods was HIV incidence, which decreased by 7.4%.

Whites. As of 12/31/20, Whites were underrepresented among PLWH in the TGA (46.5%) as compared to their representation in the TGA's 2019 general population (51.9%). However, HIV and AIDS prevalence as well as AIDS incidence increased since the 12/31/19 reporting period. HIV prevalence increased by 1.6%; AIDS prevalence increased by .97%; total PLWH increased by 1.3% and AIDS incidence increased by 46.7%. Similar to the Hispanic population, the only HIV indicator that decreased among Whites since the last reporting period was HIV incidence, which decreased by 15.2%.

Age Disparities in TGA's HIV Epidemic

Children <13. Both HIV and AIDS cases remained low in the TGA between the last two reporting periods. There was a slight decrease in the number of children under age 13 living with HIV, from 42 to 36.

Youth Ages 13-19. New AIDS cases increased since the last reporting period among youth ages 13-19. New AIDS cases among this age group increased from 0.5% to 2.5% of all new AIDS cases in the TGA.

Young Adults Ages 20-24. New AIDS cases increased 60% since 2019 reporting period among youth ages 20-24 and increased from 4.6% to 9.9% of all new AIDS cases in the TGA.

Adults Ages 25-44. Although both AIDS and HIV incidence among adults ages 25-44 decreased since the last reporting period, new AIDS cases increased from 47.9% to 58.4% and new HIV cases increased from 53.8% to 54.5% for this age group.

Adult Ages 45-64. Although new HIV cases decreased since the last reporting period, HIV incidence among ages 45-64 increased from 20.3% to 23.2% of all new HIV cases since the last reporting period.

Adult Ages 65+. HIV and AIDS incidence and prevalence decreased for adults ages 65 and older since the last reporting period.

Mode of Transmission Disparities in TGA's HIV Epidemic

There was a notable increase in the percent newly diagnosed HIV cases who reported "Unknown/Other" as HIV transmission mode (includes perinatal exposure, hemophilia, blood exposure, other types of exposures and no identified/reported risk) between 12/31/17 and 12/31/18 reporting periods (from 21.2% to 29.0%). This increase in the Unknown/Other exposure category increased again in 12/31/19 reporting period to 30.8% and again in 12/31/20 to 33.6%.

The increase in "Unknown/Other" HIV transmission category skews the year over year, and long-term trend analysis for the TGA. Even with that caveat, the following increases and decreases for each HIV transmission category have occurred in the TGA between the 12/31/19 and 12/31/20 reporting periods:

Men who Have Sex with Men (MSM). Increases occurred among MSMs in all epidemiologic categories with the exception of new HIV cases since the last reporting period ending 12/31/19. AIDS incidence increased by 61.5% ; AIDS prevalence increased by 1.0% and HIV prevalence increased by 3%. The only decrease among MSMs was in HIV incidence, which decreased by 14.2%.

Injection Drug Users (IDU). Within the TGA's IDU transmission category (MSM/IDU analyzed separately below), increases occurred in prevalence (existing cases) and AIDS incidence (new cases) while HIV incidence which remained the same list the last reporting period. AIDS incidence increased by 125% ; AIDS prevalence increased by 2.9% and HIV prevalence increased by 3.7%.

Men who Have Sex with Men and Inject Drugs (MSM/IDU). New HIV cases among MSM/IDUs have remained stable over the last three years. AIDS incidence increased by 80% and AIDS prevalence had a slight increase of 1.2% between 2018 and 2019 reporting periods. HIV prevalence had a slight decrease of 2.7 % and total PLWH had a slight decrease.

Heterosexuals. In the Sacramento TGA, the HIV transmission category of Heterosexuals includes High Risk Heterosexuals (HRH). HRH are 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 TGA also includes Heterosexuals with Multiple Partners in its definition for High-

Risk Heterosexuals (including sex industry workers, partners of HIV+ and partners of IDU).

Among Heterosexuals, there was a large 68.8% increase in AIDS incidence and a slight 0.4% increase in AIDS prevalence since 2019 reporting period. Regarding HIV epidemiology, there was a slight decrease of 2.8% in HIV incidence and a slight decrease of 1.4% in HIV prevalence.

2.A.1)b)ii. HIV/AIDS Epidemic and Socioeconomic Data Analysis: TGA and RW Clients

See Attachment 5, Table 3: Co-occurring Conditions table for demographic, health and socioeconomic data for RW Part A clients compared to the Sacramento TGA's general population in Sacramento, El Dorado and Placer Counties. These co-occurring conditions and social determinants of health are examples of issues that negatively impact the health status of PLWH and increase the healthcare needs of RW clients. This data shows a disproportionate impact of conditions such as poverty, homelessness, insurance status, mental illness, STIs and incarceration on RW clients as compared to the TGA's general population as follows:

Homelessness. The rate of homelessness and unstable housing was the highest it has ever been among new RW clients in FY20. Alarmingly, 18.2 % of *new* FY20 RW clients were homeless (3.5%) or unstably housed (14.7%); which is higher than the 14.0% of new FY19 RW clients that were homeless (2.6%) or unstably housed (11.4%). Among FY20 RW clients, 2.4% were homeless compared to a homeless rate of 0.32% in the TGA's general population in 2019. In addition, 8.5% of RW clients were in unstable housing and 5.8% were in temporary housing.

African Americans are increasingly and significantly overrepresented among homeless or unstably housed FY20 RW clients (34.9%) compared to African American representation in the TGA overall (7.3%).

Poverty. RW clients have poverty rates that are dramatically higher than the TGA's general population. 69.4% of FY20 RW clients had annual incomes at or below 100% of the Federal Poverty Level (FPL), or reported no income, which is over 6 times the rate of the TGA's general population (11.1%) at or below 100% of the poverty level. Further, 85.0% of RW clients had annual incomes at or below 250% of the FPL compared to 36.0% of the TGA's 2018 general population (US Census Bureau).

Insurance Status. FY20 RW clients were twice as likely to be on Medicaid or Medicaid/Medicare than the TGA's 2018 general population (75.1% vs. 45.5%). RW clients had other health care insurance coverage, such as private insurance or other public insurance, at a rate three times lower than the TGA's general population (21.8% vs. 71.0%).

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

2.A.1)c)i. Identifying New and Emerging Subpopulations, Challenges and Costs

Analysis of the TGA's RW client data; HIV Epidemiology data; Early Identification of HIV/AIDS (EIIHA) data; Continuum of Care data and RW Program data assist with identifying which subpopulations are emerging with higher risks for HIV, increased barriers to care, worsening health outcomes, unique challenges and higher RW costs of care. Follows are summary data analyses regarding identification of new and emerging subpopulations of PLWH across the TGA:

HIV Epidemiological Data to Identify New and Emerging Subpopulations

HIV Surveillance data since the 1995 inception of the RW Program in the TGA shows a disproportionate impact on several populations over time. The percentage of new AIDS cases that among people of color more than doubled from 27.0% to 69.9% since the TGA's first reporting period ending 6/30/1997 to the current

reporting period ending 12/31/2020. Total HIV and AIDS Prevalence (PLWH) among people of color increased from 29% to 53.5% just over the last two reporting periods, since 12/31/18.

Regarding gender, there has been a large increase in the proportion of female PLWH, which has increased from 10.0% to 16.3% of PLWH in the TGA between 1995 and 2020. Regarding HIV transmission risk, the percent of new AIDS cases from heterosexual contact almost doubled, from 7% in 1995 to 14.3% in 2020. The MSM transmission category has dropped from 61% of new AIDS cases in 1995 to 44.4% of new AIDS cases in 2020.

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

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 FY20. People of color rose from 37.7% to 55.2% of RW caseload between FY1997 and FY2020. The percentage of people of color among RW clients rose again over the last year, from 54.2% to 55.2%.

Gender Trends. The total number of RW females increased 75.6% between FY1997 to FY2020, from 270 to 474 clients. The total number of RW transgender clients were 2.2% of FY20 RW clients (54 clients), up from 1.8% of FY19 RW clients.

Mode of HIV Transmission Trends. The number of RW clients with heterosexual mode of HIV transmission tripled between FY1997 and FY2020, from 220 to 663 clients.

Age Trends. The number of youth and young adult RW clients has continued to climb since the inception of the TGA's RW Program. The number of RW clients ages 13-24 increased by 57.2% between 1997 to 2017; and increased another 14.1% between 2017 to 2020 (from 71 to 81 clients). However, PLWH ages 20-44 were significantly underrepresented among RW clients in FY20 (36.9%) compared to their representation among PLWH in the TGA (76.7) as of 12/31/20.

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 FY21 and FY22, as described below. These subpopulations were identified through analysis of data from the following sources: a) TGA's HIV Needs Assessments; b) TGA's HIV/AIDS epidemiological trends from California State Office of AIDS; c) HIV Care Continuum data for National, State, TGA and RW clients; d) RW SHARE service utilization and cost data; e) National HIV/AIDS Strategy data; f) TGA's Out-of-Care Needs Assessment; g) California Department of Public Health STD and TB Control Branches; h) US Census Bureau; i) Centers for Disease Control and Prevention; j) California's *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan*; Sacramento County's *Zero New HIV Infections Together: 2016-2021 Strategic Plan*; and k) *Ending the HIV Epidemic (EtHE),* Sacramento County DHS, Division of Public Health (SCPH) and California State Office of AIDS (SOA); and l) TGA's Unmet Needs Estimate. Unique challenges for each subpopulation and estimated costs to the RW Part A program, are described below for each emerging population:

Heterosexuals. There has been a steady increase in the number of PLWH reporting heterosexual contact as their HIV mode of transmission since 1995 when the RW Program began in the TGA. There has been a 2-fold increase in the percent of PLWH with heterosexual transmission (High Risk (HR) and non-HR combined (7% to 15.8%). The Heterosexual category represents the second largest percentage of PLWH in the TGA as of 12/31/20; and the second highest population out-of-care (28.7% in 2020).

Heterosexuals represent the second highest percentage of newly diagnosed HIV and AIDS cases (7.6% and 14.3%, respectively) during the current reporting period ending 12/31/20.

The Heterosexual transmission category has surpassed the IDU transmission category in terms of number of PLWH in the TGA. As of 12/31/20, there were close to twice as many PLWH with Heterosexual transmission as compared to PLWH with IDU transmission.

African American Heterosexuals were the largest racial group among heterosexual RW clients in FY20 (40.4%), almost twice as high as the 22.0% of African American PLWH in the TGA as of 12/31/20. Whites were the second largest racial group among heterosexual FY20 RW clients (35.3%) which is lower than their representation among PLWH in the TGA (46.5%). Asian/Pacific Islander heterosexuals are closely represented among FY20 RW clients as compared to PLWH in the TGA overall (4.5% vs. 3.9%).

African American Female Heterosexuals are overrepresented among heterosexual PLWH in all aspects. 27.2% of RW clients were infected with HIV via heterosexual contact, which is higher than the representation of heterosexuals among PLWH in the TGA (15.8%). 44.9% of female FY20 RW clients were African American, which is much higher than the 25.9% of RW clients and 7.2% of the TGA's 2019 general population who were African American. Among RW clients, females are disproportionately African American compared to males (44.9% of female clients were African American compared to 21.1% of males in FY20).

There was a disproportionately high cost of care for RW heterosexuals in FY20. The cost per heterosexual RW client was 9.5% higher than the cost per RW client overall ($1,718 vs. $1,535). There were several RW service categories in which heterosexuals had higher costs per client than RW clients overall: substance abuse-residential services ($2,392 vs. $1,940) and medical case management ($936 vs. $693).

The challenges in working with heterosexuals, including high-risk heterosexuals, include stigma regarding sexuality; addiction focused behaviors that interfere with concern for personal health and well-being; high-risk behaviors including unprotected sex with multiple partners that increases risk of contracting HIV and other Sexually Transmitted Infections (STIs); stigma regarding and limited access to prevention practices of Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP); hesitancy to seek services such as substance use disorder treatment due to fear of arrest. 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 over the last several reporting periods. Regarding youth ages 0-19 years old, HIV prevalence increased by 43.5% between the 2012 and 2020 compared to a 46.9% increase in HIV prevalence in the TGA overall. During the same timeframe, there was an alarming increase in the number in AIDS prevalence in among this age group. AIDS cases among youth ages 0-19 grew by 1.3 times, compared to an 8.5% increase in AIDS prevalence in the TGA overall. In 2020, 25.4% of HIV tests administered through the TGA's EIIHA providers were for ages 24 years and younger, greatly exceeding the 17.2% representation of PLWH under age 24 in the TGA's HIV epidemic as of 12/31/20.

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 FY20, 37.0% of RW clients ages 13-24 were African American compared to 26.0% of RW clients being African American

overall. Hispanic youth also are disproportionately impacted: 32.1% of RW clients ages 13-24 were Hispanic compared to Hispanics being 24.0% of RW clients overall.

Youth and young adult RW clients were less likely to be virally suppressed than RW clients overall (84.5%) as follows: ages 13-19 (81.3%) and ages 20-24 (66.7%). Moreover, RW clients ages 13-24 were less likely to be virally suppressed in 2020 (60%) than in the TGA (95%), California (81%) or the Nation (79%) in 2019. There clearly is more work to be done throughout the TGA to ensure that youth and young adults, in the critical ages between 13-24, are linked to HIV medical care, retained in care, and virally suppressed.

Thankfully, however, there has been some successes in the TGA over the last year in increasing service utilization for RW clients ages 13-24 years old who had higher average costs per clients that RW clients overall for almost half of all RW service categories. In FY20, RW clients ages 13-24 had 53.6% higher average service expenditures per client ($3,294) compared to RW clients overall ($1,528).

The average cost per client ages 13-24 was higher than RW clients overall in FY20 in the following services: medical case management ($2,752 vs. $693) and outpatient medical care ($1,457 vs. $559), showing increased service demand and access to care for this high-risk population. 75.3% of RW clients ages 13-24 accessed medical case management services vs. 70.8% of clients overall.

There were a few critical RW service categories that were underutilized by youth ages 13-24 during FY20, as compared to RW clients overall. For example, the average cost per clients ages 13-24 for mental health services was $384 vs. $633 for RW clients overall. 24.7% of clients ages 13-24 accessed mental health services (20/81) compared to 28.6% of RW clients overall.

Hispanics. Hispanics were the racial group most disproportionately represented among new AIDS cases and new HIV cases compared to their representation among PLWH in the TGA during the most recent reporting period ending 12/31/20. Hispanics were 29.6% of new AIDS cases and 28.0% of new HIV cases compared to 21.3% of total PLWH. Since the inception of the RW Program in the TGA, Hispanics had the largest increase in the proportion of new AIDS cases (from 6.0% to 28.0% between 1995 and 2020). Over the last five years, between 2014 and 2019, there was an 7.9% increase in the number of Hispanics living in the TGA. However, the number of Hispanic PLWH in the TGA grew by 61.6% during the same five-year period. There was an 8.8% increase in HIV prevalence; 7.8% increase in AIDS prevalence; and a 20.5% increase in AIDS incidence Among the Hispanic population between the last two reporting periods ending 12/31/19 and 12/31/20.

Hispanic Youth and Hispanic MSMs. FY20 RW program data show that Hispanic RW clients are disproportionately represented among youth ages 20-24 and among MSMs. Hispanics were 29.0% of MSMs compared to 24% of RW clients overall. In addition, Hispanics were 33.3% of ages 20-24, as compared to 24.0% of RW clients overall. The age group of 20-24 had the lowest viral suppression rates among RW clients in FY20 (66.7%). Regarding the Continuum of Care outcomes for FY20 RW Minority AIDS Initiative (MAI) clients, Hispanics were the second highest viral suppression rates (87.5%, down from 88.9% in FY19).

Although FY20 viral suppression rates among Hispanic RW MAI clients are higher than overall viral suppression rates among all MAI clients (87.5% and 84.9%, respectively), analysis of FY20 client service utilization and cost data found that Hispanic RW clients may not be accessing RW services to the same degree as other racial groups. Hispanic RW clients had a lower average cost per client ($1,344) than RW

clients overall ($1,525). Hispanics had lower costs per client ($1,344) compared to the following racial groups: African Americans ($1,582), Whites ($1,584), and Asian/Pacific Islanders ($1,785).

The challenges in working with the Hispanic population, including Hispanic MSM population and Hispanic youth, include issues such as: stigma regarding homosexuality and homophobia by religious communities that leads to isolation of MSM of color, particularly among Hispanics. These issues result in many Hispanic MSMs 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/AIDS Cases and Need for HIV Related Services

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

Regarding HIV/AIDS epidemiology across the TGA the data statistics show that, while there has been some success in reducing the rate of increase in new HIV and AIDS cases in the TGA overtime, Sacramento County has had a bit more success than the TGA's rural counties. HIV/AIDS Prevalence rose 31.1% between 2012 and 2020, from 4,078 to 5,347 PLWH across the TGA. The rise in PLWH has occurred throughout all counties in the TGA, in the large urban County of Sacramento (+29.5%) from 3,648 to 4,725 PLWH, as well as the rural counties of El Dorado (+31.0%) from 174 to 228 PLWH and Placer (+53.9%) from 256 to 394 PLWH. Regarding new HIV and AIDS cases in the rural counties of the TGA over the last ten years (from CY11 through CY20) there has been a decrease of 22.7%, from 22 to 17 new cases. In the urban county of Sacramento, new HIV and AIDS cases decreased even further, by 55.6%, from 205 to 91.

The total RW client population has increased 79% since the RW Part A Program began in the TGA (from 1,362 RW clients in 1997 to 2,436 RW clients in 2020). These increases in the number of RW clients over time are important to understand and address, including the more recent increases in the rural counties of El Dorado and Placer Counties. There were 170 new clients (never been served in the TGA) during FY20. Of the 171 new RW clients in the tri-county TGA in 2020, 88.3% resided in Sacramento County (151), 8.8% in Placer County (15), and 2.9% in El Dorado County (13). The cost of care is consistently higher for RW clients in the rural counties of the TGA, El Dorado and Placer, as compared to the urban county of Sacramento. In FY20, the average cost of care per RW client was $2,240 in El Dorado County, $2,005 in Placer County and $1,488 in Sacramento County.

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 continuing to turn to the RW Program for specialized HIV 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, continue to have a significant impact on PLWH throughout the TGA.

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 RW Program to tailor and target its HIV-related prevention and treatment efforts for each subpopulation throughout the urban and rural areas of the Sacramento TGA.

2.A.2) HIV Care Continuum

2.A.2)a). Graphic Depiction of HIV Care Continuum

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 (CA) rates, but to the TGA's general HIV+ population rates for the following five measures that comprise the National HIV/AIDS Strategy (NHAS) HIV Care Continuum: 1) Diagnosis of HIV Infection; 2) Linkage to care; 3) In Medical Care; 4) Retention in Care; and 5) Viral Suppression.

NATIONAL HIV/AIDS STRATEGY HIV CARE CONTINUUM
NATIONAL, STATE, TRANSITIONAL GRANT AREA AND RYAN WHITE PROGRAM

HIV Care Continuum Data Sources

- *FY20 Ryan White client data for the HIV Continuum of Care are from the RW Program's Sacramento TGA HIV/AIDS Reporting Engine (SHARE)*
- *CY19 California (CA) and CY19 Sacramento TGA HIV Continuum of Care data are from the California Department of Public Health (CDPH) Office on AIDS Core Indicators for Monitoring the HIV Epidemic*
- *CY19 National data for the HIV Continuum of Care fare from the Centers for Disease Control HIV/AIDS Care Continuum https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum*

2.A.2)b) Care Continuum Analysis Across Jurisdictions

The definitions for each component in the Continuum of Care vary slightly across jurisdictions and must be considered when comparing outcome data between the RW Program, the TGA, California and the Nation.

Diagnosing HIV Infection is defined as number of persons aged > 13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year.

Linkage to HIV Medical Care is defined as newly diagnosed with HIV during the year with at least one

CD4 or viral load test within one month of diagnosis.

In Medical Care is defined for RW and the Nation as PLWH having at least one viral load or CD4 test within 12 months; and for the TGA and CA, as having at least one CD4, viral load or HIV-1 genotype test during the year.

Retained in Care. For RW and the TGA, "Retained in Care" is defined as PLWH with ≥2 visits per year at least three months apart during the12-month reporting year; for CA, it is defined as two or more CD4, viral load, or HIV-1 genotype tests performed at least 3 months apart during the year; for the Nation, it is defined as ≥2 tests (CD4 or VL) ≥3 months apart during the year.

Viral Suppression is defined for the RW Program, Sacramento TGA, California and the Nation as PLWH whose most recent HIV viral load test result in during the calendar year was ≤ 200 copies/ml.

Even with the challenges in the variations in HIV Continuum of Care definitions or indicators across jurisdictions, a comparative analysis of the Ryan White Program, Sacramento TGA, State of California, and Nation on progress toward National HIV/AIDS Strategy Continuum of Care objectives continues to inform efforts to improve outcomes at all levels of care. An analysis of the data presented in the bar graph above shows the following overall observations for each component of the HIV Care Continuum across jurisdictions:

Diagnosing HIV Infection. This grant application is based on a diagnosed-based HIV Care Continuum, which is defined as all PLWH in the jurisdiction who have been diagnosed with HIV. Therefore, all jurisdictions that conduct HIV testing, including the TGA, State and National, have HIV diagnosed indicators that are at 100%. The RW Program does not conduct HIV testing and therefore this indicator is not applicable. By comparison, a prevalence-based HIV Care Continuum includes both people whose HIV infection has been diagnosed plus those people living with HIV that have not yet been diagnosed. Prevalence-based indicators for have been used in prior years but diagnosed-based indicators are currently used for the HIV Continuum.

Linkage to HIV Medical Care. A smaller proportion of PLWH with a new HIV diagnosis were linked to HIV care within 30 days following diagnosis in the RW program in FY20 (48%) than in the Sacramento TGA (89%), California (83%) or the Nation (81%) in CY19. In addition to the challenges of the COVID-19 pandemic in linking newly diagnosed PLWH to care, there have been data management challenges resulting in underreporting of linkage to care within the 30-day period for the RW Program. For example, the HIV medical care subrecipient has been challenged to obtain and report information in its Electronic Health Record (EHR) for its RW clients that might be served by another medical service provider in the region. While the RW medical provider may be able to track an outside provider's lab results, they are not obtaining copies and to update their EHR accordingly, nor consistently reporting it to the RW Care Program.

In Medical Care. RW clients were more likely to be in medical care in FY20 (79%) than PLWH in the State of California (73.8%) during CY18, or nationwide during CY19 (74.2%) and were only slightly less likely to be in care than the TGA overall in CY19 (79% and 80%, respectively). Again, due to the variations between the definition of "in medical care" across the RW Program, TGA, California and Nation, these statistical comparisons are limited.

Retained in Care. RW clients were less likely to be retained in care in FY20 (40%) than PLWH in the TGA during CY19 (54%; as well as California (48%) and the Nation (50%). Most notably, African Americans had the lowest retention in care rates across all races and across all jurisdictions (RW, TGA, CA and US).

The Sacramento TGA's RW retained in care statistics are skewed by the fact that the RW program and its subrecipients are still finalizing its reporting methodology to capture a client's second visit in the retention in care SHARE report if it falls outside a 12-month reporting period. In addition, the definition of "retained in care" varies slightly between jurisdictions.

Viral Suppression. This Continuum of Care indicator is the most informative, as the definition is consistent across jurisdictions, and the indicator is the most reliably measurable for all entities. Evidence that the low linkage-to-care and retention in care figures continue to be impacted by data reporting issues, rather than service provision issues, is demonstrated by the high viral load suppression rates of RW clients in 2020 (85%). This rate is higher than 2019 viral suppression rates for the Sacramento TGA (70%), California (65%), or Nation (66%).

Continuum of Care Analysis and Minority Populations

More thorough analysis of the Care Continuum outcomes by demographics, such as age, race, mode of HIV transmission and gender, provides a closer look at the impact of efforts on various vulnerable subpopulations across jurisdictions. It is through this more detailed analysis, the RW Program can really work to structure it's programming and services to target those subpopulations with lower outcomes across the HIV Care Continuum.

Linkage to HIV Medical Care. African Americans had the lowest "Linked to Care" rates in 2019 for California (80%) and the Nation (78%) as compared to other racial groups. For the Sacramento TGA, Hispanics had the lowest linkage-to- care rate (87%). Whites had the lowest linkage-to-care rates among RW clients in 2020 (18%).

In Medical Care. African Americans had the lowest rates of "In Medical Care" for the RW program, the TGA, California and the Nation as compared to other racial groups and to the jurisdiction's average. For example, for the Nation, 74% of African American's were in medical care compared to 76% of all PLWH. In California, 71% of African Americans were in medical care compared to 75% of California's overall. For the Sacramento TGA, 76% of African Americans were in medical care compared to 80% of PLWH overall.

Retained in Care. Again, African Americans had the lowest rates of "Retained in Care" for the RW program, the TGA, California and the nation as compared to other racial groups, and as compared to the jurisdiction's average. For example, for the Nation, 56% of African Americans were retained in care compared to 58% average; California 51% of African American vs. 56% average; TGA 50% of African Americans vs. 54% average; and RW 38% African Americans vs. 40% average. In the TGA, Hispanics also were retained in care at a rate lower than the average (52% vs. 54%).

Viral Suppression. Both African Americans and Hispanics had lower rates of viral suppression than the average across the HIV Care Continuum (RW, TGA, CA and Nation). For the nation, 61% of African Americans and 65% of Hispanics were virally suppressed compared to an average viral suppression rate of 66%. For California, 59% of African Americans and 63% of Hispanics were virally suppressed compared to an average of 65%. For the TGA, 61% of African Americans and 68% of Hispanics were virally suppressed compared to an average of 70%. For the RW program, 74% of African Americans and 81% of Hispanics were virally suppressed compared to an average viral suppression rate of 85%.

Deeper analysis of the Continuum of Care for RW minority populations was conducted for the

Sacramento TGA's RW Minority AIDS Initiative (MAI). The MAI Program operates street-side and home-based medical case management services targeted to the TGA's emerging high-risk minority populations: African American and Hispanic men and women who are homeless/unstably housed, formerly or about to be incarcerated; substance users, including injection drug users (IDUs), and women who are pregnant or at risk of dropping out of care.

Although the FY20 overall viral suppression rate among RW MAI clients (85%) was higher than the most recent 2019 viral suppression rate in the TGA (70%), California (65%) or Nation (66%), variations were found between racial groups as shown in the following table. Compared to FY17, FY18 and FY19, the percentage of RW MAI clients achieving viral load suppression increased from 69.0% in FY17 to 84.9% in FY20.

The Continuum of Care indicator of "In Medical Care" decreased between FY17 and FY20 for all racial groups in the MAI program with the exception of American Indian/Alaska Native, which increased from 72.7% to 84.6%. The Continuum of Care indicator of "On HAART" decreased between FY17 and FY20 for all racial groups with the exception of Asian, which increased from 93.3% to 94.3%.

RW Minority AIDS Initiative (MAI) Clients
HIV Care Continuum Indicators
FY17-FY20

	Viral Suppression				In Medical Care				On HAART			
	FY17	FY18	FY19	FY20	FY17	FY18	FY19	FY20	FY17	FY18	FY19	FY20
AI/AN*	55%	85.7%	94.1%	85.7%	72.7%	85.7%	94.1%	84.6%	90.9%	85.7%	88.2%	88.5%
Asian	73%	80.0%	79.5%	93.0%	86.7%	100%	82.1%	80.5%	93.3%	100%	76.9%	94.3%
Black/AA**	67%	83.2%	85.4%	83.1%	88.6%	84.6%	87.9%	78.2%	98.9%	91.9%	74.2%	93.3%
Hispanic	79%	87.1%	88.9%	87.5%	84.0%	93.1%	91.2%	79.1%	96.8%	92.1%	79.8%	92.2%
NH/PI***	100%	100%	70.0%	75.0%	100%	100%	80.0%	84.6%	100%	100%	80.0%	88.5%
Total	75%	85.1%	86.4%	84.9%	86.7%	88.5%	88.9%	78.5%	97.7%	92.2%	76.9%	93.3%

American Indian / Alaskan Native ** African American * Native Hawaiian/Pacific Islander*

Comparing the FY20 Ryan White MAI Continuum of Care data to the overall RW program, the TGA, California and the Nation, as well as the more detailed analysis by race, age, gender and transmission, the RW program determined that the following three subpopulations of PLWH are the most disproportionately impacted minority groups that need continued focus in the RW Program's MAI Program in 2022: Hispanics, African Americans and African American IDUs.

Hispanics. Hispanics were 30% of FY20 MAI clients and had viral suppression rate of 87.5%, which was slightly higher than RW MAI clients overall (84.9%). There was improvement in the percentage of Hispanic MAI clients on HAART between FY19 and FY20, from 79.8% to 92.2%.

Hispanics were 38.3% of RW MAI clients with MSM transmission that were virally suppressed, compared to 30% of RW MAI clients overall. Hispanics were 34.0% MAI clients with IDU transmission with viral suppression compared to 30% of MAI clients overall. Hispanics also were overrepresented among transgender MAI clients in FY20. Hispanics were 34.6% of transgender FY20 MAI clients compared to 30.0% of MAI clients overall.

African Americans. African Americans were 61.9% of FY20 MAI clients (up from 52.0% in FY19). For the Continuum of Care indicator for Anti-Retroviral Therapy (HAART), African American MAI clients improved between FY19 and FY20, from 74.2% to 93.3%. However, African American clients in the MAI Program had

lower viral suppression rates (83.1%) than FY20 MAI clients overall (84.9%). Comparisons between HIV mode of transmission categories show that African Americans with MSM transmission had a low viral suppression rate (47.6%) than African American MAI clients overall (61.9%). African American MAI clients with IDU transmission, however, had a viral suppression rate of 61% which is consistent with the overall viral suppression rate for African American MAI clients overall (61.9%).

Although viral suppression rates among African American RW clients increased between FY19 and FY20 (67.7% to 74.2%), African American clients had the lowest viral suppression rates compared to all other racial groups in the RW program (Whites 79%, Hispanics 81%, Asians 86%, AI/AN (77%) and NH/PI (79%).

African American IDUs. African Americans Injection Drug Users (IDUs) are a Subpopulation of Focus within the RW Program, as well as the MAI program. African Americans were 61% MAI clients with IDU transmission that were virally suppressed compared to 61.9% of MAI clients overall. Among FY20 RW MAI clients in IDU transmission category, African Americans represented 61% of RW MAI clients in FY20, followed by Hispanics (34%) and American Indian/Alaska Natives (5%).

2.A.3) Unmet Need (Attachment 4)

2.A.3)a) Unmet Needs Estimate Method and Issues

Unmet need is defined as the number of individuals with HIV who are aware of their HIV/AIDS status and are not in HIV medical care. The RW Program used the HIV/AIDS Bureau's new Unmet Need Framework which includes the following components: 1) late diagnosed PLWH; 2) PLWH with unmet need; and 3) PLWH in care, but not virally suppressed. This new framework is aimed at more broadly characterizing unmet need.

Given that this was the first year the Sacramento TGA used this new process to develop the Unmet Needs Estimate, there were several challenges in working through this framework and linking it to existing databases. In reporting unmet needs estimates across each component of the framework, the TGA used HIV surveillance data which is the format for the "Required Method" and did not use linked databases (see Attachment 4 for details). The HIV Surveillance data used to develop Unmet Need was from a Data to Care line list provided by the California State Office of AIDS (SOA) because the specific criteria required for the unmet needs framework was only available on this type of "line list" data set. Unfortunately, this data format varied from the HIV Surveillance data used for the HIV/AIDS Epidemiology data,Table 1, Attachment 3.

The HIV Data-to-Care (DtC) Line List is an Excel spreadsheet containing all HIV/AIDS cases presumed to be alive and still residing in the state of California based on the most currently available data in the Enhanced HIV/AIDS Reporting System or Surveillance database (eHARS). The cases are grouped by the most recent residence address into separate spreadsheets for each local health jurisdiction (LHJ) in California by county of residence or city of residence in the case of the Berkeley, Long Beach, and Pasadena LHJs. The monthly Line Lists are generated based on the prior end-of-month frozen eHARS data set, and therefore should reflect the most up-to-date information about each case. Cases are deemed to be "out-of-care" if they do not have a CD4, viral load, or diagnostic genotype laboratory result (i.e., a "care lab result") in eHARS during a period of 12 months prior to the date of frozen data used in the analysis (12 months ending as of the date frozen). Other labs refer to diagnostic labs for a given case.

In addition to the challenges with the specificities of the HIV Data-toCare Line List provided by the California SOA, there were different time frames for each dataset. The Table 1 HIV epidemiology timeframe for is 01/01/18-12/31/20 whereas the line list data timeframe is 1/1/20-12/31/20. The variation in data formats also led to some differences in the totals across data sets. These data differences are not of high magnitude overall and are currently being recitifed. However, these data descrepancies will not be completed by the time this grant application is submitted.

2.A.3)b) Service Needs of PLWH based on TGA's Unmet Need Estimate

2.A.3)b)i. Service Needs of Late Diagnosed PLWH

Late Diagnosed PLWH are defined as the number of late HIV diagnoses based on first CD4 test performed or documentation of an AIDS-defining condition less than or equal to three months afer a new HIV diagnosis. The Sacramento TGA's Unmet Need Framework shows 30.8% of newly diagnosed PLWH were defined as late diagnosed.. The COVID-19 pandemic reduced the avilabilty of testing activities in the TGA causing some of the late diagnosis cases. In addition to the impact of COVID-19, linkage-to-care activities for newly dignosed persons are a necessary improvement.

The service needs of late diagnosed PLWH include a need for improved linkages between HIV prevention services and HIV medical care. Linkage to HIV medical care needs to be expedited for PLWH who are late diagnosed to ensure that their HIV disease does not progress further and that their viral load is reduced as soon as possible. In addition, all care providers, as well as testing sites, need to refer newly diagnosed clients for RW eligibility screening and Health Education/Risk Reduction (Partner Services). Late diagnosed PLWH need to be provided with immediate access to counseling and resource referrals, including partner services. The Partner Services program works to not only assist clients with issues of disclosure but provides referrals to the Sacramento County Surveillance Program which provides anonymous notification of HIV+ sex and needle sharing partners regarding their exposure and assists them in getting tested. All RW Medical Case Management subrecipients are contractually required to document referrals to Partner Services.

2.A.3)b)ii. Service Needs of PLWH with Unmet Need

PLWH with Unmet Need is defined as the number/percent of people with HIV who are aware of HIV status but are without a CD4 or viral load test in the most recent calendar year. The Sacramento TGA's Unmet Need Estimate calculates 1266/24.4% of PLWH with Unmet Need.

The service needs of PLWH who are aware of HIV status but not in medical care include a need for improvement of linkages between supportive services and primary care services. Expanded services for PLWH who have dropped out of care also are needed to include improvements to provider-patient partnerships and collaborations with peers. Service needs of PLWH who have never been in care include peer facilitated linkages between points of service entry, counseling and primary medical care. Collaboration between the three TGA counties also is necessary to ensure the rural patients are linked to medical care.

To address the service needs of PLWH with Unmet Need and re-engage them in HIV medical care, the TGA's RW service providers need to continue to work closely with Sacramento County DHS HIV Prevention and Testing providers to provide outreach to communities located in those zip codes with the highest number of clients who are not in care. The RW Program funds several agencies that provide services which include Benefits and Enrollment Counseling to enhance efforts to address these service gaps and get PLWH in care. For example, enrollment in the AIDS Drug Assistance Program (ADAP), the Covered California program

(ACA) and the OA-HIPP (State Health Insurance Premium) programs all increase access to care for PLWH who have fallen out of care due to lapses in securing benefits. Many RW service providers that provide benefit enrollment services are multicultural, bilingual staff who assist clients in determining their eligibility for and application for many public benefits. A Linkage to Care Navigator has recently been added to Sacramento County DHS funded partially by the county and also with the CDC Ending the Epidemic funding to assist with linking PLWH.

2.A.3)b)iii. Service Needs of PLWH In Care Without Viral Suppression

PLWH in Care but are not virally suppressed is defined as the number/percent of PLWH who are aware of HIV status but have a viral load ≥200 copies/mL at most recent test. The Sacramento TGA's Unmet Need Estimate calculates 494/12.6% of PLWH in care without viral suppression.

The service needs of PLWH in Care who have not achieved viral suppression include services that address barriers to HIV medical care and gaps in support services for PLWH. These services are vital to improve opportunities to reach viral suppression and include services such as mental health, substance use services, emergency financial assistance, housing, transportation and food assistance services. These wrap-around support services have demonstrated their effectiveness in establishing housing stability and improving clients' ability to stay retained in medical care and improve the outcome of viral suppression.

In addition to wrap around substance use and housing services, transportation services funded with RW Part A funds continue to be enhanced. While transportation assistance has been available to clients in the form of bus vouchers, the RW field-based medical case management system also provides mileage reimbursement for RW case managers to escort clients to appointments when necessary. In addition, 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. This has reduced the need for RW case managers to provide client transportation, which increases their capacity to provide additional case management services to clients. The RW Program has continued to adjust support of transportation services to respond to the COVID-19 pandemic which has limited public transportation and increased the need for individual transportation. For example, the RW Program is providing expanded use of Uber and Lyft to ease transportation barriers since public transportation is not easily accessed by all RW clients in need of this service and poses a health risk for immunocompromised individuals.

2.A.4) 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 5, Table 3: Co-Occurring Conditions Table. The Co-Occurring Conditions Table provides a quantitative profile of FY20 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 use disorder. Documentation of data sources also is provided in Attachment 5.

Follows is an analysis of HIV epidemiology data, RW client data and TGA population data showing the disproportionate impact of comorbidities on PLWH served through the RW program, as compared to the TGA's general population:

2.A.4)a) Hepatitis C Virus

The Hepatitis C incidence rate among FY20 RW clients was almost 2 times higher than the Hepatitis C rate in the TGA's general population in 2019 (1.8% vs. 0.09%). This higher rate of hepatitis C among PLWH also was reflected in the TGA's 2018 HIV/AIDS Needs Assessment respondents who reported a 16.9% hepatitis C rate for both new and chronic hepatitis C infections. Predictably, the incidence was reported to be much higher among the IDU population.

2.A.4)b) Sexually Transmitted Infections (STIs)

Data from the Sacramento County Department of Health Services, Division of Public Health show that the TGA's general population has some of the highest STI rates in California. In 2018, Sacramento County ranked #7 for gonorrhea, #5 for chlamydia and #11 for syphilis out of 58 counties. These high STI infection rates have a big impact on the RW program's cost and complexity of care, especially when considering that 84.2% of the FY20 RW caseload with known HIV transmission category became infected with HIV through sexual contact (57.1% MSM and MSM/IDU and 27.1% Heterosexual transmission).

Chlamydia. Chlamydia cases increased by 34.7% (from 9,811 to 13,215 cases) between 2015 and 2018 in Sacramento County's general population (where over 90% of the TGA's population resides). Sacramento County ranked the 5th highest rate among California counties in 2018, which was higher than the rank of 8th highest in 2017. Throughout the TGA, STIs disproportionately impact teens and young adults, especially females. The majority (65.2%) of Sacramento County chlamydia cases in 2018 were among females with a rate of 966.6 per 100,000. More than one-third (36.6%) of female chlamydia cases were distributed in the age group 20-24 and over one quarter (27.8%) were in the age group 15-19. The highest percentages of male cases were distributed in the age groups 20-24 (29.0%) and 25-29 (20.5%).

In FY20, the average cost per RW client who reported treatment for Chlamydia was 72% higher than the average cost per RW client overall ($2,634 and $1,535, respectively); and 0.53% of RW clients were treated for Chlamydia.

Gonorrhea. Cases of Gonorrhea in Sacramento County increased 22.7% from 3,129 in 2015 to 3,838 in 2018. Sacramento County ranked the seventh highest gonorrhea rate among all California counties in 2018, which increased from the County rank of tenth in 2017. In contrast to chlamydia, males were the majority (56.3%) of Sacramento County gonorrhea cases (56.3%) in 2018 with a rate of 284.4. The highest percentage of female gonorrhea cases were distributed in the age groups 20-24 (28.5%) and 25-29 (21.0%). Male cases had a similar age pattern as females, with nearly one-quarter (21.9%) of male gonorrhea cases distributed in age group 20-24, and 20.1% in age group 25-29.

In FY20, the average cost per RW client who reported treatment for Gonorrhea was 21.6% higher than the average cost per RW client overall ($1,867 and $1,535, respectively); and 0.49% of RW clients were treated for Gonorrhea.

Syphilis. In FY20, 5.7% of RW clients had newly reported and treated syphilis cases, which is exponentially higher (over 100 times) than the 0.05% syphilis rate in the TGA's general population (1,007/2,143,230).

Primary and secondary syphilis cases in Sacramento County increased close to 5 ½ times (from 66 in 2009 to 418 in 2018). Sacramento County ranked the eleventh highest rate among all California counties in

2018, which increased from the County rank of twelfth in 2017. The number of new syphilis cases in Sacramento County increased over 3 ½ times between 2012 and 2018 (from 147 to 517 cases). Regarding gender and age trends for syphilis in Sacramento County, males comprised the vast majority (73.0%) of syphilis cases in 2018; and the age group 25-29 had the highest rate for males (130.6) and for females (58.4).

A most disturbing trend in the TGA is the increasing number of cases of congenital syphilis, which increased 3-fold between 2013 and 2017, from 2 cases in 2013 to 6 cases in 2017. In 2018, the rate increased even further. There were 10 congenital syphilis cases in 2018 with a rate of 51.3 per 100,000 live births in the County. Sacramento County ranked 18th highest for congenital syphilis out of all California counties in 2018.

Racial Disparities in STI rates

There were marked disparities in rates of STIs in Sacramento County in 2018 among various racial groups. Compared to Whites, African Americans had a chlamydia rate that was nearly five times higher, a gonorrhea rate nearly six times higher, and a syphilis rate more than three times higher. Hispanics had slightly higher chlamydia and syphilis rates than Whites, but with a similar gonorrhea rate. Asian/Pacific Islanders had the lowest STI rates compared to all other groups.

2.A.4)c) Mental Illness

The rate of mental illness among RW clients is much higher than the TGA's general population. 28.6% of RW clients received mental health services in FY20 and compared to the 19.5% rate of mental illness in the TGA's general population in 2019, based on data from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health. These high rates of mental illness among PLWH have serious implications on the RW system, especially for specific subpopulations (i.e., the homeless population, people with substance abuse issues and youth and young adults).

2.A.4)d) Substance Use Disorders

Overall, the Intravenous Drug Use (IDU) rates among RW clients are much higher than the TGA's general population, where IDU prevalence is estimated at 0.22% based on the 2019 SAMHSA National Survey on Drug Use and Health. However, the RW program served a smaller proportion of IDU and IDU/MSM clients in FY20 (10.5%) than would be expected given their representation in the HIV/AIDS epidemic overall (15.3%). In the TGA's HIV epidemiology, injection drug use (IDU) alone, or in combination with MSM exposure category (MSM/IDU), accounted for 12.7% of HIV incidence (new HIV infections); 14.3% of AIDS incidence; 19.5% of AIDS prevalence; 11.1% of HIV prevalence; and 15.3% of PLWH in the TGA as of 12/31/20.

These figures demonstrate a need for continuation of increased outreach efforts for the IDU population with living with HIV/AIDS to link them to care, and to retain them in care at a rate closer to their representation in the TGA's HIV/AIDS epidemic.

With the high rate of substance abuse among RW clients, the cost implications to the program are quite apparent. In FY20, the average cost of care for the RW IDU population was 11.5% higher than that of the overall RW population ($1,712 vs. $1,535), with an average cost per IDU client that was higher than the overall RW population in several services: housing ($1,439 vs. $960); medical case management ($777 vs. $693); emergency financial services ($318 vs. $299); medical transportation ($381 vs. $359); and oral health care ($722 vs. $700).

2.A.4)e) Homeless/Unstably Housed

10.9% of FY20 RW clients (up from 8.5% in FY19 and 6.6% in FY18) reported themselves as either homeless (2.4%) or in unstable housing (8.5%), as compared to a 2019 homelessness rate of 0.32% of the Sacramento TGA's general population. Notably, the rate of homelessness/unstable housing was much higher among clients new to the RW system in FY20. 18.2% of new FY20 RW clients were homeless (3.5%) or unstably housed (14.7%); which is higher than the 14.0% of new FY19 RW clients that were homeless (2.6%) or unstably housed (11.4%). This rise in homelessness among RW clients is consistent with the rise in the homelessness in Sacramento County overall. According to the County's 2019 point-in-time homeless count conducted by Sacramento Steps Forward, 5,570 people were experiencing homelessness, a 19% increase over 2017.

Further, African Americans are increasingly and significantly overrepresented among homeless or unstably housed FY20 RW clients (34.9%) as compared to African American representation in the TGA's general population (7.3%).

The Sacramento RW Program's 2021 Young Adult Targeted HIV Needs Assessment, which surveyed young adults ages 19-29, asked about current living arrangements. An alarming 22.0%, reported that they were currently homeless or unstably housing in a shelter or motel. This was slightly higher than the 18.7% of 2018 HIV Needs Assessment respondents (all ages of RW clients) that reported that they were currently homeless or in unstable housing. Homeless PLWH surveyed in the 2018 Needs Assessment reported unmet needs for several RW service categories at higher rates than 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 Program is significant. Homeless RW clients had the highest average cost per client in 69% (9 of 13) RW service categories in FY20 as follows: housing services, emergency financial services, food ban, health education/risk reduction, medical case management, medical nutrition therapy, medical transportation services, outreach services and residential substance abuse services. These cost figures show that the outreach efforts to the homeless population living with HIV/AIDS have been more effective in FY20.

2.A.4)f) Former Incarceration

In FY20, 23.9%, 583/2,436 RW clients reported that they had been incarcerated and released from a correctional facility (jail or prison) within the past 12 months. The TGA conducted a targeted Needs Assessment for the recently released HIV+ population to identify the service needs and gaps of twenty-one locally incarcerated PLWH in the TGA in 2012. 42.8% of survey respondents (9 of 21) were African Americans. Overall, the Needs Assessment found a high need for food services, assistance with rent/utilities, and medical case management.

2.A.4)g) Tuberculosis

The tuberculosis (TB) incidence rate among FY20 RW clients was exponentially higher than the TB rate in the TGA's 2020 general population (0.94% vs 0.003%, respectively).

2.A.5) Complexities of Providing Care

2.A.5)a) Impact and Response to FY21 RW Part A Formula Funding Reductions

2.A.5)a)i. Impact of Funding Reductions

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 only minor cost of living increases. Over the last 25 years, since the RW Part A Program was first implemented in the Sacramento TGA, the RW caseload has grown by 66.6%, from 1,462 to 2,436 clients in FY20. These increases in RW client caseload, coupled with flat overall funding and service capacity, have resulted in the elimination of several services provided through the Part A program over the past several years (for example, home health care, buddy companion services, hospice, food assistance, and psychosocial support).

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. For FY21, the RW program requested the ceiling amount offered to the Sacramento TGA in the RW Part A Notice of Funding Opportunity (NOFO) of $3,591,612. The FY21 Notice of Award amount was for $3,379,842, a reduction from the TGA's FY20 award of $3,420,715. In response to funding reductions, adjustments are made by the Council in an effort to ensure the uninterrupted provision of RW services; however, cuts to crucial services are required in some instances. Federal, State and local government budgets are adopted after RW fiscal year allocation decisions are made each year, requiring the RW Planning Council to make RW budget adjustments, or reallocations during the RW fiscal year based on these funding adjustments. As part of the allocation and reallocation processes, 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 in the TGA, combined with increases in the number of PLWH and demand for HIV related services, has had a continued impact on PLWH throughout the TGA. The Sacramento County Public Health Division experienced a 65% reduction in local government funding during the budget downfall beginning in 2009 and has only recently begun to obtain additional local and new HRSA Part A and CDC Ending the HIV Epidemic federal funding to staff those public health positions that were eliminated previously. While budgets have gained some ground, the number of HIV+ clients coming into care continues to increase year over year.

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. Many Part A RW care and treatment agencies rely on HIV prevention and testing funds to meet the diagnostic goals of the HIV Continuum of Care, and continue to have increased waiting lists, coupled with expanded service demands, when funding for these services are reduced.

2.A.5)a)ii. Response to Funding Reductions: Cost Containment and Transitional Planning

Regarding transitional planning, the Council prepares several funding plans with alternate "worst-case" scenarios so that, if faced with TGA-wide funding reductions, the RW Program can respond while minimizing health risks to PLWH. Any RW services 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 or other direct assistance category any one client may receive within a one-year period so that limited funding can serve as many RW clients as funds allow. The Council reevaluates these service directives annually to determine adjustments as necessary.

2.A.5)b) Healthcare Coverage Among PLWH

The following table provides the TGA's current data on health care coverage and income status for FY20 Ryan White clients in the Sacramento TGA as compared to the TGA's 2018 General Population. For the general population, data was compiled from National Census data, as well as the California Health and Human Services (CHHS) open data portal.

HEALTH INSURANCE STATUS AND INCOME STATUS				
	Ryan White Clients 2020		**TGA General Population 2019**	
HEALTH INSURANCE STATUS*				
Medi-Cal	1,255	49.7%	516,297	24.1%
Medicare	643	25.4%	376,388	17.6%
Medi-Cal/Medicare	n/a	n/a	75,267	3.5%
No insurance (RW included)	122	4.8%	115,062	5.4%
Private insurance	368	14.6%	1,464,321	68.3%
Other public insurance	139	5.5%	41,888	2.0%
INCOME STATUS				
No Income	718	29.5%	238,599	11.0%
100% of Poverty	815	33.5%		
101-138% of Poverty	269	11.1%	117,255	5.0%
139-250% of Poverty	268	11.0%	355,202	17.0%
251-300% of Poverty	190	7.8%	140,546	7.0%
Over 300% of Poverty	175	7.2%	1,291,628	60.0%

**Sources of insurance may overlap for one individual (i.e., other insurance and Medicare)*
Data Sources for TGA General Population: data.ca.gov and factfinder.census.gov

The percentage of Federal Poverty Level (FPL) used to determine RW eligibility in the TGA is up to 500% of poverty. A sliding fee scale is applied for RW clients from 100% to 500% of FPL according to HRSA National Monitoring Standards; with case management fees waived entirely. For clients over 300% of poverty, the sliding scale applies until the client documents expenditures of at least 10% of their income on health-related charges (i.e., insurance premiums, deductibles, co-payments, medications, etc.).

Regarding income status, as shown in the chart above, the vast majority of FY20 RW clients (63.0%) had no income or were living at or under 100% of poverty as compared to 11.0% of the TGA's 2019 general population with no income or living at or below 100% of poverty. Only 7.2% of FY20 RW clients were living above 300% of poverty as compared to 60.0% of the TGA's 2018 general population.

The table above provides the health care coverage of FY20 RW clients as compared to the health care coverage of the TGA's general population in 2019. In FY20, only 14.6% of RW clients had any form of private healthcare insurance, as compared to 68.3% of the TGA's general population in 2019. 75.1% of FY20 RW

clients had Medicaid or Medicare public insurance as compared to 45.2% of the TGA's 2019 general population. 10.3% of FY20 RW clients had had no other form of insurance or other public insurance (rather than Medicaid or Medicare) and relied on the RW Program for non-covered care and treatment services.

There is a disproportionately higher percentage of FY20 RW clients on Medi-Cal than the TGA's 2019 general population (49.7% vs. 24.1 %). In FY20, 75.1% of RW clients were enrolled in Medi-Cal or Medi-Cal and Medicare (Medi/Medi), as compared to 60.2% of RW clients in FY18 and 73.4% in FY19. 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, or the ADAP and California SOA Health Insurance Premium Payment Program (OA-HIPP). In terms of other health care insurance coverage, such as private insurance, FY20 RW clients were over four times less likely to have private insurance compared to the TGA's general population (14.6% vs. 68.3%).

The level of poverty among RW clients continues to challenge the TGA. In FY20, 74.1% of RW clients were at or below 138% of FPL and 63.0% had annual incomes at or below 100% of the FPL. 29.5% of RW clients had no income at all in FY20. These figures show poverty rates dramatically higher among RW clients than the 16.0% of the TGA's general population under 100% of FPL based on 2019 US Census Bureau data.

2.A.5)b)i. Impact of Healthcare Coverage on Services and Health Outcomes

In FY20 there was continued success in outreach and enrollment to expand insurance coverage for PLWH in the TGA. Because 92.8% of FY20 RW clients fell below 300% of Federal Poverty Level (FPL), these clients were eligible for insurance assistance under the Affordable Care Act (ACA), known in California as "Covered California." Thankfully, between FY13 and FY20, there has been a reduction from 15.5%, to 4.8% of RW clients without a source of health insurance. This shows promising success in expanding health insurance coverage for PLWH in the TGA over the past several years due to the implementation of the ACA.

Although the RW Program is making solid progress in maximizing other sources of health care coverage for PLWH in the TGA, a lower percentage of FY20 RW clients were uninsured (4.8%) as compared to the TGA's general population (5.4%) in 2019.

Coordination of Health Insurance Enrollment Efforts

The Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, funded through the California Department of Public Health, State Office of AIDS, is designed to provide payment of health insurance premiums and medical deductibles and co-pays for clients who have lost their employment and are losing their private health insurance coverage. One Community Health and Sunburst Projects 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 ACA, low-income clients who are dually enrolled in both ADAP and the OA-HIPP programs get assistance with private insurance premiums, medication co-payments and medical insurance deductibles. The efficiency of these direct enrollments by RW Program subrecipients continues to significantly improve client access to third-party reimbursement and reduces RW outpatient ambulatory medical care expenditures for new clients who are otherwise be at risk of losing their insurance. The TGA's rural counties also have certified ADAP and OA-HIPP 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 OA-HIPP program has experienced significant increases since 2015 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, California RW recipients became eligible for State assistance for medical co-payments and deductibles if they have a modified adjusted gross income that does not exceed 500% of FPL based on household size. While this program has reduced the need for Ryan White dollars to be spent on 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 from OA-HIPP for that first month of service are returned to the RW program and utilized as program income for RW services.

There are vast needs for PLWH living in poverty, and their average cost of care in the RW program has been consistently higher than the population of PLWH not living in poverty. The average cost of care for new FY20 RW clients with incomes under $20K was 40.4% higher than RW client with incomes over $20K. Given that 79.4% of RW clients had incomes under $20K, and 53.9% under $10K, the cost 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 PLWH 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 finally get healtcare coverage and access to care. For example, in FY20, the average cost of care per RW client on Medi-Cal was close to 1 ½ times the average cost of care for clients with private insurance through their employer ($1,871 vs. $673). 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 under ACA coverage. The RW Program Benefits and Enrollment staff has been increased over the last several years with the addition of another agency/subrecipient 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 available under ACA covered plans.

In addition, the TGA's RW program continues to assist PLWH with core RW services such as mental health and outpatient substance use treatment, both of which are in high demand with limited coverage under ACA plans. The RW oral healthcare services also have expanded since ACA implementation, largely because Medi-Cal dental providers are extremely limited in the TGA, and Medi-Cal offers very limited oral procedures. RW clients with private insurance through the ACA don't have dental coverage, and RW services remain their only option for oral heatlhcare. In addtion, since low income clients represent the largest percentage of PLWH in the TGA, the RW Program's support services 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 analysis to realize any significant reduction in the average annual cost of care for RW Part A clients. The overall cost per RW client did decrease between FY19 and FY20, $1,810 in FY19 to $1,535 in FY20. Given the complexities of COVID-19 on the healthcare system in 2020, including the RW system of care, it is too soon to project that this downward cost per RW client will continue into the years to come.

Between FY19 and FY20, decreases in RW cost per client were found in several RW services. For

example, outpatient medical care decreased from $567 to $559; childcare services from $2,663 to $1,482; emergency financial assistance ($408 to $299); and food bank/home delivered meals ($92 to $89).

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, despite the 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 RW funded Medical Care Clinic, One Community Heath (a Federally Qualified Health Center (FQHC) formerly doing business as Cares Community Health). Kaiser Permanente, another provider of HIV care in the TGA, is a Covered California plan. The other two Covered California plans do not list any HIV specialists in their provider network. Since only four other clinics in Sacramento provide limited HIV specialty care, RW clients have been advised to select one of the two Covered California plans that will provide 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 continues to have a limited availability of HIV specialty physicians. In FY19 One Community Health, a subrecipient of RW funds, continued to see the 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 consistently been serving close to 5% of the PLWH in the TGA over the last several years. All HIV+ children are seen at the UCD Pediatric Infectious Disease center (a RW subrecipient) 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 and Placer, however, there is only one Covered California private health care insurance plan (the California Health and Wellness Plan), and rural clients have had difficulty receiving HIV specialty medical care and maintaining coordinated medical and support services in their rural

county. Medical Case Managers in the rural county areas have found this a challenging problem. 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 County as needed. However, as described throughout this application, coordination of medical and support services is challenging and more costly for RW clients from the rural counties of the TGA.

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 and dental 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 RW systems pay for the first month of premiums while RW clients await approval from the OA-HIPP program. **(3) Limited HIV Specialty Providers in Rural Counties of TGA.** While the majority of RW Medi-Cal 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 rural county HIV patients signed up for the only 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.

2.A.5)c) Factors Limiting Healthcare Access

FY2020 and FY2021 have been unprecedented times during the COVID-19 pandemic which has spread rapidly across the Sacramento TGA, just as it has done across the globe and the United States. The RW Program, the region's network of service providers, the clients served, as well as PLWH who the program continues to work closely with to engage in care, all have been affected by the COVID-19 pandemic which is causing ongoing uncertainty.

The COVID-19 pandemic has exacerbated existing challenges that limit healthcare access. Many clinical and public health services have been curtailed due the pandemic, with staff at times redeployed to address the public health emergency. Many of the populations disproportionately affected by HIV are particularly vulnerable to the service disruptions and economic consequences of COVID-19. Issues such as unemployment, poverty, mental health, food insecurity, lack of housing and transportation have been exacerbated in the TGA. The economic impact of the pandemic will likely continue to impact health services availability due to budget constraints in the public healthcare system.

In response to the COVID-19 pandemic and its impact on limiting healthcare access, innovative approaches have been implemented across the TGA to continue to provide services. Follows are a few examples that the RW Program is engaged in to respond to COVID-19: 1) providers are conducting appointments with RW clients via telemedicine; 2) distribution of HIV home testing kits; 3) increasing the use of expedited partner therapy to ensure timely STI treatment; 4) offering multi-month medication refills and 5) partnering with pharmacies and retail health clinics to ensure continuity of care.

2.A.5)c)i. TGA HIV Needs Assessment Findings and Healthcare Access

The RW HIV Health Services Planning Council (the Council) has conducted an extensive HIV Needs Assessment every 2-3 years since the inception of the TGA's RW Part A Program in 1996. The HIV Needs Assessment collects information from clients through a comprehensive survey tool which collects data regarding their Service Needs, Unmet Needs and Barriers to Care. The most recent comprehensive TGA-wide HIV Needs Assessment, surveying all subpopulations of Ryan White clients, was conducted in 2018. Unfortunately, the 2020-21 Needs Assessment was delayed due to the risks of the COVID-19 pandemic, given that face-to-face interviews are necessary to conduct the survey.

Due to the challenges and delay due to COVID-19, the Planning Council voted to target young adults ages 19-29 in the 2021 survey process. A discussion with the TGA's Project Officer was held to discuss including adults up to ages 29 in include more clients, this was approved. In total, of the 190 RW clients in the target population served in FY20, 18 PLWH completed the survey. Although this is a small number of respondents, it is 9.5% of the target population which is higher than the 7.3% of RW clients who completed the 2018 HIV Needs Assessment survey which included a survey of RW clients of all ages.

The objective of the TGA's 2021 HIV/AIDS Young Adult Targeted Needs Assessment were similar to all previous Needs Assessments of all subpopulations of RW clients. The overriding goal was to collect and analyze data on service needs, service demand, service gaps and barriers to care for RW clients to assist the Council with effective planning for both service funding and service delivery. Service gaps and barriers to care were further analyzed by demographics and social determinants of health (SDOH) such as race, age, gender, mode of HIV transmission, co-occurring medical conditions, county of residence, socioeconomic status, and previous incarceration, to understand the unique needs of each subpopulation throughout the TGA. This analysis was done at the aggregate level as well as by RW service category to determine what services were not able to be received by which groups of PLWH, and what barriers to care were the most challenging for which RW service categories.

The most important section of the TGA's Needs Assessment is the "Unmet Need" section. Unmet Need is defined, by each RW service category, as the number of survey respondents who reported they were not able to receive the service due to at least one barrier to care they confronted for that service. The 2018 HIV Needs Assessment (all ages) and 2021 Young Adult Targeted (ages 19-29) HIV Needs Assessment further analyzed each RW service category to determine which services had disparate unmet needs for which demographic categories.

Service Demand and Unmet Need by Service Category

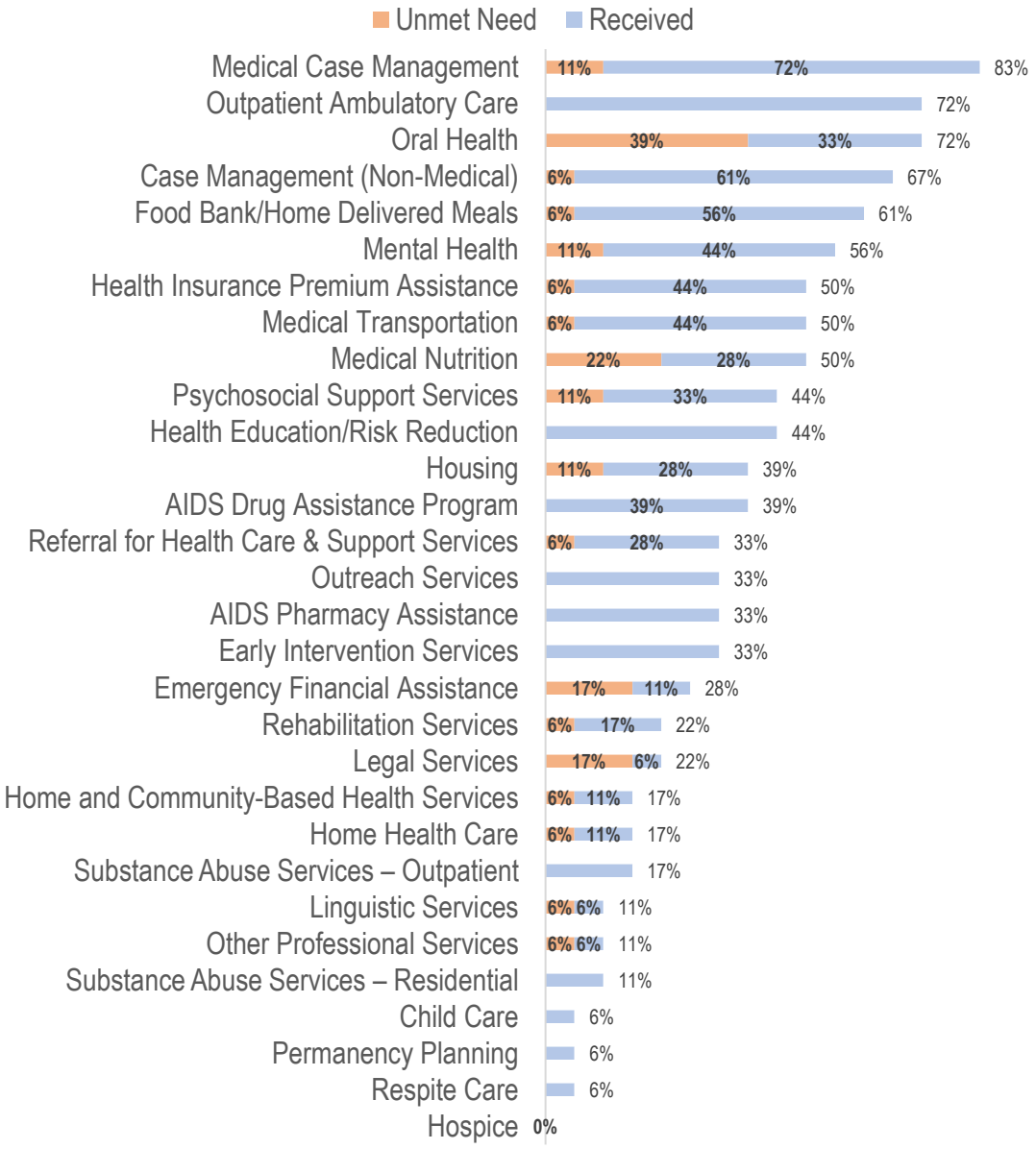
It is important to understand both Service Demand and Unmet Need to gain a clear picture of what services are needed most by PLWH and which services they are having the most difficulty obtaining. Service Demand includes the percent of survey respondents who reported that they Needed and Received the Service (Need Met) ***plus*** the percent who needed the service but could not receive it due to at least one Barrier to Care (Unmet Need).

Unmet Need by service category is the percent of respondents who needed but did not receive the service due to at least one Barrier to Care for that service. As can be noted from the definition above, Unmet Need is a subset of Service Demand. Unmet Need is a critical factor to analyze in determining the services RW clients having the greatest difficulty obtaining. Among 2021 Young Adult Needs Assessment survey respondents, Oral Health had the highest Unmet Need (39%); followed by Medical Nutrition (22%);

Emergency Financial Assistance (17%); Legal Services (17%); Medical Case Management (11%); Mental Health Services (11%); Housing (11%); and Psychological Support Services (11%).

It also is important to highlight the successful finding in 2021 that 12 services had NO unmet need, meaning that all of the young adult RW clients who reported that they needed the following services were able to receive them: Substance Abuse Services (Outpatient and Residential); Child Care; Health Education/Risk Reduction; Outreach Services; AIDS Drug Assistance Program; AIDS Pharmacy Assistance; Early Intervention Services; Hospice; Permanency Planning and Respite Care.

Service Demand by Service Category 2021
Service Demand (Total Need) = Unmet Need + Need Met



Services with High Service Demand AND High Unmet Need

There were several services that were ranked with both a high Service Demand AND a high Unmet Need by survey respondents. This shows that clients need these services at high rates, but they have not been able to receive them due to high rates of Barriers to Care. The following five services ranked the highest for combined Service Demand and Unmet Need in both 2021 Needs Assessment that targeted young adults, and the 2018 Needs Assessment, which surveyed all ages of RW clients.

SERVICES WITH HIGH SERVICE DEMAND
AND
HIGH UNMET NEED
2018 AND 2021

	2018 Needs Assessment		2021 Young Adult Targeted Needs Assessment	
Service Category	**Service Demand**	**Unmet Need**	**Service Demand**	**Unmet Need**
Oral Health	82%	27%	72%	39%
Medical Case Management	82%	29%	83%	11%
Mental Health	81%	18%	56%	11%
Housing	80%	48%	39%	11%
Medical Nutrition	78%	41%	50%	22%

Barriers to Care for RW Clients

In addition to identifying Unmet Needs and Service Gaps, the TGA's Needs Assessment goes deeper by examining Barriers to Care that are driving these issues. To determine which level of the service system the Barriers to Care exist, the categories go from broad-based TGA-wide "Access Barriers" and "Financial Barriers" to client-based "Personal Barriers," which are defined 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."

As can be noted below, of the top 10 Barriers to Care in 2021, 50% were Access Barriers, 20% were Personal and 20% were Financial. Follows are the top 10 Barriers to Care reported by survey respondents in the 2021 Young Adult HIV Needs Assessment compared to the all-ages 2018 HIV Needs Assessment:

TOP 10 BARRIERS TO CARE 2021 YOUNG ADULTS AND 2018 ALL AGES NEEDS ASSESSMENT SURVEY RESPODENTS			
2021 Young Adults*		**2018 All Ages**	
1	Did not know service was available (Access)	1	Did not know service was available (Access)
2	Did not know how to get service (Access)	2	Did not think I was eligible for service (Financial)
3	Did not think I was eligible for service (Financial)	3	Did not know how to get service (Access)
4	Did not know where to go to receive service (Access)	4	Privacy of HIV status concerns (Personal)
5	No transportation (Access)	5	Did not know where to go (Access)

TOP 10 BARRIERS TO CARE 2021 YOUNG ADULTS AND 2018 ALL AGES NEEDS ASSESSMENT SURVEY RESPODENTS			
2021 Young Adults*		**2018 All Ages**	
6	Co-pay was too high (Financial)	6	Wait times too long (Access)
7	Wanted privacy of HIV status (Personal)	7	Treated with disrespect (Personal)
8	Hard to navigate system (Personal)	8	Was told I wasn't eligible (Financial)
9	Was treated with disrespect (Personal)	9	Appointment times not convenient (Access)
10	Next available appointment not soon enough (Access)	10	Co-pay was too high (Financial)

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

80% of top 10 Barriers to Care were the same for 2021 Young Adult survey respondents and 2018 All Ages survey respondents. The barriers of "no transportation" and "hard to navigate system" were in the top 10 in 2021. Due to Covid-19, public transportation was more limited in 2020 and 2021 and did impact RW clients. In 2018, however, "wait times too long" and "appointment times not convenient) were in the top 10 Barriers to Care.

2.A.5)c)ii. Social Determinants of Health and Healthcare Access

Social Determinants of Health, including HIV provider cultural competency and Pre-Exposure Prophylaxis (PrEP)-related stigma, can impact access to services for PLWH across the TGA. In addition, demographics and co-occuring conditions, such as poverty, homelessness, language barriers, educational status, substance use, mental illness, previous incarceration, and medical comorbidities can have a dramatic impact on healthcare access.

To determine which services had disparate unmet needs for RW clients in various demographic groups, the 2018 HIV Needs Assessment further analyzed each RW service by these characteristics. The following service categories had a demographic cohort that reported an Unmet Need of >10% than the survey average:

Ryan White Service Category	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

Ryan White Service Category	Unmet Need: Demographic Disparities
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

Demographic Variances and Healthcare Access

In addition to the TGA's HIV Needs Assessments, Service Gaps and Unmet Need are identified through an annual analysis of trends in RW client service utilization by mode of HIV transmission, gender, race and age, to determine subpopulations facing additional factors that limit access to care and create service gaps. The examination of service utilization trends among various racial groups found that language barriers continue to exist among the Hispanic community, which continues to underutilize RW services. Analysis of FY20 client service utilization and cost data found that Hispanic RW clients may not be accessing RW services to the same degree as other racial groups. Hispanic RW clients had a lower average cost per client ($1,344) than RW clients overall ($1,525). Hispanics had lower costs per client ($1,344) compared to the following racial groups: African Americans ($1,582), Whites ($1,584), and Asian/Pacific Islanders ($1,785).

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.

2.B. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)

2.B.1) Planned Activities in TGA's EIIHA Plan for 2022-2024 Period of Performance

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

The Sacramento County Department of Health Services, Division of Public Health has fully integrated its HIV and STI programs (HIV/STI Prevention Program, HIV/STI Surveillance, and RW Care Programs) into the Sexual Health Promotion Programs Unit (SHPU) and an HIV/STI Programs Manager coordinates and oversees the integrated programs. This united structure has enhanced the TGA's efforts to identify HIV+ individuals and to provide risk reduction counseling. The Sacramento County SHPU relies on the expertise of the Sacramento Workgroup to Improve Sexual Health (SacWISH) to support HIV/STI prevention, testing and treatment efforts in the TGA.

To further facilitate this integration, each HIV/STI program has moved into the same office suite to facilitate coordination of staff and implementation strategies that address the full range of HIV and STI services. These services range from HIV/STI prevention and testing; to HIV/STI surveillance, disease intervention and Partner Services; to HIV/STI linkage to care and treatment; as well as re-engagement to care and treatment. This structure has supported implementation of the TGA's EIIHA Plan.

The RW Program, Sacramento County Division of Public Health, and participating government and private testing providers, have agreed to common data elements are tracked to monitor the impact of the EIIHA Plan. Through analysis of TGA-wide HIV surveillance epidemiological data through 12/31/20, as well as HIV Continuum of Care data through 2020, the FY22 EIIHA plan targets those populations overrepresented in the local HIV/AIDS epidemic, 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 and reporting those results, data collection from private testers is more challenging. Although data collection and reporting has improved among private testing sites, these efforts often are costly processes for private organizations, and despite their willingness to cooperate, these private testers often have limited resources to generate the data necessary to 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 the County Public Health Surveillance Team, or with One Community Health, the largest medical provider for RW clients, to initiate Partner Services, confirmatory tests, and access to HIV medical providers.

Since the TGA's privately funded HIV testing providers are already members of SacWISH and the HIV Prevention Coalition, they cooperate in the development and implementation of the EIIHA Plan. With years of extensive community collaboration and coordination, the TGA has a solid framework for implementing it's EIIHA Plan by targeting specific demographic groups; specific needs of people most at risk for HIV, and by limiting barriers to HIV testing and care for the TGA's most at risk populations.

The California Department of Public Health released its final 2019 Sacramento County epidemiology data in 2021, reporting that there are estimated to be 850 PLWH in Sacramento County who are unaware of their HIV status. Although HIV testing is available in numerous locations throughout the TGA, as described above, community engagement data suggests that HIV messaging and outreach is not adequately reaching several vulnerable populations, or if it is, the message is not resonating to the degree needed. These populations include people of color (including women), transgender persons, youth, injection drug users, other substance abusing individuals, people experiencing homelessness, and people who have English as a second language.

In addition, Routine opt-out-testing (ROOT) is not widely practiced throughout Sacramento County which likely decreases opportunities to diagnose many of the PLWH who are unaware of their HIV status. There is strong consensus among community engagement participants, Sacramento County staff and the HIV Health Services Planning Council that, in order to end the TGA's HIV epidemic, community-based testing needs to be widely accessible throughout the TGA and tailored to the needs of people not currently being reached.

Through enhancements to the TGA's EIIHA data collection and system level intervention described above, the primary activities of the FY22 EIIHA Plan, which have specific outcomes, targeted for each subpopulation, have been developed and are summarized below (see section 2.B.1)c) for additional details):

- Provide HIV testing to high-risk populations to make them aware of their HIV status (target testing by race, age, gender, transmission, and other risk categories).
- Conduct testing at venues accessible and familiar to high-risk populations to maximize testing efforts
- Provide prevention and harm reduction education information, including PrEP (Pre-Exposure Prophylaxis), PEP (Post-Exposure Prophylaxis) information and referrals, to individuals during all testing interactions.
- Increase percent of newly diagnosed HIV+ people linked to medical care within one month of diagnosis through targeted, TGA-wide referrals.
- Educate medical providers on HIV testing and referral resources to increase routine testing of population

at large.

- Certify and train new HIV testers on Or-Quick Rapid HIV testing to expand the TGA's capacity.
- Educate and enlist the support of community leaders to encourage their continued support of maintaining the HV/AIDS epidemic as a continuing priority through the TGA's community stakeholder group, the Sacramento Workgroup to Improve Sexual Health (SacWISH).
- 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 increased numbers of trained testers who reach more members of each target population and increase the number of individuals aware of their HIV status.
- Provide Rapid HIV testing to targeted populations and provide immediate information about their HIV status
- Decrease barriers that may prevent individuals from each target population from returning for test results.
- Increase the number of TGA residents at high risk for HIV infection who are on PrEP.

Activities to Identify Individuals Unaware of HIV Status. Since Sacramento County Department of Health Services, Division of Public Health's integration of HIV/STI 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, PEP, and other support services. In addition to HIV/STI testing, all TGA programs have contractual language requiring providers to refer all newly diagnosed individuals to the Partner Services Program. This service elicits 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 to provide free testing.

In addition to HIV/STI 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, a RW subrecipient for Part A, shares information, and coordinates outreach, education, testing and data sharing with the County 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.

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 $10 million dollars throughout the TGA between 2013 and 2020. The CARES Foundation provides grants to nonprofit agencies that strive to identify individuals unaware of their HIV status, and work with various subpopulations, such as homeless, youth, IDUs, people in the sex trade industry, the LGBT community, rural communities, and specific high-risk racial/ethnic groups, primarily Hispanics and African 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, risk reduction education and referrals for PrEP/PEP and further testing and

support services. Individuals who test positive or inconclusive 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/STI 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 coordinate services with the Sierra Foothills AIDS Foundation (SFAF), which is headquartered in Placer County with field offices in El Dorado County. SFAF participates in TGA activities related to informing rural individuals of their HIV Status. The SFAF contracts with Sacramento County HIV testing providers to continue testing in the TGA's rural counties and has been successful in encouraging HIV testing in rural county primary care centers and the county jails 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/STI testing, both programs have contractual language requiring providers to refer all newly diagnosed individuals to the Partner Services Program. This service elicits 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, are immediately referred to care. In addition to receiving resource and referral information, HIV testing provider staff are trained to provide immediate services to assist clients in accessing care.

While the TGA covers a large geographic area for HIV testing, HIV specialty medical providers are relatively limited. All testers are familiar with private providers, such as One Community Health, SFAF and Planned Parenthood, as well as government funded testing sites, and all public and private HIV testing sites currently refer 100% of newly diagnosed clients to medical care. One Community Health is currently the primary RW HIV medical care provider for adults in the TGA, and service capacity in the TGA is expanding as the Sacramento County Sexual Health Clinic completes implementation of its HIV ambulatory care and transportation services.

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 which provides low-cost confirmatory HIV 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 is used to identify sources for HIV care and treatment, as well as educational materials for HIV+ individuals. The Sacramento HIV/STI 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" where 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 to ensure that clients go to 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, Sacramento County HIV/STI Prevention is integral to the TGA's plan to link individuals to treatment. Sierra Foothill AIDS Foundation (SFAF) 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 subrecipient, 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 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, client health outcomes demonstrate this model's effectiveness in linking clients to medical care and achieving viral suppression. In FY20, 80.8% of RW clients who received RW outpatient medical care services (1,421/1,758) met the definition of "In Medical Care" by received a minimum of one medical visit in CY20 including a CD4 or viral load test. However, only 35.4% (623/1,758) met the definition of "Retained in Medical Care" by receiving at least two medical visits at least three months apart in FY20. The Continuum of Care indicator of "Retained in Medical Care" decreased from 42.5% in FY19 to 35.4% in FY20. The percent of RW clients who received medical care in FY20 prescribed HAART was 95.3%, which is a significant improvement over FY19 (75.5%). The percent of RW clients in medical care in FY20 who achieved viral suppression was maintained at a high rate of 83.0%, very similar to the FY19 rate of 83.9%.

2.B.1)b) Collaborations with HIV Prevention, Surveillance and Ending the HIV Epidemic Programs

A major achievement in the implementation of the EIIHA Plan has involved the integration of the HIV and STI Programs into one unit within the Sacramento County Division of Public Health. These efforts have enhanced the TGA's efforts to provide risk reduction education counseling to those at highest risk, to identify HIV+ individuals, and to fast track them into care and support services. Staff of the Sexual Health Promotion Unit include certified HIV test counselors whom each have been trained by the California SOA to conduct Partner Services activities.

Currently, the HIV/STI Prevention Program and its community subcontractors provide State funded HIV testing activities. When staff or community subcontractors identify HIV positive individuals, they link them directly to appropriate medical providers. Upon linking individuals to care and treatment, testing staff notify HIV surveillance staff so that they can monitor whether or not each HIV positive individual is engaged in care and follow up accordingly.

Surveillance staff also provide Partner Services, including third party anonymous notification of HIV exposure to the partners elicited by testing staff. Additionally, because surveillance staff are also certified test counselors, they are able to offer HIV rapid testing to the partners. Moreover, in coordination with the RW Program, surveillance staff help to locate and re-engage PLWH who have fallen out of care. With other funding sources, a linkage to care coordinator was hired in 2020 within the Sexual Health Promotion Unit. Staff from the Sexual Health Promotion Unit including HIV and STI Surveillance, and RW Program meet on a regular basis, along with the Sacramento County Epidemiology Unit, to determine best practices for tracking client retention and to maximize opportunities for data sharing.

To further these efforts, the Sacramento County HIV/STI Programs Manager is responsible for oversight of the SacWISH community group. The Sacramento County Public Health Division formed this entity, comprised of representatives from community medical clinics, health care plans, HIV/STI testing agencies, school districts, state and local public health departments, and nonprofit agencies. The purpose of SacWISH is to coordinate and enhance the TGA's HIV/STI prevention, testing and treatment efforts and to assist with determining best practices for client retention and data sharing. The EIIHA Plan is disseminated to SacWISH to provide regional goals and objectives, and to elicit their support in providing the RW program with annual HIV/STI testing results.

SacWISH also provides its members with promotional materials to increase community awareness of free testing sites and referral locations to link individuals to low-cost or free treatment; and provides epidemiological data and technical assistance to guide local HIV prevention efforts. SacWISH has had in-depth presentations on PrEP and PEP, Partner Services, the importance of routine testing at clinic sites, and has provided promotional materials to encourage STI/HIV testing and linkage to care throughout the TGA.

Sacramento County Public Health also expanded its capability of identifying HIV+ clients and linking them to care by opening a new Sexual Health Clinic (SHC) in May of 2019. The clinic provides a variety of sexual health services including contraception services, extragenital testing for chlamydia and gonorrhea, rapid HIV, HCV, and syphilis screening, as well as STI treatment and referral services. In the first year of operation (May 5, 2019 – August 6, 2021), the Sacramento County Department of Health Services, Sexual Health Clinic provided 638 office visits. 72% of all Sexual Health Clinic patients from 5/1/19-6/8/21 were uninsured. The clinic testing services had a 29.6% positivity rate of Syphilis, Gonorrhea and Chlamydia combined. This is a significant finding, as it is well documented that contracting Syphilis and/or Gonorrhea significantly increases the chances of contracting HIV, particularly among MSM.

In January of 2021 the Sacramento County DHS Sexual Health Clinic began offering Ryan White services such as HIV ambulatory care and transportation and has served 17 HIV clients. This represents a 2.7% HIV positivity rate within this population indicating that the clinic is drawing high risk clients. Although the outbreak of COVID-19 delayed implementation of these services, Sacramento County Department of Health Services has been providing these HIV services through the Sexual Health Clinic throughout 2020 and 2021.

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), Golden Rule Services (GRS), Sacramento LGBT Center, Wind Youth Services (Wind), Community Against Sexual Harm (CASH), Sacramento Native American Health Center (SNAHC), Sacramento County DHS HIV/STI Prevention Program, CommuniCare Health Centers (CCHC), Sunburst Projects, El Dorado County DPH, Placer County DPH, Planned Parenthood Mar Monte (PPMM), WellSpace Health, and Sierra Foothill AIDS Foundation, implement activities that identify HIV+ individuals.

One Community Health used funding from a prior CDC grant for to implement EIIHA activities in 2014, but that funding ended and was replaced in part by The CARES Foundation funding from CY 2016 to the present. GRS, HRS and the Sacramento County DHS HIV/STI Prevention Program use federal CDC funds through a SOA grant. One Community Health is a FQHC and utilizes some federal funds for testing. Planned Parenthood Mar Monte 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/STI Prevention Program. One Community Health has access to high-risk individuals and their partners who come for low-cost STI testing and treatment. HRS targets its services for people who are homeless and/or substance users, including injection drug users. HRS conducts free HIV and Hepatitis C testing, a syringe exchange program which provides clients with case management services, food, clean syringes, overdose prevention medications and transportation. GRS targets African American MSM, offering free or low-cost HIV/STI testing, Hepatitis C testing, risk reduction services, counseling, 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/STI Prevention Program and testing partners target MSM by providing testing at venues where high risk communities congregate, such as the LGBT Center, Gender Health Center, gay pride events, bars and community health fairs. These organizations work closely with County Public Health Departments to coordinate efforts to target high-risk populations throughout the TGA.

EIIHA Plan Community Collaborations to Strengthen Outcomes Across the HIV Care Continuum

In addition to the County's integration efforts and collaborations with the SacWISH community stakeholder group, the HIV/AIDS Prevention Coalition, formed by the RW subrecipient One Community Health, 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, including Sacramento County RW Program and HIV/STI Prevention Program staff, as well as representatives from other community HIV service providers such as the Sacramento LGBTQ Center, Golden Rule Services, Harm Reduction Services, Sierra Foothills AIDS Foundation, and the Gender Health Center. The HIV Prevention Coalition meets throughout the year to provide critical feedback on strategies that have proved effective in reaching people most at risk for HIV infection in the Sacramento TGA. Community testing organizations involved in the HIV Prevention Coalition diagnosed 26 HIV+ individuals though 4,303 HIV tests in 2020.

The HIV Prevention Coalition was formed by the RW subrecipient, One Community Health, and has been funded in part by The CARES Foundation, a private Foundation dedicated to funding HIV prevention and treatment services throughout the greater Sacramento region. In addition to supporting the HIV Prevention Coalition's efforts, The CARES Foundation has provided over 10 million dollars in grants to nonprofit service providers engaged in services that support the TGA's EIIHA Plan, such as HIV testing; expansion of accessible testing venues with additional trained HIV testers; linkage to care for newly diagnosed HIV+ people; HIV prevention and harm reduction education; PrEP information and referrals; education and support of community leaders to maintain the HIV epidemic as a continuing priority throughout the TGA.

The CARES Foundation has funded many community organizations throughout the TGA to strengthen and implement targeted prevention and support service activities as follows: CASH, HIV/STI Program; Central Valley AIDS Education Training Center (CAETC), PrEP Community Engagement; CommuniCare, Yolo PrEP Clinic; FREED Center for Independent Living HIV/AIDS Options; Gender Health Center, HIV

Prevention and Education, Intervention; GRS Non-Medical Case Management; HRS, Project Reach; Life Enriching Communications (LEC), Heart to Heart Project; One Community Health, HIV Prevention Coalition; Parents, Families of Lesbians and Gays (PFLAG), HIV/AIDS Local Outreach (HALO); Planned Parenthood Mar Monte (PPMM), HIV/STI Prevention; Sacramento County Public Health, PrEP Navigation; Sacramento LGBT Center, Health & Wellness; SNAHC, BE SAFE; SANE, Syringe Access Program; University of California, Davis (UC Davis), Clinical Trials; and Wind Youth Services, HIV/STI Education.

In the TGA's rural counties, the Sierra Foothills AIDS Foundation (SFAF) conducts HIV testing in Placer County using test kits provided by One Community Health and has been successful in getting community clinics in rural counties of TGA to conduct HIV testing. RW Medical Case Managers assist clients to ensure all newly diagnosed clients receive a warm hand-off to medical care and other prevention and treatment services. For example, during 2020, SFAF referred 415 at risk patients to PrEP services and conducted 32 HIV tests in the TGA's rural counties. These community collaboration efforts are instrumental in development, implementation, and oversight of the TGA's EIIHA Plan. Examples of additional efforts currently provided throughout the TGA follow:

- Sacramento County Department of Health Services (DHS) Sexual Health Promotion Unit (SHPU) has opened its Sexual Health Clinic in May 2019, providing services to high-risk patients and their partners, including low/no-cost HIV/STI testing, treatment and comprehensive PrEP services
- The SHPU, in response to COVID-19, has implemented innovative testing practices such as home HIV test kits for PrEP patients, a "door-to-door" testing program using technology such as Zoom and DocuSign for counseling and consent paperwork.
- SHPU has convened a monthly HIV Test Counselor/ PrEP Navigator workgroup to coordinate efforts across Sacramento County and support coordination of various programs, services and organizations.
- County surveillance staff in Sacramento, Placer and El Dorado Counties, as well as pharmaceutical companies, conduct ongoing, in-depth analysis to monitor the number of individuals prescribed PrEP.
- One Community Health and the Sacramento County HIV/STI 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 have provided partner services to all partners of HIV+ to ensure that they get tested. Those high-risk individuals testing negative are educated on PrEP, PEP, and other harm reduction strategies.
- Sacramento County Public Health HIV/STI Prevention Program is continuing to implement and strengthen its STI/HIV Prevention, education and testing activities.
- SacWISH is providing the PrEP Toolkit to providers and distributes prevention materials to their clients.
- Rural county RW providers are disseminating PrEP Toolkits and prevention materials to rural providers.
- Rural county testers are providing Risk Reduction/Partner Services to their clients testing negative.
- RW providers are conducting Risk Reduction/Partner Services with negative partners of their HIV+ clients.
- Collaborations are ensuring that all RW providers are equipped with information and referral agreements for partner services, PrEP, PEP, and harm reduction services that are shared with clients at every visit.

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

The TGA's FY22 EIIHA Goals, which include those for the government funded agencies, are identified in the first column of the table below; with the responsible parties/timeframes noted in the final column:

FISCAL YEAR 2022 EIIHA PERFORMANCE INDICATORS Responsible Parties/Timeframes	
Strategies to Improve EIIHA	**Responsible Parties/Timeframes**
1. Conduct testing in at least 40 venues accessible and familiar to high-risk populations to maximize number of high-risk individuals who become aware of their status.	Parties/Timeframes: Testing Providers 1/1/22-12/31/22
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: Testing Providers 1/1/22-12/31/21
3. Provide community level and social network Rapid HIV testing to the following risk populations and make them aware of their HIV status: ▪ IDUs and other Substance Using Individuals: at least 10% of tests will be administered to IDUs. ▪ Men having Sex with men (MSMs): at least 30% of total tests will be administered to MSM. ▪ Other High-Risk Groups: approximately 55% of total tests will be administered to individuals at higher risk of acquiring HIV, such as: people with an HIV+ Sex Partner; Sex Workers; IDU Partner; MSM Partner; Sex Worker Partner; previous Syphilis/Gonorrhea Diagnosis; Stimulant User; as well as members of disproportionately impacted groups, such as: Black/AA, Latinx, low-income communities, and those who are unhoused. ▪ Transgender Individuals: 5% of those tested will be transgender men, transgender women, genderqueer or non-binary Target Population Goals by Race: ▪ 30% of total clients tested will be White ▪ 20% of total clients tested will be African American ▪ 30% of total clients tested will be Hispanic ▪ 10% of total clients tested will be Asian/Pacific Islander ▪ 2% of total clients tested will be American Indian/Alaskan Native ▪ 8% of total clients tested will be Other/Undeclared	Parties/Timeframes: Testing Providers and 1/1/21-12/31/21

Contribution of EIIHA Plan to Improvements in HIV Care Continuum Outcomes

The TGA's FY21 and FY22 EIIHA goals correlate with the Goals of the National HIV/AIDS Strategy (NHAS) and Continuum of Care Initiative. Goals 1 through 6 of the TGA's EIIHA strategy are designed to achieve the following NHAS Continuum of Care Performance Indicators:

"Increase knowledge of HIV-positive status to 90%. Nationally, across age groups, young persons, 13-24 years, are most likely to be undiagnosed with fewer than half aware of their infection." The TGA's efforts target youth and young adults, in particular young men who have sex with men (MSM), to get tested. In CY20, 25.4% of tests administered through the TGA's EIIHA providers were for clients ages 24 years and younger, exceeding their 17.1% representation in the TGA's HIV epidemic as of 12/31/20. The number of PLWH in the TGA ages 24 and under as of 12/31/20 is over 4 times the 4.2% rate on 12/31/17. Further, 33% of positive tests in CY19 were found in people under age 25, which is a large increase over the 23% positivity rate just one year ago, as of 12/31/19. To maximize opportunities for HIV testing for youth and young adults, the TGA offers a wide range of testing sites accessible to various target populations of youth through venues associated with each subpopulation's culture, geography, lifestyles, and sexual orientations. Once tested, comprehensive efforts are made to ensure that youth and young adults are contacted directly, made aware of their HIV status, and linked to care as soon as possible.

In addition to youth and young adults, the TGA targets the United States' most at risk populations for

transmission of HIV: Men who have Sex with Men (MSM) and Intravenous Drug Users (IDUs). 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 who are aware of their HIV status.

Analysis of TGA-wide HIV epidemiology data shows that the Heterosexual HIV transmission category surpassed the IDU transmission category, in both absolute numbers and percentages, in 2018. This trend has continued into 2020. Longer term trends show the total number of PLWH among the heterosexual population increased 11.5% over the last seven years. 2020 efforts to target the Heterosexual population were effective, with 54.8% of total tests administered to Heterosexual individuals throughout the TGA.

"Increase linkage of newly diagnosed persons to HIV medical care within three months to 85%." The TGA's and RW Program'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. 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 RW Program's CY20 rate of 48% linkage to HIV medical care within 30-days for newly diagnosed PLWH is lower than the TGA's CY19 rate of 89%, California's CY19 rate of 83%, the National CY19 rate of 81%, as well as the NHAS goal of 85%.

In addition to the challenges of the COVID-19 pandemic in linking newly diagnosed PLWH to care, RW subrecipients have had some challenges with their Electronic Medical Record (EMR) which appears to have resulted in an underreporting of linkage to care within the 30-day period. The RW Program is working diligently to continue to improve this rate and implement additional strategies throughout the TGA to link newly diagnosed PLWH to care within 30 days.

Addressing Gaps Along the HIV Care Continuum

Analysis of client data from the 2020 RW Program allows the TGA to determine which subpopulations are less likely to be meeting targets across the HIV Care Continuum. Follows are examples of some of these variations as well as strategies in the EIIHA Plan to work to reduce these gaps. In Medical Care (receipt of at least one CD4, viral load, or HIV-1 genotype test during the year) for the 2020 RW Program was 79.5% overall. However, MSMs (78.9%) and Heterosexuals (85.9%) were less likely than IDUs (88.5%) to be in medical care. African Americans (78.2%) were less likely to be in medical care than Hispanics (79.1%) or Whites (78.7%). Males (78.2%) were slightly less likely than females (79.5%) to be in medical care. RW clients over ages 25-44 (81.8%) were slightly less likely to be in medical care than clients ages 20-24 (81.5%), clients ages 44-59 (86.3%), clients ages 60 and over (89.6%) and clients ages 3-19 (100%).

Follows are examples of innovative TGA approaches to address gaps along the HIV Care Continuum through its EIIHA Plan:

- Expanded "field-based" case management which allows medical case management (MCM) to be offered in settings of the client's choice, rather than only in an office. This model began with the MAI program in 2003, and health outcomes improved so substantially that the Council increased allocations to field based MCM from 30% in 2003 to 75% in 2020. 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 subrecipients must document each client's viral load suppression regardless of the service provided.

To further address gaps in the Continuum of Care indicators the TGA maintains its own client-level database, Sacramento HIV/AIDS Reporting Engine (SHARE), and collects intake information from all RW clients. Through this database, the TGA has developed performance indicator reports that document, by service, agency and demographics, the percent of clients in each stage of Continuum. Additionally, a "Clients Not in Medical Care," is provided monthly to RW agencies so agencies will follow up on clients to get them back in care. The reports also identify clients not virally suppressed so that agencies are better able to provide immediate assistance to address barriers.

2.B.2) Efforts to Remove Barriers and Expand Implementation of Routine HIV Testing

The Sacramento TGA's RW Program follows the lead of the California State Office of AIDS (SOA) in identifying legislation that would remove legal barriers to increasing implementation of routine HIV testing and access to care. The CDC recommends that individuals between the ages of 13 and 64 get tested for HIV at least once as part of routine health care; however, this standard does not call for mandatory testing. California has aimed to increase HIV testing through law, policy, and practice by decreasing barriers to testing, and promoting opt-out HIV testing as opposed to opt-in testing.

More recent legislation includes mandates for providers to offer an HIV test. These strategies have been used to increase HIV testing among the following populations: pregnant women, individuals obtaining a marriage license, individuals that are having their blood drawn in the course of seeking primary care services, and individuals being seen at one of four (4) emergency departments in hospitals across California that are currently piloting a project to conduct routine offering of an HIV test. Voluntary testing with informed consent continues to be the law in California.

The Fiscal Agent's RW Program Coordinator / AIDS Director for Sacramento County Public Health, participates on monthly calls of the California HIV/STD Controllers Association (CHSCA). CHSCA analyzes all HIV related legislation introduced in the California Legislature each year and provides letters of support or opposition when necessary to bills that could improve or harm HIV+ individuals or the provision of high-quality medical care to PLWH. Legislation related to prevention services also are monitored by CHSCA.

The California SOA 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 decreased testing barriers. AB 682 added a California Health and Safety Code Section in 2008 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. AB 1894 was successful in 2009 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 and to reduce financial barriers.

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

1. *Strategies targeting substance using and homeless communities.* Promote testing and testing referrals 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 to promote testing for their target populations.

2. Rapid HIV testing. All HIV testing agencies 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 location, culture and lifestyles.

3. Partner services, resource provision and referral to care. All TGA testing sites provide HIV resource and referral information to newly diagnosed clients, and partner services for those testing negative. All TGA testing sites inform newly diagnosed clients of services at One Community Health and provide linkage to care. One Community Health testing sites provide newly diagnosed clients with low-cost confirmatory tests, Partner Services, and RW medical care and support services.

2.C. SUBPOPULATIONS OF FOCUS

2.C.1) Three Subpopulations with Health Outcome Disparities and Unique Service Needs

A data driven process was used by the RW Program and the HIV Health Services Planning Council to identify the TGA's target subpopulations of focus that are disproportionately affected by HIV. This comparative analysis included review of the following data sources:

1. RW Planning Council HIV/AIDS Needs Assessments
2. State of California TGA epidemiological data through 12/31/20
3. FY20 RW service utilization, client demographic and cost data
4. Co-Occurring Conditions Data
5. Social Determinants of Health Data
6. Other Public Health Threat Data (i.e., Covid-19 pandemic)
7. RW Unmet Need Estimate
8. Continuum of Care data for RW Program, TGA, State and Nation, including demographic analyses
9. 2020 HIV testing data provided by participating local government-funded testing sites
10. RW Program's FY22-24 Early Identification of Individuals with HIV/AIDS (EIIHA) Plan

Based on analysis of these data sources, the Sacramento TGA's HIV Health Services Planning Council determined that the following subpopulations have health outcome disparities and unique service needs that qualify them as the TGA's "Subpopulations of Focus" for 2022: Men who Have Sex with Men (MSM), Heterosexuals and Intravenous Drug Users (IDUs). As noted in the bullets in the table below, each Subpopulations of Focus is comprised of the races, ages, genders, and HIV transmission modes most disproportionately affected in each subpopulation.

Sacramento TGA 2022 SUBPOPULATIONS OF FOCUS		
Men who have Sex with Men (MSM)	***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

The following narrative describes the data used from various sources to support the Planning Council's decisions for each Subpopulation of Focus: TGA's HIV/AIDS epidemiology, Needs Assessments, RW service utilization and cost data, co-occurring conditions and social determinants of health data used to support the Planning Council's decisions for each subpopulation. The additional data included in the analysis (Unmet Need Framework, Continuum of Care, EIIHA) are described in the subsequent sections 2.C.1) through 2.C.4).

2.C.1)a) Men who Have Sex with Men (MSM) – African Americans, Hispanics, Youth and Young Adults

Overall, the unique needs of the MSM subpopulation are complicated by 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, including PrEP, due the fear of others finding out about their sexuality. Follows is analysis of recent epidemiological trends among the MSM population, including African Americans, Hispanics, Youth and Young Adult MSMs living with HIV.

Since the last reporting period ending 12/31/19, increases occurred among MSMs in all epidemiologic categories with the exception of new HIV cases which decreased by 14.2% as of 12/31/20. AIDS incidence increased by 61.5%, AIDS prevalence increased by 1.0% and HIV prevalence increased by 3%. Further analysis of target populations within the MSM transmission category follow:

2.C.1)a)i African American MSMs

Although African Americans made up only 7.2% of the TGA's general population in 2019, they were 22.0% of PLWH (HIV/AIDS prevalence), 22.0% of new HIV cases (HIV incidence) and 24.9% of AIDS incidence during the most recent reporting period (1/1/18 – 12/31/20). Specific to the FY20 RW program 41.4% of African American RW clients were MSMs. This subpopulation underutilized RW services in FY20 with a 79.8% lower cost per client than RW clients overall ($1,220 vs. $1,528). This finding is consistent with 2020 HIV Continuum of Care data showing that African Americans and MSMs were less likely to be in medical care than other subpopulations. MSMs (78.9%) and Heterosexuals (85.9%) were less likely than IDUs (88.5%) to be in medical care. African Americans (78.2%) were less likely to be in medical care than Hispanics (79.1%) or Whites (78.7%).

2.C.1)a)ii. Hispanic MSMs

As a subset of the MSM Subpopulation of Focus, Hispanics were the racial group most disproportionately represented among new AIDS cases and new HIV cases as compared to their representation among total PLWH in the TGA as of 12/31/20. Hispanics were 29.6% of new AIDS cases and 28.0% of new HIV cases compared to 21.3% of total PLWH. A large percentage of Hispanic RW clients in FY20 reported MSM as their HIV mode of transmission (69.3%). Hispanics were disproportionately represented among MSMs (29%)

compared to Hispanic representation among RW clients overall (24%).

Analysis of FY20 RW client service utilization and cost data found that Hispanic RW clients did not access RW services to the same degree as other racial groups. Hispanic RW clients had a lower average cost per client ($1,344) than RW clients overall ($1,525). Hispanics had lower costs per client ($1,344) than African Americans ($1,582), Whites ($1,584), and Asian/Pacific Islanders ($1,785) in FY20.

2.C.1)a)iii. Youth and Young Adult MSMs

60.5% of FY20 RW clients ages 13-24 reported MSM as their mode of HIV transmission. Hispanics were overrepresented among youth and young adult RW clients in FY20. Hispanics were 33.3% of ages 20-24, as compared to 24.0% of RW clients overall. An important finding is that young adult MSM RW clients significantly underutilized services . The average cost per MSM client ages 20-24 was less than half the average cost per RW client overall ($732 vs. $1,528) in FY20.

2.C.1)b) Heterosexuals – African American Females, Youth and Young Adults

Unique needs of the Heterosexual subpopulation (which includes High-Risk Heterosexuals) mirrors those of other risk categories: stigma regarding homosexuality and bisexuality; hesitancy to seek substance use treatment due to fear of arrest; addiction focused behaviors challenging concern for personal health and well-being; and other high-risk behaviors including unprotected sex with multiple partners.

Analysis of the TGA's HIV/AIDS epidemiology through 12/31/20 shows a 68.8% increase in AIDS incidence in the heterosexual transmission category and a slight 0.4% increase in AIDS prevalence (from 492 to 494) since 12/31/19. HIV incidence decreased by 2.8% and HIV prevalence decreased by 1.4%. 27.2% of RW clients were infected with HIV via heterosexual contact, which is higher than the representation of heterosexuals among PLWH in the TGA (15.8%). Further analysis of Subpopulations of Focus within the heterosexual transmission category follow:

2.C.1)b)i. African American Female Heterosexuals

Females continue to be overrepresented among heterosexuals in all aspects. 44.9% of female FY20 RW clients were African American, which is much higher than the 25.9% of RW clients and 7.2% of African Americans in the TGA's 2019 general population. Among RW clients, females are disproportionately African American compared to males (44.9% of female RW clients were African American compared to 21.1% of males in FY20). There was a disproportionately high cost of care for RW heterosexuals in FY20: 9.5% higher than the cost per RW client overall ($1,718 vs. $1,535).

A disturbing trend among childbearing ages women in the TGA is the increasing number of cases of congenital syphilis, which increased 3-fold between 2013 and 2017, from 2 to 6 cases. In 2018, the rate increased to 10 congenital syphilis cases with a rate of 51.3 per 100,000 live births in the County. Sacramento County ranked 18th highest for congenital syphilis out of all California counties in 2018.

2.C.1)b)ii. Youth and Young Adult Heterosexuals

The number of youth and young adult RW clients has continued to climb since the TGA's RW Program began in 1997. RW clients ages 13-24 increased by 57.2% between 1997 to 2017; and increased another 14.1% between 2017 to 2020. Throughout the TGA, STIs disproportionately impact teens and young adults, especially females. The majority (65.2%) of Sacramento County chlamydia cases in 2018 were among females with a rate of 966.6 per 100,000. More than one-third (36.6%) of female chlamydia cases were distributed in the age group 20-24 and over one quarter (27.8%) were in the age group 15-19. The highest

percentages of male cases were distributed in the age groups 20-24 (29.0%) and 25-29 (20.5%).

2.C.1)c. Injection Drug Users (IDU) – African American and Youth and Young Adults

Unique needs of the IDU subpopulation 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 including PrEP and PEP; unprotected sex and other high-risk behaviors.

The TGA's IDU transmission category saw increases in prevalence (existing cases) and AIDS incidence (new cases) while HIV incidence which remained the same for both reporting periods since the last reporting period ending 12/31/19. AIDS incidence increased by 125%; AIDS prevalence increased by 2.9% and HIV prevalence increased by 3.7%.

In the TGA, injection drug use (IDU) accounted for 12.7% of HIV incidence (new HIV infections); 14.3% of AIDS incidence; 19.5% of AIDS prevalence; 11.1% of HIV prevalence; and 15.3% of PLWH in the TGA as of 12/31/20. However, the RW program served a smaller proportion of IDU and IDU/MSM clients in FY20 (10.5%) than would be expected given their representation in the HIV/AIDS epidemic overall (15.3%). These figures demonstrate a need for continuation of increased outreach efforts for the IDU population to link them to care, and to retain them in care at a rate closer to their representation in the TGA's HIV/AIDS epidemic. Further analysis of Subpopulations of Focus within the Injection Drug Use transmission category follow:

2.C.1)c)i. African American IDUs

African Americans IDUs are a target population within the RW Program, the MAI portion of the program, as well as EIIHA. In FY20, 37.0% of RW clients ages 13-24 were African American (30/81) compared to 26.0% of RW clients being African American overall (633/2,436). Further, African Americans are increasingly overrepresented among homeless or unstably housed FY20 RW clients (34.9%) compared to African American representation in the TGA overall (7.3%). Alarmingly, 18.2 % of *new* FY20 RW clients were homeless (3.5%) or unstably housed (14.7%); which is higher than the already high 14.0% of new FY19 RW clients that were homeless (2.6%) or unstably housed (11.4%).

2.C.1)c)ii. Youth and Young Adult IDUs

Although the upward 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 FY20, 37.0% of RW clients ages 13-24 were African American (30/81) compared to 26.0% of RW clients being African American overall (633/2,436). Hispanic youth also are disproportionately impacted: 32.1% of RW clients ages 13-24 were Hispanic (26/81) compared to Hispanics being 24.0% of RW clients overall (584/2,436).

2.C.2) Unmet Need Framework Data and Subpopulations of Focus

As disussed previously, in reporting unmet needs across each component of the framework, the TGA used HIV surveillance data which is the format for the "Required Method" and did not use linked databases (see Attachment 4 for details). The data requirements for these various analytic tools do not match exactly due to differences in the date ranges, definitions, and formats used for each database and jurisdiction. These differences have created some discrepancies in figures when conducting direct comparative analyses. Even with these data challenges, the TGA's unmet needs data supports the Planning Council's decision to identify each Subpopulation of Focus as follows:

2.C.2)a. Men who Have Sex with Men (MSM)–African American, Hispanic and Youth and Young Adults

African American MSMs African American MSMs represented 10.1 % of the unmet need population as of 12/31/21.

Hispanic MSMs Hispanic MSMs represented 12.0% of unmet need population as of 12/31/20.

Youth and Young Adult MSMs. 19.4% of late HIV diagnoses were within the MSM transmission method in 2020.

2.C.2)b. Heterosexuals – African American Women and Youth and Young Adults

The Heterosexual category represents the second largest percentage of PLWH in the TGA as of 12/31/20; and represented the second highest population out-of-care in 2020 (26.0%).

African American Women. 9.4% of African American women ages 13-24 and 7.6% of total African American women represent the unmet need population. 4.1% of African American women who had a late diagnosis as of 12/31/20.

Youth and Young Adult Heterosexuals. 30% of late diagnoses were among heterosexual females while 55.6% of late diagnosis were among heterosexual males.

2.C.2)c. Injection Drug Users (IDU) – African American and Youth and Young Adults

The third highest population out-of-care was Injection Drug Users (IDU) at 10.3% as of 12/31/20.

African American and Hispanic IDUs. African American and Hispanic IDUs represented 2.5% and 2.1% of unmet need respectively.

Youth and Young Adult IDUs 7.1% of youth represent the unmet need population as of 12/31/20 and zero percent of late diagnosis were among IDUs, both females and males.

Once Unmet Need data is determined, these findings are quantified in cost figures to project the potential increased cost to the RW program to serve the out-of-care population by applying the out-of-care data to the percentage of PLWH served by the RW program and the average annual cost per client.

For example, the FY20 RW caseload represents 45.5% (2,436/5,347) of the TGA's PLWH as of 12/31/20. Applying the 45.5% to the 1,266 PLWH out-of-care, an additional 576 persons will likely need access to the RW system of care in FY22. The potential cost to the RW program would be $884,160 annually if 45.5% of the anticipated out-of-care clients accessed the RW system of care in FY22, given that the average cost per RW client in FY20 was $1,535. This potential increased dollar figure is based on FY20 RW cost figures and doesn't factor in the rising cost of living in California, which would increase this average cost per client figure further. The increased FY22 Part A funding request will be needed not only to maintain services for the existing RW caseload, but to meet the demands of currently out-of-care PLWH.

2.C.3) Continuum of Care Data and Subpopulations of Focus

The Continuum of Care data was analyzed by the demographics such as age, race, gender, and HIV transmission for RW clients as well as PLWH in the TGA, California and the Nation to assist with identifying the Subpopulations of Focus of the RW Program.

2.C.3)a. Men who Have Sex with Men (MSM)- African American, Hispanic and Young and Young Adults

African American MSMs. 2020 HIV Continuum of Care data identified that although viral suppression rates among African American RW clients increased between CY19 and CY20 (68% to 85%); in FY20 African American clients had the lowest viral suppression rates (74%) compared to all other racial groups in the RW program as follows: Whites (79%), Hispanics (81%), Asians (86%), AI/AN (77%) and NH/PI (79%). Particularly, CY20 African Americans with MSM transmission had a low viral suppression rate (48%) compared to African American RW clients overall (62%). Regarding retention in care rates, MSMs and African Americans had the lowest rates in the RW Program (38% for both subpopulations).

Hispanic MSMs. In FY20, Hispanic RW clients had an overall viral suppression rate of 81%, which was lower than RW clients overall (85%). However, there was improvement in the percentage of Hispanic RW MAI clients on HAART between FY19 and FY20, from 79.8% to 92.2%. Regarding the Hispanic MSM subpopulation of focus, Hispanics were 38.3% of RW MSM clients that achieved viral suppression as compared to Hispanics being 30% of RW MAI clients overall.

Youth and Young Adults MSMs. Youth and young adults were overrepresented among the MSMs RW clients in FY20. 60.5% of RW clients ages 13-24 reported MSM transmission compared to 51.6% of RW clients ages 45 and older. Within the youth and young adult population, the following RW clients in the following age groups were less likely to be virally suppressed than RW clients overall (84.5%); ages 13-19 (81.3%) and ages 20-24 (66.7%). Moreover, RW clients ages 13-24 were less likely to be virally suppressed in 2020 (60%) than in the Sacramento TGA (95%), California (81%) or the Nation (79%) in 2019.

2.C.3)b. Heterosexuals – African American Women and Youth and Young Adults

Heterosexual African American Women. 77.6% of female RW clients in FY20 reported heterosexual as their mode of HIV transmission and 44.9% were African American. Within the 2020 RW Program's Continuum of Care, linkage-to-care rates were the lowest for Heterosexuals (40%) as compared to MSMs (51%) and IDUs (50%). Further, African American RW clients had the lowest viral suppression rate (74%) compared to other racial groups including Hispanics (81%), Whites (79%), Asians (86%), NH/PI (79%) and AI/AN (77%). Regarding women, there were several indicators across the HIV Care Continuum were women had outcomes lower than the average for the jurisdiction. For example, 82% of female RW clients achieved viral suppression in 2020 vs. 85% overall; 52% of females were retained in the TGA vs. 54% overall; and 74% of females were in medical care in California vs. 75% overall.

Heterosexual Youth and Young Adults The age group of 20-24 had the lowest viral suppression rates among RW clients in FY20 (66.7%). Heterosexual HIV mode of transmission was reported as the second highest, under MSM contact in FY20. Heterosexual RW clients ages 13-24 had very low cost per client in FY compared to RW clients overall ($198 vs. $1,535). The following age groups were less likely to be virally suppressed than RW clients overall (84.5%); ages 13-19 (81.3%) and ages 20-24 (66.7%) in FY20. Moreover, youth and young adults ages 13-24 in the RW Program were less likely to be virally suppressed in 2020 (60%) than in the Sacramento TGA (95%), California (81%) or the nation (79%) in 2019.

2.C.3)c. Injection Drug Users (IDUs) – African Americans and Youth and Young Adults

There were several indicators across the HIV Care Continuum were Injection Drug Users had outcomes lower than the average for each jurisdiction (RW, TGA, CA, Nation). For example, 67% of IDUs were linked to care in the TGA compared to 89% of the TGA linked to care overall. In California, 75% of IDUS were linked to care vs. 83% overall. In the Nation, 75% of IDUs were linked to care vs. 81% overall. IDUs also were less likely to meet the HIV Care Continuum indicator of in medical care in California (67%) compared

to PLWH in California overall (75%) as well as the Nation with 69% of IDUs in medical care vs. 76% overall. Similarly, IDUs were less likely to be retained in care in the TGA (50% vs. 54% overall) and the Nation (54% vs. 58%). IDUs were less likely to be virally suppressed across all jurisdictions compared to PLWH overall. For the Nation, 58% of IDUs were virally suppressed vs. 66% overall; in California, IDUs were 54% vs. 65% overall; for the TGA, 59% of IDUs were virally suppressed vs. 70% overall, and in the RW Program IDUs achieved viral suppression at 84% compared to 85% RW clients overall.

African American IDUs. 2020 Continuum of Care data show that African Americans were 61% of RW MAI clients with IDU transmission that were virally suppressed compared to 61.9% of MAI clients overall. Among FY20 RW MAI clients in the HIV transmission category of IDU, African Americans represented 61% of RW MAI clients in FY20, followed by Hispanics (34%) and American Indian/Alaska Natives (5%). As discussed above, African Americans as well as IDUs, have HIV Care Continuum indicators that are behind RW, TGA, California and National outcomes overall, including linkage to care, in medical care, retained in care and viral suppression.

Youth and Young Adult IDUs. In the FY20 RW program, 11% of clients 13-24 reported IDU as their HIV mode of transmission, a subpopulation with HIV Care Continuum indicators behind targets. In addition, as discussed above, the youth and young adult RW client population were less likely to be virally suppressed than RW clients overall (84.5%); ages 13-19 (81.3%) and ages 20-24 (66.7%). Moreover, youth and young adults ages 13-24 in the RW Program were less likely to be virally suppressed in 2020 (60%) than in the Sacramento TGA (95%), California (81%) or the Nation (79%) in 2019.

2.C.4) EIIHA Data, Activities and Subpopulations of Focus

The disparate needs and costs of PLWH who are aware of their diagnosis but who are out-of-care (Unmet Needs population), as well as the population who is unaware of their HIV diagnosis (EIIHA), is important to analyze in determining priorities, allocations, and targeted activities for Subpopulations of Focus. The RW Planning Council uses the demographics of the aware but out-of-care population (Unmet Needs) to presume similar demographics of the HIV unaware population (EIIHA) and its corresponding needs. 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. 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.

Objectives for Each Component of EIIHA for Subpopulations of Focus. For each Subpopulation of Focus, 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. Follows are examples of EIIHA strategies in the TGA, which are customized for each target subpopulation:

2.C.4)a. Men who Have Sex with Men (MSM) – African Americans, Hispanics, Youth and Young Adults

Examples of EIIHA activities targeted on this Subpopulation of Focus include the following: 1) promote opportunities for anonymous Partner Services to HIV+ clients; 2) provide Risk Reduction counseling to all clients at least once a year; and to all newly diagnosed clients immediately after diagnosis; 3) conduct broad-based media campaign to encourage individuals to get free HIV/STI testing; 4) utilize targeted marketing campaign on social networking venues such as Facebook, Twitter, Grindr, Scruff, and others; 5) provide outreach to selected venues favored by gay youth; 6) conduct outreach through partners of gay youth; 7) provide free testing and testing referral information at gay youth events and 8) utilize social marketing to expand outreach services to youth and their social networks using Facebook and other youth-friendly venues.

2.C.4)b. Heterosexuals – African American Females, Youth and Young Adults

Examples of EIIHA activities targeted on this Subpopulation of Focus include the following: 1) promote testing of HIV+ and STI Partners at all testing sites; 2) promote opportunities for anonymous Partner Referral Services to HIV+ and STI+ clients; 3) provide risk reduction counseling to all clients at least once a year, and to all newly diagnosed clients immediately after diagnosis; 4) encourage clients to bring partners in for testing on a frequent basis; 5) conduct broad-based media campaign encouraging individuals to get free HIV/STI testing; 6) utilize targeted marketing campaigns on social networking venues such as Facebook and Twitter; and 7) conduct testing venues accessible and familiar to high risk populations to maximize the number of people in the TGA aware of HIV status.

2.C.4)c. Injection Drug Users (IDU) – African Americans, Youth and Young Adults.

Examples of EIIHA activities targeted on this Subpopulation of Focus includes: 1) 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; 2) provide mobile testing on street corners and homeless camps in neighborhoods where IDUs congregate; 3) provide incentives (food vouchers, etc.) to promote testing to target population; 4) provide free testing at social venues frequented by African American IDUs; 5) disseminate culturally appropriate and multilingual printed materials for Hispanic IDUs; 6) provide outreach to selected venues and sites favored by Hispanic IDUs, such as HRS and SANE, and the local methadone clinics; and 7) provide culturally appropriate, multilingual free testing at residential substance abuse treatment centers and methadone clinics.

2.C. Local Pharmaceutical Assistance Program (LPAP) – N/A for Sacramento TGA

SECTION 3: METHODOLOGY

3.A. PLANNING RESPONISBILITIES

3.A.1) Letter of Assurance from Planning Council Chair (Attachment 6)

See Attachment 6 for Letter of Assurance from Planning Council Chair confirming that the following activities were conducted in FY21 and will be continuing through FY22: TGA-wide program planning process; Priority Setting and Resource Allocation (PSRA); Council Membership Training; and Assessment of Administrative Mechanism.

3.A.2) Resource Inventory

RW Part A planning efforts aim to expand the availability of services; reduce duplication of services; coordinate with all other public funding for HIV; bring newly diagnosed PLWH into care; retain PLWH in care; and focus on service needs not currently being met (service gaps). In order to address these planning efforts, a resource inventory was conducted to determine all other public funding sources for HIV and coordinate RW services with those other funding sources to ensure RW funds were used as the payor of last resort.

Medicaid expansion and implementation of the Affordable Care Act (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 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, in FY20 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 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 offer "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 patient's physician 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 other 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, pediatric treatment adherence, risk reduction 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 use 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 (MFTs, MFCCs, MSWs, ACSWs) who continue to proivde mental health counseling to RW clients who are on ACA waiting lists as long as these professinals are provided suprevision by the appropriately licensed mental heatlh profesional.

Impact of Marketplace Plans on Medications for PLWH

California has legislation in place 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 are authorized to share ADAP client information with the following entities: Department of Health Care Services; California Health Benefit Exchange (Covered California); 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 State law has expanded the TGA's ability to coordinate enrollment efforts with other agencies and community partners.

Impact on Part A Allocations, Health Insurance Premium and Cost Sharing Assistance

The TGA's RW Part A program increased its allocations for Benefits and Enrollment Counselors beginning in FY13 to ensure that RW clients receive assistance enrolling in public benefits, such as Covered California (ACA coverage), Medi-Cal, State Insurance Premium Assistance Programs, and the AIDS Drug Assistance Program (ADAP), throughout the TGA, including the rural counties. The RW Program's FY20 Request for Proposal (RFP) process has ensured that enrollment services continue through an expanded number of subrecipients receiving Part A furnding for non-medical case management. These agencies also have the enrollment services augmented with Part B funding which maximizes the TGA's use of resources.

The resource shifts resulting from the ACA also allowed the RW Council to increase allocations overtime to the State Office of AIDS Health Insurance Premium Assistance Program (OA-HIPP) to assist clients with financial need for premiums, deductibles and medical co-payments. A challenge for PLWH is that assistance under a Covered California plan is available from the State OA-HIPP program, but the approval wait time averages six weeks, so clients seek assistance from the RW Part A Premium Assistance service to cover premiums during that time. The OA-HIPP program provides premium assistance with a monthly cap for combined medical, dental and vision coverage. Dental co-payments are only provided if the dental insurance is included as part of the medical plan. The program also provides assistance with co-pays and deductibles up to each client's annual out-of-pocket maximum. Clients with full Medi-Cal coverage are not eligible for ADAP or OA-HIPP, so the RW program is their only source of assistance for non-covered dental procedures and co-payments.

These resource shifts in the TGA have allowed the Council to allocate more funding over the years to services such as transportation, emergency financial assistance, childcare, residential substance abuse treatment and emergency housing, although client needs continue to far outpace the TGA's ability to respond.

3.A.2)a). Coordination of Services and Funding Streams (Attachment 7)

See Attachment 7 for the TGA's HIV resources inventory table that includes: 1) public funding sources for HIV prevention, care and treatment services; 2) total available funds in the FY21 period of performance for each funding source; and 3) use of resources including services delivered.

SECTION 4: WORKPLAN

4.A. HIV CARE CONTINUUM TABLE AND NARRATIVE

4.A.1) FY2022 HIV Care Continuum Table (Attachment 8)

See Attachment 8 for the FY22 HIV Care Continuum Table which is comprised of the diagnosed-based HIV Care Continuum Service Table; baseline indicators for each stage; the desired target outcome to be achieved during the FY22 project period; and the RW Part A funded service categories to support desired outcomes.

4.A.2) HIV Care Continuum Narrative

4.A.2)a) HIV Care Continuum Changes, Impact and Response 2018-2020

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, and ultimately achieving viral suppression. 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. Examples from this analysis follow.

The RW Council addresses these disparities along the HIV Care Continuum by allocating funds to services identified as having the greatest unmet needs for the populations with the greatest health disparities. For example, over the last several years, between 2018 and 2020, the Planning Council has increased funding for emergency financial assistance, housing assistance, and transportation. Enrollment and benefits counseling funds also have increased, as well as field-based case management funding. Expansions in funding for these services were maintained by the Council for FY22, 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.

HIV Care Continuum Overall Changes

An analysis of all HIV Continuum of Care indicators for the RW Program, TGA, State and Nation, as well as comparison between the last two reporting periods was used by the Planning Council in its priorities and allocations discussions and is summarized below:

A slightly higher proportion of PLWH with a new HIV diagnosis were linked to HIV care within 30 days following diagnosis in the RW program in FY20 (48%) than FY19 (46.9%). The linkage to care rates for the 2020 RW program, however, were below TGA (89%), State (83%) and National (81%) rates for 2019. FY20 RW clients were more likely to be in medical care (78%) than PLWH in California in CY19 (75%) or the Nation (76%) but was behind the TGA rate (80%). FY20 RW clients were less likely to be retained in care (40%) than PLWH in the TGA during CY19 (54%), the State (56%) or the Nation (58%). The retained in care statistics are *skewed by the fact* that the RW program is still working on improving 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. The RW Program is further analyzing data on this effort, as it appears to continue to be an issue. Evidence that the lower retention in care figures likely are more of a reporting problem than a service provision problem is demonstrated by the high viral load suppression rates of RW clients in FY20. A greater proportion of RW clients in FY20 were virally suppressed (85%) than PLWH nationwide during CY19 (66%), the TGA (70%) and California (65%) in CY19.

The most common challenge in the TGA's development of its Continuum of Care roadmap has been in identifying and obtaining data sources for the same time periods from other jurisdictions required to monitor the TGA's successes or to identify areas needing improvement. This challenge is most apparent when it comes to analyzing demographic disparities, such as age categories, which vary between the RW Program, TGA, State and Nation. 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 FY20 RW program) of "newly diagnosed with at least one CD4, viral load or HIV-1 genotype test within 30 days of diagnosis."

Additional data limitations and tracking challenges for the Continuum of Care indicators continue at the RW service provider level. For example, the largest RW medical service provider in the TGA has been challenged to consistently obtain and report the viral load information in its Electronic Health Record (EHR) for its RW clients that might be served by another medical service provider in the region. While the RW medical provider may be able to track an outside provider's lab results, they are not obtaining copies and to update their EHR accordingly, nor consistently report it to the RW Care Program.

Another data issue surrounds State Office of AIDS surveillance data reporting of unknown/unreported viral load counts. The SOA supplies as much data as it has available from its State Office of AIDS data systems to the TGA's RW Program; however, 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. The SOA also supplies the data sets used for Attachment 3, Table 1: HIV and AIDS Incidence, HIV and AIDS Prevalence and the information for the Unmet Needs table. Some data from these various sources does not match exactly due to differences in the date ranges, definitions, and formats used for each database which can create discrepancies in figures when conducting comparative analyses.

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 Council analyzes best practices used at the state and national level to improve the TGA's Care Continuum and integrate those findings into the RW Program.

For example, the TGA coordinates efforts with the California Department of Public Health, Office of AIDS, on several large-scale projects: California's Needs Assessment for HIV, California's Integrated HIV Surveillance, Prevention and Care Plan "Laying a Foundation for Getting to Zero," as well as the State of California's "Ending the HIV Epidemic" (EtHE) planning efforts. The 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 HIV Needs Assessment and develops statewide plans and TGA level strategies to overcome barriers to care. In addition, the TGA's RW Program and Planning Council are currently involved in the California Office of AIDS "Ending the HIV Epidemic " plan which is aimed at reducing and ultimately eliminations new HIV infections and optimizing the health of PLWH.

The TGA's RW Program conducted a comprehensive HIV/AIDS Needs Assessment in 2018 using an updated survey tool. The findings of the 2018 Needs Assessment were analyzed and used throughout this application and assist with development of programmatic changes across the Continuum of Care to improve services for each subpopulation of PLWH. In addition, the TGA conducted a Targeted Young Adult Needs Assessment in 2021, which was smaller in scope due to the risks of Covid-19, as face-to-face interviews are necessary to conduct the detailed and personal survey.

The Council is working diligently to continue to improve outcomes along the HIV Care Continuum for all subpopulations of PLWH, specifically improving linkage to care and retained in care efforts. Much of the RW Program's successes are due to the cooperative outreach conducted by numerous nonprofit agencies dedicated to HIV prevention, treatment, and wrap-around support services for PLWH across the Sacramento Region. However, these efforts need to be adjusted and expanded, particularly in these challenging times during the Covid-19 pandemic. 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 Sacramento County Department of Health Services, Division of Public Health has integrated its HIV prevention and treatment programs to operate under the same unit, which includes the RW Program. To further streamline and coordinate efforts for persons living with, or at risk for HIV/AIDS in the TGA, planning bodies for HIV prevention and treatment programs were successfully consolidated by merging the Sacramento Alliance to Prevent AIDS (SAPA) into the RW HIV Health Services

Planning Council (the Council) in 2010. With the RW CARE Program operating as Fiscal Agent for both Part A and B funding, all services, planning efforts and implementation strategies continue to be improving coordination and efficiency.

In addition to various hospitals and private labs, the TGA has numerous HIV testing, education and prevention sites. One Community Health, which was established in 1989 as the Center for AIDS Research, Education and Services (CARES), transitioned to become an FQHC in 2015 and is now called One Community Health. Through this transition, it has maintained itself as a provider of services to PLWH in the Sacramento Region. Part of One Community Health's strategy to maintain its HIV testing and education services includes cooperative agreements with the Sierra Foothills AIDS Foundation (SFAF) to provide testing kits for the TGA's rural counties. In addition, SFAF has obtained private funding for HIV testing staff. Government-funded testing sites and One Community Health, which rely 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 FY22 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 Service Category Plan that enable newly infected and underserved persons, including disproportionately impacted communities of color, to access and remain in HIV medical care. The TGA's care providers that conduct HIV testing (noted above) work closely with the Sacramento County DHS HIV Prevention and Testing outreach providers to serve 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, 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 FY2003 to 86.1% in FY20, a level which represents 51.1% more than the minimum allocation of 35% established by the Council.

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 FY22 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 (78%) in FY20 than PLWH in California during (80%) or in the Nation (76%) in 2019. A greater proportion of FY RW clients were virally suppressed (85%) in 2020 than PLWH in the TGA in 2019 (70%); California in 2019 (65%), and the United States in 2019 (66%).

In two of four Continuum of Care indicators, however, the RW program had outcomes that were lower than TGA, State and National 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 2020 (48%) than the TGA in

(89%), California (83%), and Nation (81%) in 2019. Although RW funding has increased support for linkage to care by hiring additional Enrollment and Benefits Counselors to help clients apply for health coverage through the ACA, there is more work to be done in this area. In addition, the RW program had lower outcomes for retention in care in 2020 (40%) than in the TGA (54%), California (56%) or the Nation (58%) in 2019.

Access to Antiretroviral Therapy and Viral Load Suppression. The RW Council continues to prioritize HIV Outpatient Ambulatory Care, Medical Case Management and HIV/AIDS Prescription Medications to ensure that RW clients not only access HIV care but remain in care and maintain access to antiretroviral therapy. The TGA's web-based system, SHARE, collects basic medical service utilization data from RW providers. This system tracks clients who receive a service, but are not in ongoing primary medical care, and each provider receives a monthly report with the unique client identifier for all clients out of medical care. Providers are contractually obligated to follow up with these clients to ensure that they overcome barriers and receive primary medical care for their HIV/AIDS. This integrated service model has been achieving successful health outcomes throughout the TGA. For example, in FY20, 85% of RW medical care patients were virally suppressed, which is much higher than PLWH nationwide (66%) in 2019.

4.B. FUNDING FOR CORE AND SUPPORT SERVICES

4.B.1) FY2022 Service Category Plan

4.B.1)a) FY2022 Service Category Plan Table (Attachment 9)

The TGA's Service Category Plan (Attachment 9), lists the TGA's core medical services and support services, covering all of Part A funded services for 2022. 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 FY22 Service Category Plan also lists separately the Minority AIDS Initiative (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

4.B.1)b)i. MAI Implementation to Address Subpopulations of Focus

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 clients; and women who are pregnant or at risk of dropping out of care.

.

A comparison of the demographics of MAI clients in in FY20 show that 61.9% were African American; 30.0% Hispanic; 2.9% American Indian/Alaskan Native; 6.0% Asian, and 1.1% Native Hawaiian/Pacific Islanders. Care Continuum outcomes for FY20 RW MAI clients show that 84.9% achieved viral suppression. In FY20, Asians had the highest viral suppression rate, followed by Hispanics (87.5%), American Indian/Alaska Natives (85.7%), African Americans (83.1%) and Native Hawaiian/Pacific Islanders (1.1%).

As the MAI figures show, RW subrecipients have been able to continue to build trust within the community to reach the targeted minority populations and forge the working relationships necessary with clients and other agencies to ensure that ongoing medical services are received for these vulnerable populations. The subrecipients use a combination of several types of medical case management, including in-home, street-side and pre/post incarceration services, to reach those in need. Based on the MAI data, the time and effort provided to serve these high-risk clients is proving effective in many ways. However, affordable housing is reported as MAI clients' greatest barrier to care and transportation is the second most reported barrier.

Although bus and light-rail systems are available in the greater Sacramento metropolitan area, they are inadequate to meet the large area covered by the TGA, including the rural counties which have little to no public transportation systems. These access issues have been exacerbated by the COVID-19 pandemic as discussed elsewhere in this application.

4.B.1)b)ii. MAI Implementation to Decrease Health Disparities and New HIV Infections

Since the inception of the TGA's RW program, the MAI funded subrecipients often have overspent their federal MAI allocations, so the TGA's RW Part A funds have been allocated by the Council to MAI funded subrecipients to maintain essential MAI programs. The primary goal of the TGA's MAI Plan is to enhance access to ambulatory medical care and provide ongoing assistance to link and retain high risk minority clients in medical care. Programs funded through the MAI grant operate street-side, home-based and pre/post incarceration 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. As of 12/31/20, the combined number of African Americans and Hispanics accounted for 43.3% of PLWH in the TGA, while their prevalence in the general population was 7.2% and 21.0%, respectively, based on 2019 US Census figures.

One of the main goals of the TGA's MAI Plan is to help clients in the area of medication adherence where appropriate for clients on HAART. This goal is achieved by providing "field-based" Medical Case Managers who serve as client advocates to fast-track clients into specialty medical care and other intensive support services throughout the RW service area as needed. In previous years, Medical Case Managers spent many hours in a client's place of residence or in their homeless camp to encourage clients to seek and maintain medical care. During the COVID-19 pandemic in FY2020 and FY2021, telehealth has been implemented and is extremely important, although there are challenges in conducting telehealth visits with the homeless population if they do not have internet connection. Despite COVID-19 and the challenges to conducting field-based and telehealth visits, the MAI Program's Medical Case Managers have continued their work which is vital to linking and keeping clients in care.

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 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 compliance with their medical care regimen.

MAI funds were allocated by the RW Program's Planning Council according to the overall HIV Services Plan which documents needs for each subpopulation of PLWH as described throughout this RW Application. For example, in the Sacramento TGA's FY20 RW system of care, younger RW clients were less likely to be virally suppressed than older clients. RW clients aged 13-24 had a viral suppression rate of 60%, while RW clients ages 20-44 had a viral suppression rate of 67%, ages 25-44 rate of 75%, clients ages 45-59 had viral suppression rate of 82% and RW clients ages 65+ had viral suppression rate of 90%.

One strategy to address this issue of out-of-care youth is that one of the TGA's subrecipients receiving MAI funding transitioned its clients into the field-based medical case management program targeting youth of color between the ages of 13-24, with a special emphasis on newly HIV diagnosed youth. As a result of this intense effort dedicated to the RW program's youth in FY20, 100% of RW clients ages 3-12 achieved a viral suppression. Viral suppression rates among RW clients ages 13-19 increased from 40.0% in FY19 to

81% in FY20 and from 57.4% to 67% for ages 20-24 between FY19 and FY20.

Overall, 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 through FY20, as compared to earlier years, show that the percentage of RW MAI clients that achieved viral load suppression increased from 69.0% in FY16 to 84.9% in FY20. These FY20 viral suppression rates among RW MAI clients are well above the most recent 2019 National viral suppression rate (66%) and 2019 State viral suppression rate (65%).

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 subrecipients to all eligible PLWH. The RW Program's FY22 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 subrecipient 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 subrecipients with resource information on free and low-cost cultural competency training opportunities.

There are several core medical services that are prioritized by the RW Council but are not funded with RW funds because they 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 through RW Part A:

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. Medical Case Managers at the rural County sites and Sunburst Projects also are certified as ADAP enrollment workers.

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: 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 A, B and C funding, this service is offered at One Community Health. Part A funds a small portion of this service.

4.B.1)c) Unmet Need

4.B.1)c)i. Interventions to Improve Outcomes for PLWH with Unmet Need

By analyzing the Unmet Needs found in the TGA's HIV Needs Assessments, out-of-care, epidemiology and cost data, the Council developed four strategies to increase access 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, 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 who are not in care. When clients are newly diagnosed with HIV, care providers, as well as testing sites, refer clients for RW eligibility screening and Health Education/Risk Reduction (Partner Services), which provides immediate access to counseling and resource referrals. The Partner Services program not only assists clients with issues of disclosure but provides referrals to the Sacramento County Surveillance Program's Partner Services program which provides anonymous notification of HIV+ sex and needle sharing partners regarding their exposure and assist them in getting tested. All RW Medical Case Management subrecipients are contractually required to document referrals to Partner Services.

The RW Program also funds several agencies that provide services that include Benefits and Enrollment Counseling to enhance efforts to address service gaps with Part A funds. All RW Benefits and Enrollment Counselors have received certifications to assist clients with document preparation and application uploads into secure servers. The AIDS Drug Assistance Program (ADAP), the Covered California program (ACA) and the OA-HIPP (State Health Insurance Premium) programs all require such certifications. Many RW service providers that provide benefit enrollment services are multicultural, bilingual staff who assist clients in determining their eligibility for and application for many public benefits.

4.B.1)c)ii. Activities to Re-engage in Care PLWH with Unmet Need

To further address service gaps and barriers to care, transportation services funded with RW Part A funds have been enhanced. While transportation assistance has been available to clients in the form of bus vouchers, the RW field-based medical case management system also provides mileage reimbursement for RW case managers to escort clients to appointments when necessary. In addition, 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. Further, due to the increased barriers to public transportation during the COVID-19 pandemic, the RW Program has added Uber or Lyft services as an option for PLWH to be tranpsorted to medical visits and support services. This has reduced the need for RW case managers to provide client transportation, which increases their capacity to provide additional case management services to clients.

HRSA and CDC Ending the Epidemic funding have helped to add county positions that were elimated back in 2009 and create new positions such as additional Communicable Disease Investigators, Linkage to Care Coordinator, Health Educators, Community Health Worker to work in tandem with the Ryan White Part A program to to re-engage in PLWH with unmet need.

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

SECTION 5: RESOLUTION OF CHALLENGES

The following table summarizes the challenges encountered by the RW Part A Program in designing and implementing the activities in the RW Service Category Plan, as well as integrating the HIV Care Continuum Services Plan into the RW Program. This table also addresses approaches used throughout the TGA to resolve the challenges and barriers discussed throughout this application in the larger context of implementing the RW program.

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Continuum of Care Data Definitions and Tracking Across Jurisdictions			
Challenges/Barriers	**Proposed Resolutions**	**Intended Outcomes**	**Current Status**
Variations in Continuum of Care definitions across jurisdictions decrease the integrity of comparative findings as follows: **<u>Retained in Care</u>** This measure for RW and the TGA is defined as PLWH with =>2 visits per year at least three months apart during the12-month reporting year; for CA, it is defined as two or more CD4, viral load, or HIV-1 genotype tests performed at least 3 months apart during the year; for the Nation, it is defined as ≥2 tests (CD4 or VL) ≥3 months apart during year. The "retained in care" measure is not very informative for the TGA's RW Program, as many clients with suppressed viral loads (85% in 2020) are only seen by their medical provider once	The RW Program took much time and effort to revise local tracking and database systems to utilize the HRSA/HAB "retained in care" definition and these efforts have been completed. The Planning Council's CQI Committee would like HRSA to consider amending the "retained in care" measure requirement. The inconsistency in the definitions across jurisdictions (RW, TGA State, Nation) make comparisons difficult. The true measure of quality care is viral suppression rates. Viral suppression is consistently measured across jurisdictions and can be tracked using specific measurement	All local tracking system reports were re-coded to track the Continuum of Care according to HRSA and CDC guidelines. Since the State Office of AIDS revised their definition of 'in medical care" to reflect only those visits where a viral load or CD4 count test was conducted, the Sacramento TGA has re-coded its tracking system to reflect this measure as "in medical care".	The TGA's RW Program has new reports for "retained in care" which are provided to each RW provider monthly and reported to the Planning Council quarterly. These reports use the "retained in care" definition of at least two viral load/CD4 tests at least 3 months apart in a 12-month period. This definition does not capture the true picture of a client's status if their first or second visit falls outside the reporting period. Annual statistics for the RW Program are skewed to reflect lower than actual results for "retained in care". Viral suppression rates for the TGA's RW Program exceed TGA, CA and National rates in 2020 and more accurately reflect RW clients' health status.

every 12 months due to stable health status.	tools (lab tests).		
HIV Diagnosed Continuum of Care indicator at the local level is challenging because RW does not fund HIV testing. The private testing agencies, while cooperative, do not always have resources to track demographic data on HIV testing clients and State surveillance data has reporting delays.	The TGA's RW Program has established collaboration and coordination between government funded HIV testing agencies and two of the largest HIV private testers in the area (One Community Health and Planned Parenthood).	Through the HIV/STI Stakeholders group (SacWISH), the TGA is gaining access to more data from non-government funded HIV testers.	The RW Fiscal Agent and Planning Council continue their outreach efforts to obtain HIV testing data from non-government funded testers in the TGA.
Continuum of Care Data Issues for RW Subrecipients			
Challenges/Barriers	**Proposed Resolutions**	**Intended Outcomes**	**Current Status**
Care Continuum data with RW Subrecipients (Subs) is challenged by staff turnover at the service provider level; lack of staff training; and limited staff time to ensure data integrity. The ongoing impact of the COVID-19 pandemic has exacerbated these issues for service providers and their staff workloads.	RW program staff has provided technical assistance to Subs. Much progress has been made to get all data updated in SHARE, but work is still ongoing to continue to improve processes and procedures. Data reports have been distributed and trainings are occurring, not only at individual Sub provider levels, but also at Service Provider Caucus meetings.	There have been improvements to RW Program data integrity across service providers. Agencies are working with staff on "retention in care" efforts and are making data integrity a priority. RW Subs have participated in decisions and development of reports that benefit them most.	RW Subs 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 served at their agency. This procedure gives providers the means to follow up on clients whose indicators are under target. These reports will continue to be monitored and improved to be most useful to RW Subs and the TGA as a whole.
Continuum of Care Integration into RW Program Service Improvement			
Challenges/Barriers	**Proposed Resolutions**	**Intended Outcomes**	**Current Status**
The process of integrating the full HIV Continuum of Care into the RW Part A program has been challenging at the TGA's RW Program level, but even more so at the State level.	California State Office of AIDS has worked hard to reach a point where the State and local health jurisdictions will be using the same surveillance data and NHAS indicators, including demographic categories, to track the Continuum.	The RW Program has a quarterly client level data import, resulting in RW client health information which is more current than State HIV data. RW Program and Sacramento County Public Health Unit mangers are developing strategies to conduct ongoing reconciliation of the RW Program's HIV lab reports with the SOA	Full integration of the Continuum of Care into the Part A program will continue to be modeled at the TGA's RW Program level and integrated at the State level.

		reports to identify additional PLWH who are out of care and engage them back in medical care.	
Access Barriers to HIV Care Continuum Services			
Challenges/Barriers	**Proposed Resolutions**	**Intended Outcomes**	**Current Status**
People of Color. African American and Hispanic communities continue to be disproportionately impacted by HIV/AIDS and are more likely to be behind target indicators across HIV Care Continuum that other racial groups. The COVID-19 pandemic has exacerbated many of these inequities.	Outreach, HIV prevention messaging and testing resources need to be expanded and continue to be targeted to reach Black and Brown communities. Increase telehealth services to provide direct patient care during COVID-19 pandemic.	Continue to increase the percentage of MAI clients that achieve viral suppression. Increase efforts across TGA to build trust within minority populations to increase contact with target population and increase linkage to HIV care.	Field-based medical case management system, which includes both in-home, street side and per/post incarceration services, has been implemented through Minority AIDS Initiative (MAI) Program. Percentage of RW MAI clients that reached viral suppression increased was 84.9% in FY20.
Transportation continues to be sited as a barrier to care for clients on Needs Assessments, Annual Client Satisfaction Surveys, and through Planning Council and other meeting forums where clients have a voice. This barrier has increased during the COVID-19 pandemic due to more limitations and challenges with public transportation options. The need for increased access to transportation does not appear to be solely due to limited funding, and proposed resolutions are broader in scope.	The TGA has adequately funded transportation services; however, strategies are needed to improve the quantity and quality of the public transit system. Because the TGA is large tri-county geographic region with two rural counties, and primary HIV medical care is centrally located in Sacramento County transportation services are challenging for PLWH to access. Telemedicine addresses the transportation barrier, especially during COVID-19, and primarily for rural county clients.	Continue to adjust support of transportation services to respond to COVID-19 pandemic. For example, provide expanded use of Uber and Lyft to ease transportation barriers since public transportation is not easily accessed by all. This has been an increasing issue during the COVID-19 pandemic when public transportation has been more limited and poses a health risk for immunocompromised individuals.	A transportation coordinator has been integrated into the RW program to assist with arranging transportation and ride share services. Additional Subs applied for and received transportation services in the recent RW Program's Request for Proposal.
Housing continues to be sited as a barrier to care for clients on Needs Assessments, Annual Client Satisfaction Surveys, and through Council and other meeting forums where clients have	The Sacramento and Placer County Board of Supervisors, and Sacramento City Council, have initiated projects to assist homeless	Continue to have housing coordinator at Volunteers of America (VOA) to assist with arranging housing services for PLWH. Continue to advocate for	Housing coordinator continues to assist clients with this service. More Subs applied for and received housing service and case management funds in most recent RW Request for Proposal.

a voice. Housing has become an even greater barrier to care over the last couple of years with the COVID-19 pandemic as well as a major housing shortage in the greater Sacramento TGA with extremely high housing prices.	individuals. With 11% RW clients homeless or unstably housed in FY20, compared to 0.32% in the TGA, these proposed resolutions are in need of increased funding.	increased funding and services for the homeless and unstably housed PLWH, especially during the COVID-19 pandemic when health risks issues are so high for HIV clients.	

SECTION 6: EVALUATION AND TECHNICAL SUPPORT CAPACITY

6.A. CLINCAL QUALITY IMPROVEMENT(CQI)

6.A.1) Changes to CQI Program Based on Past Outcomes and Experiences

During FY20, the RW Program continued to focus on its Continuous Quality Improvement efforts to assure conditions for optimal health for people living with HIV across the TGA. An updated CQI Plan was developed in March 2020, which was updated June 2020, and again in September 2021. The purpose of the CQI Plan is to systematically plan for, measure, evaluate and improve the quality of RW funded services delivered to its current clients and PLWH eligible for its services. The plan is a "living" document designed to be updated as part of the continuous quality improvement process and is reviewed annually at a minimum.

The RW Program's CQI Manager works directly with the Sacramento RW Program Coordinator and is responsible for coordinating the RW CQI program, including reviewing progress from all RW subrecipients regarding their CQI activities. The CQI Manager also serves as the RW liaison to external quality improvement work groups throughout the TGA and, for example, coordinates webinars and training opportunities around quality improvement for CQI committee members and RW Program subrecipients.

The CQI Manager also facilitates the activities of the Planning Council's CQI Committee which provides input to and oversight of the CQI Plan. Each CQI committee member serves an important role in ensuring accountability and standardization of CQI efforts, identifying gaps in RW services, and fostering collaboration among service providers. The CQI Committee Work Plan, which is part of the CQI Plan, delineates activities, with specific timelines and responsible parties, to be implemented in order to achieve CQI goals and objectives. The CQI Committee Work Plan, also is reviewed annually and revised as needed.

To support the RW Program's CQI efforts, 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 - renamed the Sacramento HIV/AIDS Reporting Engine – SHARE). The SHARE database is a sophisticated system that stores RW client-level data at service category and point-of-service levels. This data, along with EHR/Client Chart Reviews and on-site subrecipient reviews, is thoroughly analyzed by the Fiscal Agent and Planning Council and is compared to State and National benchmark data.

In FY2008, the Fiscal Agent went further in its analysis of its client-level data and developed a detailed series of reports identified as the RW Annual Statistical Summary Project (RASSP). These comprehensive statistical reports provide multi-level cross-tabulations of the RW Program's client-level data to determine cost and service utilization by multiple fields such as gender, race, transmission, age, income, insurance,

housing, co-occurring conditions, etc. These detailed reports are instrumental to the CQI Program which is based on past outcomes and experiences to identify where improvements can be made, for which subpopulations of RW clients, to improve health outcomes along the HIV Care Continuum.

To provide an example of the TGA's extensive CQI activities particular to the RW program in FY20, the following provides information about the ongoing improvement efforts for the Minority AIDS Initiative (MAI) aspect of the RW Program. MAI funding has been instrumental in evaluating and addressing the impact of HIV/AIDS on disproportionately affected minority populations. The RW Program's CQI outcomes data show that the RW MAI Program continues to address disparities among PLWH throughout the TGA and improve access to clinical care. In FY20, the percentage of MAI clients that met the definition of "Viral Suppression" follows: 75.0% of Native Hawaiian/Pacific Islanders (up from 73.7% in FY19); 93.0% of Asians (up from 81.5% in FY19); 87.5% of Hispanics (up from 82.2% in FY19): 83.1% of African Americans (up from 77.5% in FY19); and 85.7% of American Indian/Alaskan Natives (up from 85.7% in FY19). The chart below provides a summary of HIV Care Continuum Performance Measures for each minority served in FY20 MAI Program.

As can be noted, Viral Load Suppression and on HAART were two of the Sacramento TGA's Planned CQI Outcome measures for FY20 MAI Program. The Viral Load Suppression target was met (84.9% Virally Suppressed, 85% goal); as well as the HAART outcome measure (93.3% on HAART, 90% goal).

FY20 HIV CQI Outcomes – RW Minority AIDS Initiative (MAI)							
	American Indian Alaskan Native	Asian	African American	Hispanic	Hawaiian/PI	Total	RW MAI Goal
MAI Clients	18	40	368	175	6	607	n/a
In Medical Care	84.6%	80.5%	78.2%	79.1%	84.6%	78.5%	n/a
Virally Suppressed	85.7%	93.0%	83.1%	87.5%	75.0%	84.9%	85%
On HAART	88.5%	94.3%	93.3%	92.2%	88.5%	93.3%	90%

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

These ongoing Continuous Quality Improvement efforts assist the Fiscal Agent and RW Planning Council in evaluating disparities in care within the RW Program and inform the development of strategies and coordination efforts with service providers to reduce and eliminate disparities. CQI data is used by the RW Program to improve patient care, health outcomes, and patient satisfaction. Not only do these CQI efforts guide the RW Program to improve direct client services they provide input for the State of California's planning efforts which include strategic long-range service delivery planning at the State and TGA levels. These efforts also are developed in coordination with national efforts to end the HIV epidemic.

As part of the CQI Program, Performance Indicators have been established and updated for the RW Program to be consistent with State and National efforts across the HIV Care Continuum. Follows is RW baseline data for FY19 and FY20 as compared to National HIV/AIDS Strategy (NHAS) targets for FY22:

RW CARE Program Continuous Quality Management Indicators FY19 Baseline, FY20 Outcomes and FY2022 Targets					
Indicator	**Performance Measure**	**Data Source**	**RW Program Baseline FY19**	**RW Program Outcomes FY20**	**Target FY22**
Linkage to HIV Medical Care	% of newly diagnosed clients who attend a routine HIV medical care visit within 1 month of diagnosis	SHARE	42.5%	56.7%	85%
Prescribed HAART*	% of still active clients prescribed HIV/AIDS antiretroviral therapy (HAART) for treatment of HIV	SHARE	76.9%	92.8%	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	78.2%	72.8%	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	37.1%	29.8%	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	77.5%	82.9%	90%
Housing	% of still active clients with HIV who were stably housed in 12-month measurement period	SHARE	26.4%	57.0%	54%

The most common challenge in the RW Program's development of its Continuum of Care roadmap has been in identifying and obtaining data sources with consistent dates and data definitions across jurisdictions (RW Program, TGA, California and National levels). In addition, it is challenging to obtain data that is consistently detailed by demographic categories such as race, age, gender, and HIV transmission that line up between jurisdictions. For example, there are several different breakdowns for age categories across jurisdictions. Further, Care Continuum indicators cover different time periods. The majority of National, State and TGA data is available for 2019, while RW data is available through 2020. Therefore, comparisons for the Continuum of Care are not consistently covering the same timeframe or demographic breakdowns which creates some limitations in their analysis.

Another data issue surrounds State HIV Surveillance data reporting of unknown/unreported viral load counts. The SOA has been cooperative in supplying as much data as is available, but it takes SOA surveillance systems more than a year to mature, so real-time progress is not always possible to monitor.

Another data issue has to do with the Continuum of Care definitions which have changed from year to year which make consistency of reporting difficult and reduce the value of year over year analysis. 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 since FY17 for RW program) of "newly diagnosed with at least one CD4, viral load or HIV-1 genotype test within 30 days of diagnosis."

In addition, "In Medical Care" is defined for RW and the Nation as PLWH having at least one viral load or CD4 test within 12 months; and for the TGA and CA, as having at least one CD4, viral load or HIV-1genotype test during the year. For the RW Program and the TGA, "Retained in Care" is defined as PLWH with =>2 visits per year at least three months apart during the12-month reporting year; for CA, it is defined as two or more CD4, viral load, or HIV-1 genotype tests performed at least 3 months apart during the year; for the Nation, it is defined as ≥2 tests (CD4 or VL) ≥3 months apart during the year. These variations in HIV Care Continuum indicator definitions across jurisdictions, as well as variations in time periods for the data, diminish the usefulness of comparative analysis.

Additional data limitations and tracking challenges for the Continuum of Care indicators continue at the RW service provider level. For example, the largest RW medical service provider in the TGA has been challenged to consistently obtain and report the "in medical care" and "retained in care" information in its EHR for RW clients that might be served by another service provider in the region. While the RW medical provider may be able to track an outside provider's lab results, they are not consistently obtaining copies and updating their EHR accordingly, nor consistently reporting it to the RW Program.

HIV Care Program Performance Measures have 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 FY20, there were 94 quality of care performance indictors across 15 service categories which set 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 CQI at the provider level. This process is effective in continually improving health outcomes for RW clients. The RW Program's CQI 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 CQI reports to the RW Fiscal Agent on a quarterly basis. The following provides Continuum of Care CQI service indicators and collection strategies for the TGA, with FY20 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 continually surpassed its 35% minimum allocation requirement of the percentage of MCM funds directed to this model of care. In FY20, 75.6% of MCM funds were directed to the field-based services. 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, RW's Retention in Care rate for its FY20 Medical Care Management clients (77.1%, which is a marked improvement over FY19 rate of 39.5%), exceeds the 2019 National retention in care rate of 58%. In addition, the HIV Viral Load Suppression rate for the FY20 RW Medical Care Management clients (81.8% for both FY18 and FY19) exceeds the 2019 National rate (66%):

FY20 RW Medical Case Management Clients CQI Measurements and Outcomes				
Outcome Measure	**Definition**	**RW Program FY19**	**RW Program FY20**	**National FY19**
HHS Measure: Retention in HIV Medical Care	#/% of HIV patients with at least two medical visits at least three months apart	590/1491 39.6%	1322/1715 77.1%	58%
HAB Core Measure: HIV Viral Load Suppression	#/% of patients with HIV viral load <200 copies/ML	1219/1491 81.8%	1408/1715 81.8%	66%

Outpatient Medical Care. As can be seen in the chart below, the HIV Viral Load Suppression rate for the FY20 RW Outpatient Medical Care patients (83.1%) exceeds the 2019 National rate (66%) for all diagnosed PLWH. The RW Program's FY20 Retention in HIV Medical Care rate for outpatient medical care

clients (80.8%) exceeded the FY19 National rate for all diagnosed PLWH of 58%.

FY20 RW Outpatient Medical Care Clients CQI Measurements and Outcomes				
Outcome Measure	**Definition**	**RW Program FY19**	**RW Program FY20**	**National FY19**
HHS Measure: Retention in HIV Medical Care	#/% of HIV patients with at least two medical visits at least three months apart	1,618/1,851 87.4%	1421/1758 80.8%	58%
HAB Core Measure: Prescription of HIV Antiretroviral Therapy	#/% of HIV patients prescribed HIV antiretroviral therapy	1,398/1,851 75.3%	1676/1758 95.3%	n/a
HAB Core Measure: HIV Viral Load Suppression	#/% of HIV patients with HIV viral load <200 copies/ML	1,552/1,851 83.8%	1460/1758 83.1%	66%
HHS Measure: Housing Status	#/% of RW clients with permanent housing	Denominator is all RW clients 698/2,642 26.4%	1077/1758 61.3%	84.7%

In addition to the RW Program's efforts to improve its HIV Care Continuum for RW clients accessing primary medical care, the RW clients receiving primary medical care in FY20 were reflective of the TGA's proportion of PLWH by race/ethnicity as follows:

Racial Reflectiveness of RW Outpatient Medical Care Patients FY20				
Race	**% of F18 RW Ambulatory Care Clients**	**% of FY19 RW Ambulatory Care Clients**	**% of FY20 RW Ambulatory Care Clients**	**% of TGA's PLWH**
White	47.1%	45.5%	44.3%	46.5%
African American	25.0%	26.9%	27.0%	22.0%
Hispanic	22.2%	21.8%	22.9%	21.3%
Asian/Pacific Islander	4.3%	4.5%	4.7%	3.9%
American Indian/Alaskan Native	1.2%	1.1%	1.0%	0,4%
Multi-Race/Other/Not Specified	0%	0%	0.2%	5.0%

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 (Attachments 1, 2 and 11)

The Chair of the Sacramento County Board of Supervisors, as the Chief Elected Official (CEO) for RW Part A funds, has delegated authority to Ann Edwards, 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 administration of RW Part A funds within the Sacramento TGA and **Attachment 11** for Organization Chart.

The STI/HIV Program Manager, Staci Syas, a Master of Public Health (MPH) and directly supervises the Sr. Health Program Coordinator and AIDS Director who runs the day-to-day operations of the RW Program. Ms. Syas has over 25 years' experience with Sacramento County Public Health and provides oversight and development of programs addressing the continuum of Sacramento County HIV and STD service efforts; coordinates the integration of efforts between HIV/STD Prevention Program, HIV/STD Surveillance Unit, RW

CARE Program, Epidemiology Unit, and the County STD Controller. Ms. Syas facilitates the development and implementation of a Community STD Prevention Action Plan through engagement with community stakeholders, health care providers, and staff of schools and state agencies. Ms. Syas is presently a member of the California STD Controllers Association and National Coalition of STD Directors.

The AIDS Director and Sr. Health Program Coordinator position is held by Michelle (Chelle) Gossett. Ms. Gossett has over 22 years' experience working with the Ryan White (RW) CARE program as a Part C and D Program Director and Director of Grants Management for the TGA's largest FQHC that specializes in HIV specialty care. She has experience as the Fiscal monitor for the CBO for RW as a subrecipient for Parts A and B. Ms. Gossett's position is responsible for fiscal and programmatic oversight of the RW Program, including coordinating/facilitating collaborative efforts among multi-faceted organizations; administering program objectives, activities, staffing needs and funding allotments; writing grant applications; preparing/monitoring program budgets; subrecipient program monitoring; coordinating functions of CQI activities, acting as a liaison/resource to subrecipients, HIV Health Services Planning Council (HHSPC), County Departments and State or other funding sources, as well as other responsibilities (see Attachment 1 Staffing Descriptions. The AIDS Director and Sr. Health Program Coordinator position is allocated to Part A RW program 46% FTE as follows: Part A Administration (25%), CQI (15%), and MAI Administration (6%).

The RW Program Coordinator and Human Services Program Planner, Paula Gammell, has a Master of Public Health, MPH. and over 18 years' experience in management of the TGA's Ryan White program. Ms. Gammell is the CQI Program Manager and Planning Council staff with responsibilities that include working closely with the HHSPC, coordinating and attending all Committee and Council meetings, and providing epidemiological, demographic, needs assessment, financial and service utilization data to Council members. Ms. Gammell provides data and assistance required for Community Needs Assessments, compiling and analyzing data for grant proposals, HIV/AIDS Comprehensive Work Plans, HRSA reports, and epidemiological studies. Ms. Gammell responds to the needs of the HHSPC and its committees to assist them in achieving and improving their work plans and goals. As the Continuous Quality Improvement (CQI) Program Manager, Ms. Gammell oversees perations of the CQI program including tracking of client-level and contractor level data in the program's client–level database (SHARE); provides technical assistance to subrecipients on CQI measures; develops CQI Committee outcomes and measures, standards/expectations, and performs fiscal and programmatic CQI site visits/audits. The RW Program Coordinator and Human Services Program Planner position is allocated to RW Part A program 67% FTE as follows: Administration (5%), Part A CQI (33%), Part A MAI Admin (4%), Part A MAI CQI (5%) and Planning Council (20.0%).

The Administrative Services Officer (ASO) II position is held by Alden Hunter. Mr. Hunter has a Bachelor's Degree in Health Administration and over 12 years providing program support for various Sacramento County health and human services. Mr. Hunter is the RW Program's liaison with the fiscal and contracts units who is responsible for contract preparation, subrecipient compliance, and assists with claims processing, budget preparation, and subrecipient procurement. The ASO II position is allocated 28% FTE to RW Part A program as follows: Part A Admin (8%) and Part A CQI (20%).

The Epidemiologist position of held by Helen Zheng, Epidemiologist, a Master's in Public Health, who has over 17 years serving as the providing epidemiological data in the Sacramento County Division of Public Health. Ms. Zheng provides epidemiology data to program for grant writing and other reporting purposes, assists with HIV cluster and other programmatic information, supports the CQI program by preparing epidemiological reports, studies and tracking systems. Ms. Zheng codes and prepares Access queries designed and developed by the CQI Committee to track new performance measures, downloads and

analyzes statewide and national epidemiological data for local comparison on selected CQI Performance Measures. The Epidemiologist position is allocated 10% FTE to Part A Admin and 11% FTE to CQI.

The Dental Program Coordinator position is held by Jan Resler, a Registered Dental Hygienist with a Master's in Public Administration and Bachelor's in Dental Hygiene. Ms. Resler oversees pre-authorizations for Dental Project services to assure compliance with Dental Rate Schedule and Eligible Dental Procedures. This position is 7% FTE allocated to the Part A Administration.

The Account Technician position is held by Mai Chang, who has a Bachelor's in Business Administration and five years' experience working in a governmental capacity. Ms. Chang is responsible for processing subrecipients' invoices, reconciling internal grant workbooks, assisting with subrecipient budget revisions, reconciliation between program and fiscal departments and assisting the Senior Health Program Coordinator with the fiscal oversight of the RW CARE Program. This position is 53% FTE to Part A Administration.

Administrative Services Officer I is held by Cherisse Thomasson who has over eight years' experience working for Sacramento County. Ms. Thomasson is a liaison with Human Resources and Information Technology (IT). Responsibilities include providing hiring support, preparing and updating organization charts, as well as other support including processing travel and mileage claims and Planning Council Member reimbursement expenses. Supports program through routine clerical assistance. This position is 10% FTE to Part A Administration.

All 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. Thankfully, as can be noted above by the long-term commitment of staff allocated to RW CARE Program, vacancies have been extremely infrequent since the RW Program began in the TGA in 1996.

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 subrecipient'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 subrecipient's actual performance measures on a monthly basis. The protocols for off-site monitoring of programmatic performance are similar to those for fiscal monitoring, with additional protocol reports that assess quality of care data collected through SHARE. Subrecipienets also are required to submit semi-annual program narratives to the FA, with a cumulative year-end report.

FY20 Site Visits Conducted

On 06/19/20, HRSA's HIV/AIDS Bureau (HAB) sent a letter to all RW Program Part A and Part B recipients regarding the annual subrecipient site visit monitoring requirement during the COVID-19 public heatlh emergency. HRSA acknowledged the difficulty that recipients are facing to engage safely in site visits with subrecipients and decided to waive the monitoring requirement during the COVID-19 pandemic. Even

though these site visits have been temporarily halted, the Sacramento RW Program is continuing to monitor the activities of subrecipients to ensure that funding is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. These monitioring efforts are being conducted with subrecipients through phone calls and virtual meeting platforms including Microsoft Teams, Zoom and Skype.

Prior to receiving this notice, the Sacramento RW Program was already conducting its ongoing contract oversight processes conducted at the Fiscal Agent offices, incuding the full fiscal, programmatic and quality management on-site monitoring visit of each subrecipient. The FA's annual on-site programmatic monitoring includes investigations of CQI 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 CQI 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 new areas identified by HRSA's National Monitoring Standards and new Service Standards adopted by the RW Part B Program.

Corrective Action Procedures for Subrecipients and Summary of Findings for FY20

If significant fiscal or programmatic deficiencies are noted for any subrecipient based on the Fiscal Agent's monitoring procedures, the FA notifies the subrecipient 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 subrecipient 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 subrecipient with corrective action.

On June 19, 2020, HRSA HIV/AIDS Bureau (HAB) established a waiver for the annual subrecipient site visit monitoring requirement during the COVID-19 pandemic public health emergency. Therefore, site visits were incomplete at end of FY20. HRSA acknowledged the difficulty that recipients were facing to engage safely in annual comprehensive monitoring site visits with subrecipients in FY20 as expected by the National Monitoring Standards (NMS). However, RW recipients must continue to monitor the activities of subrecipients to ensure that funding is used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved.

Prior to receiving this notice, the Sacramento RW Program was already conducting its ongoing contract oversight processes conducted at the Fiscal Agent offices, including the full fiscal, programmatic and quality management on-site monitoring visit of each subrecipient. The FA's annual on-site monitoring includes investigations of CQI through client chart reviews, agency policies and procedures, and evaluation systems.

Technical Assistance (TA) to Subrecipients in FY20

As part of its Annual Administrative Assessment process, the FA maintains a TA log to document all TA provided throughout the FY20 verifying 347 instances of individual TA to RW service providers, averaging 29 instances of TA per month. Throughout FY20, technical assistance was provided by RW program administrative staff to 35 RW Consumers, 5 Governmental Agencies, and 10 other Community Agencies.

The TA provided in FY20 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 also was also provided for invoice / payment issues, Continuous Quality Improvement issues, RW service issues, site visit inquiries and other grant issues. There were also inquiries and TA needed regarding subrecipient contract documentation issues; assistance in identifying client resources, medication co-payments and specialty medical care; contract document related requests; subrecipient site visit inquiries and assistance; HIV/AIDS statistics and health outcome inquiries; provision of information regarding ADAP; assistance in developing revised budgets; interpretation of service standards, HAB information and AAHIV National advocacy updates.

Additional TA was provided by the FA to all subrecipients through the Service Providers Caucus, a mandatory monthly meeting. Updates regarding HRSA Policy Guidelines, TGA Service Directives, Poverty Guidelines, and Provider Orientation Manual updates were explained to all RW subrecipients. The Provider Orientation Manual includes 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 AIDS Drug Assistance Program (ADAP), the status of the Continuum of Care and its implications on the TGA. Service providers received training from the FA on the updated Federal Poverty Guidelines; information on the SHARE database access and password changes; AIDS Drug Assistance Program (ADAP) updates; SHARE invoicing updates; updates on the National HIV/AIDS Strategy (NHAS); aged-related HIV conditions; HIV Treatment Adherence; Trauma Informed Care; and local utility benefits for low-income households.

The RW Fiscal Agent also arranged training sessions for the Planning Council, which included training sessions on the mechanics of the Council a presentation on the Anal HPV, Healthy Aging (AHHA Trial), and a presentation on the State Office of AIDS' Ending the Epidemic Plan." Presentations were provided by two 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. Two community educational programs sponsored by pharmacology companies were provided.

7.A.2)a)ii. Subrecipient Compliance with Audit Requirements

All subrecipients must submit financial audits to the RW Coordinator and the DHS Fiscal Services within sixty days of the end of each fiscal year. Notices are sent by the Department's contract unit reminding each subrecipient of their audit due date. If audits are not received on a timely basis, the County discontinues payment to the contractor until they reach compliance with the audit submission requirement. Six of the eight (75%) FY19 subrecipients receive enough Federal funding to fall under the OMB Single Audit guideline requirements. Audits first are reviewed by the RW Coordinator and the Sacramento County DHS' Chief Financial Services Officer to ensure that no audit exceptions or audit concerns exist. To date, six subrecipients that were required to have Single Audit compliant audits have submitted their current audits showing no audit exceptions or serious financial disclosures. The two subrecipients not required to have a Single Audit are required to submit audited financial statements; and both subrecipients also have complied and submitted acceptable audited financial statements. All current subrecipients 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 subrecipients and makes recommendations to the Department Director. If the problem appears to be correctable, Sacramento County requires a corrective action plan within a specific time frame. If the problem appears beyond the subrecipient's ability for correction, the Department's contract language allows the

County to immediately terminate the subrecipient's RW contract.

7.A.2)b) Third Party Reimbursement

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

Contract language between the Fiscal Agent and each subrecipient includes requirements for screening for payer of last resort and application of the TGA's Eligibility standards. In addition, all subrecipients are required to attend a comprehensive training on Benefits Eligibility Determination at the start of their 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 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 subrecipients to assist them in identifying all RW eligibility documentation required for client files and documentation of identifying payer of last resort efforts and this checklist is available as a resource within the TGA's Electronic Database (SHARE).

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

The TGA has clear and thorough policies and procedures to establish each client's initial eligibility for the RW Program, and for recertification to qualify for continued RW assistance. Implementation of these policies and procedures ensures that the RW Program is always the payer of last resort. During the initial eligibility and intake process for the RW system of care, potential RW clients must present HIV verification, proof of TGA residency, and documentation of annual income. The service standard for determining eligibility and share of cost requires that clients up to 500% of poverty are eligible for RW services at a share of cost schedule that conforms to HRSA National Monitoring Standards.

Each RW client must be recertified at a minimum of six-month intervals to qualify for continued RW assistance and to ensure that the RW program continues to be each client's payer of last resort. To verify that each RW subrecipient is compliant with this requirement client charts are pulled randomly to verify appropriate documentation of recertification of RW eligibility for each client during subrecipient site visits conducted by the Fiscal Agent. Although site visits have temporarily been suspended due to COVID-19, these requirements continued to be monitored through phone calls and virtual meeting platforms between the FA and RW subrecipients. Another change that has occurred since COVID-19 is that HRSA has implemented a policy to accept to electronic signatures during the pandemic.

To provide RW funded services to eligible RW clients, case files must include denials from all other potential funding sources, and documentation of the lack of an alternative service provider. Through the SHARE database, the FA provides quarterly reports to subrecipients indicating Client Intake Forms that require updating, allowing the FA to regularly monitor subrecipient adherence to RW eligibility requirements and ensure recertification. The SHARE system also includes a "Resource" tab that includes readily available Intake Form instructions; Standards of Care; Eligibility Guidelines; 6-month Health Chart checklists; Poverty Guidelines; and pertinent changes to RW Program service directives and Standards of Care to ensure that every RW service provider has the most recently updated information and forms to conduct ongoing client eligibility and recertification processes to ensure that the RW Program is only used as the payer of last resort.

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

To monitor appropriate tracking and use of program income, the Fiscal Agent reviews subrecipient 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 Sr. Health Program Coordinator has responsibility for reporting, reconciliation and tracking program expenditures; and the County systems have crosscheck 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 improvement, MAI, and direct service expenses). Each service category has an order number for formula, supplemental, and MAI 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 MAI funds for each grant, as well as programs within those grants. The RW Sr. Health Program 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 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 subrecipients that all funds invoiced below 5% of budget will be redirected unless the affected subrecipients 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 subrecipient 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. Subrecipient Reimbursement Process

The TGA's SHARE database supports online submission of subrecipient invoices. Each subrecipient's budget is in the database with approved allocations for service codes as stipulated by contract. On a monthly basis, subrecipients enter data which includes a client's unique identifier, service date, service code and number of units served. The system generates invoices for each subrecipient based on approved service cost. The system has monitoring protocols which generate error reports and prohibit subrecipients from submitting invoices that do not comply with contractual requirements or service maximums set by the Council.

Once the subrecipient submits signed invoices, the FA reviews and approves payment, indicating the order number to be charged. The RW Accounting Technician logs 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. Invoices are processed within

ten days of receipt of signed approved invoice and paid within 30 days.

7.B. MAINTENANCE OF EFFORT (MOE) and MOE BUDGET ELEMENTS (Attachment 12)

See Attachment 12 for the Maintenance of Effort (MOE) Table that identifies the baseline aggregate for FY19 TGA expenditures for HIV-related services, FY20 estimate of these expenditures, as well as an explanation of the process and elements used to determine the amounts in the MOE table calculations.

Ryan White (RW) Key Staff Biographical Sketches/Job Descriptions

Michelle (Chelle) Gossett, AIDS Director and Sr. Health Program Coordinator: Ms. Gossett has over 22 years' experience working with the Ryan White (RW) CARE program as a Part C and D Program Director and Director of Grants Management for the TGA's largest FQHC that specializes in HIV specialty care. She has experience as the Fiscal monitor for the CBO for RW as a subrecipient for Parts A and B. Current duties include complete fiscal and programmatic oversight of the Sacramento County Ryan White CARE Program. Responsibilities include coordinating/facilitating collaborative efforts among multi-faceted organizations; administering program objectives, activities, staffing needs and funding allotments; writing grant applications; preparing/monitoring program budgets; all aspects of subrecipient program monitoring; acting as a liaison/resource to subrecipients, HIV Health Services Planning Council, County Departments, State or other funding sources, and community and business organizations; compiling/maintaining accurate records and files regarding program activities, periodic and special statistical and narrative reports, program documentation, policies, procedures and protocols and other written materials; and monitoring sub-recipients to ensure quality of care to PLWH/A. This position also supervises daily operations of the Accounting Technician. Monitors expenditure rate of CQI activities and budget; Coordinates functions of Part A Continuous Quality Improvement (CQI) program with other RW programs. Assists with the development of the CQI Committee; CQI performance measures; and provision of T.A. to subrecipients on CQI activities.

Paula Gammell, Human Services Program Planner/CQM Program Manager: Ms. Gammell, M.P.A., has over 18 years serving as the Human Services Program Planner with the RW CARE Program. Responsibilities include working with the HIV Health Services Planning Council (HHSPC) to provide assistance and data required for Community Needs Assessments; compiling/analyzing/interpreting data as needed for grant proposals, HIV/AIDS Comprehensive Work Plans, HRSA mandated reports, and local and statewide epidemiological studies; working closely with the RW CARE Program Coordinator to respond to the needs of the HHSPC to assist them in achieving their work plans and goals; providing daily staff support to the HHSPC; and designing/monitoring/evaluating the effectiveness of the CQI Care Program; As the CQI Program Manager, Ms. Gammell oversees daily operations of the CQI program. Continuous improvement and development of Continuous Quality Improvement Plan, tracking of client-level and contractor level data in the program's client–level database (SHARE); provides technical assistance to sub-recipients on CQI performance measures; develops with CQI Committee outcomes and measures, standards/expectations, and performs fiscal and programmatic continuous quality management site visits/audits.

Mai Chang, Account Technician: With a Bachelor's Degree in Business Administration and five years' experience working in a governmental capacity, Ms. Chang is responsible for processing subrecipients' invoices, reconciling internal grant workbooks, assists with subrecipient budget revisions, reconciliation between program and fiscal departments and assisting the Senior Health Program Coordinator with the fiscal oversight of the Sacramento County Ryan White CARE Program.

Alden Hunter, Administrative Services Officer II: With a Bachelor's Degree in Health Administration and over 12 years providing program support for various County services, Mr. Hunter is the program's liaison with the fiscal and contracts units who is responsible for contract preparation, subrecipient compliance, and assists with claims processing, budget preparation, and subrecipient procurement.

Cherisse Thomasson, Administrative Services Officer I: With over eight years' experience working for Sacramento County, Ms. Thomasson is a liaison with Human Resources and Information Technology (IT). Responsibilities include providing hiring support, preparing and updating organization charts, as well as other support including processing travel and mileage claims and Planning Council Member reimbursement expenses. Supports program through routine clerical assistance.

Helen Zheng, Epidemiologist: With a Master's in Public Health, Ms. Zheng has over 17 years serving as the providing epidemiological data in the Sacramento County Division of Public Health. Ms. Zheng provides epidemiology data to program for grant writing and other reporting purposes. Assists program with HIV cluster and other relevant programmatic information. Supports the CQI program by preparing Epidemiological reports, studies and tracking systems. Codes and prepares Access queries designed and developed by the CQI Committee to track new Performance measures. Downloads and analyzes statewide and national epidemiological data for local comparison on selected CQI Performance Measures.

Jan Resler, Dental Program Coordinator: As a Registered Dental Hygienist with a Master's in Public Administration and Bachelor's in Dental Hygiene, Ms. Resler oversees pre-authorizations for Dental Project services to assure compliance with Dental Rate Schedule and Eligible Dental Procedures.

Staci Syas, Health Program Manager: Ms. Syas, M.P.H., has over 25 years' experience with Sacramento County Public Health. Ms. Syas provides oversight and development of programs addressing the full continuum of Sacramento County HIV and STD service efforts; coordinates the integration of efforts between HIV/STD Prevention Program, HIV/STD Surveillance Unit, Ryan White Care Program, Epidemiology Unit, and the County STD Controller. Facilitates the development and implementation of a Community STD Prevention Action Plan through engagement with community stakeholders, health care providers, and staff of schools and state agencies. Ms. Syas is presently a member of the California STD Controllers Association and National Coalition of STD Directors.

Appendix: A

FY 2022 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part A HIV Emergency Relief Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area Sacramento, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)[5, 6]
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of people with HIV, as well as the size and demographics of the estimated population of people with HIV who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying people with HIV who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)
The EMA/TGA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative expenses only.

---

[5] All statutory references are to the Public Health Service Act, unless otherwise specified.
[6] TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

Pursuant to Section 2604(c)
The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA/TGA will, for each of such populations in the eligible area expend, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of people with HIV, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
b. during the period of performance, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the health care system for the purpose of facilitating EIS for individuals diagnosed with HIV infection.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature_____ Date 9/16/21

This page intentionally blank

Table 1: AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence by Demographic Group and Exposure Category-Sacramento TGA

Demographic Group/Exposure Category	HIV Incidence*: 01/01/18 to 12/31/20		AIDS Incidence*: 01/01/18 to 12/31/20		AIDS Prevalence ** as of 12/31/20		HIV (not aids) Prevalence ** as of 12/31/20		PLWH Prevalence ** as of 12/31/20	
	HIV incidence is defined as the number of new HIV cases reported during the period specified.		*AIDS incidence is defined as the number of new AIDS cases reported during the period specified.*		*AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*		*HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.*		*PLWH Prevalence is defined as the estimated number of diagnosed people living with HIV or AIDS as of the date specified.*	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	138	30.1	66	34.9	1,345	49.4	1,141	43.5	2,486	46.5
Black, not Hispanic	101	22.0	47	24.9	624	22.9	551	21.0	1,175	22.0
Hispanic	136	29.6	53	28.0	536	19.7	605	23.1	1,141	21.3
Asian/Pacific Islander	24	5.2	9	4.8	78	2.9	128	4.9	206	3.9
American Indian/Alaska Native	2	0.4	1	1.4	10	0.4	12	0.5	22	0.4
Multi-Race	16	3.5	9	1.4	23	0.8	87	3.3	110	2.1
Not Specified/Other	42	9.2	4	2.1	107	3.9	100	3.8	207	3.9
Total	459	100.0	189	100.0	2,723	100.0	2,624	100.0	5,347	100.0
Gender	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
Male	372	81.0	158	83.6	2,271	83.4	2,193	83.6	4,464	83.5
Female	81	17.6	29	15.3	446	16.4	428	16.3	874	16.3
TG:MTF	5	1.1	2	0.0	4	0.0	3	0.0	7	0.1
TG:FTM	1	0.2	0	0.0	2	0.0	0	1.0	2	0.0
Total	459	100.0	189	100.0	2,723	100.0	2,624	100.0	5,347	100.0
Age at Diagnosis (Years)	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**
<13	0	0.0	1	0.5	22	0.8	25	1.0	47	0.9
13-19	12	2.6	4	2.1	67	2.5	87	3.3	154	2.9
20-24	78	17.0	20	10.6	287	10.5	411	15.7	698	13.1
25-44	249	54.2	106	56.1	1,851	68.0	1,550	59.1	3,401	63.6
45-64	106	23.1	48	25.4	474	17.4	514	19.6	988	18.5
>65	14	3.1	10	5.3	22	0.8	37	1.4	59	1.1
Total	459	100.0	189	100.0	2,723	100.0	2,624	100.0	5,347	100.0

Table 1: AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Prevalence (Cont'd)

Demographic Group/ Exposure Category	HIV Incidence*: 01/01/18 to 12/31/20		AIDS Incidence*: 01/01/18 to 12/31/20		AIDS Prevalence ** as of 12/31/20		HIV (not aids) Prevalence ** as of 12/31/20		PLWH Prevalence ** as of 12/31/20	
	HIV incidence is defined as the number of new HIV cases reported during the period specified.		*AIDS incidence is defined as the number of new AIDS cases reported during the period specified.*		*AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*		*HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.*		*PLWH Prevalence is defined as the estimated number of diagnosed people living with HIV or AIDS as of the date specified.*	
Adult/Adolescent AIDS Exposure Category	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	***Number***	***% of Total***
Men who have sex with men	212	46.2	84	44.4	1,449	53.2	1,491	56.8	2,940	55.0
Injection drug users	27	5.9	18	9.5	284	10.4	141	5.4	425	7.9
Men who have sex with men and inject drugs	31	6.8	9	4.8	248	9.1	150	5.7	398	7.4
Heterosexuals	35	7.6	27	14.3	494	18.1	349	13.3	843	15.8
Other***	154	33.6	51	27.0	248	9.1	493	18.8	741	13.9
Total	459	100.0	189	100.0	2,723	100.0	2,624	100.0	5,347	100.0
Pediatric AIDS Exposure Categories	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	**Number**	**% of Total**	***Number***	***% of Total***
Mother with/at risk for HIV infection	0	N/A	0	N/A	18	81.8	21	84.0	39	0.7
Other/hemophilia/blood transfusion	0	N/A	0	N/A	1	4.5	0	0.0	1	0.0
Risk not reported or identified	0	N/A	0	N/A	3	0.0	4	16.0	7	0.1
Total	0	N/A	0	N/A	22	100.0	25	100.0	47	0.9

Reporting Template A - Unmet Need

Jurisdiction Name: Sacramento TGA

Approach? Required
Linked Databases Used? No

	Definition/Description	Number	Percent	Data Source	Year(s) of Data
A	B	C	D	E	F
HIV SURVEILLANCE DATA					
Late Diagnosed					
1	**Late diagnoses:** Number of people with late diagnosed HIV in the most recent calendar year in the jurisdiction based on residence at time of diagnosis. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition ≤3 months after a diagnosis of HIV infection	24	30.8%	HIV Surveillance data	2020
2	**New diagnoses:** Number of people in the jurisdiction with HIV diagnosed in the most recent calendar year based on residence at time of diagnosis	78			
Unmet Need					
3	**Unmet need:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year	1,266	24.4%	HIV Surveillance data; if linked databases are used please specify[1]	2020
4	**Population size:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or any other HIV-related lab data (e.g., CD4, VL, genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period	5,196		HIV Surveillance data	2016 -2020
In Care, Not Virally Suppressed					
5	**Not virally suppressed:** Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was ≥200 copies/mL in the most recent calendar year	494	12.6%	HIV Surveillance data; if linked databases are used please specify[1]	2020

Reporting Template B - Priority Populations

Jurisdiction Name: Sacramento TGA

Approach? Required

	Category	Totals	Numerical Inputs				Auto-Calculated Percentages					
							Within Categories			Across Categories		
		# of People Living with Diagnosed HIV infection	# New Diagnoses	# Late Diagnosed	# Unmet Need	# In Care, Not Virally Suppressed	% Late Diagnosed	% Unmet Need	% In Care, Not Virally Suppressed	% Late Diagnosed	% Unmet Need	% In Care, Not Virally Suppressed
A	B	C	D	E	F	G	H	I	J	K	L	M
HIV SURVEILLANCE DATA												
1	Total	5,196	78	24	1,266	494	30.8%	24.4%	12.6%	100.0%	100.0%	100.0%
2	**PRIORITY POPULATIONS (Determined by Jurisdiction)**											
	Men Who have Sex with Men (MSM)	2,910	31	6	629	237	19.4%	21.6%	10.4%	25.0%	49.7%	48.0%
	Heterosexuals- including high-risk	1,155	28	13	331	93	46.4%	28.7%	11.3%	54.2%	26.1%	18.8%
	Injection Drug Users (IDU)	421	3	0	130	0	0.0%	30.9%	21.6%	0.0%	10.3%	12.8%

This page intentionally blank

Table 3: CO-OCCURRING CONDITIONS

	Ryan White Clients-Incidence Fiscal Year 2020			TGA General Population			
Condition	**Rate**	**Numerator [1]**	**Denominator**	**Rate**	**Numerator [1]**	**Denominator [2]**	**Source for General Population Numerator (Latest Available)**
Tuberculosis	0.9%	23		0.003%	62		2020 California Department of Public Health, TB Control Branch
Hepatitis C*	1.8%	43		0.09%	1,999		2018 California Department of Public Health, STD Control Branch
Syphilis **	5.70%	25		0.05%	1,007		2018 California Department of Public Health, STD Control Branch
Gonorrhea	0.49%	12		0.19%	4,167		2018 California Department of Public Health, STD Control Branch
Chlamydia	0.53%	13		0.62%	13,216		2018 California Department of Public Health, STD Control Branch
Intravenous Drug Use	10.5%	256		0.22%	4,715		2019 SAMHSA National Survey on Drug Use and Health[3]
Mental Illness ***	28.6%	696		19.5%	417,716		2019 SAMHSA National Survey on Drug Use and Health[3]
Homeless / Unstable Housing	10.92%	266		0.32%	6,927		2020 Placer, 2019 El Dorado and 2019 Sacramento County Homeless Point in Time Counts
Uninsured	5.01%	122	**2,436**	5.4%	115,062	**2,143,230**	2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Under 100% FPL (incl no Income)	69.4%	1,691		11.1%	238,641		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Recently Incarcerated****	23.90%	583		0.58%	12,432		2019 California Board of State and Community Corrections
American Indian or Alaskan Native	1.03%	25		0.43%	9,235		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Black or African-American (not Hispanic)	26.0%	633		7.2%	153,488		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Hispanic/Latinx	24.0%	584		21.0%	449,523		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
More than One Race	0.0%	0		5.0%	106,841		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Asian / Pacific Islander	3.57%	87		14.4%	309,666		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
Unknown / Unreported / Other	0.0%	0		0.15%	3,109		2019 U.S. Census Bureau American Community Survey 1-Year Estimates
White (not Hispanic)	44.8%	1,092		51.9%	1,111,368		2019 U.S. Census Bureau American Community Survey 1-Year Estimates

Footnotes

1. Sacramento EMA System (SHARE) client-level tracking database; infection rates supplemented by electronic health record data

2. TGA denominator based on 2019 U.S. Census Bureau American Community Census 1-Year Estimates Data Profiles

3. Overall local TGA prevalence estimate based on extrapolation from nationwide or statewide rates

** RW and TGA HCV counts include both chronic and new infections (i.e., prevalence)*

***25 of 437 FY20 RW clients with reported results were treated for Syphilis in past 12 months*

**** 696 FY20 RW clients recived mental health services in FY20*

***** RW client repoted release from correctional facility within last 12 months*

This page intentionally blank

HIV Health Services Planning Council
9616 Micron Ave, Suite 930
Sacramento, Ca 95827
(916) 875-5881

August 19, 2021

Chevon Kothari, Director
Sacramento County Department of Health Services
7001-A East Parkway, Suite 1000
Sacramento, CA 95823

RE: Letter of Concurrence from Planning Council Chair

Dear Ms. Kothari:

This letter is written to provide concurrence that the following mandates have been addressed by the HIV Health Services Planning Council (Council) and the Ryan White program.

a) The Sacramento TGA conducted a comprehensive *HIV Needs Assessment of RW clients* in 2018 and a *Young Adult Targeted Needs Assessment* in 2021. In December 2020 the *Sacramento County Ending the HIV Epidemic Report* was published by the California State Office of AIDS with input from the TGA's RW Program. In 2016, the TGA participated in *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan.*

b) Priority Setting and Resource Allocation
   i) Priority Setting and Resource Allocations (PSRA) for FY 2022 were determined by the Council using the Council approved priority setting process outlined in policy document PAC 01 – PRSA Processes. This included review of the HIV needs assessments; TGA-wide epidemiology and demographic data; RW client utilization data; cost per RW client data; and financial data, such as increases or decreases in other funding streams.

      In addition, Unmet Need framework estimates, HIV Care Continuum and Early Identification of Individuals with HIV/AIDS (EIIHA) data also were reviewed to address the needs of the populations with HIV with unmet need and those unaware of their HIV status. Through this data driven PSRA process, the Council works to maximize access to services for historically underserved communities, including subpopulations and women, infants, children and youth.

   ii) There are four seated non-aligned PLWH who are consumers of the RW Program involved in planning on the Priorities and Allocations Committee. Additionally, final decisions are determined by the Planning Council which includes an additional eight seated non-aligned consumers. Consumer input is highly valued and instrumental in the PSRA process.

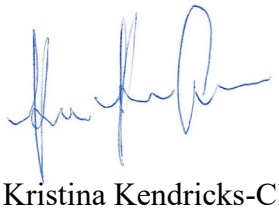
   iii) According to monthly expenditure reports, the Ryan White FY 2021 Part A Formula, MAI and Supplemental funds awarded to the Transitional Grant Area (TGA) are being expended according to the priorities and allocations established by the Council.

c) In addition to all Priorities and Allocation Committee (PAC) members receiving an annual PAC process training (5/10/21), the Council received annual membership training on the Mechanics of

the Planning Council on 3/24/21. The Council also receives ongoing monthly trainings which include presentations from community-based organizations, Fiscal Agent training on administrative and legislative mandates; and issues and trends as they relate to local, state and federal HIV issues.

d) The Administrative Assessment was conducted on June 11, 2021, and all standards were "met and exceeded" including PSRA, fiscal and program monitoring and timeliness of allocation and contracting of funds and payments to contractors.

Thank you for your time and attention,



Kristina Kendricks-Clark, Chair
Sacramento TGA
HIV Health Services Planning Council

Coordination of Services and Funding Streams Table

Funding Source	FY21 Funding Amount		Number of Agencies	Prevention Services	HIV Testing & Policy Alignment Efforts	PLWH/Partner Prevention Services	Condom Distribution	Core Medical-related Services	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Supportive Services	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Medical Transportation Services	HIV Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Substance Abuse Services – Residential
	Dollar Amount	%																															
Part A	$2,698,060	8.2%	9						x			x		x			x	x	x	x		x	x	x		x	x	x	x				x
Part A MAI	$174,807	0.5%	3																x														
Part B	$1,137,617	3.5%	4						x			x					x	x	x			x		x	x	x	x	x	x				
Part B MAI	$58,388	0.2%	3																										x				
Part C	$494,628	1.5%	1						x		x	x	x	x			x	x		x		x											
Part D	$377,592	1.2%	1								x	x					x		x	x													
HRSA ETHE	$809,905	2.5%	1						x													x			x	x		x					
CDC EHE	$760,424	2.3%	2		x	x			x										x														
HRSA COVID 19	$240,919	0.7%	6						x								x		x						x		x	x					
County MOE	$250,000	0.8%	2						x																								
County HIV Prevention Funds	$649,000	2.0%	2		x	x	x																										
ADAP*	$5,897,110	18.0%	7																														
FFS Medi-Cal**	$16,877,451	51.5%	4																														
Medicare	$165,061	0.5%	1						x								x																
SAMHSA	$200,000	0.6%	0		x																												
HOPWA	$825,826	2.5%	3																					x			x						
Other Federal - 340b Program	$35,713	0.1%	1		x					x	x						x		x										x	x	x		
Other Federal - SBA	$10,000	0.0%	1		x												x		x							x			x				
Other State	$250,000	0.8%	1		x	x	x															x											
Fundraising	$46,975	0.1%	5		x	x	x								x		x		x				x	x		x			x		x		x
Foundation Grants	$757,562	2.3%	5		x	x	x			x			x		x		x		x							x			x	x	x		
Miscellaneous Revenue	$33,897	0.1%	1		x								x				x		x							x			x		x		
Interest Income	$6,496	0.0%	2		x																												
Grand Total	$32,757,431	100.0%																															

*ADAP funds are Fiscal Year 2020-2021 - most recent data available

**Medi-Cal funds are Fee-for-Service only from July 2019 through June 2020. Managed Care figures, the bulk of Medi-Cal expenditures in the TGA, are only available from one clinic in Sacramento.

This page intentionally blank

Diagnosis-Based HIV Care Continuum Services Table

Stages of the HIV Care Continuum						Service Category (One or More May Apply)
I. Diagnosed: Percentage of persons aged ≥13 years with HIV infection who know their serostatus.						N/A
Goal	Prevent new HIV infections.	**Objective**	By 2025, increase the percentage of people with HIV infection who know their serostatus to at least 95 percent. (Source: HNSP, Indicator 1***)			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. Data Source: NHSS 202012 (Reference Source: Vol 31*).	N/A		**Denominator:** Number of persons aged ≥13 years with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year. ****	N/A	N/A	
Baseline						
Numerator (same as above)	151		**Denominator** (same as above)	151	100%	
II. Receipt of Care: Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.						Ambulatory Care Services, Health Ins. Premium Asst, Emergency Financial Asst., Transportation, Oral Health, Child Care, Housing, Mental Health, Outreach, MAI Case Management, Substance Abuse Outpatient, Substance Abuse Residential
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	1915		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	2439	78.52%	
Baseline						
Numerator (same as above)	3913		**Denominator** (same as above)	4793	81.65%	
III. Retained in Care: Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.						Medical Case Management, Mental Health, Ambulatory Care Services
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	970		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	2439	39.77%	
Baseline						
Numerator (same as above)	2668		**Denominator (same as above)**	4793	55.70%	
IV. Viral Suppression: Percentage of persons with diagnosed HIV infection whose most recent HIV viral load test in the past 12 months showed that HIV viral load was suppressed.						Outpatient Ambulatory Care, Medical Case Management, Case Management-non-Medical, Substance Abuse-Outpatient, Substance Abuse-Residential, MAI Medical Case Management, Mental Health, Medical Nutritional Counseling
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSP, Indicator 6***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200 copies/mL at the most recent viral load test. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	2045		**Denominator:** Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.	2439	83.85%	
Baseline						
Numerator (same as above)	3913		**Denominator (same as above)**	4793	87.50%	
V. Linkage to Care: Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.						Medical Transportation, Outreach , Health Education and Risk Reduction Services, Non-Medical Case Management
Goal	Improve HIV-related outcomes for people with HIV.	**Objective**	By 2025, increase the percentage of persons with newly diagnosed HIV infection who are linked to HIV medical care within one month of diagnosis to at least 95%. (Source: NHSP, Indicator 5***).			
FY2022 Target						
Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 25 No 2**).	33		**Denominator:** Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.	67	45.83%	
Baseline						
Numerator (same as above)	131		**Denominator (same as above)**	151	86.80%	

This page intentionally blank

Part A Service Category Plan Table

Service Categories	2021 Allocated					2022 Anticipated				
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Priority #	Anticipated Amount	Unduplicated Clients	Service Unit Definition	Service Units
Core Medical Services										
AIDS Drug Assistance Program (ADAP) Treatment	2	$ -	-	Not Presently Funded	-	2	$ -	-	Not Presently Funded	-
Health Insurance Premium & Cost Sharing Assistance	3	$ 13,798	9	1 unit = 1 Vendor Paid Insurance, Medical Visit or Deductible Co-pay dollar	12543.64	3	$ 9,120	6	1 unit = 1 Vendor Paid Insurance, Medical Visit or Deductible Co-pay dollar	8290.91
Medical Case Management (Incl. Treatment Adherence)	5	$ 911,545	876	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	104837.35	5	$ 1,011,384	972	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session	116319.89
Medical Nutrition Therapy	15	$ 3,980	18	1 unit - 1 Medical Nutritional Therapy face-to-face encounter	159.20	15	$ 10,731	49	1 unit - 1 Medical Nutritional Therapy face-to-face encounter	429.24
Mental Health Services	7	$ 411,253	391	1 unit = 1 face to face or other encounter	9627.75	7	$ 422,500	402	1 unit = 1 face to face or other encounter	9891.05
Oral Health Care	4	$ 390,952	437	1 unit = 1 visit or vendor dollar	109842.90	4	$ 376,157	420	1 unit = 1 visit or vendor dollar	105686.06
Outpatient/ Ambulatory Health Services	1	$ 388,032	631	1 unit = 1 visit or vendor dollar	28660.64	1	$ 459,954	748	1 unit = 1 visit or vendor dollar	33972.91
Substance Abuse Outpatient Care	9	$ 198,631	140	1 unit = 1 face to face or other encounter	5616.25	9	$ 209,575	148	1 unit = 1 face to face or other encounter	5925.69
CORE MEDICAL TOTAL		$ 2,318,191					$ 2,499,421			
Support Services										
Child Care Services	12	$ 38,122	16	1 unit = 1 Vendor Child Care Dollar	34656.36	12	$ 28,000	12	1 unit = 1 Vendor Child Care Dollar	25454.55
Emergency Financial Assistance	13	$ 68,058	161	1 unit = 1 Vendor Paid Other Critical Need	61870.91	13	$ 85,692	186	1 unit = 1 Vendor Paid Other Critical Need	77901.82
Food Bank/ Home Delivered Meals	14	$ -	-	Part B Only	-	14	-	-	Part B Only	-
Health Education/ Risk Reduction	16	$ 4,712	20	1 unit = 1 face to face or other encounter	4712.00	16	$ 5,006	21	1 unit = 1 face to face or other encounter	5006.00
Housing	11	$ 11,067	37	1 unit = 1 Vendor paid lodging dollar	10060.91	11	$ 13,729	70	1 unit = 1 Vendor paid lodging dollar	12480.91
Medical Transportation	8	$ 125,720	254	1 unit = 1 One-Way trip or Vendor transportation dollar	101390.07	8	$ 77,006	156	1 unit = 1 One-Way trip or Vendor transportation dollar	62103.43
Non-Medical Case Management Services	6	$ 20,946	50	1 unit = 1 Benefits Counseling face to face or other encounter	2294.48	6	$ 51,491	123	1 unit = 1 Benefits Counseling face to face or other encounter	5640.46
Outreach Services	17	$ 20,526	125	1 unit = 1 face to face or other encounter	821.04	17	$ 11,640	71	1 unit = 1 face to face or other encounter	465.60
Substance Abuse-Residential	10	$ 54,302	16	1 unit = 1 Detox Hour	8136.64	10	$ 60,977	18	1 unit = 1 Detox Hour	9136.83
SUPPORT TOTAL		$ 343,453					$ 333,541			
GRAND TOTAL		$ 2,661,644					$ 2,832,962			

FY 2021 PART A Allocations		
	Core Medical Services	Support Services
2021 Percentages	87.10%	12.90%

FY 2022 PART A Allocations		
	Core Medical Services	Support Services
2022 Percentages	88.23%	11.77%

FY 2021 PART A + MAI Allocations		
	Core Medical Services	Support Services
2021 Percentages	87.90%	12.11%

FY 2022 PART A + MAI Allocations		
Core Medical Services	Core Medical Services	Support Services
2022 Percentages	88.94%	11.06%

MAI Service Category Plan Table

Service Categories	2021 Allocated						2022 Anticipated					
	Priority #	Allocated Amount	Undup-licated Clients	Service Unit Definition	Service Units	Subpopulation(s) of Focus	Priority #	Anticipated Amount	Undup-licated Clients	Service Unit Definition	Service Units	Subpopulation(s) of Focus
Core Medical Services												
Medical Case Management (Incl. Treatment Adherence)	5	$ 128,135	269	1 15-minute *face to face or other* Medical Case Management encounter	14251	Black/African American	5	$ 134,542	443	1 15-minute *face to face or other* Medical Case Management encounter	23469	Black/African American
Medical Case Management (Incl. Treatment Adherence)	5	$ 35,978	182	1 15-minute *face to face or other* Medical Case Management encounter	6444	Hispanic/Latino	5	$ 37,777	200	1 15-minute *face to face or other* Medical Case Management encounter	7081	Hispanic/Latino
Medical Case Management (Incl. Treatment Adherence)	5	$ 5,100	34	1 15-minute *face to face or other* Medical Case Management encounter	415	Asian	5	$ 5,355	43	1 15-minute *face to face or other* Medical Case Management encounter	525	Asian
Medical Case Management (Incl. Treatment Adherence)	5	$ 4,800	11	1 15-minute *face to face or other* Medical Case Management encounter	938	American Indian/ Alaskan Native	5	$ 5,040	21	1 15-minute *face to face or other* Medical Case Management encounter	1791	American Indian/ Alaskan Native
Medical Case Management (Incl. Treatment Adherence)	5	$ 793	6	1 15-minute *face to face or other* Medical Case Management encounter	912	Native Hawaiian/ Pacific Islander	5	$ 833	8	1 15-minute *face to face or other* Medical Case Management encounter	1216	Native Hawaiian/ Pacific Islander
CORE MEDICAL TOTAL		$ 174,806						$ 183,547				
Support Services												
SUPPORT TOTAL		$ -						$ -				
GRAND TOTAL		$ 174,806						$ 183,547				

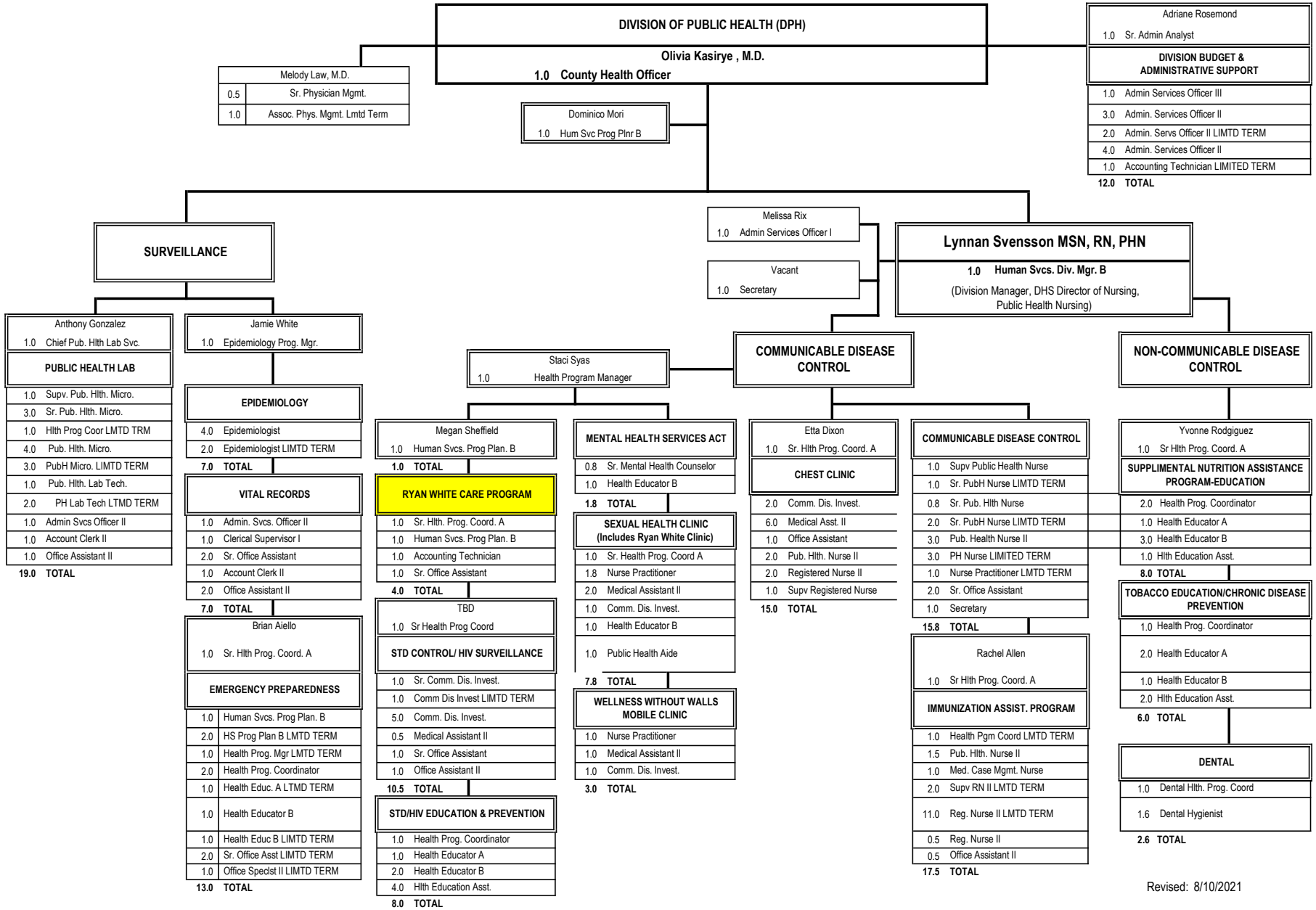
FY 2021 MAI Allocations		
2021 Percentages	**Core Medical Services**	**Support Services**
	100.00%	0.00%

FY 2022 MAI Allocations		
2022 Percentages	**Core Medical Services**	**Support Services**
100.00%	100.00%	0.00%

SACRAMENTO COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF PUBLIC HEALTH
BU 7207500 - HEALTH OFFICER
FY 2021-2022

Attachment 11 Organization Chart
RWHAP Part A Emergency Relief Grant

166.5 Total FTEs



Revised: 8/10/2021

This page intentionally blank

MAINTENANCE OF EFFORT

Core Medical Service and Support Service Budget Elements to Document MOE

MOE Expenditures Based on Core Medical Services and Support Services

Item No.	Item Description	Agency/Department/Other Government Unit	FY 20 Actual Expenditures	FY 21 Estimated Expenditures
1	Outpatient Ambulatory Care-Ryan White CARE Program	Department of Health Services, Ryan White CARE Program	$250,000	$250,000
		Total	**$250,000**	**$250,000**

Process Used to Determine Amount of Expenditures in MOE Table

The Maintenance of Effort (MOE) computations are made in accordance with the Section II, Chapter 4: Maintenance of Effort of the Ryan White CARE Act, of the Part A manual. MOE computations for the Sacramento TGA include actual expenditures for HIV-related core and support services from all sources in Sacramento, Placer and El Dorado counties. All counties operate on a July 1 through June 30 Fiscal Year. Currently, as in the past, the only Core service supported directly by the Sacramento TGA is Outpatient Ambulatory Care. Formerly the Primary Care Division of Sacramento County's Department of Health Services (DHS) maintained a contract with the RW program's HIV/AIDS specialty ambulatory care clinic, One Community Health, for services to PLWH meeting eligibility criteria for "Medically Indigent" services. MOE funding is now used to fund HIV outpatient ambulatory care services for the Sacramento County Sexual Health clinic. This contract was the only budget in DHS that has not been reduced because of the Maintenance of Effort requirement by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (and reauthorized in October of 2010). While the three counties of the TGA do have other State funding for HIV, that funding is for surveillance, and HIV Prevention and testing, service categories that do not fall within the Part A eligible service categories. MOE computations for all expenditures for FY20 were compiled using a coding system that applies each of the expenditures to the applicable program in each of the County's accounting and reporting systems. For FY21, all HIV related expenditures funded locally in the Sacramento TGA are spent in Sacramento County, by the Sacramento County DHS, which has a line item budget that funds HIV related activities. Sacramento County DHS incurs additional expenditures to supplement the revenues from grants that do not pay for indirect expenses, or are under-funded. All HIV/AIDS activities are coded by a system of order numbers that track each separate program and activity in Sacramento County DHS' accounting and reporting system (COMPASS). Total HIV/AIDS expenditures minus HIV/AIDS revenues determine the locally funded HIV/AIDS related expenditures.

As the basis for the Maintenance of Effort, the Sacramento County Board of Supervisors authorizes general funds in the amount of $250,000 ***annually*** to support needed Core services in the Ryan White CARE Program. For Fiscal Year 2020, MOE funds were expended on Outpatient Ambulatory Care services to PLWH. This action has ensured annual Maintenance of Effort at previous levels. The Sacramento County Board of Supervisors has already authorized the $250,000 for the current FY21 and it is anticipated that all of these funds will be expended by June 30, 2022.

This page intentionally blank