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Divisions
Behavioral Health Services
Primary Health
Public Health
Departmental Administration

FY17 Annual Progress Report, Sacramento Transitional Grant Area

I.a. FY2017 FINAL IMPLEMENTATION PLAN

See **Attachment A**

I.b. ACCOMPLISHMENTS

I.b. UTILIZATION AND TRENDS IN CARE:

Utilization and trend data are compiled for March 2017 through February 2018. Overall, the Transitional Grant Area (TGA) served 2,496 unduplicated clients. This represents a 4.8% decrease (127 fewer clients) over the prior year ***total*** clients of 2,623 in 2016.

During Fiscal Year 2017, the TGA and Yolo County, served a total of 240 ***new*** unduplicated clients, or clients who have never been served by the Ryan White system of care in any previous year. Whereas in Fiscal Year 2016, the TGA served a total of 345 new unduplicated clients. This data reflects a 30.4% decrease in new clients over the previous year in the three-county TGA and the Yolo County area.

Of the 223 new clients (in the TGA) in 2017, 194 resided in Sacramento, 17 in Placer, and 12 in El Dorado County. However, of the 327 new unduplicated clients in 2016, 282 resided in Sacramento, 32 in Placer, and 13 in El Dorado County. This marks a 31.2% decrease in clients in Sacramento and a 46.9% decrease in clients in Placer County.

Additionally, 17 new clients were reported from Yolo County, a non-TGA county compared to the prior year (FY16) when there were 18 new unduplicated clients.

Comparisons of year-to-date FY2017 client demographics and FY 2016 data reveal the following trends:

Total Clients:

In 2017, the TGA served 2,496 total clients compared to 2,623 last year representing a 4.8% decrease in total clients overall. Of the 2,496 clients served in FY17, 2,455 were people living with HIV/AIDS and there were an additional 41 Affected/Indeterminate clients receiving services. In FY16, 2,578 were people living with HIV/AIDS and there were an additional 45 Affected/Indeterminate clients receiving services.

Of the total clients, 101 clients lived in Yolo County, a non-TGA county compared to the prior year (FY16) when there were 111 Yolo County clients.

New Clients:

As mentioned in the Utilization and Trends in Care above, the TGA has served a total of 223 new unduplicated clients who had never been seen in the Ryan White system of care before this year. This represents a 30.4% decrease over the prior year in which the three-county TGA served 345 new clients.

Yolo County served 17 new unduplicated clients in FY17 compared to 18 the prior year.

Clients by CD4:

Based on a comparison between fiscal years 2016 and 2017, clients' CD4 counts showed a slight improvement overall with a 1.6% decrease in CD4 counts below 499, and a 2.3% increase in CD4 counts over 500. There was also a decrease in the number and percent of unknown CD4 counts. Below is a breakdown of the HIV+ client's CD4 counts.

	2016			2017	
CD4 Range	# of HIV+ Clients	% of HIV+ Clients		# of HIV+ Clients	% of HIV+ Clients
Below 200	253	9.8%		228	9.2%
200 - 499	775	30.0%		713	29.0%
500 - 749	771	29.9%		695	28.3%
750 - 1,499	675	26.1%		732	29.8%
Greater than 1,500	36	1.3%		39	1.5%
Unknown/Unreported	68	2.6%		48	1.9%
Group Total	2,578			2,455	
Affected/Indeterminate	45			41	
Total Clients	2,623			2,496	

Clients by Viral Load:

A review of clients by viral load for fiscal year 2017 in comparison with fiscal year 2016, notes a 2.4% increase in clients who are virally suppressed (VL < 200), but within that range, a 5% increase in undetectable viral load counts.

	2016			2017	
Viral Load	# of HIV+ Clients	% of HIV+ Clients		# of HIV+ Clients	% of HIV+ Clients
Unknown/Unreported	79	3.0%		48	1.9%
<= 20 (Undetectable)	1,600	62.0%		1,647	67.0%
21 - 200 (Virally Suppressed <=200)	441	17.1%		357	14.5%
201 - 999	77	2.9%		73	2.9%
1,000 - 4,999	81	3.1%		64	2.6%
5,000 - 9,999	42	1.6%		34	1.3%
10,000 - 24,999	58	2.2%		69	2.8%
25,000 - 74,999	104	4.0%		82	3.3%
75,000 or Higher	96	3.7%		81	3.2%
Group Total	2,578			2,455	
Affected/Indeterminate	45			41	
Total Clients	2,623			2,496	

Clients by County:

During fiscal year 2017, 85.5% of the clients (2,135) resided in Sacramento County. Placer County was home to 6.29% (157 clients); El Dorado 4.13% (103 clients); and, Yolo County 4.05% (101 clients).

In comparison, during fiscal year 2016, 85.93% of the clients (2,254) resided in Sacramento County. Placer County was home to 6.06% (159 clients); El Dorado 3.66% (96 clients); 0.04% in Alpine (1 client); and, Yolo County 4.23% (111 clients).

Of significant note is the increase in clients in El Dorado County where there is only one Ryan White provider, Sierra Foothills AIDS Foundation. The increase of clients creates a strain on the limited resources and increases transportation costs for clients seeking medical care at One Community Health (formerly known as Cares Community Health) in Sacramento County.

While the Counties of Alpine and Yolo are not part of the Part A Sacramento Transitional Grant Area, the County of Sacramento is the Fiscal Agent for the Part B funds from the State of California. These clients may also obtain services in Sacramento. Therefore, the clients are

included for reference. It should be noted that any increases in clients in Yolo County also creates a strain on services with the one Ryan White funded provider, Communicare Health Center, in that county.

Clients by Age:

In this reporting period, the Sacramento TGA observed decreases in the clients between the ages of 0-44 (874 clients in FY2017 compared to 946 in 2016). The age group of 25-44 years of age saw the greatest *decrease* (0.9%) in the percent of clients. Youth 13-19 showed the highest *increase* both in number and percent. While the total numbers are relatively small compared to other age groups, the increase of 8 clients or 72.7% in youth in this age group is alarming.

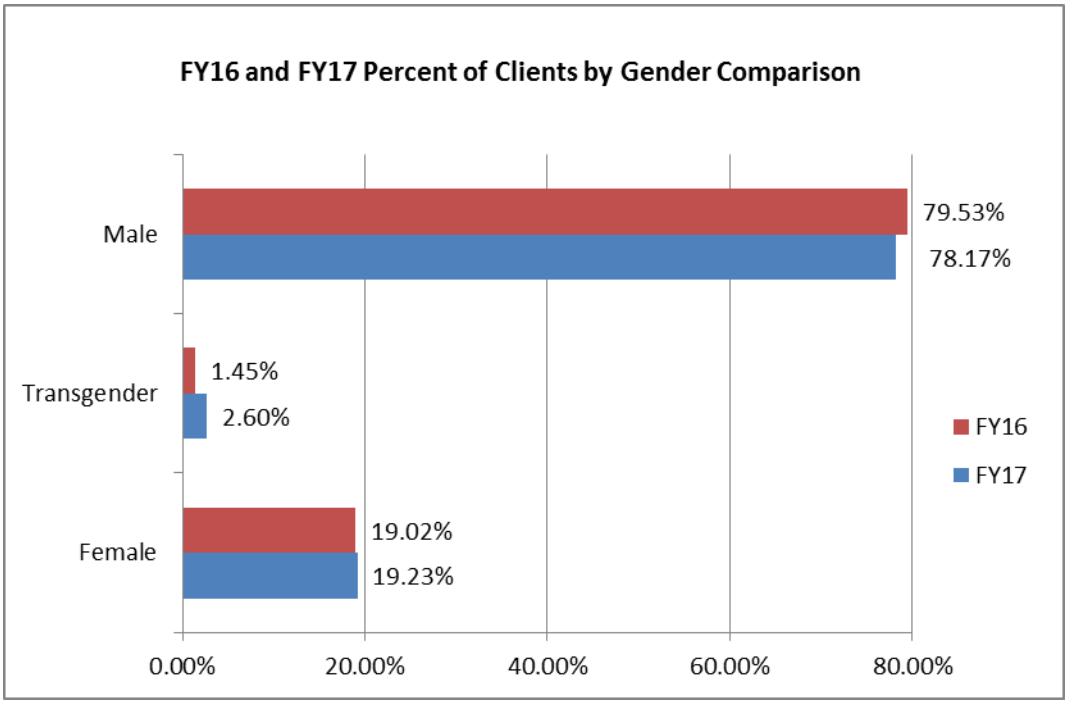
For those 45 years and over, there was a 30.6% decrease in clients served in 2017 (1,581 clients) compared to 2016 (1,631 clients). Additionally, during the current year, the Ryan White system has been following the exposed infants who must be medically followed until they are two years old before they can be confirmed as negative clients. These client are HIV Indeterminant (under age 2), and the TGA followed a total of 4 exposed infants during this time period.

	2016					2017			
Age Category	# of HIV+ Clients	# of HIV- Clients	% of HIV+ Clients	% of HIV- Clients		# of HIV+ Clients	# of HIV- Clients	% of HIV+ Clients	% of HIV- Clients
Infants 0 - 2 years	0	10	0.00%	0.38%		0	4	0.00%	0.16%
Children 3 - 12 years	8	23	0.30%	0.88%		4	22	0.16%	0.88%
Youth 13 - 19 years	11	12	0.42%	0.46%		19	15	0.76%	0.60%
Youth 20 - 24 years	68	0	2.59%	0.00%		56	0	2.24%	0.00%
Adults 25 - 44 years	859	0	32.75%	0.00%		795	0	31.85%	0.00%
Adults 45 - 59 years	1,182	0	45.06%	0.00%		1,114	0	44.63%	0.00%
Adults 60+	449	0	17.12%	0.00%		467	0	18.71%	0.00%
Unknown	1	0	0.04%	0.00%		0	0	-	0.00%
Group Total	2,578	45	98.28%	1.72%		2,455	41	98.35%	1.64%
Total Clients	2,623		100.00%			2,496		99.99%*	

* Percentage off due to rounding

Clients by Gender:

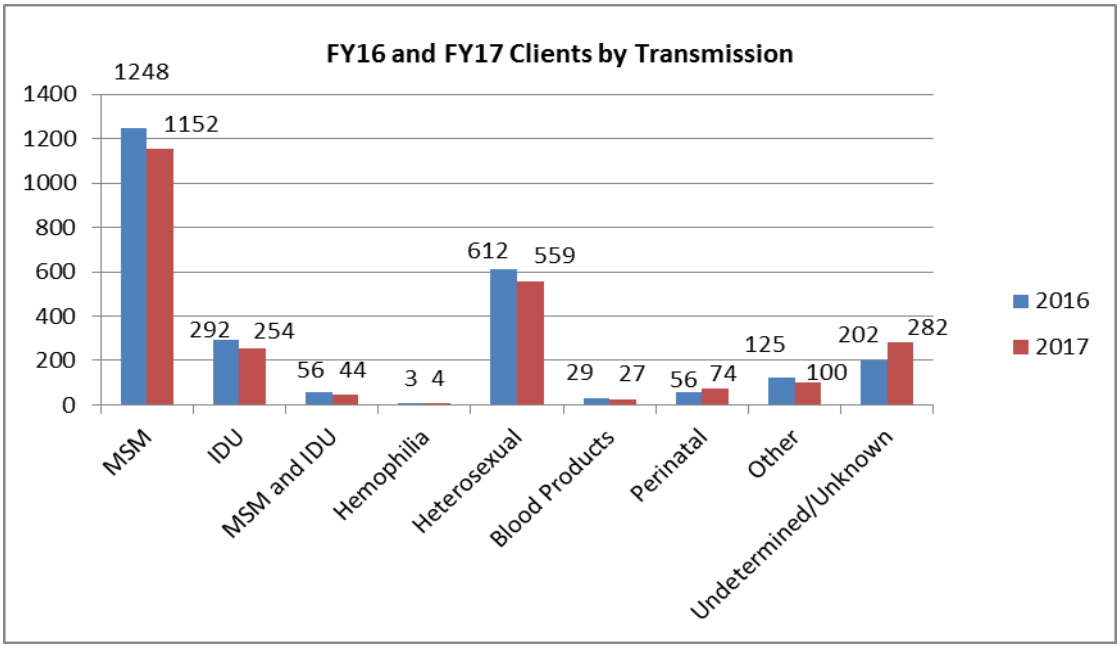
In FY17, males represented 78.17% of the clients; transgender represented 2.6% of the clients; and, females 19.23%. Due to a decrease in the total clients served in FY17 (2,496) compared to FY16 (2,623), this reflects an increase in the percentage of clients for both transgender and female clients compared to fiscal year 2016. In fiscal year 2016, males represented 79.53%; transgender clients represented 1.45% of the total clients; and, females 19.02%.



Our final WICY (Women, Infants, Children and Youth) expenditures show that Sacramento is responding to the needs of women by allocating and expending funds targeted to women in an amount that exceeds their current representation in the epidemic. Total expenditures for WICY must meet a minimum of 18.93% of the total Part A and Part A MAI direct service grant award. At year-end, WICY expenditures ($1,046,785) represented 36% (Part A and Part A MAI) of the grant award direct service expenditures. See **Attachment B**.

Clients by Transmission:

There has been no significant change in the transmission methods of the clients in the TGA. Men Having Sex with Men (MSMs) continues to represent the highest transmission level at 47.91% (MSM and MSM/IDU combined), followed by heterosexual transmission (22.4%) and Intravenous Drug Use (10.18%). As documented in our FY18 grant application, High-Risk Heterosexuals experienced an increase in the percent of people living with HIV (PLWH) transmission between 1995 and 2016 (7% vs 17.5%). This category now represented the second largest percent of PLWH in the TGA and has overtaken the IDU transmission category.



Clients by Income:

Although there were fewer clients served in FY17 compared to FY16, there was an increase in the number/percent of clients below 138% of poverty. In FY17, clients with an income of 138% or less accounted for 82.89% of individuals (2,069) receiving Ryan White services. In FY16, they accounted for 75.64% (1,984 clients).

Clients by Income	2016		2017	
	Count	Percent	Count	Percent
No Income	532	20.28%	860	34.46%
100% of Poverty	1,115	42.51%	986	39.50%
101- 138% of Poverty	337	12.85%	223	8.93%
139-250% of Poverty	425	16.20%	294	11.78%
251-300% of Poverty	73	2.78%	48	1.92%
Over 300% of Poverty	141	5.38%	85	3.41%
Totals	2,623	100.00%	2,496	100.00%

Clients by Ethnicity:

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

I.b.1. National Goals to End the HIV Epidemic:

- Accomplishments in reducing new infections:

On behalf of the Sacramento Community, Sacramento County Public Health Division continues to host an STD/HIV Stakeholder group, the Sacramento Workgroup to Improve Sexual Health (SacWISH) with a goal of intensifying HIV and STD prevention, testing, and treatment efforts in the community in order to reduce new infections and increase the percentage of persons who know their sero-status and are linked to and receive care. The Coalition is comprised of a broad range of community partners including medical clinics, testing agencies, school districts, local and state public health representatives and non-profit agencies that work closely with high-risk populations. Additionally, in an effort to provide more integrated and enhanced services, the Public Health Department itself merged its STD, HIV and Surveillance programs, and all Communicable Disease Investigators and STD Investigators have been cross-trained to ensure that follow up with persons with any reportable STD or HIV condition receive appropriate testing for all of these conditions. Intensive follow-up is conducted to ensure that all clients access medical care as soon as possible. The Ryan White CARE program is working closely with the surveillance staff and STD/CDI staff to share information to determine a client's status of care.

Additionally, the *ZERO New HIV Infections TOGETHER* campaign, initiated last year by the One Community Health FQHC clinic continues its collaborative community-wide campaign to advance information and activities to reduce new HIV infections including the distribution of provider tool kits and client information on the availability of PrEP in our community. The Strategic Plan is included as **Attachment D.**

- Increasing access to care:

The Ryan White CARE Program continued its funding support for Benefit and Enrollment Counselors in FY16 to ensure clients receive assistance in enrolling in any public benefits for which they may be eligible, including Medi-Cal (Medicaid), Covered California (ACA) health plans, California's ADAP program, and the State Health Insurance Premium Payment programs. There were 980 clients receiving Benefits and Enrollment Services in FY17, a decrease of approximately 33.9% over FY16 when 1,483 clients received those same services.

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

- Reducing Health-Related Disparities:

The TGA has employed a Continuous Quality Management program that utilizes a significant number of field based Medical Case Managers who provide services to clients at various sites that are more comfortable and convenient to the clients, often meeting them in their homes or in homeless camps to ensure their access to care. Quality Indicators for the TGA

require that all Ryan White sub-recipients, regardless of the service they provide, document and track a client's retention in care and viral load status. Clients who receive their care from the Ryan White system are provided high quality care that strives to meet all PHS Guidelines for the treatment of persons with HIV/AIDS. The TGA's only outpatient HIV clinic also offers a one-stop shop for clients where they can fill their medications at the on-site pharmacy, obtain Mental Health and Substance Abuse counseling, Medical Case Management, Benefits Counseling, Nutritional Counseling, Oral Health Care and support services such as transportation, insurance and medical co-payment assistance and Emergency Financial Assistance. By adding the Insurance Premium Assistance category of services funded by Ryan White since the implementation of the ACA, the Planning Council has taken a step to reduce health disparities of our HIV+ population by ensuring eligible clients have assistance when needed to pay for their medication and medical visit co-payments, ensuring a seamless system of access to care. While all eligible clients are enrolled in the State's Health Insurance Premium Assistance program, Ryan White funds may still be needed for the first month's premiums while program eligibility approval is being process by the State. A process is in place to recover those payments once the State pays those premiums retroactively, and those recoveries become program income.

I.b.2. Evolving Healthcare Landscape

- Impact on Planning and Allocations:

The Sacramento TGA's HIV Health Services Planning Council's Priorities and Allocations Committee (PAC) is tasked with recommendations for priority setting and allocations. With Fiscal Year 2013 marking the implementation of the Affordable Care Act (ACA), the Committee, in addition to considering historical utilization data, Needs Assessments, and year-end reports, also accounted for potential cost-savings from clients who had enrolled in ACA insurance plans. The primary cost savings have been in viral load and CD4 lab tests. The Planning Council did fund the Health Insurance Premium and Cost-Sharing Assistance Program service category in an attempt to ensure clients could meet their deductibles and co-pays. In FY17, 33 clients received Health Insurance Premium and Cost-Sharing Assistance while 44 clients received those same services in FY16, representing a 25% decrease in clients receiving Health Insurance Premium and Cost-Sharing Assistance over the prior year.

- Enrollment

At the end of FY 2017, 92.21% of the clients in the Ryan White system of care had a third party payer: 8.20% had private insurance and 84.01% had some form of public insurance through Medicare, Medicaid, or local other governmental programs. However, 7.79% had no insurance.

At the end of FY 2016, 92.22% of the clients in the Ryan White system of care had a third party payer: 8.2% had private insurance and 84.02% had some form of public insurance through Medicare, Medicaid, or local other governmental programs. 7.78% had no insurance.

We estimate that 5% of the clients with no insurance were undocumented and therefore ineligible for public health insurance benefits, and some clients were awaiting approval from government funded insurance carriers.

I.b.3. Achieving all HIV Care Continuum Targets:

Quality-of-Care issues are addressed through on-going technical assistance training by the Recipient at mandatory Service Provider/Sub-recipient meetings. Reports on Clients In/Not in Medical Care, Incomplete Intake Reports, HAB information, AAHIV National Advocacy updates, and various HIV related articles are distributed to sub-recipients at meetings and via e-mail. Sub-recipients are apprised of new Service Standards under review by the Planning Council and encouraged to provide input toward the development of standards within their areas of expertise. Once adopted by the Council, Service Standards are distributed to all sub-recipients for implementation with training and assistance provided by the Recipient at various meetings. Sub-recipients are also provided with a "Provider Orientation Manual" which contains on-going up-dates of Service Standards and Service Directives adopted by the Planning Council each year. This system of sub-recipients participation in the development of new or up-dated standards promotes acceptance and immediate implementation of new standards. These activities improve the quality of care issues involving all of the TGA's funded service categories and address HRSA's emphasis to improve quality of care to all Ryan White service recipients.

On-going monitoring of performance and outcome indicators has revealed that the TGA is doing an exceptional job of providing quality care to its clients. Refer to **Attachment E**, "FY17 Outcome Indicators". During the fiscal year 2017, the Sacramento Transitional Grant Area served 2,496 unduplicated clients. Of the total 1,972 clients who received Ryan White Ambulatory Care services from the continuum of care, 87.84% (1,697 out of 1,932) met the definition of " in medical care" (having a minimum of one CD4 or viral load count during the reporting period), 84.47%% (1,632) were virally suppressed and 97.46% (1,883 were on HAART). Quality management monitoring has demonstrated that care is being provided in accordance with high quality services to our clients.

I.b.3.i. Comprehensive TGA Quality Management Assessment:

During FY 2017, the Fiscal Agent conducted all site visits including reviews of subcontractors Quality Management activities and plans. One sub-recipient required some technical assistance in updating their quality management program, and one sub-recipient was provided technical assistance on improving the documentation of their quality management activities/meetings.

The TGA's ambulatory care clinic utilizes an Electronic Health Record System (EHR). This system provides up-to-date client-level quality management data which assists with on-going assessment of HIV Quality Outcomes. The system provides "flags" for physicians to remind them of required labs, vaccinations, etc. The process has improved the TGA's provision of high quality medical care and its ability to provide accurate and timely monitoring of Public Health Guidelines and adopted performance measures. The Ambulatory Care Clinic's monthly "data upload" into the TGA's client-level database provides current client-level medical information to the TGA's data system.

I.b.3.ii. Development of New Service Standards and Outcome Indicators:

The HIV Health Services Planning Council's Quality Advisory Committee reviewed and updated the FY17 Outcome Indicators to include HAB Systems-Level Measures and HAB Core Measures. The Quality Advisory Committee reviewed/updated three service standards during the Fiscal Year.

I.b.3.ii. Medical Case Management System Improvements:

Evaluation of prior years' data has documented the success of this specialized medical case management process in reaching high-risk populations and assisting them in remaining in care. While the three-county TGA saw an increase of 223 new unduplicated clients, 164 of these new clients (73.5%) received ambulatory care services from the Ryan White program as a result of the medical case management services. This is testimony to the critical work performed by medical case managers to facilitate clients into care.

As for Yolo County, medical case management services enhanced access to Ryan White Part B medical care for 64.7% of the new unduplicated clients (11 out of 17).

I.b.3.iv. Increased Access to the Continuum of Care:

Utilization reports for the web-based system allow identification of clients who are not in care by sub-recipient. Reports are sent on a regular basis to alert sub-recipients of the specific clients who need follow-up because they are either not in medical care, have dropped out of care, or the electronic records need updating. The system also provides tools to alert sub-recipients that Client Intake information is incomplete or incorrect, with specific lists of items needing further clarification.

The ***new*** 223 unduplicated clients in the three-county TGA utilized Ambulatory Care, Medical Case Management, non-Medical Case Management, Mental Health, Oral Health, Housing, Emergency Financial Assistance, Health Education and Risk Reduction Services, Health Insurance Premium and Cost Sharing Assistance, Medical Nutritional Therapy, Outreach Services, Substance Abuse Services – both residential and outpatient, Medical Transportation and Food Bank services, effectively demonstrating the TGA's successes in increasing access to the region's continuum of care. The category in the TGA which assisted the greatest number of new unduplicated clients was Outpatient Ambulatory Medical Care providing medical services to 164 new unduplicated clients. The 17 new clients in Yolo County received Ambulatory Care, Emergency Financial Assistance, Medical Case Management, Food Bank, Medical Transportation, Mental Health and Housing services.

The TGA continues to strive to provide 100% access and 0% disparity in providing "comprehensive high quality, client-centered, timely and cost-effective outpatient medical services to HIV infected persons at all stages of disease. The following table provides the total number of unduplicated clients served within each service category for the combined Ryan White Part A and B funds.

All Counties-Parts A & B	FY14 UDC	FY15 UDC	FY16 UDC	FY17 UDC
Case Management – Non-Medical	1,203	1,618	1,483	980
Child Care Services	39	37	35	37
Emergency Financial Assistance	164	162	183	241
Food Bank/Home Delivered Meals	*Not Funded*		10	518
Health Education and Risk Reduction (PCRS)	224	190	116	142
Health Insurance Premium and Cost-Sharing Assistance	18	26	44	33
Housing Services	20	24	44	143
Medical Case Management	1,114	1,153	1,320	1,152
Medical Nutrition Therapy	279	406	421	364
Medical Transportation Services	340	387	437	563
Mental Health Services	879	895	918	738
Oral Health Care	587	695	625	553
Outpatient Ambulatory Care	1,792	1,673	1,972	1,932
Outreach Services	766	718	329	297
Substance Abuse - Residential	17	18	30	62
Substance Abuse - Outpatient	310	298	327	310

I.b.3.v. Administrative Assessment Mechanism:

The Sacramento Transitional Grant Area's Administrative Assessment Committee (AdAC) conducted monitoring assessments of the Fiscal Agent for Fiscal Year 2017. The FY17 year-end assessment will be conducted on June 11, 2018. The FY17 mid-year assessment findings indicated 100% of the 67 Outcomes reviewed were Met/Exceeded.

During Fiscal Year 2009, the Fiscal Agent assumed the duties of the Planning Council staff responsibilities due to budget reductions and contract limitations. In 2017, the Council's Executive Committee reviewed the Planning Council's staff performance. Staff continually met or exceeded standards. Additionally, Fiscal Agent staff for the Planning Council maintains the website for the Sacramento TGA which provides information to the general public on meetings, providers, services, etc. The website is www.sacramento-tga.com.

I.b.3.vi. Strategic Initiative:

In 2014, Cares Community Health, now known as One Community Health, launched the "Equally Well" Initiative for the community's underserved populations. One Community Health's goal is to continue working to end new cases of HIV, reduce disparities experienced by the mentally ill and help those without insurance obtain it to live healthier lives. One Community Health believes health isn't a privilege. It is a human right. Everyone must have the opportunity to be **equally well**.

To do so, in the most basic terms, here are the steps they intended to undertake with their Equally Well Campaign:

- Find everyone who does not know they have HIV and link them to health care.
- Find all those who were once in medical care and get them to return to care.
- Keep everyone who is currently in medical care engaged in their care.
- Keep high risk negatives from getting HIV by providing free condoms, access to post- exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP).

Accomplishments 2014-2017:

- Distributed nearly 2 million condom and lube packets in greater Sacramento through 254 locations. Offered free phone apps to locate condom distribution sites listed on condomfinder.org
- Reengaged 536 people in medical care
- Over a two-year period, linked 103 newly diagnosed HIV+ individuals to care through their STD testing clinic and an additional 106 HIV+ individuals from community testing sites
- 2015 Exceptional Women of Color Conference – PrEP workshop.
- Established Zero Together, a prevention coalition of service agencies and funding sources, to work as a group to reduce HIV transmission rates in the Sacramento region
- Maintained funding for syringe exchange programs in the community.
- Continued low or no-cost drop in STD/HIV testing and marketed to the highest impacted communities
- 2015 PrEP Town Hall was held in partnership with the Sacramento Gay and Lesbian Center for the community.
- Launched PrEP website GetPrEPSac.org with resources on what PrEP is, patient resources, and provider resources. Sponsored Facebook ads, hook-up site ads, and other social media site ads targeting gay men in Sacramento to promote PrEP awareness
- 2016 and 17 Gay Pride celebration with a focus on a promoting PrEP
- 2016 Hosted Know Your Status PrEP and PEP Talk in partnership with National Coalition of 100 Black Women to spread information on PrEP in the African American communities
- In partnership with the County Department of Health Services, Division of Public Health, distributed PrEP Tool Kits to all physicians in the Sacramento Medical Society.

As mentioned above, One Community Health launched the "Zero Together" Initiative in 2015, focused on reducing the number of new HIV infections by educating the community about PrEP through various marketing methods including a site specific website, www.getprepsac.org. For patients and prospective patients, they provide a diverse resource database for a variety of patients on what PrEP is, what it does, how to pay for PrEP, its usefulness to particular communities, PrEP statistics and more so clients and their health provider can make informed decisions when it comes to starting a PrEP regimen. For providers, the website includes clinical practice guidelines, patient education tools, and training assistance information. The coalition

created a Provider Tool Kit which was disseminated widely to local physicians by the Sacramento County Public Health Officer. This Provider Tool Kit is also available on the Sacramento GetPrepSac website.

Diagnosis and Linkage to Care

Nationwide, CDC estimates that about 13% of the people who are HIV+ don't know they are infected. Using the Current Method for the Unmet Need Framework, there are about 4,889 people who are HIV+ aware as of December 31, 2016, in the Sacramento area. 791 of these people living with HIV are out of care according to the FY16 Unmet Need Estimate. Finding these people is a challenge. Promotion of universal HIV testing, as recommended by the Center for Disease Control, would greatly increase opportunities to identify unknown positives. One Community Health will continue to remind providers that all insurance plans are required to pay for HIV testing even if there are no symptoms or perceived risk. In the meantime, other activities include:

- Increasing testing in the drop in STD clinic by advertising on social media with a focus on Latino and African American men who have sex with men
- Advocating for all community clinics to test all patients for HIV
- Insure that 100% of people who test positive for HIV are linked to a medical provider and remain in medical care
- Increase Partner Services for newly diagnosed people so that people who may have been exposed are brought in for testing

Finding those who have fallen out of care and re-engage them in care

In the United States, 52.8% of those who know they are HIV+ are not retained in care. The reasons are varied but most cases involve mental health or substance abuse issues. Because of the work of HIV providers in the Sacramento area, the *out of care* percentage identified through our 2016 unmet need process was 16.2%, a ten percent reduction from the previous year. While this is laudable, it is still unacceptable and more work needs to be done to bring this number closer to zero. Activities to find those out of care include:

- Work as a consortium to identify all those who have fallen out of care and research where we can find them
- Develop a strong patient navigation program to aggressively engage people in care by providing needed supportive services and community resources
- Provide adherence counseling as needed

Surveillance figures for the FY 2017 out of care figures have not yet been received from the State, but are anticipated by August 1 of 2018.

Keep everyone in medical care

Finding people who have fallen out of care is difficult, so ***keeping*** people in care is a priority. One Community Health will work with its staff and community partners to provide services that do everything possible to engage patients. Activities include:

- Monitoring appointments to insure that people on the verge of falling out of care remain in care

- Providing care that meets the needs of various cultures and life styles
- Strengthening medical case management & case conferencing services to include retention in care activities

Keep High Risk people from getting HIV

The number of interventions proven to prevent HIV infection is small but robust in their effectiveness. The *Zero Together Initiative* partners (**See Attachment D)** will insure that these activities continue until the epidemic is over. These include:

- Aggressively publicize appropriate utilization of PrEP and PEP
- Increase needle exchange activities as needed
- Aggressively publicize the availability of free condoms in areas where STD's and HIV are most prevalent
- Publicize the availability of free or low-cost STD/HIV testing sites.

I.b.4. Ensuring Programmatic and Fiscal Accountability:

During FY 2017, the Fiscal Agent completed all of its required on-site visits to sub-recipients utilizing a comprehensive monitoring tool and all sub-recipients were thoroughly reviewed and received corrective action notices.

The TGA's web-based client data system provides for electronic submission of invoices as well as client-level data. As a result, monitoring tools have been developed to provide on-going tracking of client utilization and expenditures, both at a sub-recipient level as well as a system-wide level. The Recipient is able to identify over and/or under expenditure of funds in a timely manner which facilitates the reallocation of funds and minimizes the potential for carryover. This year, the TGA expended all but $92,395 of its Part A funds. Of this carryover amount, only $2,451 were direct service dollars. The Fiscal Agent had unused expenses due to staff turnover and IT billings that did not hit the system in time to be claimed in the year services were rendered.

II. PLANNING COUNCIL ACTIVITIES

II.a. PLANNING COUNCIL ACCOMPLISHMENTS

11.a.1. Allocations and Reallocations:

The Priorities and Allocations Committee (PAC) approved its FY17 Funding recommendations in April of 2017, which was approved by the Sacramento HIV Health Services Planning Council (HHSPC) the same month. Additionally, PAC and HHSPC approved a General Directive which provides direction to the Fiscal Agent how to allocate funds should the award come in at various percentages higher or lower than projected.

In October of 2017, PAC and HHSPC approved the reallocation of funds. Providers requested an additional $95,500 in allocations for services including Mental Health, Oral Health, Health Insurance and Cost-Sharing Assistance, Medical Case Management, Outpatient

Substance Abuse and Medical Nutritional Therapy. However, there was only $56,625 in funds available for reallocation.

At mid-year, Oral Health was 18% over the projected budget with invoices still outstanding; Medical Case Management was 5% over the projected budget with a waiting list of nine clients; Health Insurance Premium and Cost-Sharing Assistance was overspending by 27%; and, Mental Health had one provider overspending by 5 % with a waiting list of nine clients. The $56,625 was distributed between these four services.

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

II.a.2. Medical Transportation Service Expansion:

Lack of affordable and insufficient public transportation is an ongoing barrier reported by consumers and providers in the Sacramento TGA. In a local KCRA news article (**http://www.kcra.com/article/which-city-has-the-most-expensive-transit-fares-in-the-us/6249544**), from January 25, 2016, Sacramento's transit fares were tied for the third highest in the country. In FY16, in an effort to alleviate transportation barriers, the Sacramento HIV Health Services Planning Council approved the use of carryover money to fund a Transportation Coordinator to coordinate transportation for clients to vital appointments. However, the carryover funds were insufficient to support a full-year budget for a Transportation Coordinator.

In FY16 and FY17, the TGA was successful in obtaining Part B Supplemental Funding from the California State Office of AIDS, which was used to continue funding a Transportation Coordinator for the balance of those years. The increased funding for transportation services resulted in a 28.8% increase in unduplicated clients (563 clients in FY17) over the prior year (437 clients in FY16).

II.a.3. California Planning Group:

The California Planning Group (CPG) is the statewide HIV planning body that enables key stakeholders, communities, and providers to engage in active and ongoing dialogue with the Office of AIDS (OA) to reach the goals of the National HIV/AIDS Strategy and the statewide Integrated Plan. The main functions of this group are to work collaboratively with OA to develop a comprehensive HIV/AIDS surveillance, prevention, care, and treatment plan; to monitor the implementation of this plan; and to provide timely advice on emergent issues identified by OA and/or other key stakeholder parties.

The Sacramento TGA has two members, the Planning Council Chair [Susan Farrington] and a Council Member [Andrew Henkin], appointed to the CPG. In addition to being the Chair of the Planning Council, Susan Farrington is the Executive Director of Sierra Foothills AIDS Foundation, the Ryan White sub-recipient in both El Dorado and Placer Counties, the TGA's two

rural counties. Andrew Henkin, in addition to his membership on the Council, is employed at a Ryan White sub-recipient, Harm Reduction Services, working with active substance users, sex workers, and/or homeless individuals. Both these members provide valuable feedback to the State Office of AIDS on the needs of the people living with HIV and high risk populations in the Sacramento TGA. In turn, they are able to provide regular updates to the Sacramento HIV Health Services Planning Council on the achievements made by the CPG.

II.a.4. <u>Consumer Educational Programs:</u>

The Affected Communities Committee has tasked Council Staff with coordinating educational programs for people affected or infected by HIV. Council Staff coordinates these presentations with pharmaceutical companies who provide the speaker and topic to keep the community informed of updates and increase awareness of HIV, HIV treatment and HIV education. In FY17, these programs included:

- The Evolution of HIV Treatment
- Making the Most of Your Healthcare Visits
- Protecting Yourself and Others
- HIV, Mental Health, and Substance Abuse
- Sticking to Your HIV Treatment Plan
- HIV Medication Update
- HIV in the Black Community

These educational programs may be attended by case managers and individuals affected and infected by HIV. In many instances, case managers are transporting clients to the programs and obtaining updated client information. Not only do these programs allow attendees to increase their understanding of issues/concerns surrounding HIV, but they provide a valuable opportunity to ask questions, identify barriers to care and discuss medication needs.

An additional benefit of these programs is that the HIV Health Services Planning Council has received two applications for membership. One individual has already been appointed to the Council while another is pending an interview.

II.a.5. <u>Member Education and Training:</u>

Through Fiscal Year 2017, the Sacramento HIV Health Services Planning Council received training on various topics related to the Ryan White system of care. The trainings were a mixture of both guest presenters and staff/member-lead presentations. Member trainings and presentations included training on the *Mechanics of the Planning Council* and presentations on services provided by Ryan White sub-recipients and non-Ryan White funded community based organizations. These trainings provide programmatic updates, as well as, an overview and update of services available from both Ryan White funded subrecipients and other community based organizations.

In FY17, these trainings included:

- Mechanics of the Planning Council:

  Council Staff, Paula Gammell, conducted the annual *Mechanics of the Planning Council* training. The training highlighted the interrelated duties and tasks to be completed by the Recipient and members of the Council.

- One Community Health

  Chelle Gossett presented on the new services being funded by the Part B Supplemental Funding received by One Community Health through the Ryan White Program. Services include transitional housing, residential substance abuse treatment, transportation, and food vouchers.

- Sacramento Steps Forward

  Ryan Loofburrow, the Chief Executive Officer of Sacramento Steps Forward, provided an overview of the agency. Sacramento Steps Forward (SSF) is working to end homelessness in the Sacramento region. By using a collaborative, data-driven, outcomes-based approach, they help ensure that individuals and families experiencing homelessness have access to housing, employment, health, education, and other resources necessary for economic stability and an improved quality of life.

- Union Gospel Mission

  Jed Dahlen and Mike Blain of Union Gospel Mission provided an overview of services at their agency. Union Gospel Mission (UGM) provides various services for the homeless in Sacramento including but not limited to, shelter, clothing, drug rehabilitation, showers, and food.

- Quality Management Indicators

  Adrienne Rogers addressed the Medical Performance Indicators presented to the Council which will be included in future Fiscal Agent Quarterly Reports. The report includes information on the number and percent of newly diagnosed clients Linked to Care, and active RW clients In Medical Care, Retained in Care, Virally Suppressed, On Drug Therapy, and Stably/Permanently Housed.

- Sisters in Survival

  Dalene Ingraham-Caywood provided an overview of the Sisters in Survival. Their mission is to amplify the voice of women living with HIV/AIDS. Through diverse self-expression, art, and life stories, they allow themselves to be seen and heard. Sisters in Survival is hosting a writer's workshop and will be producing their second book, *Lives Goes On.*

- Open Arms

  Anna Cresap is the Program Manager at Open Arms, a HOPWA (Housing Opportunities for People with AIDS)-funded shelter operated by Volunteers of America. Open Arms is a confidential and safe site providing up to a 90-day stay for individuals with HIV. Open Arms works with clients to stabilize their health and connect them to permanent housing.

- Safer Alternatives thru Networking and Education

  Rachel Anderson, Executive Director, of Safer Alternatives thru Networking and Education (SANE) presented. The mission at SANE is to provide services and education for people who inject drugs which helps them enhance their health and wellness and improve their quality of life, as well as to employ the principles of humanism, harm reduction and respect for human rights and dignity.

II.b. PLANNING COUNCIL CHALLENGES

II.b.1. Needs Assessment:

In FY17, the HIV Health Services Planning Council conducted its Needs Assessment utilizing an updated survey instrument which included questions on HIV Prevention and PrEP. Unfortunately, the new formatting, which was streamlined and intended to reduce the complexity of the survey itself, has created new challenges with data extraction. The data extraction has been so problematic that it has delayed the findings/final report. Additionally, the survey instrument needs to be updated and reformatted to prevent data extraction problems going forward. The Sacramento TGA anticipates completing the community Needs Assessment during Fiscal Year 2018.

II.b.2. Substance Abuse Epidemic:

The Sacramento TGA has experienced an increase in its substance abuse issues in recent years. In an article published by the Sacramento Bee on August 17, 2015, (http://www.sacbee.com/site-services/databases/article31324532.html), opioid overdoses in Sacramento, El Dorado and Placer Counties were higher than the statewide average. On March 29, 2016, the Sacramento Bee (http://www.sacbee.com/opinion/editorials/article68896827.html) published an article in which the Sacramento County's Public Health Officer, Dr. Olivia Kasirye, called a public health emergency when 28 people had overdosed on Fentanyl since the prior Thursday [March 24, 2016). Resolution of this public health emergency required the collaboration of the County Public Health Division along with the FBI and local law enforcement to determine the source of the Fentanyl distribution.

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

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

Harm Reduction Services (HRS), a Ryan White funded provider, has utilized other funding sources to offer Overdose Recognition and Response Training since 2014. Information obtained from their website (http://harmreductionservices.org/overdose-prevention-response-training/) indicates that their training has resulted in 538 opiate overdose reversals.

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

II.b.3. Homelessness:

Housing is a particular struggle for individuals with low or no income, past evictions, mental health issues, criminal records, and current or past drug use. In fact, in a report by Drew Bollea on May 4, 2017, (http://sacramento.cbslocal.com/2017/05/04/high-rent-housing-crisis-rent-control/) Sacramento had the fastest growing average rent in the country in 2016 with an average rent increase of nearly 36% in the last decade and people are spending more than 30% of their income on rent. Additionally there is a low inventory in Sacramento.

The Sacramento Bee reported, on August 21, 2017, that California's high housing costs are driving poor and middle income people out of their homes. Additionally, homelessness is on the rise in California. The article (http://www.sacbee.com/news/politics-government/capitol-alert/article168107042.html) states that California is home to 12 percent of the United States' population but 22 percent of its homeless population.

The California State University in Sacramento (CSUS) in coordination with Sacramento Steps Forward conducted a *Point in Time* (PIT) homeless study (http://www.saccounty.net/Homelessness/Documents/2017_SacPIT_Final.pdf) which included the following findings:

- Since 2015, we estimate a real growth in nightly homeless of approximately 30% (from 2,822 to 3,665).
- The majority of homeless (56%) in the county are sleeping outdoors (unsheltered), a dramatic change in proportion from previous PIT counts
- Indeed, there has been more pronounced growth among homeless who are unsheltered and sleeping outdoors (from 1,111 to 2,052; or 85% increase).

Both the City Council and the County Board of Supervisors in Sacramento, as well as, Placer County have initiated projects aimed at assisting homeless and low-income individuals.

However, with approximately 74% of the TGA's Ryan White clients served in FY2017 living at or below 100% of poverty, coupled with housing shortages and rent increases, the TGA anticipates these efforts to be insufficient to meet the needs in the region.

II.b.4. Capacity Issues:

The TGA continues to experience a waiting list for Mental Health services. The demand for services exceeds the capacity of the providers. Finding qualified Mental Health providers who understand the intricacies of HIV and mental health. Having a serious health issue, such as HIV, can lend itself to a source of major stress and the mere diagnosis can negatively impact your well-being, cause depression and/or complicate any existing mental health conditions. With the lack of qualified mental health practitioners, people living with HIV who are experiencing increased mental health issues may be left untreated. Untreated mental health conditions can lead to increased medical problems, not to mention negative interactions with others which may impact employment, housing, and negative interactions with law enforcement.

II.c. Planning Council Legislative Challenges:

II.c.1. Reflectiveness:

An "aligned" consumer is currently defined as a consumer that is staff, a paid consultant or Board member of a Part A-funded agency. The Sacramento TGA's Planning Council currently has three *aligned* consumers. While one of the aligned consumers is a Board member of a Part A-funded agency, the other two are employed in non-management roles, a medical case manager and a janitor, which do not have the authority to make policy changes within their respective agency. None of the three have been specifically selected as the agency representative to the Council. The Chair of the Sacramento TGA, Susan Farrington, has previously addressed this concern with HRSA and it is this Council's belief that this should be revisited in future legislation.

II.c.2. Needs Assessment:

The Sacramento TGA's Needs Assessment is presently pending due to data extraction issues. In an effort to streamline the survey instrument, the instrument was updated however created technical issues impacting the analysis of the responses In addition to conducting its own community Needs Assessment this year, the TGA is participating in on-going Needs Assessment efforts as partners with the State Office of AIDS. Needs Assessment "briefs" are being researched and developed based on selected topics. The most current brief on homelessness in California will be released in the near future. The Sacramento TGA will also complete its local regional Needs Assessment report in the 3rd quarter of 2018.

III. Early identification of Individuals with HIV/AIDS (EIIHA) Update

III.a. Describe the activities of the TGA's EIIHA Plan Implemented during FY17:

The Sacramento TGA's EIIHA FY17 Goals are identified in the first column of the table below, with the planned outcomes, as well as the CY2016 accomplishments identified in the final column. Final outcomes of FY17 activities are not compiled until the end of June of each

year. The Plan can only include goals for the government funded agencies, as the private partners (One Community Health and the Sierra Foothills AIDS Foundation) do not have a specific number of test goals. Rather, they test any individual who comes to the clinic or test site, regardless of residence, income, insurance or immigration status. Thus, the actual number of tests performed in 2016 (2,270) was 78.6% the stated goal of 2,890 tests. The percentages of the target populations were developed based on the total number of tests administered by government funded providers (2,270), but exclude the additional testing in rural counties funded solely by private funds and tests by private agencies.

Strategies to Improve EIIHA	**Responsible Parties / Timeframe**	**Success Indicators and Monitoring Status 12/31/16**
1. Conduct testing at 89 venues accessible and familiar to high risk populations to maximize number of high risk individuals who become aware of their status.	Parties/Timeframes: Government-Funded Testing Providers 1/1/17-12/31/18	Indicator: Testing provided at 136 locations, 128% of goal of 106. Status: Standard met and exceeded.
2. Certify and train new testers on Ora-Quick Rapid HIV testing to expand the region's ability to administer a minimum of 1,100 tests and inform individuals of their HIV status.	Parties/Timeframes: Government-Funded Testing Providers 1/1/17-12/31/18	Indicator: 2,270/2,890 tests were conducted by government agencies or 78.6% of goal of 2,890. Total of 14,771 tests were provided by government and private agencies combined. Status: Standard not met by government agencies alone
3. Provide community level and social network Ora-Quick rapid testing to the following risk populations to make them aware of their HIV status: ▪ IDUs and other Substance Abusing Individuals: 10.1% of total tests will be administered to IDUs. ▪ Men having Sex with men (MSMs): of 28.7% of total tests will be administered to MSM	Parties/Timeframes: Government-funded Testing Providers and Cares Community Health. 1/1/17-12/31/18	Indicator: 752/5,614 or 13.40% of clients tested were IDUs and other Substance-Abusing individuals. Status: 132.7% of goal achieved Indicator: 1,500/5,614 tests or 26.8% of total tests were MSM Status: 98.1% of goal achieved, 1.9% under goal

▪ Men Who Have Sex with Men and are Injection Drug Users (MSM/IDU) 2% of total tests will be administered to MSM/IDU.		Indicator: 88/5,614 or 1.57% of total tests was MSM/IDU. Status: 78.5% of goal achieved, 21.5% under goal
▪ High-Risk Heterosexuals: 35% of total tests will be administered to High-Risk Heterosexuals: HIV+ Sex Partner; Sex Worker; IDU Partner; MSM Partner; Sex Worker Partner; Syphilis/Gonorrhea Diagnosis; Stimulant User; Heterosexual Multiple Partners.		Indicator: 1,512/5,614 or 27% of total tests were High-Risk Heterosexuals Status: 63.22% of goal achieved, 7.2% under goal
▪ Transgender: 1% of those tested will be transgender		Indicator: 78/5,614 tests or 1.4% of total tests were Transgender individuals. Status: 104% of goal achieved.
▪ Low and Moderate Risk Community: 4.7% of total tests will be administered to Low Risk, or Risk Not Reported individuals.		Indicator: 256/5,614 tests or 4.6% of total tests were Other/Unreported risk. Status: 97.4% of goal achieved, 2.6% under goal
Target Population Goals by Race: ▪ 53.6% of total clients tested will be White		Indicator: 2,246/5,614 or 40% of total clients tested were White Status: 74.7% of goal of 3,008 achieved.
▪ 23.3% of total clients tested will be African American		Indicator: 1,089/5,614 or 19.4% of total clients tested were African-American. Status: 83.3% of goal of 1,308 achieved.

▪ 17.1% of total clients tested will be Hispanic		Indicator: 453/5,614 or 8.1% of total clients tested were Hispanic Status: 47.2% of goal of 960 achieved
▪ 3.7% of total clients tested will be Asian/Pacific Islander		Indicator: 100/5,614 or 1.8% of total clients tested was Asian/Pacific Islander. Status: 208% of goal of 208 achieved.
▪ 0.7% of total clients tested will be American Indian		Indicator: 87/5,614 or 1.6% of total clients tested was American Indian. Status: 223.1% of goal of 39 achieved.
▪ 1.5% of total clients tested will be Other/Undeclared		Indicator: 1,300/5,614 or 23.2% of total clients tested were Other/Undeclared. Status: 1,544% of goal of 84 achieved.

Data for the outcomes on EIIHA activities for CY17 are just now being compiled and are not available for this report.

III.b. EIIHA Plan's Contribution to the National Goals to End the HIV Epidemic

b.i. Contribution to the Goals of the NHAS:

The goals of the TGA's EIIHA strategy correlate closely with the NHAS. Goals 1 through 6 of the TGA's EIIHA strategy are designed to achieve the following NHAS Goals:

NHAS Strategy: "Reducing New Infections by 2020, increasing from 79% to 90% the percentage of people living with HIV who know their sero-status."

NHAS Action Steps*:*

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

NHAS Strategy: Achieving a More coordinated National Response to the HIV Epidemic.

NHAS Action Steps:

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

While the TGA's EIIHA efforts clearly aim to increase the number of persons who know their sero-status, the coordinated work of the Sacramento TGA to refer negative clients to risk reduction counseling, and the immediate transition of HIV+ clients into care, will accomplish the following NHAS goal:

"By 2020, NHAS Strategy: "Increasing Access to Care and Improving Health Outcomes for People Living with HIV: increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85%."

NHAS Action Steps:

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

b.ii. Contribution to the Goals of the White House Continuum of Care Initiative:

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

"Increase knowledge of HIV-positive status to 90%. Nationally, across age groups, young persons, 13-24 years, are most likely to be undiagnosed with fewer than half aware of their infection." The TGA's efforts target youth, in particular young gay men, to get tested. In CY16, 36.6% of tests administered through the TGA's EIIHA providers were for clients ages 24 years and younger, exceeding their 3.6% representation in the TGA's HIV epidemic as of 12/31/16. Further, 29.1% of positive tests were for those under age 25, a 7.3% increase in

positive tests for this age group over CY15. The TGA offers a wide range of testing sites accessible to target populations through venues associated with their culture, geography, lifestyles, and sexual orientations. Once tested, individuals are made aware of their HIV status. In addition to young adults, the TGA targets the United States' most at risk populations for transmission of HIV: MSM and Intravenous Drug Users. The TGA's efforts of providing testing at needle exchange sites, and offering incentives to clients who get tested, are proving successful at increasing the number of IDUs in the TGA aware of their HIV status. Another finding in the TGA's analysis of HIV epidemiology, Unmet Need, Continuum of Care and HIV testing data show that the High-Risk (HR) Heterosexual category has surpassed, in absolute numbers and percentages, the IDU category across all demographic aspects. CY16 efforts to target this population proved successful with 22.1% of total tests administered to HR Heterosexual individuals compared to 19.8% of their representation in the epidemic.

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

III.c. Incorporating and Addressing Activities Surrounding Unmet Need by EIIHA:

The Council comprehensively considers the service needs, gaps, barriers to care and costs of the unmet needs population (those aware but not in care) and the unaware population, in determining the TGA's priorities and allocations. The Council also uses the demographics of the "unmet need" population to presume similar demographics of the unaware population and its corresponding needs. Tracking the annual goals of the EIIHA Strategy and Plan, the Planning Council has updated the demographics of the targeted high risk populations for testing, and has updated the outcomes of newly diagnosed populations.

The Unmet Need Population closely follows the TGA's HIV/AIDS epidemiology data for CY16. Comparing Epidemiology, Unmet Need, and EIIHA data for 2016, the FY18 EIIHA Plan indicates that the MSM population continues to rank the highest at-risk population in the TGA; the High-Risk Heterosexual population continues to rank second and the IDU population ranks third. These findings mirror the surprising shift in 2015 where High-Risk Heterosexuals overtook IDUs as the second highest at-risk population in the TGA. The Unmet Need data stratifies these transmission populations even further, identifying the most at risk by gender and race. This breakdown is not fully available for HIV testing data in the TGA, as only government funded testing providers and One Community Health maintain client transmission information. Therefore, the Unmet Need data is used to presume similar demographics of the unaware population.

III.d. Efforts Untaken to Remove Legal Barriers to routine HIV Testing:

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

The Sacramento TGA follows the lead of the State Office of AIDS in terms of identifying legislation that would promote routine testing, and the Fiscal Agent's Ryan White Program Coordinator, who is also the AIDS Director for Sacramento County Public Health, participates on monthly calls of the California Conference of Local AIDS Directors (CCLAD). CCLAD analyzes all HIV related legislation introduced in the California Legislature each year and provides letters of support or opposition when necessary to bills that could improve or harm HIV+ individuals or the provision of high quality medical care to this population. Legislation following activities related to prevention is also monitored by CCLAD.

III.e. Impact of EIIHA Plan Outcomes for January 1, 2016 through December 31, 2016*:

Newly Diagnosed HIV Test Events-Government and Cares Private Funding 1/1/16 – 12/31/16						
	MSM	***High Risk Hetero-Sexual***	***MSM/IDU***	***IDU***	***Other Risk Groups***	***Total***
(a) Test events: Government Testers and Private Testers Cares Community Health and Sierra Foothills AIDS Foundation.	***1,453***	***2,171***	***87***	***963***	***19,424***	***24,098***
(b) Newly diagnosed positive test events. *(see note below)*	***87***	***24***	***1***	***2***	***20***	***133***
(c) Newly diagnosed positive test events with client linked to HIV medical care	***86***	***24***	***1***	***2***	***20***	***132***
(d) Newly diagnosed confirmed	***87***	***24***	***1***	***2***	***20***	***133***

positive test results						
(e) Newly diagnosed confirmed positive test events; client interviewed for Partner Services	***86***	***24***	***1***	***2***	***20***	***132***
(f) Newly diagnosed confirmed positive test events; client referred to prevention services	***87***	***24***	***1***	***2***	***20***	***133***
(g) Newly diagnosed confirmed positive test events received CD4 count and viral load test	***86***	***24***	***1***	***2***	***20***	***132***

As reflected in the above statistics, the Sacramento TGA is doing an outstanding job in identifying newly infected HIV+ clients and all but one of those clients have been transitioned to care. We believe this is a direct result of the tremendous effort put forth by the community partners in the newly formed STD Stakeholder group.

III.f. FY1 EIIHA Target Populations

a. The Target Groups in the TGA's 2017 EIIHA Plan included the following populations most likely to be unaware of their HIV status, are most in need of being referred to supportive services, and are most in need of being linked to medical care in the TGA:

Target Groups in 2017 EIIHA Plan			
Men who have Sex with Men (MSM)	*High-Risk (HR) Heterosexuals*	*Intravenous Drug Users (IDU)*	*Men who have Sex with Men and Inject Drugs (MSM/IDU)*
• White MSM • African American MSM • Hispanic MSM • Youth MSM	• Female African American • Female and Male • Caucasian • Hispanic Male	• Male White IDUs • Male African American IDUs • White Female IDUs • Male Hispanic IDUs	• White MSM/IDU • African American MSM/IDU

The TGA's EIIHA Strategy has customized its approach to uniquely target its prevention and testing efforts in each affected community. These advisory boards, made up of members of affected communities, provide the basis for strategies, goals and plans to reach their targeted communities. Provider organizations incorporate their advice into the best practices identified by the State and local HIV Prevention Plans. The Youth Initiative, funded by Kaiser Permanente, trained a group of young people to distribute prevention and testing information, as well as condoms; and to recruit other youth to get tested. This testing recruitment has resulted in

a dramatic increase in the number of people under the age of 30 who tested positive for HIV in the TGA.

a.i. Achieving successful outcomes: The integration of the STD and HIV Surveillance Units within the Sacramento County Department of Public Health has enhanced the TGA's efforts to identify HIV+ individuals and to provide risk reduction counseling. In addition, the Sacramento County Health Division recently formed an STD/HIV Stakeholder Group, Sacramento Workgroup to Improve Sexual Health (SacWISH) to intensify HIV and STD prevention, testing and treatment efforts in the TGA.

In the rural counties, the Sierra Foothills AIDS Foundation (SFAF) has encouraged community clinics in both El Dorado and Placer County to resume HIV testing at their sites. In CY16 no clients were positively diagnosed in the rural counties. SFAF also conducts HIV testing at their Placer County offices using test kits provided by One Community Health in Sacramento. These test sites inform rural county residents of the availability of treatment and services at One Community Health as well as other providers in the TGA.

The TGA's EIIHA strategy has expanded its ability to obtain testing data from the few privately funded sites that provide HIV testing. Since these providers are already members of the STD/HIV Stakeholder group, they have cooperated in the development of the EIIHA Plan. With years of community collaboration and coordination, the TGA has a solid framework for implementation of its EIIHA Plan by targeting demographic characteristics, specific needs and barriers to HIV testing and care for the TGA's most at risk populations. In addition to these efforts, One Community Health created the CARES Foundation in 2011 to provide grants to organizations in the TGA that directly serve the needs of PLWH or aid in the prevention of HIV transmission. The CARES Foundation has expanded to providing over 1.4 million dollars in grant funds during 2017 to nonprofit agencies for services such as needle exchange, HIV/AIDS education, healthcare navigation, condom distribution, health outreach, and other essential services for PLWH that strengthen outcomes across the HIV Care Continuum.

a.ii. Resources and Partnerships: One Community Health, Golden Rule Services, Safer Alternatives through Networking and Education (SANE), HRS, Gender Health Services (GHS), Sacramento LGBTQ Center, Wind Youth Services (Wind), Community Against Sexual Harm (CASH), Sacramento Native American Health Center, Sacramento County Department of Health Services (DHS) Education, Prevention and Testing Unit (EPT), El Dorado County Department of Public Health, Placer County Department of Public Health, Planned Parenthood, WellSpace Health, Sierra Foothills AIDS Foundation (SFAF), Strategies for Change and Molina Health Centers are entities responsible for ensuring activities to identify individuals are implemented. One Community Health used funding from a prior CDC grant in 2014, but that funding ended and was replaced by CARES Foundation funding for CY 2015, 2016 and 2017. Additional funding has been provided by a Sacramento County EPT grant, RW Part C funds (test kits only), and private funds for its testing efforts (CARES Foundation). Golden Rule Services, HRS and the Sacramento County DHS EPT Unit use federal CDC funds through a SOA grant; One Community Health and Molina Health Centers are federally qualified health centers and utilize

some federal funds for testing, and Planned Parenthood uses State and private funds for testing and reproductive health services.

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

The Sacramento TGA has used all of the available resources, both internal and external, in its efforts to produce favorable outcomes in its effort to achieve the Early Identification of Individuals with HIV/AIDS. We believe that despite the lack of additional funding, we will see an expansion of our efforts to reach the private testing community as a result of the newly formed STD Stakeholder group initiated by the Sacramento County Public Health Division.

a.iii. Barriers and/or Challenges to Achieving Successful Outcomes: The Sacramento TGA's EIIHA Plan has numerous approaches to address barriers for its target populations, three of which address barriers to accessing testing and treatment as follows:

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

2. All government-funded testing agencies, One Community Health, and County testing sites throughout the TGA provide Ora-Quick rapid HIV testing to targeted populations to provide immediate results of HIV status, and to remove barriers that may prevent people from returning for results. These providers make testing sites accessible to targeted populations through venues associated with their culture, geography and lifestyles.

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

III.g. Presentations/Dissemination of the EIIHA Plan

This year**,** results of the EIIHA Plan and Outcomes were disseminated to publicly-funded testing agencies and private testers through presentations at the SacWISH group quarterly meetings. All active EIIHA Plan participants received these results, and evaluated them to finalize the 2018 EIIHA Plan. Members of the One Community Health's "*Zero New HIV Infections Together*" Prevention Coalition also provided input into the proposed goals and objectives of the 2018 EIIHA Plan. The RW Council also received results of the EIIHA Plan and outcomes and used the information in its priority setting and allocation process to ensure that the final FY18 RW Service Category Plan corresponds with the needs of the target populations identified in the EIIHA Plan, the Unmet Needs data, and the Surveillance data for the TGA. The Sacramento County Public Health Department's STD/HIV programs participated in the development of the Plan's goals and objectives, and disseminated this information to its community partners. One Community Health, with its former "*Strategic Initiative to End New Cases of HIV in 5 Years", its subsequent "Equally Well" campaign and its current "Getting to Zero"* campaign (See Attachment D), has spearheaded a communitywide effort to not only participate in the development of the TGA's EIIHA Plan, but to create a portal of ongoing access to key players involved in EIIHA. These annual updates allow community partners to remain involved in new directions that are continually evaluated to reach the TGA's targeted populations.

IV: MINORITY AIDS INITIATIVE

IV.a. MAI Achievements of Goals and Objectives:

Goal for MAI Medical Case Management

The goal of Medical Case Management is to enhance access to ambulatory outpatient medical care and provide on-going assistance to keep these high-risk clients in medical care (one medical visit per year including either a CD4 Count, Viral Load Test or on HAART). A secondary goal is to provide assistance to clients in the area of medication adherence where appropriate for clients on HAART.

This goal is achieved when Medical Case Managers act as a client advocate who fast-track clients into specialty care and more intensive support services provided at the TGA's primary HIV clinic, One Community Health (formerly known as Center for AIDS Research, Education and Services (CARES and/or Cares Community Health)). One Community Health provides a full range of HIV Specialty/primary care services including medical, dental, mental health, outpatient substance abuse, clinical trials, medications, and other supportive services. Follow-up occurs on a regular basis through the Medical Case Management system and continuous quality assurance tracking system. All means are employed to ensure that the client's access to medical care is not jeopardized by their social or emotional health. One Community

Health through Ryan White Parts A, Part B, Part C and Part D funding sources, cooperatively provides a full range of services and tracks health outcomes of newly identified target clients.

Medical Case Managers (MCM) follows each client closely for a minimum of six months. Following closely is defined as until such time the client successfully demonstrates consistent independence. In addition to current Medical Case Management standards, the MAI Case Managers are required to:

- Contact each client two days prior to any appointment (Medical or Social Service case management, psychiatric therapy or mental health, medical, dental, substance abuse, etc.)
- Arrange for child care services as needed to ensure clients can freely attend required appointments
- Arrange for medical transportation services as needed to ensure clients can freely attend required appointments
- Provide a monthly visit until such time the client successfully demonstrates consistent independence to transition to walk-in clinic services
- Follow through with service agencies and clients to ensure appointments are kept and service needs are being met
- Assist clients with access to medical care and maintaining medical adherence when appropriate

Objectives:

To provide Intake/Assessment and Transitional Medical Case Management services to clients who have previously been identified as being HIV+ but are not in care or at risk of dropping out of care within the Communities of Color, particularly African American and Hispanic HIV+ men and women, entering the Client Services System.

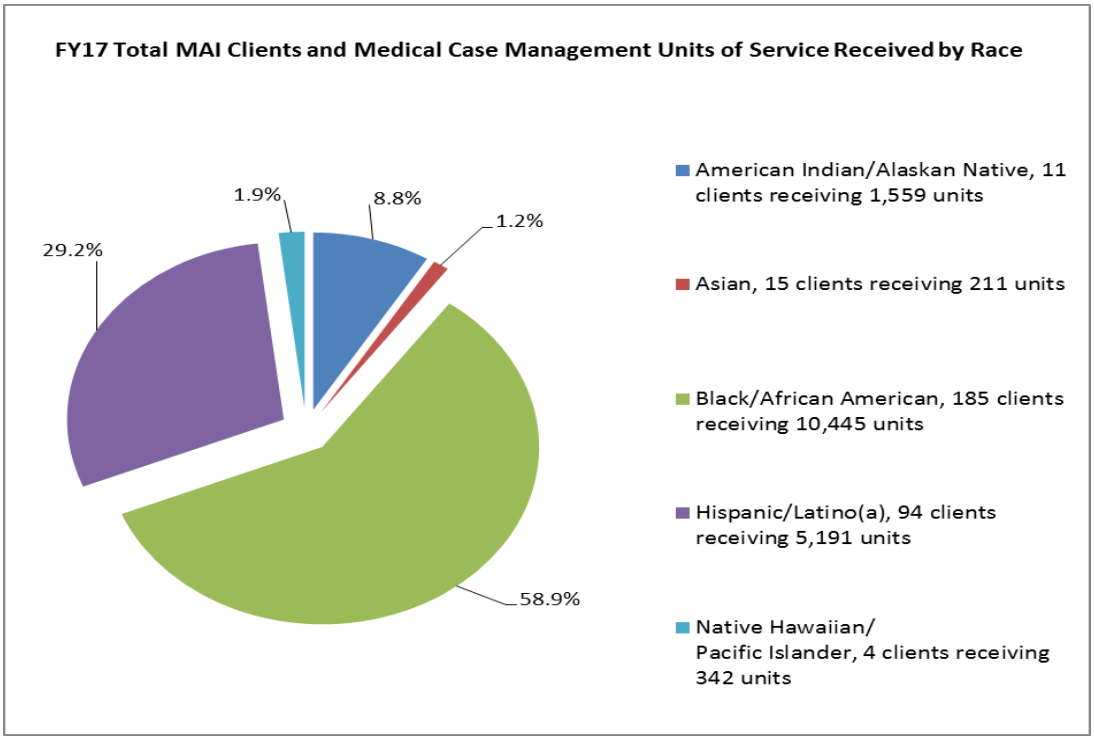
Outcomes for MAI Medical Case Management

During fiscal year 2017-2018, Harm Reduction Services and One Community Health provided MAI Medical Case Management Services. The sub-recipients served 309 clients, 43.1% above the planned goal of 216 unduplicated clients at year-end for Medical Case Management. A breakdown of the targeted/planned clients versus actual clients receiving services is indicated in the following chart.

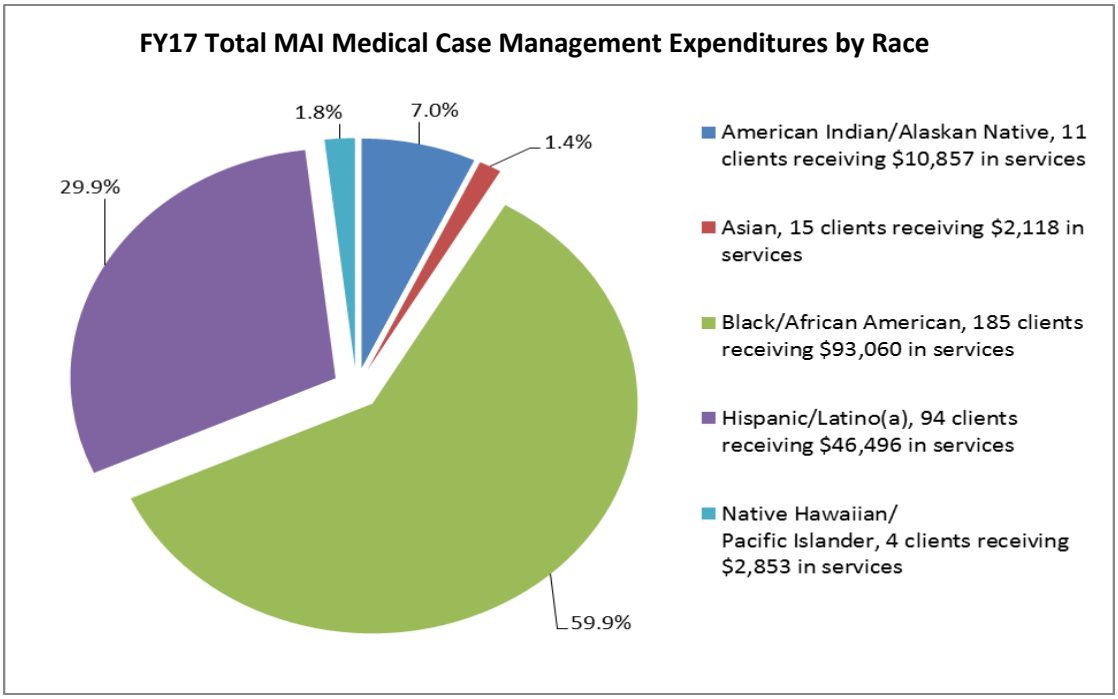
FY17 Projected Medical Case Management Services by Race and Gender				
Race	Male	% Male	Female	% Female
African American	88	40.7%	53	24.5%
Hispanic	43	19.9%	7	3.2%
Asian	12	5.6%	2	0.9%
American Indian/Alaskan Native	6	2.8%	2	0.9%
Native American/Pacific Islander	3	1.4%	-	
More Than One Race	-	-	-	-

FY17 Actual Medical Case Management Services by Race and Gender						
Race	Male	% Male	Female	% Female	Transgender	% Transgender
African American	114	36.9%	62	20.1%	9	2.9%
Hispanic	77	24.9%	14	4.5%	3	1.0%
Asian	11	3.6%	3	1.0%	1	0.3%
American Indian/ Alaskan Native	10	3.2%	1	0.3%	0	0%
Native American/ Pacific Islander	4	1.3%	0	0%	0	0%

The initial MAI Medical Case Management Plan was to provide a total of 19,931.9 units of services. The TGA actually provided 17,748 units of MAI direct funds which is 11% less than projected. The 185 Black/African American clients received the greatest quantity of services, receiving 58.9% or 10,445 units of services during the reporting period. The 94 Hispanic MAI clients served during the reporting period received 29.2% of the services with 5,191 units of service.



The chart below highlights the expenditures by race. African Americans are the largest target population in the Sacramento TGA receiving $93,060 (59.9%) in MAI services during FY17.



IV.b.1. MAI Outcomes toward HIV Care Continuum:

The chart below shows a snapshot of each race category and its performance throughout the spectrum of the HIV Care Continuum. There were 309 MAI clients served during FY17. In viewing the information below, Native Hawaiian/Pacific Islander have exceptional outcomes along the Care Continuum, however it should be noted that there are only four clients for that race. Further analysis of each stage of the Care Continuum will be individually.

FY17 MAI Clients HIV Care Continuum Outcomes	American Indian/ Alaskan Native	Asian	Black or African American	Hispanic or Latino(a)	Native Hawaiian/Pacific Islander
Clients Per Race	11	15	185	94	4
Linked to Care	-	-	-	-	-
In Medical Care	72.73%	86.67%	88.65%	84.04%	100%
Retained in Care	54.55%	66.67%	70.81%	67.02%	100%
Virally Suppressed	54.55%	73.33%	73.51%	78.72%	100%
On HAART	90.91%	93.33%	98.92%	96.81%	100%

IV.b.2. MAI Clients Linked to Care

There were no newly diagnosed MAI clients receiving MAI Medical Case Management services in FY2017.

IV.b.3. MAI Clients In Medical Care

In FY17, 86.7% (268 out of 309) of the overall MAI clients in FY17 were in medical care during the reporting period. All four of the Native Hawaiian/Pacific Islander MAI clients were "in medical care". The second highest ranking population by race was Black or African Americans at 88.65%. This is the primary MAI target population in the Sacramento TGA. While only 72.73% of American Indian/Alaskan Natives were "in medical care" during the reporting period, it should be noted that there are only 11 total clients in this category. Unfortunately, in comparison to the percentages by race in FY16, outcomes were lower in FY17 than the prior reporting period as seen in the chart below, with the exception of Native Hawaiian/Pacific Islander which remained constant at 100% (all four clients).

Race/Ethnicity	FY17 Total Number of MAI Clients by Race	FY17 Number of Clients within Race Category In Medical Care	FY17 Percent of Clients within Race Category In Medical Care	FY16 Number/ Percent within Race Category in Medical Care
American Indian/Alaskan Native	11	8	72.73%	15/16, 93.8%
Asian	15	13	86.67%	17/17, 100%
Black or African American	185	164	88.65%	299/310, 96.5%
Hispanic or Latino(a)	94	79	84.04%	172/173, 99.4%
Native Hawaiian/Pacific Islander	4	4	100.00%	7/7, 100%
Totals:	309	268	86.7%	510/523, 97.5%

IV.b.4. MAI Clients Retained in Medical Care

Due to data extraction, the Sacramento TGA based "retained in care" on a client having at least two viral load tests at least three months apart. As can be seen on the chart below, all the Native Hawaiian/Pacific Islanders were *retained in care*, however it should be noted that there are only four clients within that race category. Black/African American is our largest target population which maintained 70.8% of clients *retained in care* during the measurement year. All races noted an increase in the outcomes/number of clients retained in care over the prior reporting period.

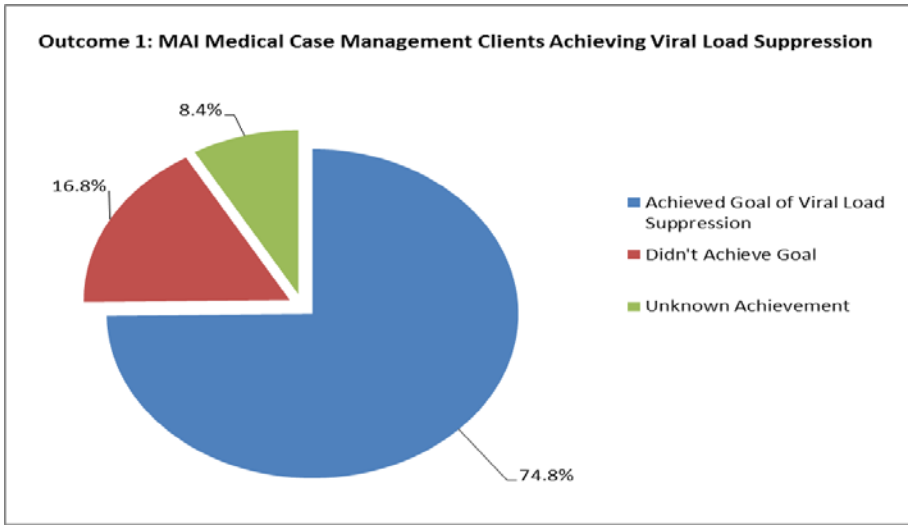
Race/Ethnicity	FY17 Total Number of MAI Clients by Race	FY17 Number of Clients within Race Category Retained in Care	FY17 Percent of Clients within Race Category Retained in Care	FY16 Number/Percent of Clients within Race Category Retained in Care
American Indian/Alaskan Native	11	6	54.55%	7/16, 43.75%
Asian	15	10	66.67%	9/17, 52.94%
Black or African American	185	131	70.81%	147/310, 47.42%
Hispanic or Latino(a)	94	63	67.02%	95/173, 54.91%
Native Hawaiian/Pacific Islander	4	4	100.00%	5/7, 71.43%
Totals:	309	214	69.26%	263/523, 50.29%

IV.b.5. MAI Clients Virally Suppressed

Viral Load Suppression was one of the TGA's Planned Outcomes submitted at the beginning of the fiscal year.

Planned Outcome #1 and Indicator(s): HAB Core Measure: HIV Viral Load Suppression: Number/Percent of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral Load test during the measurement year. 85% of clients will be virally suppressed.

Actual Outcome 1: Of the 309 total MAI Medical Case Management clients, 231 clients (74.8%) were virally suppressed at the date of their last viral load test. 16.8% of the clients did not achieve viral load suppression. Unfortunately, 8.4% clients viral load results were not reported or unavailable.



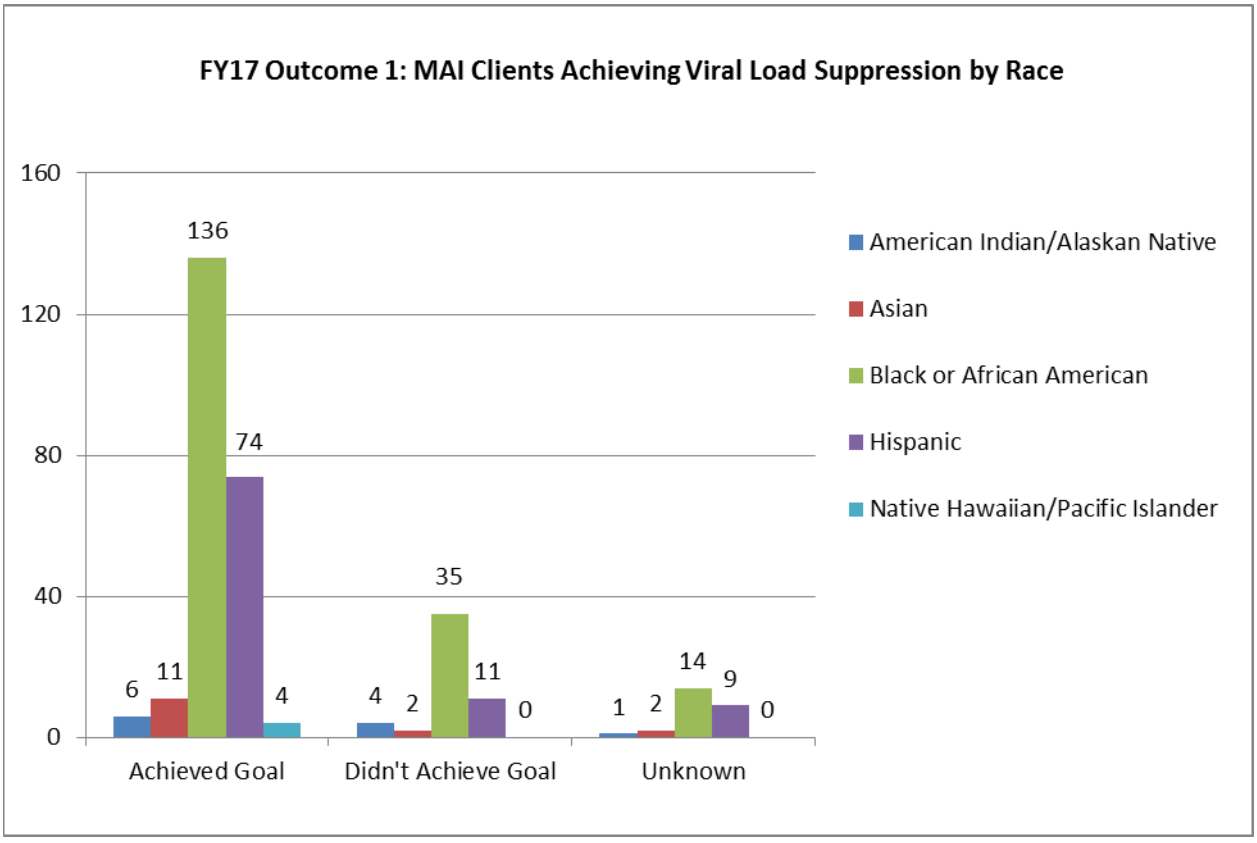
In comparing the percent of the 231 clients achieving Viral Load Suppression by Race, 100% Native Hawaiian or Pacific Islanders achieved Viral Load Suppression however there were only four clients. Of the overall 231 total clients that were Virally Suppressed, 58.87% of Black or African American's (136 clients), the TGA's largest MAI population. However, of the 185 total Black or African American clients, 73.51% were Virally Suppressed.

Hispanic or Latino(a) accounted for 32.03%, 74 clients of the total 231 who were Virally Suppressed at the date of their last viral load test. However, of the 94 Hispanic/Latino(a) clients served, 74 (78.72%) were virally suppressed.

In comparison to the prior reporting period (FY16), there was an increase in all outcomes except for the American Indian/Alaskan Natives. However, there was a 31% decrease in the number of American Indian/Alaskan Native clients served in FY17 compared to the prior year.

Race/Ethnicity	FY17 Total Number of Clients by Race	FY17 Number of Clients within Race Category Achieving Viral Load Suppression	FY17 Percent of Clients within Race Category Achieving Viral Load Suppression	FY16 Number/Percent of Clients within Race Category Achieving Viral Load Suppression
American Indian/ Alaskan Native	11	6	54.55%	12/16, 75%
Asian	15	11	73.33%	12/17, 70.59%
Black or African American	185	136	73.51%	209/310, 67.42%
Hispanic or Latino(a)	94	74	78.72%	121/173, 69.94%
Native Hawaiian/ Pacific Islander	4	4	100.00%	7/7, 100%
Totals	309	231	74.76%	361/523, 69.02%

Below are the outcomes for each race regarding progress toward Viral Load Suppression.

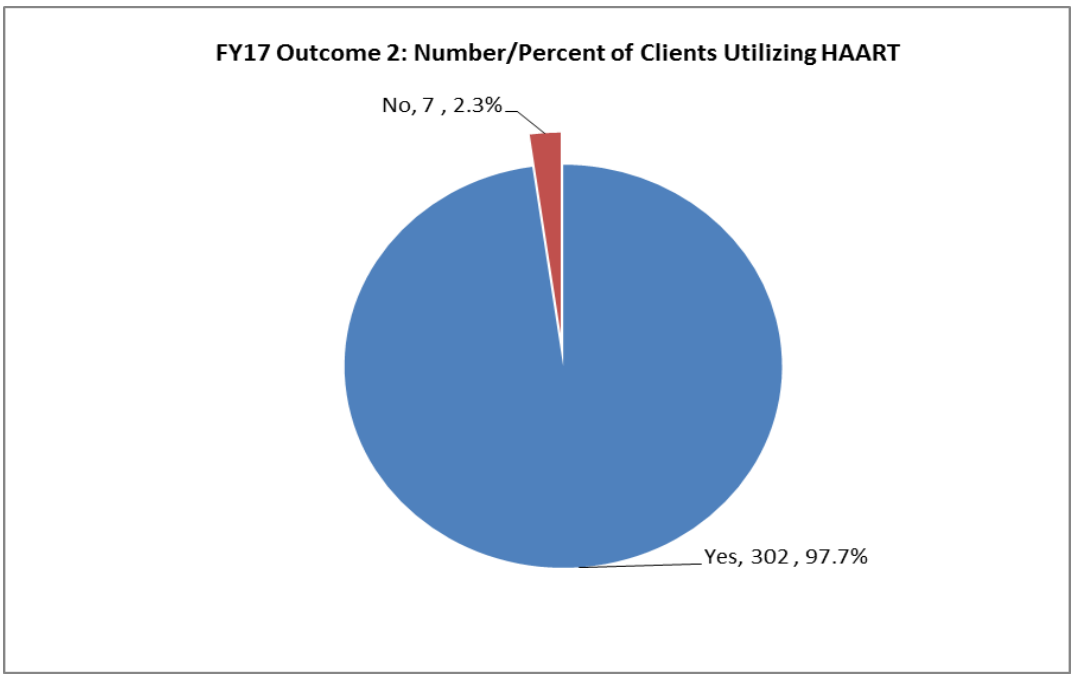


IV.b.6. MAI Clients On Drug Therapy

Utilizing Drug Therapy was one of the TGA's Planned Outcomes submitted at the beginning of the fiscal year.

Planned Outcome #2 and Indicator(s): HAB Core Measure: Prescription of HIV Antiretroviral Therapy: Number/Percent of HIV+ patients, regardless of age, prescribed HIV antiretroviral therapy. 90% of clients receiving MAI Medical Case Management Services will be utilizing HAART.

Actual Outcome 2: Of the 309 clients receiving MAI Medical Case Management services, 302 clients (97.7%) were on HAART during the reporting period.

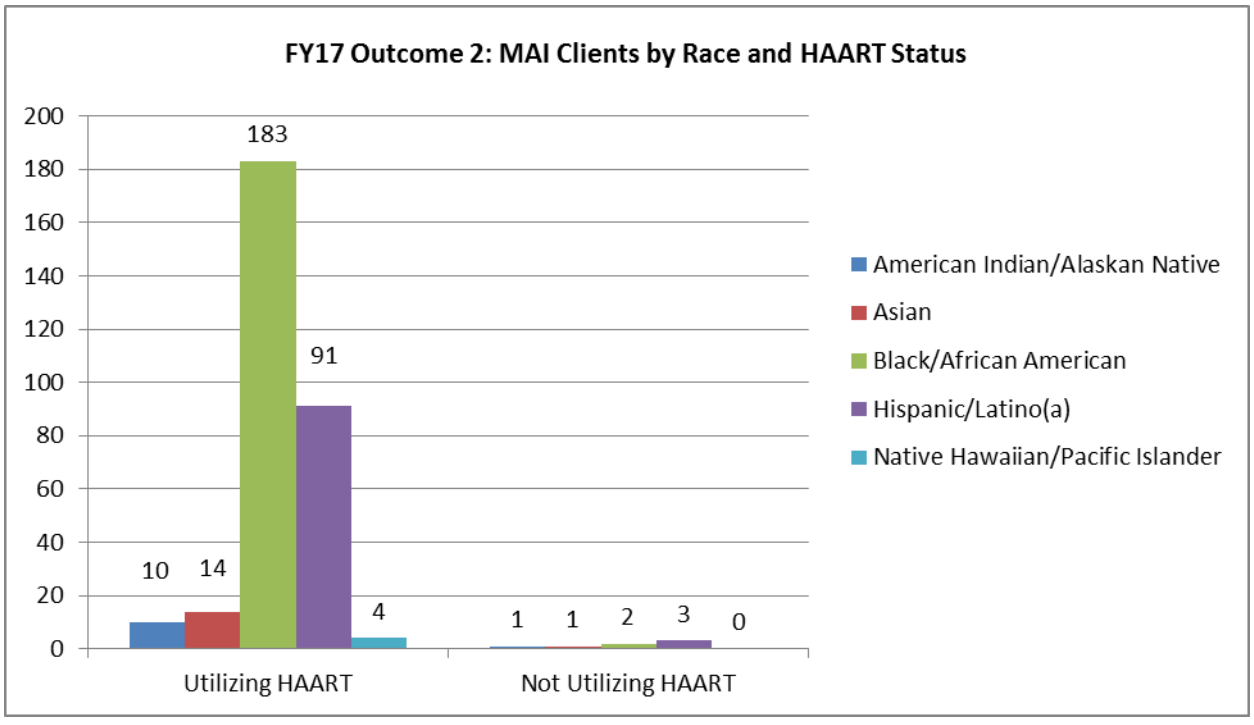


Of the 302 clients utilizing HAART, 60.6% (183 clients) were Black or African American, which is the TGA's largest population served by the Minority AIDS Initiative. Hispanic/Latino(a) comprised 30.1% (91 clients) utilizing HAART during the reporting period. However of the 185 total Black or African American clients served, 183 (98.9%) were on HAART. Likewise, of the 94 Hispanic/Latino(a) clients served, 91 (96.8%) were on HAART.

In comparison to the prior reporting period (FY16), the TGA experienced a decrease in the percentages of American Indian/Alaskan Native, Asian, and Hispanic/Latino clients on HAART.

	FY17 Total Number of Clients by Race	FY17 Number of Clients within Race Category on HAART	FY17 Percent of Clients within Race Category on HAART	FY16 Number/Percent of Clients within Race Category on HAART
American Indian/ Alaskan Native	11	10	90.91%	16/16, 100%
Asian	15	14	93.33%	17/17, 100%
Black or African American	185	183	98.92%	302/310, 97.4%
Hispanic or Latino(a)	94	91	96.81%	170/173, 98.3%
Native Hawaiian/ Pacific Islander	4	4	100.0%	7/7, 100%
Totals	309	302	97.73%	512/523, 97.90%

The chart below highlights the number of clients by race in comparison to their status on HAART for FY17.



IV.c. MAI Challenges and Barriers:

The Minority AIDS Initiative in the Sacramento Transitional Grant area served 309 clients though only projecting 216 clients during the fiscal year for MAI Medical Case

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

In Sacramento, the MAI sub-recipients have been able to build the trust within the community to reach the targeted population and forge the working relationship necessary with clients and other agencies to ensure on-going medical services are received. The sub-recipients utilize a combination of in-home medical case management services, street-side medical case management and pre/post incarceration medical case management services to reach those in need. Many an hour is spent in a client's place of residence or on the side of a river, encouraging clients to seek and maintain care. Based on the numbers presented in this report, the time and effort has proven worthwhile.

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

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

V. CERTIFICATION OF AGGREGATE ADMINISTRATIVE COSTS

See Attachment F.

VI. TECHNICAL ASSISTANCE

VI.a. <u>Technical Assistance Received:</u>

In January 2018, the Sacramento TGA's HIV Health Services Planning Council requested Technical Assistance regarding the definition of aligned consumers. HRSA provided the requested Technical Assistance in February 2018. Current legislation has set the definition of "aligned" consumer. The Sacramento TGA requests a reinterpretation of the definition at the time of the next legislation update.

VI.b. Technical Assistance Needed: None

VII. FY 2017 WOMEN, INFANTS, CHILDREN AND YOUTH (WICY) REPORT:

Women, Infants, Children and Youth (WICY): By February of 2018, the TGA had exceeded its required expenditures for Women, Infants, Children and Youth. Total expenditures for WICY must meet a minimum of 18.93% of the total Part A grant award less the fiscal administrative costs. At year-end, WICY total expenditures represented 36% (Part A) of the grant award direct service expenditures.

	% Women	% Infants	% Children	% Youth
CDC Epidemiological	15.80%	0.03%	0.26%	2.84%
FY17 Sacramento TGA Data	**25.54%**	**0.09%**	**1.51%**	**8.93%**

See Attachment B.

VIII. LOCAL PHARMACY ASSISTANCE PROGRAM (LPAP) SUMMARY

Not applicable.