FY19 Annual Progress Report Attachments

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Attachment A

FY 19 Sacramento TGA

Service Category Table and Comments

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Part A Service Category Plan Table

Service Categories	FY 2019 Estimated					FY 2019 Actual					
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Expended Amount	Variance %	Unduplicated Clients	Variance %	Service Units	Variance %
Outpatient/ Ambulatory Health Services	1	$ 385,370	840	1 unit = 1 visit or vendor dollar	36,761	$ 535,995	39%	1,162	38%	59,488	62%
ADAP/Prescription Medications	2	-	-	-	-	-	-	-	-	-	-
Health Insurance Premium & Cost Sharing Assistance	3	$ 6,120	22	1 unit = 1 Vendor Paid Insurance, Medical Visit or Deductible Co-pay dollar	5,563	$ 15,242	149%	27	23%	13,851	149%
Oral Health Care	4	$ 397,374	373	1 unit = 1 visit or vendor dollar	386,185	$ 377,251	-5%	429	15%	114,121	-70%
Medical Case Management (Incl. Treatment Adherence)	5	$ 938,651	732	1 unit = 1 face to face or other encounter	64,293	$ 1,133,729	21%	1,110	52%	64,247	0%
Non-Medical Case Management Services	6	$ 58,040	880	1 unit = 1 Benefits Counseling face to face or other encounter	5,902	$ 49,039	-16%	684	-22%	2,296	-61%
Mental Health Services	7	$ 414,151	771	1 unit = 1 face to face or other encounter	17,663	$ 402,381	-3%	801	4%	4,104	-77%
Medical Transportation	8	$ 148,443	301	1 unit = 1 One-Way trip or Vendor transportation dollar	83,076	$ 80,178	-46%	459	52%	79,890	-4%
Substance Abuse Outpatient Care	9	$ 200,981	438	1 unit = 1 face to face or other encounter	6,684	$ 199,595	-1%	349	-20%	4,924	-26%
Substance Abuse-residential	10	$ 63,237	21	1 unit = 1 Detox Hour	9,742	$ 58,073	-8%	31	48%	9,003	-8%
Housing	11	$ 12,216	36	1 unit = 1 Vendor paid lodging dollar	11,105	$ 13,076	7%	27	-25%	11,886	7%
Child Care Services	12	$ 38,590	35	1 unit = 1 Vendor Child Care Dollar	35,082	$ 50,600	31%	19	-46%	46,000	31%
Emergency Financial Assistance	13	$ 60,375	99	1 unit = 1 Vendor Paid Other Critical Need	54,886	$ 67,136	11%	159	61%	61,030	11%
Food bank/Home Delivered Meals	14	-	-	-	-	-	-	-	-	-	-
Medical Nutrition Therapy	15	$ 10,541	75	1 unit = 1 Vendor Paid Nutrition Voucher Dollar	2,391	$ 10,220	-3%	201	168%	9,290	289%
Health Education/ Risk Reduction	16	$ 4,768	27	1 unit = 1 face to face or other encounter	42	$ 4,768	-	44	63%	79	90%
Outreach Services	17	$ 20,769	20	1 unit = 1 face to face or other encounter	900	$ 11,086	-47%	148	640%	239	-73%

MAI Service Category Plan Table

Service Categories	FY 2019 Estimated					FY 2019 Actual					
	Priority #	Allocated Amount	Unduplicated Clients	Service Unit Definition	Service Units	Expended Amount	Variance %	Unduplicated Clients	Variance %	Service Units	Variance %
Medical Case Management (Incl. Treatment Adherence) **African American/Black**	5	$ 110,884.00	145	1 15-minute face to face Medical Case Management or 1 15-min other Medical other staff encounter	13,572	$ 111,935.01	1%	356	146%	17,938	32%
Medical Case Management (Incl. Treatment Adherence) **Hispanic/Latino**	5	$ 36,991.00	52	1 15-minute face to face Medical Case Management or 1 15-min other Medical other staff encounter	4,354	$ 42,798.27	16%	262	404%	6,375	46%
Medical Case Management (Incl. Treatment Adherence) **Asian**	5	$ 7,491.00	14	1 15-minute face to face Medical Case Management or 1 15-min other Medical other staff encounter	808	$ 3,272.96	-56%	39	179%	287	-64%
Medical Case Management (Incl. Treatment Adherence) **American Indian/Alaska Native**	5	$ 7,259.00	8	1 15-minute face to face Medical Case Management or 1 15-min other Medical other staff encounter	965	$ 5,775.29	-20%	17	113%	886	-8%
Medical Case Management (Incl. Treatment Adherence) **Native Hawaiian/Pacific Islander**	5	$ 5,729.00	3	1 15-minute face to face Medical Case Management or 1 15-min other Medical other staff encounter	869	$ 4,572.83	-20%	10	233%	708	-19%

Service Category	Comments
AIDS Drug Assistance Program (ADAP) Treatment	Not funded with Part A funds
AIDS Pharmaceutical Assistance (LPAP)	Not funded with Part A funds
Health Insurance Premium & Cost Sharing Assistance	The TGA expended more funds in this service category especially in our more rural counties, El Dorado and Placer to service clients with their health insurance assistance needs.
Medical Case Management (Incl. Treatment Adherence)	This service category is the gateway to Ryan White services. With a 2.6% increase in newly diagnosed clients this year, we had an increase in the need for MCM as well.
Medical Nutrition Therapy	Within 5% of Target- slightly underspent
Mental Health Services	Within 5% of Target- slightly underspent
Oral Health Care	Within 5% of Target- slightly underspent
Outpatient/ Ambulatory Health Services	This service category was 39% overspent, served 38% more unduplicated clients, and had 62% more units of service. All of the other categories are to support clients keeping their ambulatory care appointments. This year our TGA needed to move some additional funds to support this service category due to increased client need.
Substance Abuse Outpatient Care	N/A
Child Care Services	Increase in demand for child care services while patients go to necessary RW appointments. Costs for child care has increased substantially in our service area.
Emergency Financial Assistance	EFA services were 11% over budget while the number of unduplicated clients served was 61% over.
Food Bank/ Home Delivered Meals	Not funded with Part A funds
Health Education/ Risk Reduction	Within 5% of Target
Housing	Ryan White Funds are used for short-term or emergency housing defined as necessary to gain or maintain access to medical care.
Medical Transportation	Funds were reallocated from this service category at the request of the sub recipient due to staffing challenges during the HIV Planning Councils Reallocation process. Funds were moved to much needed categories such as Ambulatory Care, Oral Health, child care, and Medical Case Management. Even at the lower funded amount, there still was a 52% increase in the number of unduplicated clients served with this service and units of service were within 4%.
Non-Medical Case Management Services	This category is also funded by Part B funds. Sub recipient requested to move some of their part A budget to Ambulatory Care to cover that service category. The client need was still met in the TGA for benefits counseling and the increased need for Ambulatory Care services was also met.

Outreach Services	The sub recipient had personnel challenges in this category. They did exceed the number of unduplicated clients serviced with the personnel they had on staff.
Substance Abuse-residential	This category had an increase in the number of unduplicated clients serviced and slightly underspent the amount of funding it was allocated.

Attachment B

FY 19 Care Continuum

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HIV Care Continuum Table*

Stages of the HIV Care Continuum	Goal	Outcome			Service Category (One or More May Apply)
I. Diagnosed	90%	**Baseline**	**Target**	**Actual**	N/A
		N/A	N/A	N/A	
Comments as needed	Sacramento Ryan White funds do not support Testing and therefore cannot report "Diagnosed" within the Ryan White system.				
II. Linked to Care	85%	**Baseline**	**Target**	**Actual**	Medical Transportation, MAI Outreach (for newly diagnosed clients only), Health Education and Risk Reduction Services
		69.6% 103/148	90.6% 68/75	43.43% 43/99	
Comments as needed	N/A				
III. In Medical Care	90%	**Baseline**	**Target**	**Actual**	Health Ins Premium Assistance; Emergency Financial Assistance; Transportation; Child Care; Housing; Oral Health; Mental Health; Outreach; MAI Outreach
		78.2% 1309/1674	90% 2318/2576	77.61% 2014/2595	
Comments as needed	Outpatient Ambulatory Care: counted in Medical Care as one ambulatory care visit that included at least one CD4 count, viral load test or genotype test within a 12 month period.				
IV. Prescribed ART	90%	**Baseline**	**Target**	**Actual**	Outpatient Ambulatory Care
		79.8% 2118/2654	97% 1911/1970	76.18% 1977/2595	
Comments as needed	N/A				
V. Virally Suppressed	80%	**Baseline**	**Target**	**Actual**	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
		81.4% 2159/2654	90% 2318/2576	78.69% 2042/2595	
Comments as needed	N/A				

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Attachment C

FY 19 WICY Report

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FY 2013 Ryan White Part A
WICY Expenditure Report Worksheet

	A	B	C	D	E	F	G	H	I
1	**Section A: Identifying Information**		FY 2019 Part A Core Medical Service Expenditures	$2,415,606.00	Total FY 2019 Part A Formula Award	$2,151,850.00			
2	Chelle Gossett		FY 2019 Part A Support Service Expenditures	$333,957.00	Total FY 2019 Part A Supplemental Award	$1,094,768.00			
3	916-875-2776		FY 2019 Part A MAI Service Expenditures	$168,354.00	Total FY 2019 Part A MAI Award	$198,063.00			
4					Total FY 2018 Part A Carryover Amount (Including MAI)	$106,411.00			
5									
6			TOTAL Service Expenditures from ALL FUNDING SOURCES	$2,917,917.00	GRAND TOTAL from ALL Awards	$3,551,092.00			
7									
8									
9									
10	**Section B: Percent of HIV/AIDS Cases in the EMA/TGA**	Note: *In some cases the below cells will automatically convert the percentage based upon the numbers entered. Therefore, if the percent of estimated living HIV/AIDS cases for children in your EMA/TGA is 0.02%, you must input the number as .0002 so when the cell converts it, it becomes 0.02%.*							
11	CDC Data Percentage (insert based on applicable percentages on CDC data tab)	Women:	15.51%	Infants:	0.00%	Children:	0.14%	Youth	3.27%
12	Total Part A Funds Used to Provide Services in FY 2019:	#1. Amount	#2. Percent	#3. Amount	#4. Percent	#5. Amount	#6. Percent	#7. Amount	#8. Percent
13		$712,902.00	24.43%	$553.00	0.02%	19,713.00	0.68%	$257,760.00	8.83%
14	Are you requesting a WICY Waiver? (select "yes" or "no" in the dropdown menu in cell B14):								
15									
16	**Section C: WICY Waiver Expenditures FY 2019** *(If you have Part A Expenditures less than the Percent of HIV/AIDS Cases in the EMA/TGA for any WICY Population, complete the Expenditure information below. This information will serve as the justification for the Waiver)*	**Use CDC Data from Calendar Year 2018 for FY 2019 Reporting of WICY Expenditure Report**							
17	Total Part B Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
18	Total Part C Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
19	Total Part D Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
20	Total Medicaid Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
21	Total Medicare Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
22	Total CHIP Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
23	Other Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
24	Other Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
25	Other Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
26	Other Funds Used to Provide Services in FY 2019:	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%	$0.00	0.00%
27	Total	$712,902.00	24.43%	$553.00	0.02%	$19,713.00	0.68%	$257,760.00	8.83%

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Attachment D

FY19 Client Demographic Reports

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County of Sacramento
Department of Health Services
Public Health

New Clients by County and Service Category Report

DHS - CARE System

Client Demographic Reports

Selection Criteria: Dates From 3/1/2019 To 2/29/2020

Service Category	New Clients
Alpine	1
Emergency Financial Assistance	1
Medical Case Management	1
Medical Transportation Services	1
Oral Health Care	1
El Dorado	13
Emergency Financial Assistance	7
Food Bank/Home Delivered Meals	1
Health Education/Risk Reduction	4
Medical Case Management	9
Medical Transportation Services	7
Non-Medical Case Management	5
Oral Health Care	3
Outpatient /Ambulatory Health Services	8
Placer	21
Emergency Financial Assistance	6
Health Education/Risk Reduction	3
Health Insurance Premium & Cost Sharing Assistance	1
Medical Case Management	6
Medical Transportation Services	6
Mental Health Services	3
Non-Medical Case Management	4
Outpatient /Ambulatory Health Services	8
SACRAMENTO	218
Emergency Financial Assistance	7
Food Bank/Home Delivered Meals	13
Health Education/Risk Reduction	44
Housing Services	13
Medical Case Management	148
Medical Nutrition Therapy	61
Medical Transportation Services	43
Mental Health Services	63
Non-Medical Case Management	94

New Clients by County and Service Category Report

DHS - CARE System

Client Demographic Reports

	Oral Health Care	29
	Outpatient /Ambulatory Health Services	162
	Outreach Services	58
	Psychosocial Support Services	2
	Substance Abuse Services - Residential	3
	Substance Abuse Services-Outpatient	29
Yolo		20
	Emergency Financial Assistance	4
	Food Bank/Home Delivered Meals	5
	Health Education/Risk Reduction	2
	Medical Case Management	10
	Medical Nutrition Therapy	2
	Medical Transportation Services	7
	Mental Health Services	2
	Non-Medical Case Management	5
	Oral Health Care	1
	Outpatient /Ambulatory Health Services	5
	Outreach Services	3
Grand Total - All Counties and Service Categories		273

This report shows new clients grouped by County and Service Category for clients with service detail records within a specified

County of Sacramento
Department of Health Services
Public Health

Clients by CD4 Report

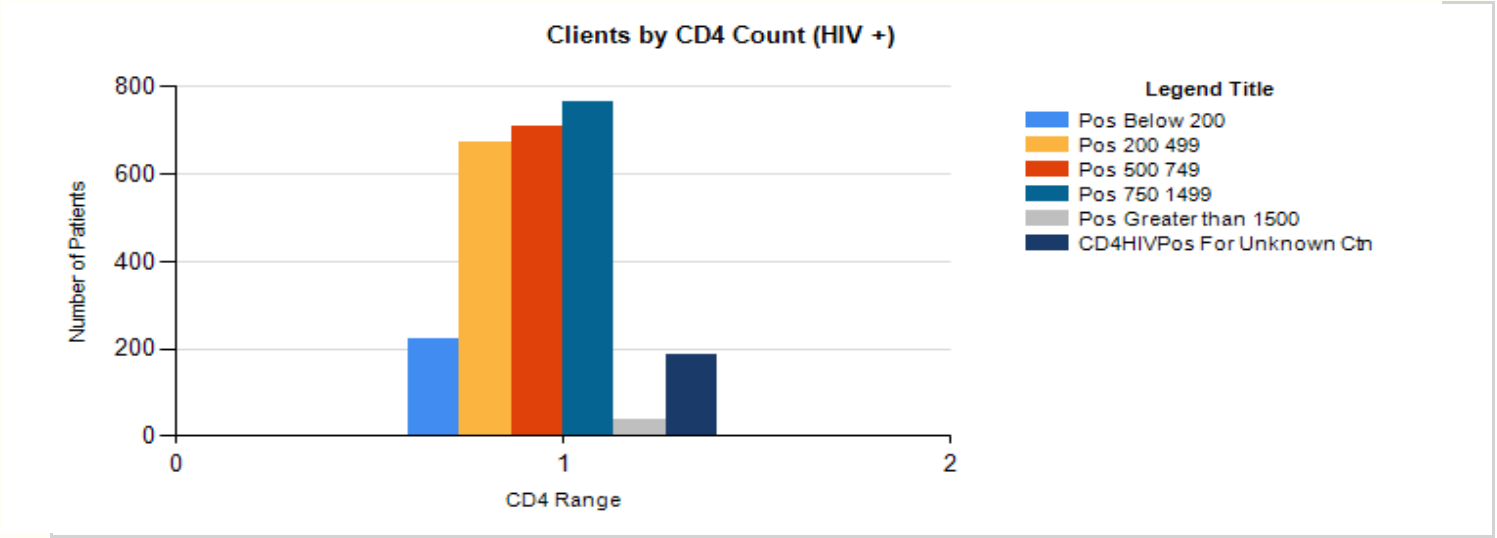
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Numeric Analysis	CD4 Range	Number of Clients HIV+	Number of Clients HIV-	Percentage HIV+
	Below 200	223	0	8.44%
	200 - 499	672	0	25.44%
	500 - 749	710	0	26.87%
	750 - 1499	766	0	28.99%
	Greather than 1500	38	0	1.44%
	Unknown/Unreported	186	47	7.04%
	Group Total	**2,595**	**47**	**98.22%**
	Total Clients	**2642**		**98.22%**

Visual Analysis:



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

County of Sacramento
Department of Health Services
Public Health

Clients by Viral Load Report

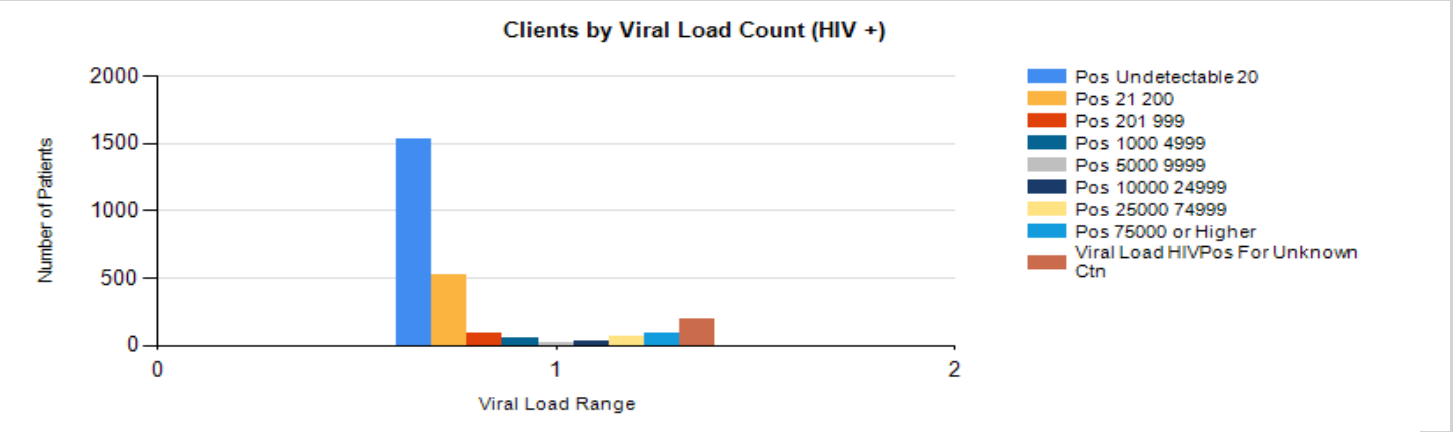
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Numeric Analysis	CD4 Range	Number of Clients HIV+	Number of Clients HIV-	Percentage HIV+
	Unknown/Unreported	199	47	7.67%
	<= 20 (Undetectable)	1,526	0	58.81%
	21 - 200 (Virally suppressed <=200)	518	0	19.96%
	201 - 999	86	0	3.31%
	1,000 - 4,999	57	0	2.20%
	5,000 - 9,999	16	0	0.62%
	10,000 - 24,999	34	0	1.31%
	25,000 - 74,999	71	0	2.74%
	75,000 or Higher	88	0	3.39%
	Group Total	**2,595**	**47**	**100.00%**
	Total Clients	**2642**		**98.22%**

Visual Analysis:



County of Sacramento
Department of Health Services
Public Health

Clients by County Report

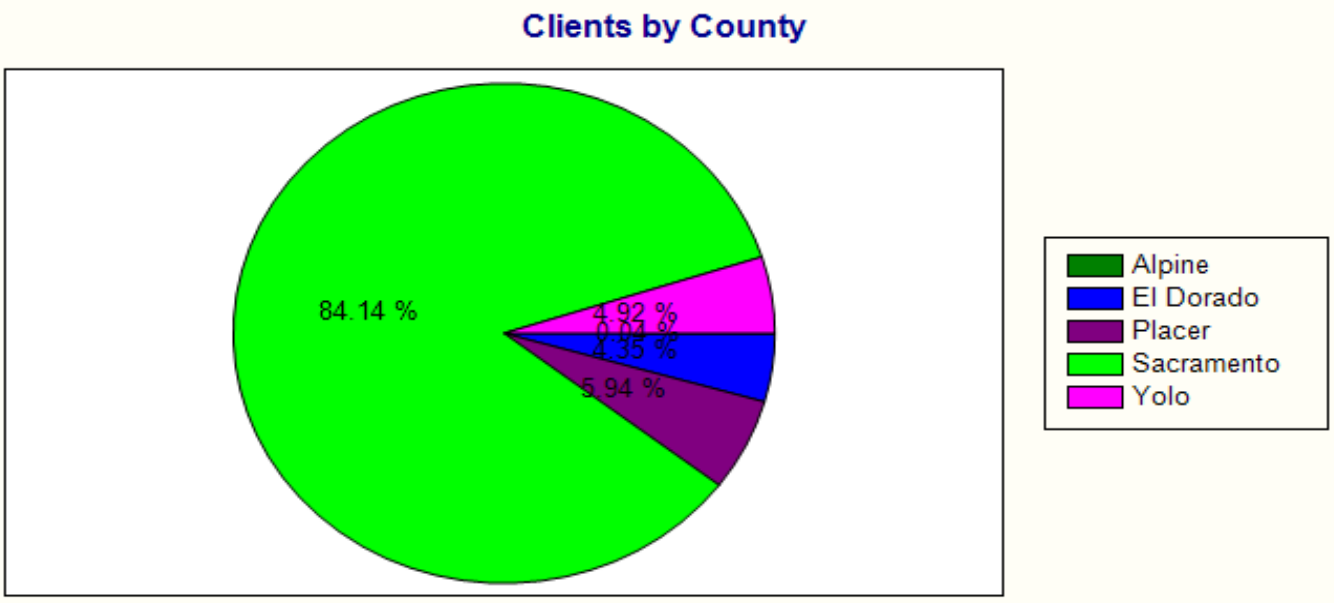
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Numeric Analysis	County	Number of Clients	Percentage
	Alpine	1	0.04%
	El Dorado	115	4.35%
	Placer	157	5.94%
	Sacramento	2,223	84.14%
	Yolo	130	4.92%
	Total Clients	2,626	99.39%

Visual Analysis:



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

County of Sacramento
Department of Health Services
Public Health

Clients by Age Report

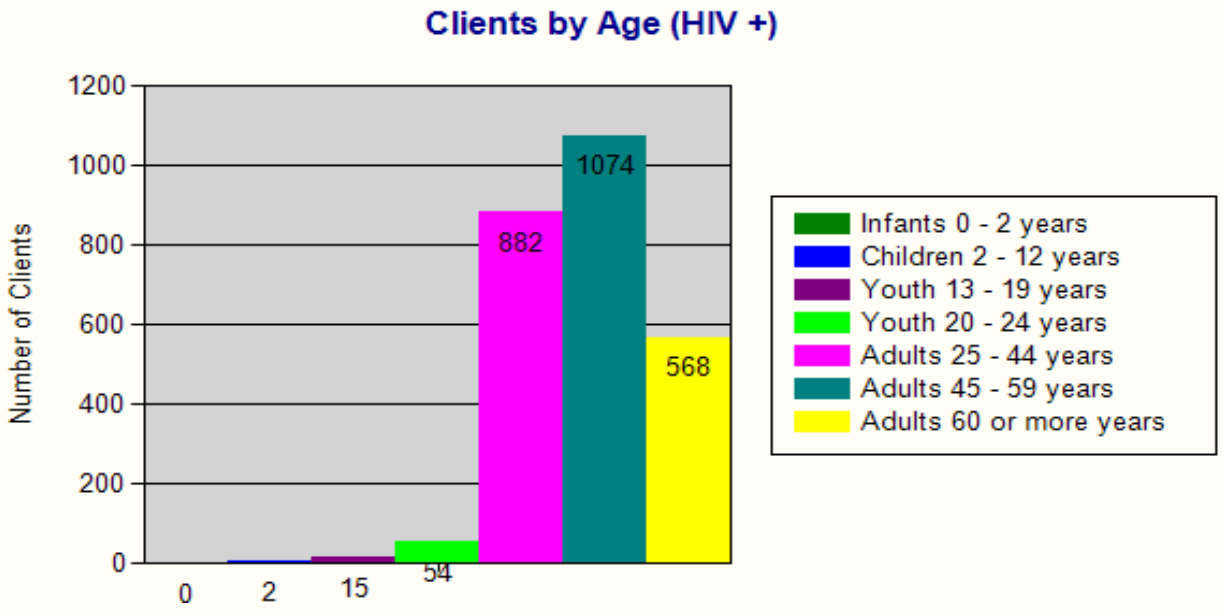
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Numeric Analysis	Age Category	Number of Clients HIV+	Number of Clients HIV-	Percentage HIV+	Percentage HIV-
	Infants 0 - 2 years	0	3	0%	0.11%
	Children 3 - 12 years	2	24	0.08%	0.91%
	Youth 13 - 19 years	15	19	0.57%	0.72%
	Youth 20 - 24 years	54	0	2.04%	0.00%
	Adults 25 - 44 years	882	1	33.38%	0.04%
	Adults 45 - 59 years	1,074	0	40.65%	0.00%
	Adults 60 or more years	568	0	21.50%	0.00%
	Group Total	2,595	47	98.22%	1.78%
	Total Clients	2642		100.00%	

Visual Analysis:



County of Sacramento
Department of Health Services
Public Health

Clients by Gender Report

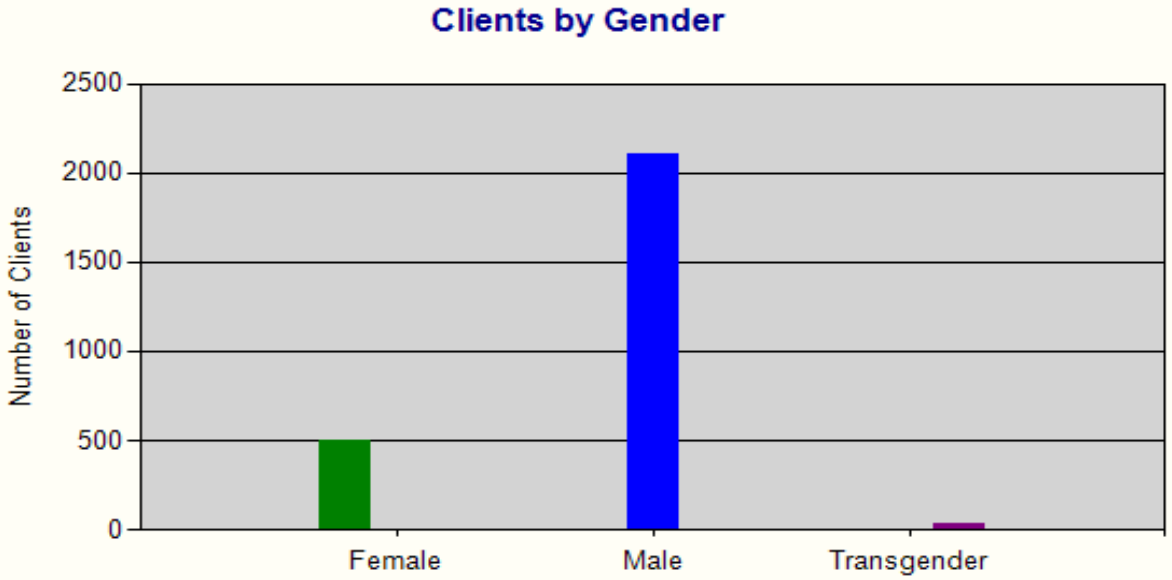
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Numeric Analysis	Age Category	Number of Clients	Percentage
	Female	499	18.89%
	Male	2,109	79.83%
	Transgender	34	1.29%
	Total Clients	2,642	100.01%

Visual Analysis:



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

County of Sacramento
Department of Health Services
Public Health

Clients by Transmission Method Report

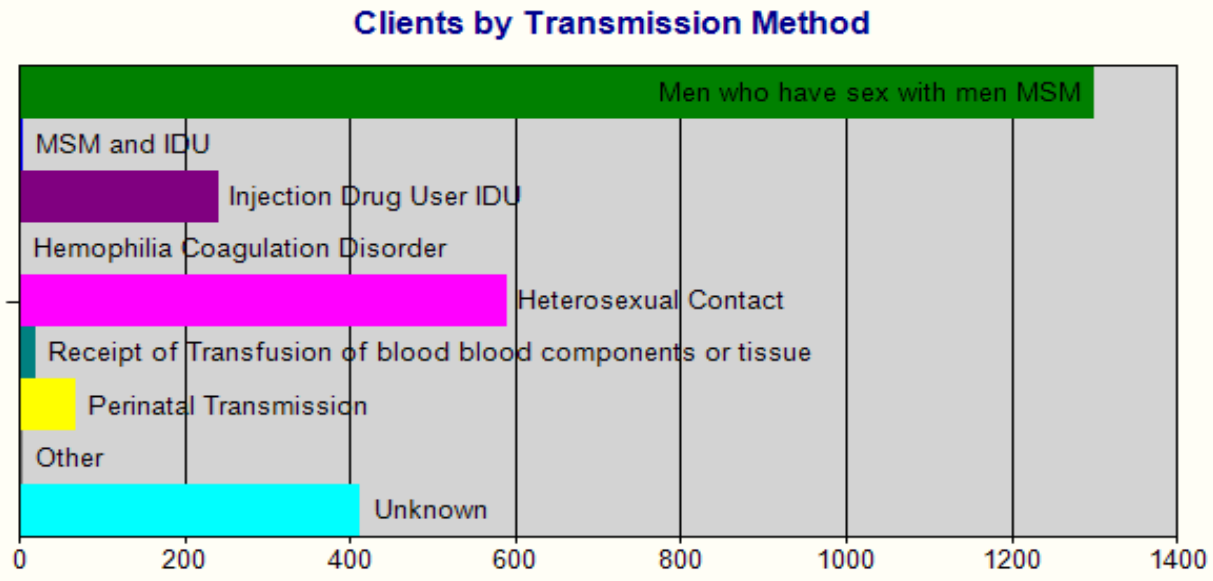
DHS - CARE System

Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Numeric Analysis	Transmission Method	Number of Clients	Percentage
	Men who have sex with men (MSM)	1,299	49.17%
	Injection Drug Use (IDU)	241	9.12%
	MSM and IDU	5	0.19%
	Hemophilia/Coagulation disorder	2	0.08%
	Heterosexual contact	589	22.29%
	Receipt of blood transfusion, blood components, or tissue	21	0.79%
	Perinatal transmission	69	2.61%
	Other	4	0.15%
	Undetermined/Unknown/Risk not reported or identified	412	15.59%
	Total Clients	2,642	100.00%

Visual Analysis:



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

County of Sacramento
Department of Health Services
Public Health

Income By Persons in Household Report

DHS - CARE System
Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020
Using US Poverty Guidelines from 2019

Persons in Household	No Income			100% of Poverty			101-138% of Poverty			139-250% of Poverty			251-300% of Poverty			Over 300%		
	Guide	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct	Guide =>	Count	Pct
1	0	1,202	45.50%	$12,490	488	18.47%	$17,236	176	6.66%	$31,225	205	7.76%	$37,470	143	5.41%	$37,471	72	2.73%
2	0	25	0.95%	$16,910	48	1.82%	$23,336	20	0.76%	$42,275	39	1.48%	$50,730	37	1.40%	$50,731	19	0.72%
3	0	6	0.23%	$21,330	20	0.76%	$29,435	10	0.38%	$53,325	7	0.26%	$63,990	12	0.45%	$63,991	1	0.04%
4	0	3	0.11%	$25,750	23	0.87%	$35,535	9	0.34%	$64,375	11	0.42%	$77,250	4	0.15%	$77,251	5	0.19%
5	0	1	0.04%	$30,170	23	0.87%	$41,635	3	0.11%	$75,425	6	0.23%	$90,510	1	0.04%	$90,511	0	0.00%
6	0	0	0.00%	$34,590	12	0.45%	$47,734	1	0.04%	$86,475	4	0.15%	$103,770	0	0.00%	$103,771	0	0.00%
7	0	0	0.00%	$39,010	1	0.04%	$53,834	0	0.00%	$97,525	1	0.04%	$117,030	0	0.00%	$117,031	0	0.00%
8	0	0	0.00%	$43,430	3	0.11%	$59,933	1	0.04%	$108,575	0	0.00%	$130,290	0	0.00%	$130,291	0	0.00%
Total		1,237	46.82%		618	23.39%		220	8.33%		273	10.33%		197	7.46%		97	3.67%

Total Clients 2,642

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

County of Sacramento
Department of Health Services
Public Health

Clients by Ethnicity Report

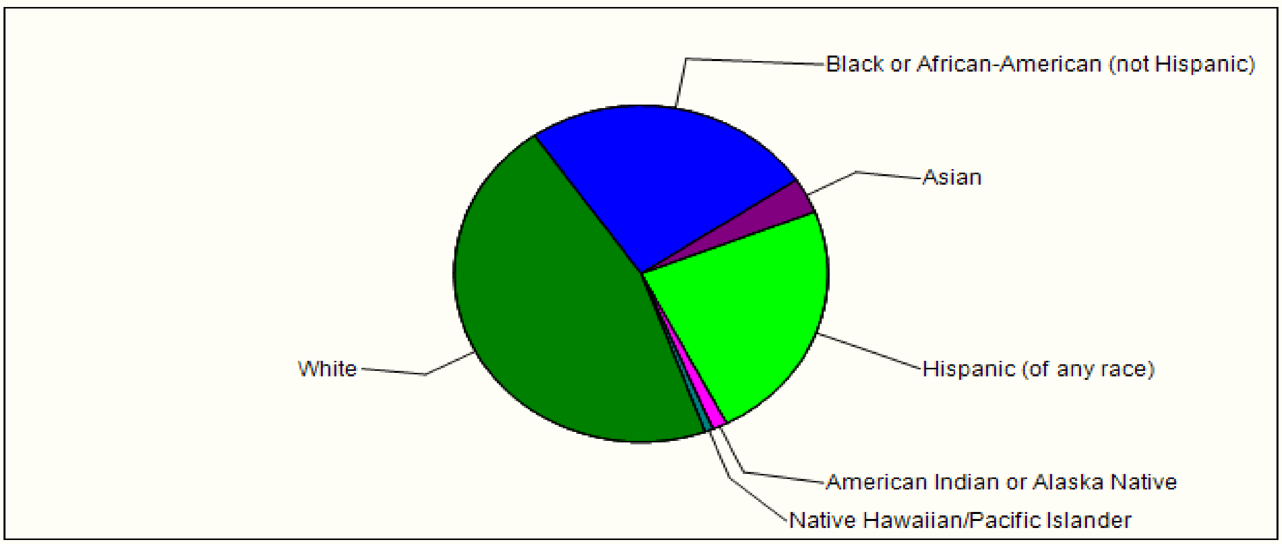
DHS - CARE System
Client Demographic Reports

Selection Criteria: Reporting on Dates From March, 2019 To February, 2020

Ethnicity	Number of Clients	Percentage of Current Clients	Percentage of AIDS Prevalence	Percentage of HIV AIDS	Percentage of General Population
White	1,212	45.87%	56.00%	55.80%	59.50%
Black or African-American (not Hispanic)	668	25.28%	24.20%	23.40%	7.50%
Asian	90	3.41%	3.10%	3.20%	12.40%
Hispanic (of any race)	619	23.43%	15.80%	16.30%	20.00%
American Indian or Alaska Native	34	1.29%	0.60%	0.70%	0.60%
Native Hawaiian/Pacific Islander	19	0.72%	0.30%	0.60%	0.00%
Total Clients	2,642	100.00%	100.00%	100.00%	100.00%

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

Visual Analysis:



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

Attachment E

Zero Together Plan

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2016 – 2021

Strategic Plan

End New HIV Infections in the Sacramento Area

ZERO TOGETHER Coalition Members:

Cares Community Health
Harm Reduction Services
Golden Rule Services
Gender Health Center
Sierra Foothills AIDS Foundation
Sacramento LGBT Center
Sacramento County HIV/STD Prevention, Surveillance, and Ryan White Staff
AIDS Education & Training Center

Funding Provided by

THE CARES FOUNDATION

Sacramento County HIV/AIDS Prevention
Ryan White Care Act
Cares Community Health

EXECUTIVE SUMMARY

This plan embraces the National HIV/AIDS Strategy and the California Integrated HIV Surveillance, Prevention and Care Plan, and integrates local needs of the Sacramento area.

The primary components of the plan include: testing of high risk people, aggressive linkage and retention in care, use of Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP), syringe exchange and widespread condom distribution.

While we all support universal testing, the practice has not been adopted by a sufficient number of practitioners to make a significant impact. Instead the focus must be on testing those most likely to have acquired HIV based on current testing

data. In the Sacramento area that data supports increased testing among young Black and Latino men who have sex with men.

Equally important is the focus on linkage and retention in care. Linkage means getting newly positive people into care as soon as possible- even the same day if that is feasible. Research has shown that the newly diagnosed should get on antiretroviral medication as soon as possible without even waiting for a viral load test. Retention in care means doing everything necessary to keep a person engaged in their medical care. The overall goal of both linkage and retention in care is getting viral loads suppressed since those with undetectable viral loads do not spread HIV to others.

PrEP and PEP are important prevention tools. PEP is used after a potential exposure to HIV either from a needle stick or from sexual exposure from someone who has a high likelihood to be HIV positive. PrEP is used for those who want to protect themselves from acquiring HIV through sexual contact or needle sharing. PrEP is a proven way to reduce HIV infection in a community and is widely understood to be a valuable tool in ending the spread of HIV.

The Sacramento area has an extremely high STD rate, ranking first among other counties in Chlamydia and within the top five in gonorrhea and syphilis. People with STD's are more likely to get HIV than people without STD's. Because of this, widespread condom distribution is an important activity is both STD and HIV prevention.

Finally, the Sacramento area has been fortunate to have had strong syringe exchange programs for the last twenty years and for that reason, HIV among injection drug users is relatively low. To keep that trend from reversing we need to continue and even expand syringe exchange programs.

Goals & Objectives for the Sacramento Area

1. Reduce new HIV infections

A. Increase the estimated percentage of people with HIV who know their serostatus to at least 95%.

Actions:

- Increase testing among high risk gay men and heterosexuals by marketing all testing sites in Sacramento area.
- Increase testing among young black and Latino men who have sex with men by determining where and how those young men hook up and marketing accordingly

Measurement:

- Increase percentage by 1% per year based on estimates. Latest TGA estimates are 86% in 2014.

2016 – 88%	2017 – 89%	2018 – 90%
2019 – 91%	2020 – 93%	2021 – 95%

B. Expand PrEP use to at least 3,100 people.

Actions:

- Implement a wide spread media campaign to educate the public about PrEP beginning in 2016 and annually as needed.
- Conduct provider education efforts using PrEP toolkit each year as needed.

Measurements:

2016 – 600 on PrEP 2017 – 1100 2018 – 1600
2019 – 2100 2020 – 2600 2021 – 3100

C. Increase the number of people with HIV who are tested at least annually for
STD's to at least 75%

Actions:

- Work with Cares Community Health, Kaiser, and VA Medical Center to track STD testing rates of patients with HIV.

Measurements:

- Develop baseline measures and set annual improvement goals.

D. Increase the percentage of newly diagnosed people with HIV who are linked
to medical care within one month of their diagnosis to at least 85%

Actions:

- Develop MOU's between all testing sites and providers.
- Work with Kaiser and VA Medical Center to improve linkage to care.

Measurements:

2014 – TGA 77%, RW Patients 99%. Increase overall TGA rate by 2% per year
2016 – 79% 2017 – 81% 2018 – 83%
2019 – 85% 2020 – 85% 2021 – 85%

F. Increase the percentage of HIV+ people who are virally suppressed to at

least 83%.

Actions:

- Work with Kaiser, VA Medical Center and others to track viral load suppression.

Measurements:

2015 - TGA 62%, RW Patients 83%. Increase overall TGA rate by 3.5% per year beginning in 2016.

2016 – 65.5%	2017 – 69%	2018 – 72.5%
2019 – 76%	2020 – 79.5%	2021 – 83%

2. Reduce HIV related disparities and health inequities

A. Decrease new HIV diagnoses among all groups by 50% by 2021

Actions:

- Increase testing in each subgroup

Measurements:

African Americans	2014 – 42	2021 – 21
Hispanic	2014 – 37	2021 – 19
13-24 years old	2014 – 30	2021 – 14
High risk heterosexuals	2014 – 47	2021 – 24
Men having sex with men	2014 – 80	2021 – 40

B. Continue to increase public awareness and fight the stigma of HIV through increased media attention to progress toward ending HIV.

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Attachment F

FY 19 Performance Outcomes

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FY2019
Performance Outcomes

(All Funding Sources)

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

CASE MANAGEMENT (NON-MEDICAL)		**Total Clients: 1,161**
Performance Measure	**Indicator**	**Outcome**
1. HAB Core Measure: Prescription of HIV Antiretroviral Therapy.	1. Number/Percentage of HIV+ patients, regardless of age, prescribed HIV antiretroviral therapy.	1. 856/1161 73.7%
2. HAB Core Measure: HIV Viral Load Suppression.	2. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	2. 976/1161 84.1%
Quality of Care		
1. Standards of Care for Benefits and Enrollment Case Management are met.	1. 90% of Benefits and Enrollment Case Management charts reviewed will comply with Case Management (non-medical) service standards. *(site visit)*	1. 26/34 charts reviewed, 76.5%
2. Benefits and Enrollment assistance.	2. 95% of people requesting Benefits and Enrollment case management will receive advice and assistance in obtaining needed services.	2. 100%
3. Referrals to non-Ryan White entitlement programs.	3. 95% of clients receiving Benefits and Enrollment case management services will be referred to all appropriate (non-Ryan White) entitlement programs to maximize benefits.	3. 100%
4. Health care referrals.	4. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic. *(chart review)*	4. 100%
5. Improved quality of life.	5. 60% of clients surveyed who received Case Management (non-medical) services will report improved quality of life. *(postcard survey)*	5. 21/24 clients surveyed, 87.5%
6. Follow-up	6. 100% of clients will receive case management (non-medical) follow-up.	6. 100%

CHILDCARE		**Total Clients: 19**
Performance Measure	**Indicator**	**Outcome**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	1. 8/19, 42.1%
Quality of Care		
1. Standards of Care for Childcare are met.	1. 100% of childcare providers will comply with child care service standards. *(site visit)*	1. 0%. HIPAA Privacy Notice not signed
2. Awareness of childcare services.	2. 75% of clients with children under 15 living in the home will be made aware of available childcare resources funded by Ryan White. *(client satisfaction survey)*	2. There were 148 responses. 78 responded that the question is not applicable. Of the 70 respondents answering year or no, 45/70, 64.3% responded "yes" they were made available of childcare services.
3. Childcare for HIV-related service appointments.	3. 100% of clients surveyed who requested childcare services for medical or support service appointments will have referrals or financial assistance made available, as funding is available. *(postcard survey)*	3. There were not respondents to the postcard survey

Emergency Financial Assistance		**Total Clients: 184**
Performance Measure	**Indicator**	**Outcome**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	1. 67/184, 36.4%
Quality		
1. Adherence to Standards of Care for Direct Emergency Assistance.	1. 100% of providers will comply with applicable Emergency Financial Assistance service standards. *(site visit)*	1. 30/34 charts reviewed, 88.2%

FOOD BANK/HOME DELIVERED MEALS		**Total Clients: 197**
Performance Measure	**Indicator**	
1. HAB Core Measure: HIV Viral Load Suppression.	1. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	1. 172/197, 87.3%
	Quality	
1. Standards of Care for Food Bank/Home Delivered Meals are met.	1. 100% of providers offering Food Bank/Home Delivered Meals will comply with Food and Nutrition service standards. *(site visit)*	1. 11/14 charts reviewed, 78.6%
2. Improved Management of HIV/AIDS	2. 60% of clients receiving Food Bank/Home Delivered Meal services will report that these services have allowed them to better manage living with HIV/AIDS. *(postcard survey)*	2. 8/10 clients surveyed, 80%
3. Improved Quality of Life	3. 60% of clients receiving Food Bank/Home Delivered Meal services will report improved quality of life. *(postcard survey)*	3. 8/10 clients surveyed, 80%
4. Improved Medical Status	4. 60% of clients receiving Food Bank/Home Delivered Meal services will report improved ability to remain in medical care. *(postcard survey)*	4. 8/10 clients surveyed, 80%

HEALTH EDUCATION AND RISK REDUCTION		**Total Clients: 159**
Performance Measure	**Indicator**	**Outcome**
1. HAB Systems-Level Measures: Linkage to HIV Medical Care	1. Number/Percentage of newly diagnosed HIV+ persons linked to care within 30 days of their HIV+ diagnosis.	1. 14/28 newly diagnosed linked to care within 30 days, 50%
	Quality	
1. Standards of Care for Health Education and Risk Reduction are met.	1. 100% of Health Education and Risk Reduction (PCRS) providers will comply with Health Education and Risk Reduction service standards. *(site visit)*	1. 7/12 charts reviewed, 58.3%

HEALTH INSURANCE PREMIUM AND COST-SHARING ASSISTANCE		**Total Clients: 27**
Performance Measure	**Indicator**	
1. HAB Core Measure: HIV Viral Load Suppression.	1. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	1. 21/27, 77.8%
Quality		
1. Standards of Care for Health Insurance Premium and Cost-Sharing Assistance are met.	1. 100% of Health Insurance Premium and Cost-Sharing Assistance providers will comply with Health Insurance Premium and Cost-Sharing Assistance service standards. *(site visit)*	1. 9/13 charts reviewed, 69.2%
2. Linkage documentation.	2. 100% of all referrals and linkages to services for HIV+ clients receiving Health Insurance Premium and Cost-Sharing Assistance services shall be documented.	2. 100%
3. Health care referrals.	3. 100% of HIV+ clients who do not have an identified primary care provider will receive a referral to an appropriate physician or clinic. *(chart review)*	3. 100%
4. Payment processing.	4. 100% of clients who received Health Insurance Premium and Cost Sharing Assistance will indicate payments had been processed and approved for medical co-payments and/or health insurance premiums. (chart review)	4. 100%

HOUSING		**Total Clients: 137**
Performance Measure	**Indicator**	**Outcome**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1. 68/137, 49.6%
Quality		
1. Standards of Care for Housing are met.	1. 100% of providers will comply with applicable Housing Assistance service standards. *(site visit)*	1. 14/18 charts reviewed, 77.8%
2. Improved or stable housing.	2. 85% of all clients surveyed who received housing assistance will report improved or stable housing as compared to their housing situation in the previous year. *(postcard survey)*	2. 5/6 surveyed, 83.3%
3. Improved quality of life.	3. 60% of clients surveyed who received housing assistance will report improvements in or maintenance of their general health status and/or quality of life. *(postcard survey)*	3. 6/6 surveyed, 100%

MEDICAL CASE MANAGEMENT including MAI & PEDIATRIC TREATMENT ADHERENCE **Total Clients: 1516 (HIV+ 1491 ; Affected 21; Indeterminate 4)**		
Performance Measure	**Indicator**	**Outcome**
Medical Case Management: 1. HAB MCM Measure: Medical Case Management: Care Plan.	1. 95% of clients will have a care plan developed based upon assessment. *(chart review)*	1. 224/229 charts reviewed, 97.8%
2. HHS Measure: Retention in HIV Medical Care.	2. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	2. 590/1491, 39.6%
3. HAB Core Measure: HIV Viral Load Suppression.	3. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	3. 1219/1491, 81.8%
4. HHS Measure: Housing Status.	4. Number/Percent of Ryan White clients with stable/permanent housing.	4. 318/1491, 21.3%
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MEDICAL CASE MANAGEMENT including MAI & PEDIATRIC TREATMENT ADHERENCE Continued:		
Quality of Care		
Medical Case Management: 1. Standards of Care for medical case management are met.	**Medical Case Management:** 1. 95% of medical case management charts reviewed will comply with Medical Case Management service standards. *(site visit)*	1. 51.6%
2. Acuity Scale is used as client assessment tool. 3.	2. 95% of clients will be assessed using an acuity scale. *(chart review)*	2. 226/229 charts reviewed, 98.7%
4. Care Plan Development.	3. 95% of clients will have a care plan developed based upon assessment. *(chart review)*	3. 224/229 charts reviewed, 97.8%
5. Maintenance or improvement of health status and quality of life.	4a. 60% of clients surveyed who received medical case management services will report adherence to their anti-retroviral drug treatment plans. *(postcard survey)* 4b. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic. *(chart review)*	4a. 35/37 surveyed, 94.6% 4b. 100%
Pediatric Treatment Adherence: 1. Accurate antiretroviral agents for HIV dispensed.	**Pediatric Treatment Adherence:** 1. 100% of Medication Adherence (Pediatric) providers will dispense medications (including prescriptions for antiretroviral agents for HIV) according to PHS Pediatric HIV Treatment guidelines. *(site visit)*	1. 100%
2. Medication dispensation.	2. 100% of pediatric clients will receive their needed medication within 48 hours.	2. 100%
3. Assessed for sensitivities, resistance, and side effects	3. 100% of clients receiving treatment adherence services will be assessed for sensitivities, resistance, and side effects at least once every six months by a registered nurse AND a pharmacist. *(chart review)*	3. 100%
4. Medication Adherence.	4. 75% of clients receiving treatment adherence services will adhere to medication program. *(year-end outcomes from UCD)*	4. 13/16 81.3%
5. Improved health indicators.	5. 70% of pediatric clients receiving treatment adherence services will show improved health indicators. *(chart review)*	5. 13/16, 81.3% are undetectable
6. Adherence counseling.	6. 85% of pediatric clients will receive HIV medication adherence counseling at least twice in a 6 month period. *(database)*	6. 100%

MEDICAL NUTRITIONAL THERAPY		**Total Clients: 535**
Performance Measure	**Indicator**	
1. HAB Core Measure: HIV Viral Load Suppression.	1. Number/Percentage of HIV+ patients, regardless of age, with an HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	1. 457/535, 85.4%
Quality		
1. Standards of Care for Medical Nutritional Therapy are met.	1. 100% of Medical Nutritional Therapy providers will comply with Medical Nutritional Therapy service standards. *(site visit)*	1. 33/41 charts reviewed, 80.5%
2. Individualized nutritional plans.	2. 100% of clients receiving medical nutritional therapy will have an individualized nutritional plan developed within 60 days of assessment by the licensed registered dietitian. (chart review)	2. 40/41 charts reviewed, 97.6%

MEDICAL TRANSPORTATION		**Total Clients: 555**
Performance Measure	**Indicator**	
1. HAB Systems-Level Measures: Linkage to HIV Medical Care	1. Number/Percentage of newly diagnosed HIV+ persons linked to care within 30 days of their HIV+ diagnosis.	1. 13/26, 50%
2. HHS Measure: Retention in HIV Medical Care.	2. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	2. 235/555, 42.3%
Quality		
1. Standards of Care for Medical Transportation are met.	1. 100% of Transportation providers will comply with Medical Transportation service standards. *(site visit)*	1. 40.2%
2. Availability of medical transportation services.	2. 75% of clients surveyed who showed evidence of need for medical transportation services will receive medical transportation for HIV/AIDS-related care appointments. *(postcard survey)*	2. 5/7, 71% reported "always" being able to access medical transportation services

MENTAL HEALTH THERAPY		**Total Clients: 795 (HIV+: 755; Affected: 40)**
Performance Measure	**Indicator**	**Outcomes**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1. 351/755, 46.5%
Quality of Care		
1. Standards of Care for Mental Health Therapy are met.	1. 100% of mental health providers will comply with Mental Health service standards. *(site visit)*	1. 43/99 chats reviewed, 43.4%
2. Health Care Referrals	2. 100% of clients who do not have an identified primary care provider at intake will receive a referral to an appropriate physician or clinic. *(chart review)*	2. 100%
3. Decreased mental health symptoms.	3. 60% percent of clients who receive Mental Health services will report a decrease in symptoms that initiated referral into mental health services. *(postcard survey)*	3. There were no respondents to the postcard survey
4. Improved functionality.	4. 60% of clients surveyed who received mental health counseling will report improved functionality. *(postcard survey)*	4. There were no respondents to the postcard survey

ORAL HEALTH CARE		**Total Clients: 601**
Performance Measure	**Indicator**	**Outcomes**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year.	1. 299/601, 49.8%
2. HAB Oral Care Measures: Oral Health Services: Dental Treatment Plan.	2. Number/Percent of clients receiving oral health care services will have a dental treatment plan. (Chart review)	2. 100%
Quality		
1. Adherence to Standards of Care for Dental Services.	1. 100% of dental care providers will comply with Oral Health Care service standards. *(site visit)*	1. 22/30 charts reviewed, 73.3%
2. Appropriate specialty care.	2. 100% of clients receiving specialty oral health services will receive appropriate dental care as determined by County authorization review. *(database)*	2. 100%
3. Improved oral health.	3. 60% of clients surveyed who received Oral Health Care will report improved oral health through self-report. *(postcard survey)*	3. 13/14 surveyed, 92.9%

OUTPATIENT/AMBULATORY CARE		**Total Clients: 1851**
Performance Measure	**Indicator**	**Outcomes**
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1. 787/1851, 87.4%
2. HAB Core Measure: Prescription of HIV Antiretroviral Therapy.	2. Number/Percentage of HIV+ patients, regardless of age, prescribed HIV antiretroviral therapy.	2. 1398/1851, 75.5%
3. HAB Core Measure: HIV Viral Load Suppression.	3. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	3. 1552/1851, 83.9%
4. HHS Measure: Housing Status.	4. Number/Percent of Ryan White outpatient/ambulatory care HIV+ clients with stable/permanent housing.	4. 256/1851, 13.8%
5. Minimize health disparities by ensuring access to primary medical care services by people of color.	5. Number/Percent of clients accessing primary medical care will be reflective of TGA's proportion of PLWH/A by race/ethnicity. *(database)*	5. See Note 1 below
6. Minimize health disparities by ensuring access to primary medical care services by women, infants, children and youth (WICY).	6. Number/Percent of clients accessing primary medical care will be reflective of TGA's proportion of WICY living with HIV/AIDS. *(database)* Number and percentage of persons with HIV viral suppression.	6. See Note 2 below
Quality of Care		
1. Improved adherence to Public Health Service Guidelines for the treatment of people living with HIV/AIDS.	1. 100% of primary care services offered will meet PHS guidelines. *(site visit)*	1. 100%
2. Mortality Rate Reduction.	2. Decreased or stable mortality rate for all HIV+ persons in routine outpatient/ambulatory care. *(database)*	2 22/2595, 0.85%
3. Viral Load Suppression.	3. Number/Percentage of persons with HIV Viral Load Suppression will exceed National standards.	3. 1552/1851, 83.85% of RW clients utilizing RW Ambulatory Care Services. 2044/2595, 78.77% of total HIV+ clients receiving Ryan White services. National Rate: 50.1%

Note 1: Black/African American, Hispanic and American Indian/Alaskan Native clients receiving ambulatory care services in the Sacramento TGA exceed their reflectiveness of the percent of the HIV/AIDS Prevalence in the TGA. White, Asian and Native Hawaiian/Pacific Islanders are under-represented of the clients in ambulatory care compared to their HIV/AIDS Prevalence in the TGA.

Number/Percent of ambulatory care clients is reflective of TGA's proportion of PLWH/A by race/ethnicity.	Number of Ambulatory Care Clients	Percent of Ambulatory Care Clients	Percent of TGA's HIV/AIDS Prevalence
White	844/1851	45.60%	50.1%
Black/African American	499/1851	26.96%	23.0%
Hispanic	403/1851	21.77%	19.2%
Asian/Pacific Islander	68/1851	3.67%	4.0%
American Indian/Alaskan Native	21/1851	1.13%	0.4%

Note 2: WICY Ambulatory Care Expenditures ($ out of total Part A ambulatory care expenses of $). % over the TGA's WICY proportion established by CDC at %. WICY expenditures should be a minimum of 18.92%. Of RW clients receiving ambulatory care services, expenditures were at 13.72% ($144,460). Of RW clients receiving any RW service, expenditures were at 22.1% ($1,000,921).

Number/Percent of ambulatory care clients is reflective of TGA's proportion of PLWH/A by WICY.	Number of Ambulatory Care WICY Clients	WICY Percent of All Ambulatory Care Clients	Percent of TGA's HIV/AIDS WICY Prevalence	WICY Percent for "any" RW Services
Women	221/1851	11.94%	15.51%	17.9%
Infants	0/1851	0%	0%	0.1%
Children	1/1851	0.05%	0.14%	0.9%
Youth	3/1851	1.73%	3.27%	3.1%

OUTREACH SERVICES		**Total Clients: 906**
Performance Measure	**Indicator**	**Outcome**
1. HAB Systems-Level Measures: Linkage to HIV Medical Care	1. Number/Percentage of newly diagnosed HIV+ persons linked to care within 30 days of their HIV+ diagnosis.	1. 6/10, 60% See note below
Quality		
1. Standards of Care for Outreach services are met.	1. 100% of outreach providers will comply with Outreach service standards. *(site visit)*	1. 33/41 charts reviewed, 80.5%
2. Outreach referrals	2. 100% of all referrals and linkages to services for HIV+ clients receiving Outreach services shall be documented.	2. 100%
3. Health care referrals.	3. 100% of HIV+ clients who do not have an identified primary care provider at initial contact will receive a referral to an appropriate physician or clinic. *(chart review)*	3. 100%

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

PSYCHOSOCIAL SUPPORT SERVICES (Part B Supplemental Funds Only)		**Total Clients: 34**
Performance Measure	**Indicator**	**Outcomes**
	Health	
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	1. 16/34, 47.06%
2. HAB Core Measure: HIV Viral Load Suppression.	2. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	2. 30/34, 88.24%
	Quality of Care	
1. Standards of Care for Psychosocial Support Services are met.	1. 100% of psychosocial support service providers will deliver services according to Standards of Care. *(site visit)*	1. 20/20 charts reviewed, 100%
2. Health Care Referrals	2. 100% of clients who do not have an identified primary care provider will receive a referral to an appropriate physician or clinic. *(database)*	2. 100%
3. Current care plan.	3. 80% of clients will have a current care plan in their files. (chart review)	3. 20/20 charts reviewed, 100%
4. Reduced risk behaviors.	4. a. 60% of clients surveyed who psychosocial support services will reduce risk behaviors as measured by self-report. *(postcard survey)*	4a. 8/8 surveyed, 100%
	b. 60% of clients surveyed who received psychosocial support services will reduce risk behaviors for transmission of HIV and other communicable diseases as measured by self-report. *(postcard survey)*	4b. 7/8 surveyed, 87.5%

SUBSTANCE ABUSE TREATMENT OUTPATIENT		**Total Clients: 307**
Performance Measure	**Indicator**	**Outcomes**
	Health	
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	**1a. Outpatient:** 144/307, 46.91%
2. HAB Core Measure: HIV Viral Load Suppression.	2. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	**2a. Outpatient:** 256/307, 83.39%
	Quality of Care	
1. Standards of Care for Substance Abuse Treatment are met.	1. 100% of substance abuse providers will deliver services according to Standards of Care. *(site visit)*	**1. Outpatient:** 34/39 charts reviewed, 87.2%
2. Health Care Referrals	2. 100% of clients who do not have an identified primary care provider will receive a referral to an appropriate physician or clinic upon completion of substance abuse treatment. *(database)*	**2. Outpatient:** 39/39 charts reviewed, 100%
3. Current care plan.	3. 80% of clients will have a current care plan in their files. (chart review)	**3. Outpatient:** 100%
4. Reduced risk behaviors.	4. a. 60% of clients surveyed who received outpatient substance abuse services will reduce risk behaviors for substance use as measured by self-report. *(postcard survey)*	**4.a. Outpatient:** 7/7, 100% of respondents reported reduced risk behaviors for substance use.
	b. 60% of clients surveyed who received outpatient substance abuse services will reduce risk behaviors for transmission of HIV and other communicable diseases as measured by self-report. *(postcard survey)*	**4.b. Outpatient:** 6/7, 85.7% reported reduced risk for transmission of HIV and other communicable diseases.

SUBSTANCE ABUSE TREATMENT RESIDENTIAL/DETOX		**Total Clients: Residential 13; Detox: 39**
Performance Measure	**Indicator**	**Outcomes**
	Health	
1. HHS Measure: Retention in HIV Medical Care.	1. Number/Percentage of HIV+ patients, regardless of age, with at least two medical visits at least three months apart in the measurement year	**1. Residential/Detox:** 23/39, 58.97%
2. HAB Core Measure: HIV Viral Load Suppression.	2. Number/Percentage of HIV+ patients, regardless of age, with a HIV viral load less than 200 copies/ML at last HIV Viral load test during the measurement year.	**2. Residential/Detox:** 34/39, 87.18%
	Quality of Care	
1. Standards of Care for Substance Abuse Treatment are met.	1. 100% of substance abuse providers will deliver services according to Standards of Care. *(site visit)*	**1. Residential/Detox:** 19/22 charts reviewed, 86.4%%
2. Residential Treatment Participation	2. 25% of clients entering residential/detox substance abuse treatment will complete residential treatment program. (provider exit reports)	**2a. Residential:** 9/13, 69.2% of **c**lients completed a three-month residential treatment program. (Part B Supplemental Funds only) **2b. Detox:** 25/41, 61% of clients participating in detox completed the program. Two Clients participated more than once during the reporting period.
3. Health Care Referrals	3. 100% of clients who do not have an identified primary care provider will receive a referral to an appropriate physician or clinic upon completion of substance abuse treatment. *(database)*	**3. Residential:** 22/22 charts reviewed, 100%
4. Current care plan.	4. 80% of clients will have a current care plan in their files. (chart review)	**4. Residential:** 100%
5. Reduced risk behaviors.	5. a. 60% of clients surveyed who received residential/detox substance abuse services *will reduce risk behaviors for substance use* as measured by self-report. *(postcard survey)*	**5.a. Residential/Detox**: 3/3 respondents, 100%
	b. 60% of clients surveyed who received residential/detox substance abuse services will *reduce risk behaviors for transmission of HIV* and other communicable diseases as measured by self-report. *(postcard survey)*	**5.b. Residential/Detox:** 3/3 respondents, 100%

Attachment G

FY 19 Aggregate Administrative Costs

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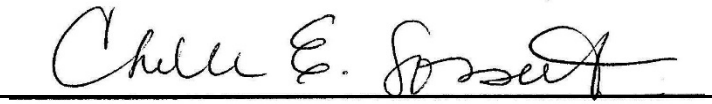
Appendix 1

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

REPORTING PERIOD - March 1, 2019 – February 29, 2020	
RECIPIENT	County of Sacramento DHS
GRANT NUMBER	H89HA00048
AGGREGATE TOTAL OF ALL HIV SERVICE DOLLARS EXPENDED	$3,008,371
AVAILABLE AGGREGATE ADMIN COST	$300,087
ACTUAL AGGREGATE ADMINISTRATIVE COST	$282,044
ACTUAL AGGREGATE ADMIN EXPENDITURE PERCENTAGE	9.38%

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

Name/Title: Chelle Gossett, Ryan White CARE Program Coordinator	Date:
Signature 	6/29/29

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