Sacramento County
Department of Health Services
HIV Health Services Planning Council
Executive Committee

www.sacramento-tga.com

Meeting Agenda
June 13, 2024, 3:00 p.m. to 5:00 p.m.

Meeting Location –
4600 Broadway, Sacramento, CA 95820
2nd Floor Conference/Community Room 2020

Facilitator: Kristina Kendricks-Clark – Council Vice Chair
Scribe: Angelina Olweny– Council Staff

Meeting Invitees:

Kristina Kendricks-Clark – Council Vice Chair
Kelly Gluckman – QAC Chair
Melissa Willett – AdAC Chair
Zach B. - ACC Chair
Chelle Gossett – Recipient
Jake Bradley-Rowe – PAC Chair
Ronnie Miranda - NAC Chair
Jake Bradley-Rowe – Gov Chair

- Open to the Public

Public Comment: This provides opportunities for the public to address the Council as a whole in order to listen to opinions regarding matters within the jurisdiction of the Council during Regular meetings and regarding items on the Agenda at all other meetings. Public Comment time limit is three (3) minutes.

*Action Items

Topic	Presenter	Start Time and Length
Welcome and Introductions	Kendricks-Clark	3:00 pm
Announcements	All	
Public Comments-Agenda Items	Kendricks-Clark	
June 2024 Agenda*	Kendricks-Clark	

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Minutes of May, 2024*	Kendricks-Clark	As Needed
Committee/Work Group Updates ➢ Administrative Assessment Committee ➢ FY23 AdAC Mid Year-End Review 06/13/2024 ➢ Affected Communities Committee ➢ Community Outreach ➢ Reflectiveness ➢ Mentorship Program ➢ Priorities and Allocations ➢ FY25 Allocations ➢ Quality Advisory Committee ➢ Oral Health Service Standard* ➢ Housing Service Standard* ➢ EFA Service Standard* ➢ Needs Assessment Committee ➢ HIV & Aging Needs Assessment* ➢ Ad-Hoc Workgroup ➢ Governance	Willett Zach B. Bradley-Rowe Gluckman Miranda Basler Bradley-Rowe	
Set Planning Council Agenda for June 26, 2024*	All	As Needed
Public Comments-Non-Agenda Items	All	
Technical Assistance	Kendricks-Clark	
Adjournment	Kendricks-Clark	5:00 pm

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Attachments:

- Minutes of May, 2024*
- Oral Health Service Standard*
- Housing Service Standard*
- EFA Service Standard*
- HIV & Aging Needs Assessment
- Planning Council Agenda for June 26, 2024* Draft

Next Meeting: September 12, 2024

HIV HEALTH SERVICES PLANNING COUNCIL Executive Committee

Meeting Minutes

May 9, 2024, 3:00 p.m. to 5:00 p.m.

Meeting Location:

Sacramento Sexual Health Center, 4600 Broadway, Conference Room 2020, Sacramento, CA 95820

Facilitator: Kristina Kendricks-Clark – Council Vice Chair

Scribe: Angelina Olweny – Council Staff

Committee Member Attendees:

Chelle Gossett – Recipient, Richard Benavidez – Council Chair, Jake Bradley-Rowe –PAC Chair, Kelly Gluckman – QAC Chair, Melissa Willett – AdAC Chair, Zach Basler – ACC Chair

County Staff: Paula Gammell

Members Excused: Richard Benavidez – Council Chair, Ronnie Miranda – NAC Chair, Michael Ungeheuer – Governance Chair

Members Absent: N/A

Topic	Minutes
Welcome, Introductions, and Announcements	The meeting began at 3:09 p.m. NorCal AIDS Cycle (NCAC) is next week. NCAC is looking for volunteers to assist at the event on Sunday. The Skills Building Symposium will focus on HIV Mental Health and Aging. It will be held in Campbell on June 5. The Collaboration and Care Conference on Aging and Thriving Beyond HIV will be held on September 18-20 in San Diego. The HIV Community Conversation is on May 29, 6:00 PM – 7:00 PM. The meeting Sacramento Pride is on June 8-9. Placer Pride is on May 18. Davis Pride is on June 1. Elk Grove Pride is on June 15. Sunburst Projects has an open house on June 26, from 5:00 PM – 7:00 PM.
Public Comments-Agenda Items	Committee members were reminded to limit side conversations during committee meetings and Council meetings.
May 2024 Agenda Review*	The May agenda was presented for review and approval. Jake Bradley-Rowe motioned to accept the agenda as presented and Zach Basler seconded the motion. The motion passed with a majority.

Topic	Minutes
	Accept: Chelle Gossett, Jake Bradley-Rowe, Kelly Gluckman, Kristina Kendricks-Clark, Melissa Willett, Zach Basler Oppose: N/A Abstain: N/A
March 2024 Minutes Review*	The March minutes were presented for review and approval. Jake Bradley-Rowe motioned to accept the agenda as presented and Melissa Willett seconded the motion. Kelly Gluckman should be included as an attendee in the March minutes. Zach Basler motioned to accept the agenda with the changes made and Kelly Gluckman seconded the motion. The motion passed with a majority. Accept: Chelle Gossett, Jake Bradley-Rowe, Kelly Gluckman, Kristina Kendricks-Clark, Melissa Willett, Zach Basler Oppose: N/A Abstain: N/A
Committee/Work Group Updates ➢ Administrative Assessment Committee (AdAC)	There were a few changes to the AdAC Assessment document. On page 7-part 5i, the term negotiated was changed to initiated. On page 8-part 6h, the sentence should read "All stages of the reallocation process are completed as required by the Council approved PAC 002 Policies and Procedures". On page 11-part 9a, the word "made" was changed to "initiated".

Topic	Minutes
	Jake Bradley-Rowe motioned to accept the AdAC assessment document with the changes made and Melissa Willett seconded the motion. The motion passed with a majority. Accept: Jake Bradley-Rowe, Kelly Gluckman, Kristina Kendricks-Clark, Melissa Willett, Zach Basler Oppose: N/A Abstain: Chelle Gossett The executive committee recommended that the three scoring criteria that the Administrative Assessment Committee should use is "Standard Met and Exceeded, "Standard Met," and "Standard Not Met". The rating "Standard Met at Minimum" will be phased out and will not be used in the mid-year FY24 Administrative Assessment. Zach Basler motioned to accept the modified scoring criteria and Jake Bradley-Rowe seconded the motion. The motion passed with a majority. Accept: Jake Bradley-Rowe, Kelly Gluckman, Kristina Kendricks-Clark, Melissa Willett, Zach Basler Oppose: N/A Abstain: Chelle Gossett
➢ Affected Communities Committee (ACC)	ACC did not meet in May.

Topic	Minutes
➢ Reflectiveness	ACC is looking to fill the Native American seat, the transgender seat with individuals receiving Ryan White Part A Services. They are also looking to recruit members from the BIPOC community who receive Ryan White Part A Services.
➢ Priorities and Allocations (PAC) FY25 Service Priorities*	The FY25 Service Priorities were presented for review and approval. PAC selected Medical Case Management as the top service category because the recipients of Ryan White Part A services need a medical case manager before they can qualify to receive related Ryan White Part A services. Non-Medical Case Management was the second core category, Ambulatory/Outpatient Medical Care was third, Oral Health Care was the fourth core service and Mental Health Services was the fifth core service. The committee ranked twenty-four additional service categories based on need. Zach Basler motioned to accept the FY25 Service Categories and Kristina Kendricks-Clark seconded the motion. The motion passed with a majority. Accept: Jake Bradley-Rowe, Kelly Gluckman, Kristina Kendricks-Clark, Melissa Willett, Zach Basler Oppose: N/A Abstain: Chelle Gossett
➢ PAC Workplan	The FY24 Work Plan was presented for informational purposes. The Work Plan outlined the activities for the current fiscal year and selected strategies from the California Integrated HIV Prevention and Care Plan that apply to the work of the PAC Committee. The next PAC meeting is on June 12.

Topic	Minutes
➢ Quality Advisory Committee (QAC)	QAC voted to use the MediCal-Dental program standards to determine the dental services that will be covered by the Sacramento TGA Ryan White Part A program. The committee is also working on updating the Housing Standard and Emergency Financial Assistance (EFA) Standard. The next meeting is on June 4.
➢ Needs Assessment Committee (NAC)	NAC met in May. A final Needs Assessment will be presented to NAC for a final review at the meeting in June. The report will be shared with the Planning Council for review and approval.
➢ Ad Hoc Workgroup	The Work Group is working to determine if there are Dental Programs in the Sacramento region that can provide free dental services to Ryan White recipients that are not covered by the Ryan White Part A program. A few committee members will attend the Sacramento Pride event to gather information from participating organizations and make connections to create awareness about the Planning Council.
➢ Governance	There are no new updates
Set Planning Council Agenda for May 29, 2024	The May planning council agenda was presented for review and approval. Zach Basler motioned to accept the agenda as presented and Jake Bradley-Rowe seconded the motion. The following changes were made: The presentation that will take place at the meeting in May is the Mechanics of

Topic	Minutes
	the Planning Council. The CPG elections should be listed as an action item under CPG/STI updates. SOA Ending the Epidemic will be removed. QAC and NAC Work Plans will be included in the Committee updates. Zach Basler motioned to accept the agenda with the changes made and Kristina Kendricks-Clark seconded the motion. The motion passed with a majority. Accept: Chelle Gossett, Jake Bradley-Rowe, Kelly Gluckman, Kristina Kendricks-Clark, Melissa Willett, Zach Basler. Oppose: N/A Abstain: N/A
Technical Assistance	Reach out to Kristina Kendricks-Clark if you need technical assistance.
Public Comment	N/A
Adjournment	The meeting adjourned at 5:01 p.m.

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Oral Health

No.: SSC03
Date Approved: 06/98
Date Revised: ~~06/22/22~~
Date Reviewed: ~~06/22/22~~

As directed by the HIV Health Services Planning Council established priorities, when funded, the following service standards will apply to ~~Ryan White~~ HIV Care Services Program contracted subrecipients.

1. Ryan White CARE Act funding is to be used for any service designed to significantly improve client access and adherence to HIV/AIDS medical resources. As such, any Oral health services, which are provided by agencies and paid for using Ryan White Part A and Part B funding, shall be related to healthcare or other critical needs that present barriers to healthcare access or maintenance.

2. Ryan White CARE Act Part A and B funding is to be expended in a cost effective, equitable manner which is based upon verified client need and encourages self-reliance of clients. Clients may be referred to Oral Health Services through medical case management services, their medical provider, or self-referral. Regardless of referral source, Oral Health Services, which are paid for with Ryan White Part A and Part B funds, shall be delivered only after verification of client eligibility and payer of last resort, and shall be provided in accordance with the allocation priorities and directives which are adopted by the Sacramento TGA HIV Health Services Planning Council ("HIV Planning Council").

3. Coverage for patients is only good for twelve months and they must re-enroll to maintain coverage. Patient eligibility and status will be confirmed prior to the appointment. This will allow time for the subrecipient to contact the client before their appointment if an update or various intake forms are needed. Updates and intake forms may include but are not limited to:

- CD4 **or** Viral Loads within the past 12 months
- Release of information,
- Grievance,
- Rights and responsibilities,
- State ARIES/HCC forms, etc.

Reimbursement for services can only be paid for active clients meeting eligibility.

3. The United States Health Resources Services Administration (HRSA) defines Oral Health Care as outpatient diagnostic, preventive, and/or therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

In accordance with the HRSA HIV Performance Measures and with the above:

A. Ryan White-funded Oral Health services must conform to the ~~adopted Ryan White~~ most current Medi-Cal Dental Program Provider Handbook including ~~Oral Health Program Operations Manual and Oral Health Rate Schedule~~the Manual of Criteria & Maximum Allowances, as ~~published~~ distributed by the Sacramento County ~~Department of Health Services~~ Public Health, Sexual Health Promotion Unit, HIV Care Services Program.

B. Subrecipients shall provide oral health care to persons living with HIV, ensuring equal access across populations through direct service or referral processes that emphasize a full continuum of oral health care services including:

- Service that is determined medically necessary, including diagnostic screenings, shall be paid for with Ryan White funds, as defined by the ~~Ryan White Program Dental Program Operations Manual and Dental Rate Schedule~~ most current Medi-Cal Dental Program Provider Handbook including the Manual of Criteria & Maximum Allowances.
- Medical history taking
- Comprehensive oral exam
- A documented dental treatment plan including a referral system for urgent care matters and/or services needed by clients but not fundable through Ryan White.
- Diagnostic dental care
- Preventative dental care
- Therapeutic dental care
- Documentation of oral health education
- Coordination of care with primary care provider and other services
- Documented provision of ~~at least one periodontal~~ any oral examination during the measurement year (March- February for Part A) (April-March for Part B)
- Documentation of initial and updated health history including:
  a. Current medications

b. Appropriate lab values
c. Name of primary medical care provider
d. Review of substance use (smoking/tobacco, alcohol, and drug use)

- Documentation of progress, review, and outcome of the dental treatment plan

Monitoring

Service- Develop scopes of work for the provision of oral health that:

- Specify allowable diagnostic, preventive, and therapeutic services.
- Define and specify the limitations or caps on providing oral health services.
- Ensure that services are provided by dental professionals certified and licensed according to state guidelines.
- Ensure that clinical decisions are informed by the American Dental Association Dental Practice Parameters.

C. Service Characteristics

Initial Oral Health Care Appointments: Initial Oral Health Care appointments should be made as soon as possible to avoid potential drop out. Emergency or urgent appointments should be provided as soon as possible, on the same day if feasible. Initial non-urgent appointments must occur no later than 90 calendar days after the first client referral to a Ryan White oral health provider.

Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after request ~~in order to~~to minimize the need for urgent or emergency services.

As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with patients. Missed appointments and subrecipient attempts at rescheduling must be documented in the file.

Monitoring

Appointment Times - Procedures for ensuring the first appointment for new clients is offered within 90 days, as well as urgent/emergent appointments and subsequent non-urgent appointments, will be reviewed through submission of agency written procedures. Agencies will be asked to submit to the Ryan White Program, written procedures for client follow-up after missed appointments.

igibility Screening and Intake

The Oral Health Care subrecipients must ensure that the client has been deemed eligible for Ryan White-funded services by the referring agency; subrecipients should verify that intake has been performed at the start of ~~HCP~~ service provision and if not, perform an intake. Subrecipients should ensure that any consents and Releases of Information specific to dental care are completed and in the client's file; subrecipients must take the necessary steps to obtain these forms if missing.

Initial Assessment

At the start of Oral Health Care Services, a baseline dental evaluation must be conducted. This evaluation should include, at a minimum:

- **Medical history.** The subrecipient shall perform a complete medical history for every new patient. This should include:
  - Client's chief complaint
  - HIV medical care provider
  - Current medication regimen(s) and adherence, including HIV medications
  - Alcohol, drug, and tobacco use
  - Allergies
  - Usual oral hygiene
  - Date of last dental examination, and name of last dentist if known

- **Oral examination.** Each patient should be given a comprehensive oral examination and assessment. This examination should include:
  - Documentation of the client's presenting complaint
  - Medical and dental history
  - Caries (cavities) charting
  - X-rays: Full mouth radiographs or panoramic and bitewing x-rays
  - Complete oral hygiene and periodontal exam
  - Comprehensive head and neck exam
  - Complete intra-oral exam, including evaluation for HIV-associated lesions or STIs
  - Soft tissue exam for cancer screening
  - Pain assessment
  - Risk factors

Education: Clients should always be provided with information regarding prevention, early detection of oral disease, and preventive oral health practices, including what to do if having a dental emergency. See the *Preventative Care and Maintenance* section of this document for more details.

Referral / Linkage: Clients requiring specialized care should be referred for and linked to such care via the client's case manager and/or HIV care team, with documentation of that referral in the client file and available upon request.

A referral to specialty care does not guarantee coverage by the HIV Care Services Program.

Documentation: All client contacts, findings, procedures, diagnoses, education, and other information pertinent to patient care must be recorded in the client chart.

Treatment Plan

Oral Health Care subrecipients should create an individualized dental treatment plan for each patient. The plan should:

- Identify and prioritize the patient's dental care needs
- Incorporate client input
- Describe the proposed interventions and treatment schedule
- Include any referrals and linkages to specialty care or other needed services
- Be signed and dated by the provider

The treatment plan should be reviewed at each appointment and revised as needed with client input.

Preventative Care and Maintenance

Oral Health Care subrecipients should emphasize prevention, early detection of oral disease, and preventive oral health practices. Education shall include:

- Instruction on oral hygiene, including proper brushing, flossing, and mouth rinses
- Counseling regarding behaviors that may influence oral health (e.g., tobacco use, unprotected oral sex, body piercing)
- General health conditions that may compromise oral health
- Effects of poor oral health on overall health
- The effect of nutrition on oral health.

NOTE: Toothbrushes, toothpaste, dental floss, and mouth rinses may be purchased under the Food Bank/Home-Delivered Meals service category.

In addition, clients should be scheduled for routine dental health maintenance visits, as follows:

- Routine examinations and prophylaxis up to twice a year

- Comprehensive cleaning ~~at least once~~ up to twice a year, preferably twice a year
- Other procedures, ~~such as root planing/scaling as needed~~ as determined medically necessary by using criteria listed in the most current Medi-Cal Dental Program Provider Handbook and as stated in the Manual of Criteria & Maximum Allowances.

Fiscal Management

- Subrecipient will make every reasonable attempt to provide clients with a referral to local, free, or low-cost non-Ryan White related grant, community partner or other service that may be available to the client to access the service not provided by Ryan White Provider.
- The current Medi-Cal Dental Program's Manual of Criteria is followed when determining which services will be covered by the Sacramento TGA Ryan White HIV Care Services program.
- The current Medi-Cal Dental Schedule of Maximum Allowances is followed when determining the fee coverage maximum covered by the Sacramento TGA HIV Care Services program.
- No Medi-Cal Dental provider is located within 30 minutes or 15 miles of a client's residence or workplace. (Medi-Cal Dental Provider Search)
- No Medi-Cal Dental provider is accepting new patients within 30 minutes or 15 miles of a client's residence or workplace.
- A Medi-Cal Dental eligible client who is having an oral health emergency and cannot get an appointment with a Medi-Cal Dental provider.
- The total cost for services per client is capped at $1,800, regardless of funding stream. To exceed this cap, a request for approval must be submitted to the Recipient. Dental providers must document the reason for exceeding the yearly maximum amount and must have documented approval from the Recipient.

Subrecipients must show adequate documentation of the above-mentioned exceptions. In these situations, the subrecipient will submit a usual and customary reduced negotiated ~~fee schedule~~ rate to the Recipient with ~~the~~ ~~invoice~~ a Treatment Authorization Referral (TAR), prior to services being rendered for approval for utilization of Ryan White funding.~~.~~ Subrecipients cannot bill the HIV Care Services program for services billed, or eligible services, to the Medi-Cal Dental Program.

Subrecipients are not required to enter into a contract with ~~the~~ Medi-Cal Dental fee-for service dentists if the proposed dentist is using the Medi-Cal Dental Manual of Criteria & Maximum Allowances. It is up to the subrecipient to ensure the dentist agrees to fee amounts ~~allowed~~ set by the ~~Recipient~~ HIV Services Planning Council~~.~~

In El Dorado, Placer and Yolo counties, when no Medi-Cal Dental Provider is available, the subrecipient will negotiate the best rate and request approval by the Recipient.

Monitoring

Fiscal Management - In cases where clients are eligible for ~~Denti-Cal~~ Medi-Cal Dental Program but no Medi-Cal Dental Program providers are available (i.e. the "time/distance exception" referenced above), providers must submit documentation to the Recipient that clearly demonstrates the absence of providers in this time/distance range per a recent review of Medi-Cal Dental Program providers listed on the DHCS website.

D. Reasonable efforts will be made to overcome any barriers to access and utilization, including efforts to accommodate linguistic and cultural barriers.

E. All services will be provided in accordance with Public Health Service and American Dental Association Guidelines for treatment of HIV disease.

F. Dental Service subrecipients shall ensure and provide documentation that the dentists, hygienists, oral surgeons, nurses, and others providing oral health care are appropriately licensed/certified to practice within their area of practice, consistent with California laws.

G. Subrecipient staff must receive ongoing training/continuing education relevant to dental health assessment and treatment of persons living with HIV.

4. **Provider Qualifications**
Education/Experience/Supervision
Professional diagnostic and therapeutic services under this service category must be provided by clinicians licensed by the Dental Board of California. Clinicians can include:
- General Dentists
- Endodontists

- Oral and Maxillofacial Surgeons
- Periodontists

Other professional and non-professional staff may provide services appropriate for their level of training/education, under the supervision of a clinician. These may include, but are not limited to:

- Dental Hygienists (RDH)
- Dental Assistants (RDA, RDAEF)
- Dental Students
- Dental Hygiene Students
- Dental Assistant Students

Any non-clinician staff providing services must be (1) supervised by a clinician; (2) hold current licensure as required by the State of California when applicable; (3) provide services appropriate for their level of training/education; and (4) be trained and knowledgeable about HIV.

Staff Orientation and Training

Initial: All RW-funded staff providing Oral Health Care must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge, such as HIV transmission, care, and prevention.
- Diagnosis and assessment of HIV-related oral health issues
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including access to dental insurance through ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position, including continuing education required by the State of California to maintain licensure. Training must be clearly documented and tracked for monitoring purposes.

5. All Dental services shall be provided in a culturally and/or linguistically competent manner, which is respectful to the client's cultural health beliefs, practices, and preferred language.

6. Subrecipients shall assure that no client receives any RW funded services unless such client is found to be eligible for services under such Eligibility Standards as may be adopted by the Planning Council.

7. Staff/Providers at subrecipient agencies may at any time submit to the ~~RW~~ Recipient requests for interpretation of these or any other Services Standards adopted by the HIV Health Services Planning Council, based on the unique

medical/dental needs of a client or on unique barriers to accessing medical/dental care which may be experienced by a client.

8. Subrecipients shall provide a means by which staff/providers can obtain in-servicing and on-call advice related to interpreting client medical/dental needs.

9. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the ~~RW~~ subrecipient shall be made available to each client upon intake.

Signed: _____ Date: ~~06/22/22~~

Kristina Kendricks-Clark, Vice Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Housing Assistance Services

No.: SSC 15
Date Approved: 05/26/04
Date Revised: ~~06/22/22~~
Date Reviewed: ~~06/22/22~~

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council the following Housing Assistance Standard will apply to all County HIV Care Services Program contracted vendors that provide housing services.

1. Ryan White CARE Act funding is to be used for HIV/AIDS medical care including psychosocial and support services designed to significantly improve client access and adherence to such resources. Housing Assistance services that are provided by agencies and paid for through Ryan White funding will be part of a comprehensive medical care plan that promotes the optimal state of health for the afflicted individual and shall be related to maintaining a client's housing stability, thereby improving ability to maintain or access medical care.

2. Ryan White CARE Act funding is to be expended in a cost effective, equitable manner based upon verification of client need. Referral to housing services is accomplished through medical case management providers, or by self-referral. Payment for housing assistance services through Ryan White funding is authorized only in circumstances where client eligibility is validated, and no other payment guarantor has been identified.

3. Coverage for patients is only good for twelve months and they must re-enroll to maintain coverage. Patient eligibility and status will be confirmed prior to the appointment. This will allow time for the subrecipient to contact the client before their appointment if an update or various intake forms are needed. Updates and intake forms may include but are not limited to:

    - CD4 **or** Viral Loads within the past 12 months
    - Release of information,
    - Grievance,
    - Rights and responsibilities,
    - State ARIES/HCC forms, etc.

Reimbursement for services can only be paid for active clients meeting eligibility.

~~3.~~4. In accordance with the above:

A. Definition:

Housing services provide transitional, short-term, or emergency housing assistance (including hotel/motel vouchers) to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and increase stability for clients, allowing them to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated at least every six months, to guide the client's linkage to permanent housing. Housing services also can include housing referral services; assessment, search, placement, and advocacy services; as well as payment of fees associated with these services. Providers must have written policies and procedures that indicate the percentages of a client's monthly rent they can pay through this program.

Allowable activities in this service category include:

- Housing that provides some type of core medical or support services, such as:
  - Residential substance use disorder services
  - Residential mental health services
  - Residential foster care
  - Assisted living residential services
- Housing that does not provide direct core medical or support services but is essential for a client or family to initiate or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. This includes paying or supplementing rent. In some cases, this can include hotel/motel vouchers, when done on a limited basis as part of an overall plan to transition the client to permanent housing.
- Housing referral services to other (non-Ryan White) housing programs

NOTE: Utilities, including firewood, may be paid for under the Emergency Financial Assistance service category, but are not allowable in this service category.

Unallowable Activities
Housing services **may not:**

- Be used for mortgage payments.
- Be in the form of direct cash payments to clients.
- Be used for rental or security deposits. Such deposits are typically returned to clients as cash, which would violate the prohibition on providing cash payments to clients.

Intake
The Housing Services provider must ensure that the client intake has been performed prior to Ryan White service provision and if not, perform an intake. See the Common Standards of Care for detailed intake requirements. Providers should ensure that any consents specific to housing are completed and in the client's file.

Orientation
Each new client receiving Housing Services must receive an orientation to provided services, document this orientation in the client file.

Housing Plan
Housing Service providers should create an individualized housing plan for each client. The plan must include:

- Assess current housing needs
- Incorporate client input
- Guide the client's linkage to permanent housing
- Include any referrals and linkages to other needed services
- Be signed and dated by staff providing Housing Services

Reassessment
The client's housing plan must be updated at least every six months.

Service Characteristics
Eligibility Screening: If the Housing Services provider is the client's first contact with a Ryan White service provider, the client must be screened for eligibility as described in the Common Standards of Care.

Newly Identified Clients: Housing Services providers should work with other Ryan White-funded subrecipients to ensure that newly diagnosed clients and clients new to the Ryan White system are evaluated for and provided with Housing Services as needed.

Appointments: Initial Housing Services appointments should be made as soon as possible to avoid housing disruptions. Appointments must occur no later than 10 calendar days after the first client referral, which can be a self-referral. Subsequent non-urgent appointments must be scheduled as soon as feasible, but no more than 30 days after a request. As clients may miss appointments, agencies must have a process in place to ensure timely follow-up with clients, preferably within 24 hours. Missed appointments and provider attempts at rescheduling must be documented in the file.

Duration: Services are intended to be temporary in nature. The U.S. Department of Housing and Urban Development (HUD) defines transitional housing as lasting up to 24 months. Providers may extend services beyond 24-months, if necessary, based on individual client assessment, which must include a transition plan to permanent housing with a concrete timeline. The Ryan White Recipient must be made aware of such an instance.

Documentation: All client contacts, as well as services, referrals, and other assistance provided to clients to help them obtain housing must be recorded in the client chart.

- If the client is not placed in housing that also provides some type of core medical or support services, the necessity of housing services to support treatment plan adherence must be documented.
- Documentation must include confirmed appointments for HIV-associated medical care, whether provided through their housing services provider or externally.

B. Instructions:
Housing assistance may include rent subsidies, move-in costs other than deposits, or emergency shelter. All housing assistance will be provided through vendor paid dollars. Rental/shelter verification (rental agreement, receipt, etc.) is required.

Clients must deplete other housing resources dollars, including HOPWA-eligible clients, before receiving rent subsidies through Ryan White. At no time will total housing assistance, whether provided solely through rent subsidies, move-in costs, or emergency housing, or through a combination thereof, exceed the equivalent of two months' rent, unless specific contractual agreements with funding sources provide extensions.

i. Rent Subsidies
   a. Clients may receive rent subsidy assistance services once each fiscal year, not to exceed $1,000, unless additional assistance is authorized by the Recipient. Eligible Ryan White clients must meet the following criteria for eligibility for rent subsidy assistance:
      1. Be in medical care and compliant with their case management plan.
      2. Provide proof of pending eviction or 3-day notice of eviction.
      3. Provide landlord name and tax identification information.

   b. Clients requiring rent subsidies will contribute as much of their monthly income to the cost of rent as is feasible. The actual percentage of the client's income to be used in this calculation shall be based upon what the client can reasonably dedicate to housing costs, as determined by the case management provider. The remaining balance between the client's contribution and their actual rent may be subsidized through Ryan White housing assistance.

   c. A Medical Case Manager will assess the housing situation of any client ~~receiving~~ requesting a rent subsidy twice within a twelve-month period. The assessment will be used to identify more affordable housing solutions, which might include relocating, or shared housing.

   d. Ryan White rent subsidies will not be provided to clients currently or simultaneously receiving any other federally subsidized housing assistance.

ii. Move-in Costs
   a. A one-time annual payment of move-in cost, i.e. the first month's rent, may be paid
   b. Client must have documentation of ongoing ability to maintain rental payments (e.g., check stub, disability income verification, etc.).
   c. No deposits shall be paid as deposits are refundable to the client as a cash payment.~~.~~

iii. Emergency Housing
   a. Authorization to place a client in Emergency Housing must be approved by a licensed clinician or contracted subrecipients' Executive Director. Written documentation must be placed in the client's file.

b. No more than $1,800 per client, per year, for Emergency Housing can be used. Additional assistance must be approved by the TGA's Recipient.

~~a.~~c. Emergency housing may include motels, hotels, rooming houses, etc.

~~b.~~d. Emergency housing payments may be utilized on an emergency or transitional basis for no more than 14 nights per year, at the most reasonable rate available in the community for emergency per-diem housing which meets acceptability standards, unless specific contractual agreements with funding sources provide extensions~~.~~ or in the state or federally designated emergencies when additional nights are approved by the state or federal funder.

e. This assistance will be accompanied by a documented plan to obtain more permanent housing and such medical case management and advocacy as is needed to pursue the plan.

~~4.~~5. Subrecipients which provide Housing Assistance shall develop and adhere to budgets for housing services which reflect the principles referred to above. In addition, if available funding levels are anticipated to be less than the total need, agencies shall ensure that funds are distributed among the maximum possible number of clients who rely on RW CARE Act funded housing services for critical needs. Subrecipients shall assure that all clients receiving any RW CARE Act funded services are found to be eligible for services under such eligibility standards as may be adopted by the planning council.

~~5.~~6. Medical Case Managers at HIV Care Services program subrecipients may at any time submit to the Recipient requests for interpretation and/or exceptions of these or any other service standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

~~6.~~7. Subrecipients shall provide a means by which Medical Case Managers can obtain in-service training and advice related to interpreting client medical needs.

Education/Experience/Supervision

There are no minimum educational standards for Housing staff. Housing-related referrals must be provided by ~~persons~~people who possess a comprehensive knowledge of local, state, and federal housing programs and how to access these programs.

Individual supervision and guidance must be available to all staff as needed.

Staff Orientation and Training
Initial: All staff providing Housing Services must complete an initial training session related to their job description and serving those with HIV. Training should be completed within 60 days of hire; topics must include:

- General HIV knowledge, such as transmission, care, and prevention
- Local housing resources including HOPWA
- Privacy requirements
- Navigation of the local HIV system of care including ADAP

Ongoing: Staff must also receive ongoing annual training as appropriate for their position. Training may be any combination of (1) in-person, (2) articles, (3) home studies, or (4) webinar, and must be clearly documented and tracked for monitoring purposes.

~~7.~~8. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review / grievance policies and procedures for the subrecipient shall be made available to each client upon intake.

Adopted: _____ Date: ~~06/22/22~~
Kristina Kendricks-Clark, Vice Chair

HIV Health Services Planning Council
Sacramento TGA
Policy and Procedure Manual

Subject: Emergency Financial Assistance

No.: SSC 16
Date Approved: 05/26/04
Date Revised: ~~06/22/22~~
Date Reviewed: ~~06/22/22~~

NOTE: Other Critical Needs is not a funded service category under Policy Clarification Notice (PCN) 16-02. Rather, it is a component of Emergency Financial Assistance. As such, the service standard for Other Critical Needs was re-named to Emergency Financial Assistance. Additionally, the TGA's previous Utilities Assistance Service Standard (SSC10) was inactivated and incorporated into the Emergency Financial Assistance Service Standard on May 27, 2020, as it too is a component of Emergency Financial assistance and not a funded service under PCN 16-02.

Consistent with funded Service Priorities established by the Sacramento TGA HIV Health Services Planning Council, the following Emergency Financial Assistance will apply to all HIV Care Services Program subrecipients that provide Other Critical Needs services.

Emergency Financial Assistance provides limited one-time or short-term payments to assist a client with an emergent need for paying for essential utilities, housing, food (including groceries and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted.

It is expected that all other sources of funding in the community for emergency financial assistance (i.e., general fund relief, local non-profit services) will be effectively used and that any allocation of Ryan White funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client may not be funded through Emergency Financial Assistance.

1. Ryan White CARE Act funding is to be used for HIV/AIDS medical services and for psychosocial and support services, which improves access and adherence to medical care. All such Other Critical Needs services initiated by agencies receiving Ryan White funding will be related to sustaining continuity of healthcare as defined by HRSA.

2. Ryan White CARE Act funding is to be expended in a cost effective, equitable manner that is based upon verified client need. Facilitating self-empowerment of the client's coordination of Other Critical Needs services shall be carried out through case management in accordance with the allocations, priorities and directives adopted by the Sacramento TGA HIV Health Services Planning Council (Planning Council), or through an alternative assessment process administered by a ~~RW agency~~HIV Care Services Program subrecipient.

3. Coverage for patients is only good for twelve months and they must re-enroll to maintain coverage. Patient eligibility and status will be confirmed prior to the appointment. This will allow time for the subrecipient to contact the client before their appointment if an update or various intake forms are needed. Updates and intake forms may include but are not limited to:

    - CD4 **or** Viral Loads within the past 12 months
    - Release of information,
    - Grievance,
    - Rights and responsibilities,
    - State ARIES/HCC forms, etc.

    Reimbursement for services can only be paid for active clients meeting eligibility.

~~3.~~4. To be eligible for Other Critical Needs assistance, the requested service must directly assist the client in overcoming a barrier to accessing medical care or adhering to a medical regimen.

~~4.~~5. **Service Characteristics**

Emergency Financial Assistance services are intended to provide emergency fiscal support for essential services to eligible clients for a limited time. Key characteristics include:

Orientation

Each new client enrolled in Emergency Financial Assistance must receive an orientation to the services ~~at~~on the first visit. Document this orientation in the client file.

Eligibility Screening: If the Emergency Financial Assistance subrecipient is the client's first contact with a Ryan White-funded provider, the client must be screened for eligibility as described in the Common Standards of Care.

Assessment: The Emergency Financial Assistance subrecipient will determine the need for emergency financial assistance. Clients must submit proof of the need (i.e., a utility shut-off notice). Emergency Financial Assistance funds can only be used as a last resort for payment of services and items for a short period of time (i.e., not indefinitely/ongoing). Ensure funds are only used to supplement, and not supplant, existing federal, state, or local funding for HIV-related services. Example: Funds may not be used for utilities if the client lives in housing through programs that include the cost of utilities (e.g. Section 8 housing).

Service Provision:

Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Emergency Financial Assistance provides limited one-time or short-term payments to assist clients with an urgent need for essential items or services necessary to improve health outcomes, including:

- Utilities: The term "utilities" shall be interpreted to include electric power, water and sewer service, natural gas and alternative heat sources such as propane, wood or fuel pellets for homes which use such fuels as the primary source of heating. Purchase of containerized water may be included for homes lacking either a piped water connection or a well.
- Housing Assistance requests must also comply with the Housing Service Standard (SSC15) and Housing Directive
    - Housing rent subsidy: One-time rent payments, for clients in permanent, or unsubsidized housing, not to exceed $1,000.
    - Emergency Housing Assistance: No more than $1,800 per client, per year, for Emergency Housing can be used. Not to exceed 14 nights per year.
- food (including groceries and food vouchers)
- transportation
- medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance

Program Guidance:

Emergency Financial Assistance funds used to pay for otherwise allowable services must be accounted for under the Emergency Financial Assistance category. Direct cash payments to clients are not permitted. Continuous provision of an allowable service to a client must not be funded through Emergency Financial Assistance.

All client contacts and other information pertinent to services must be recorded in the client chart.

Emergencies are defined as facing an imminent threat of losing basic utilities or access to needed medications. Funds are intended to help a client through a temporary, unplanned crisis to sustain a safe and healthy living environment.

When accessing Emergency Financial Assistance funds, clients must work with case managers or other service providers to develop a plan to avoid similar emergencies in the future. Changes should be made to the client's care plan, when relevant

Fiscal Management: Payments made on behalf of clients need to maintain client confidentiality and should not indicate "HIV" or "AIDS" on the check. If the name of the organization includes "HIV" or "AIDS", generic checks should be used.

Subrecipients must have systems in place to account for disbursed funds under EFA. The systems must track the client's name, the staff person who distributed the funds, the date of the disbursement, the recipient of the funds and the dollar amount. These data elements can be tracked on the ARIES/HCC Services screen if no other tracking system is available.

Unallowable Activities

This emergency financial assistance may not be used for:

- Ongoing payments for any services or goods for clients
- Direct cash payments to clients
- Activities that can be paid for under another Ryan White service category including ADAP or another payer source
- Funds may NOT be used for direct maintenance expense (tires, repairs, etc.) of a client's privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees. (PCN 10-02)
- Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied) (PCN 10-02)
- Funds may NOT be used for funeral, burial, cremation, or related expenses (PCN 10-02)
- Funds may NOT be used to purchase clothing (PCN 10-02)

- Funds may NOT be used to support employment, vocational, or employment-readiness services (PCN 10-02)

5.6. Subrecipients shall ensure that RW CARE Act funded services are provided only to such clients that meet eligible criteria as defined or stipulated within the Eligibility Standards as adopted by the Planning Council.

6.7. Standards applied include:

a. Assistance that is intended to provide access to a range of services which address needs frequently encountered by People Living with HIV (PLWH) with emphasis on self-care health maintenance.

b. All requests for funding will be accompanied by an assessment of the individual's need for the designated service, completed by a representative of the case management agency.

c. Assessment findings must be documented in case notes.

d. Services must be vendor or voucher based. Direct cash payments to clients are prohibited.

e. Case managers will work with the clientele to develop a budget that enables the individual to live within their existing resources.

7.8. Subrecipients which provide Other Critical Needs assistance shall develop and adhere to budgets that comply with the principles and standards described herein. When funding levels are anticipated to be less than the total need, agencies shall ensure that distribution of remaining funds will maximize number of clients who rely on RW CARE Act funded Other Critical Needs assistance.

8.9. Medical Case Managers at subrecipients may at any time submit to the HIV Care Services program recipient requests for interpretation and/or exception of these or any other service standards adopted by the HIV Health Services Planning Council, based on the unique medical needs of a client or on unique barriers to accessing medical care which may be experienced by a client.

9.10. Subrecipients shall provide a means by which Medical Case Managers can obtain in-service training and advice related to interpreting client medical needs.

Education*/Experience/Supervision*
There are no specific education or licensing requirements for Emergency Financial Assistance providers. Services must be provided by persons who possess knowledge of:

- Sources of emergency funding in the local community, including those offered by local utilities
- AIDS Drug Assistance Program (ADAP)
- HIV and related issues
- Understanding of the Ryan White CARE Program

Individual supervision and guidance must be routinely provided to all staff.

Staff Orientation and Training
Initial: All Ryan White-funded staff providing Emergency Financial Assistance must complete an initial training session related to their job description and serving those with HIV. HIV training should be completed within 60 days of hire. Topics must include:

- General HIV knowledge such as transmission, care, and prevention
- Privacy requirements and HIPAA regulations
- Navigation of the local system of HIV care including HOPWA and ADAP

Ongoing: Staff must also receive ongoing annual HIV training as appropriate for their position. Training must be clearly documented and tracked for monitoring purposes.

~~10.~~11. Clients shall have the right to request a review of any service denials under this or any other Services Standards adopted by the HIV Health Services Planning Council. The most recent review/grievance policies and procedures for the RW Agency shall be made available to each client upon intake.

Adopted: _____ Date: ~~06/22/22~~
Richard Benavidez, Chair

Sacramento Transitional Grant Area (TGA)
HIV Care Services Program

2023-24

HIV AND AGING
TARGETED NEEDS ASSESSMENT
PLWH 50+

HIV AND AGING
TARGETED NEEDS ASSESSMENT
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APPENDIX

Attachment 1: Sacramento TGA 2022 Needs Assessment Survey Tool

HIV AND AGING TARGETED NEEDS ASSESSMENT PLWH 50+
EXECUTIVE SUMMARY

BACKGROUND

The HIV Health Services Planning Council (Council) conducts bi-annual needs assessments of People Living with HIV (PLWH) who receive Ryan White (RW) funded services to learn about their service needs, barriers to care, successes and challenges. Getting input directly from clients assists the Council with effective funding and service delivery for the Transitional Grant Area (TGA) of Sacramento, El Dorado, and Placer Counties.

Given the increasing age of RW clients and their higher costs and complexity of care, the Council's Needs Assessment Committee (NAC) voted to conduct a targeted analysis of aging clients 50 and older compared to clients under age 50 by drilling down into the extensive data collected through the 2022 needs assessment survey of 191 clients, of which 64% were ages 50+. This executive summary provides pertinent highlights of findings and recommendations which are detailed in the full report.

PARTICIPANT FINDINGS

Demographics and HIV Epidemiology

The disproportionate impact of HIV on older people found in the HIV Needs Assessment data was validated by analysis of the TGA's HIV Epidemiology reports provided by the California State Office of AIDS, as well as RW client demographic profiles. Several demographic disparities existed between those 50 years or older compared to those under age 50. For example, among older PLWH 50+ there were fewer people of African American, Latinx, American Indian and mixed race; fewer transgender and non-binary people; and fewer people with Male-to-Male Sex as their mode of HIV transmission.

Social Determinants of Health (SDOH)

Disparities in SDOH between clients in these two age cohorts show that, on average, aging PLWH 50 years and over reported being more impacted by unemployment and disability, but less impacted by poverty and homelessness, than those under age 50 as follows:

Poverty. Older respondents ages 50+ were less likely to report living under 100% of Federal Poverty Level than under age 50 (54% vs. 70%).

Supplementary Income. Older clients 50+ reported receiving more benefits than those <50 (e.g., 38% of clients 50+ receive Supplemental Security Income vs. 19% of clients <50).

Employment / Disability. Older PLWH 50+ were employed at lower rates than clients <50 (15% vs. 38%), partly due to disability (55% vs. 22%) and retirement (11% vs. 1%).

Housing Status. Older PLWH ages 50+ were less likely to report being homeless than those under age 50 (13% vs. 26%) or temporarily housed in a shelter/motel (12% vs. 32%). Clients ages 50+ were more

likely to report stable housing than clients <50 (84% vs. 58%). Further analysis of older PLWH found that those ages 50-59 had a higher unmet need for housing than senior PLWH ages 60+ (20% vs. 6%).

HIV Healthcare Status and Engagement

Health Status Rating. Older PLWH 50+ were less likely to report their health as "much better" now than when they first sought HIV treatment compared to clients <50 (44% vs 52%). More PLWH 50+ reported that their physical health was "much worse" now compared to those <50 (8% vs. 3%).

HIV Healthcare Engagement

- Clients 50+ were less likely than PLWH <50 to be out of care for over a year (17% vs. 22%).
- PLWH 50+ reported factors that help them stay in HIV medical care at higher rates than those under age 50; for example, "my HIV case manager or social worker" (66% vs. 48%) and "the support of family and friends" (51% vs. 41%).

HIV Prevention Practices

Pre-exposure Prophylaxis (PrEP). Aging PLWH 50+ reported themselves as less informed about PrEP, less likely to disclose HIV status, and less likely to use condoms compared to PLWH <50, for example:

- 26% of PLWH 50+ had never heard of PrEP compared to 19% of those <50
- PLWH 50+ disclose HIV status to partner(s) at lower rates than PLWH <50 (56% vs. 64%)
- 20% of PLWH 50+ feel comfortable talking to their HIV negative partner(s) about PrEP vs. 30% of those <50
- 16% of PLWH 50+ use condoms if their partner(s) is on PrEP vs. 32% of PLWH <50

Partner Services assists PWLH in notifying their sexual and/or syringe sharing partners of possible HIV exposure. PLWH 50+ were less likely than PLWH <50 to know about partner services (41% vs. 47%); to have used partner services (11% vs. 14%) or be willing to use partner services (46% vs. 50%).

SERVICE DEMAND FINDINGS

Service demand (total need) is the number of survey respondents who needed each RW service, including both those who needed and received it (need met) plus those who needed but were not able to receive the service due to barriers to care (unmet need).

Service Demand was at least 10% **higher** for older clients 50+ than clients <50 for the following:

- Medical Case Management (91% vs. 81%)
- Oral Health (80% vs. 67%)
- Outpatient Ambulatory Care (74% vs. 63%)
- Mental Health (67% vs. 58%)
- Home and Community Based Health Services (46% vs. 24%)

Service Demand was at least 10% **lower** for older clients 50**+** than clients <50 for:

- Housing (46% vs. 58%)
- Health Insurance Premium Assistance (42% vs. 58%)

- Early Intervention Services (42% vs. 54%)
- Emergency Financial Assistance (35% vs. 51%)
- Legal or Professional Services (11% vs. 22%)

Service Demand Ages 50-59 Compared to Ages 60+

To examine service demand disparities within the aging 50+ population, a deeper analysis was conducted of 50-59 years old compared to those 60 years and older. For 4 of the 5 services with highest service demand among PLWH 50+, clients ages 60+ had higher demand than those 50-59 for the following 5 services: 1) oral health, 2) non-medical case management, 3) outpatient ambulatory care and 4) medical nutrition. Only one service, outpatient substance use treatment, had a lower service demand for those ages 60+ compared to those 50-59.

UNMET NEED FINDINGS

Unmet need is a subset of service demand and is critical to understanding the services that RW clients need, but have not been able to receive, due to barriers to care that limit access.

Top 10 Services with Highest Unmet Need for PLWH 50+ and PLWH <50

9 of 10 of the services with the highest unmet need were the same among aging PLWH 50+ and <50: 1) housing, 2) oral health, 3) medical nutrition, 4) emergency financial assistance, 5) mental healthcare, 6) medical transportation, 7) psychosocial support services, 8) home/community-based services, and 9) legal Services .

1 of the 10 top services with highest unmet need differed between the two age cohorts as follows:

- Respite care was in the top 10 for aging PLWH 50+
- Food bank / home delivered meals was in the top 10 for clients <50

Unmet Need Ages 50-59 Compared to Ages 60+

To examine unmet need disparities among PLWH 50+, clients 50-59 years old were compared to seniors 60+. For 4 of the 5 services with highest service demand among PLWH 50+, clients ages 50-59 had notably higher unmet need than those 60+ for the following 4 services: 1) housing, 2) mental healthcare, 3) emergency financial assistance, and 4) outpatient substance use treatment. Only one service, medical nutrition, had a higher unmet need for 60+ year olds compared to those 50-59.

BARRIERS TO CARE FINDINGS

Survey respondents were asked to complete the barriers to care section for each service they needed but had been unable to receive due to at least one barrier. To figure out the level of the service delivery system where barriers exist for each service, they are classified into five categories to examine broad-based TGA-wide “Access” and “Knowledge” issues in addition to more specific client-based “Financial”, “Health”, and “Personal” issues.

Top 5 Barriers for PLWH 50+ and PLWH <50

- The top barrier to care for both age cohorts was "Didn't know service was available" (47% of PLWH 50+ and 43% PLWH <50).
- 4 of top 5 barriers for aging PLWH 50+ were knowledge barriers: 1) didn't know service was available, 2) if I was eligible, 3) how to get, or 4) where to receive service.
- 1 of top 5 barriers for 50+ was different than those <50: "appointments not soon enough."
- 2 of top 5 barriers for PLWH <50 were different than PLWH 50+: "previous incarceration" and "no transportation."

Barriers to Care by Service Categories with Highest Unmet Need

Barriers were asked for each service category to clarify what barriers limited access to which services for each age cohort. Knowledge barriers were the greatest contributors to unmet need for most services. The 5 services with the highest unmet needs among PLWH 50+ were: 1) Oral Health, 2) Emergency Financial Assistance, 3) Housing, 4) Medical Nutrition and 5) Mental Healthcare, follows are examples of disparities in barriers reported by clients ages 50+ compared to those <50:

Oral Health. 14% of respondents ages 50+ with an unmet need stated transportation was a barrier to access, compared to none of the respondents under 50. The most common barrier among PLWH under 50 was lack of insurance (18%), over twice the rate of older PLWH 50+ (7%).

Emergency Financial Assistance (EFA). A higher percentage of clients 50+ didn't know EFA was available (45% vs. 25%), didn't know they were eligible (36% vs. 7%), or didn't know where to get it (27% vs. 7%) compared to clients <50.

Housing. PLWH 50+ had more knowledge barriers that limited access to housing than those <50, such as: didn't know they were eligible (31% vs. 12%); didn't know how to get help (37% vs none) and didn't know where to go to find housing (25% vs. 12%). Fewer PLWH ages 50+ reported that previous incarceration was a barrier to housing compared to PLWH under age 50 (12% vs. 25%).

Medical Nutrition. PLWH <50 reported inconvenient times were a barrier at five times the rate of older respondents (37% s. 7%) and that childcare was more of an issue (25% vs. 7%).

Mental Healthcare. Although half of respondents 50+ reported knowledge barriers, no clients under <50 did, but instead reported access and personal barriers at much higher rates than clients 50+.

RECOMMENDATIONS FOR CONSIDERATION

SERVICE SYSTEMS IMPROVEMENTS

It is important that the client input gained through this needs assessment be used to continue to decrease barriers to care that clients state have limited their ability to access needed HIV treatment and support services. Although not an exhaustive list of strategies, the following are examples of

service system improvements the Council and HIV Care Services Program should continue to work on to meet client service need, reduce unmet need, and decrease barriers to care for PLWH 50+:

- ***Address Knowledge Barriers.*** 4 of top 5 barriers for aging PLWH 50+ were knowledge barriers. Models of care for outreach, education and case management should continue to be assessed and improved. For example, service providers should increase awareness of services through targeted strategies of direct client contact, tailored outreach, and social media campaigns. Case Managers and support staff should consistently contact clients directly to provide information and referrals to services needed. In addition, case managers should increase efforts to follow up with clients and providers to ensure services are received. In addition, cost-effective models of care that use peers to conduct outreach and education should be expanded.

- ***Medical Care Retention.*** To support retention in ongoing medical care, case managers and support staff should continue to increase efforts to contact patients directly to encourage and incentivize re-entry into medical care. All RW service agencies should continue to: 1) make appointment reminder calls, 2) facilitate transportation assistance; and 3) improve and implement "no-show" tracking and follow up protocols.

- ***Partner Services***. 61% of PLWH 50+ reported never being informed of partner services; 56% reported that they would be willing to use them; but only 6% had done so. The Planning Council and HIV Care Services Program should consider supporting efforts to increase education and provision of client incentives for partner services.

- ***PrEP*** was reported as underutilized: 26% of aging PLWH 50+ had never heard of PrEP vs. 19% of those <50. Strategies to continue to improve PrEP education, referrals, and navigation services, including client follow up and release of information between service providers, should be expanded.

- ***Technical Assistance/Capacity Building.*** The Council should continue to work with organizations across the TGA to share this and prior HIV needs assessments, as well as other local HIV data (see last bullet below). These data sharing efforts should be used to develop and implement technical assistance and capacity building strategies to continue to improve services along the HIV continuum of care.

- ***Provider Access to Health Insurance Payments.*** HIV Care Services Subrecipients report difficulties with billing third party payors, including Medi-Cal and Medicare. If these barriers could be addressed, health insurance organizations could provide significant other sources of funding to HIV Care providers for the services they offer to PLWH. The Council should consider polling the HIV service provider community to assess barriers and needs related to health insurance provider enrollment and reimbursement. Based on provider input, the Council also should consider supporting strategies for funding and delivering various capabilities to maximize provider reimbursement from third party sources.

- ***Quality Improvement.*** The Council's Quality Advisory Committee should continue to expand efforts to get input from PLWH and service providers as part of its Continuous Quality Improvement (CQI) efforts. The HIV Care Services Program should consistently get input from PLWH in local planning, decision-making and service delivery improvements. For example, client and service provider focus groups should be facilitated to evaluate the TGA's overall service delivery system, including coordination of care and provider collaboration. These quality improvement strategies should continue to prioritize issues of racial equity and stigma reduction across all strategies of communication, program development and implementation.

- ***Leverage Local HIV Data.*** The HIV Care Services Program should continue to use its database, Sacramento HIV/AIDS Reporting Engine (SHARE), to generate "Clients Not in Care" reports to identify PLWH not in HIV medical care; to resolve data issues; to track progress of CQI projects; to identify areas for program improvement; and to assist with re-engaging clients in medical care. In addition, the HIV Care Services Program should continue to share data that reflect HIV epidemiology trends, client service utilization and community-based strategies used by other TGAs to improve the HIV care system and inform resource allocation.

NEEDS ASSESSMENT TOOL AND SURVEY PROCESS

Survey Tool Revision Recommendations

The HIV Needs Assessment Survey Tool was revised in 2022 to streamline the questions of Service Need, Need Met, and Unmet Need by RW service category. In addition, the survey collected data on Barriers to Care and Sub-Barriers by service category. This format resulted in more consistent answers from survey respondents and was able to be completed in less time and with less confusion than in previous surveys.

Based on the analysis conducted for this targeted analysis focused on PLWH 50+, there are several additional improvements to the survey format and content that could help improve the reliability and utility of survey responses in the future. A complete list of recommendations to improve survey questions are included in the full report (see pages 35-37).

Survey Process Adjustment Recommendations

In addition to the list of recommended revisions to the HIV Needs Assessment survey tool, there are a few improvements to the process to ensure that each participant's input is represented as accurately and thoroughly as possible.

The quality and completeness of data would likely be improved if each respondent's completed survey was reviewed by survey administration staff prior to providing the respondent with a gift card. Staff could answer any questions the client has about the instructions, format, or intent of the survey questions. This is particularly important for client's whose primary language is not English.

ACKNOWLEDGMENTS

The 2023-24 Sacramento TGA's HIV and Aging Needs Assessment Report has been a collaborative effort among the TGA's HIV Care Services Program, RW service providers, consumers of RW services, and the HIV Health Services Planning Council (the Council). The Council would like to recognize the following individuals and organizations for their dedication to plan, coordinate, implement and evaluate a community Young Adult HIV Needs Assessment for RW clients:

Members of the HIV Health Services Planning Council

Members of the Planning Council Needs Assessment Committee:

Ronnie Miranda (Chair), Richard Benavidez, Jake Bradley-Rowe, Kelly Gluckman, Lenore Gotelli, Melissa Willett

HIV Care Services Subrecipients in Sacramento Region:

CommuniCare+OLE, Golden Rule Services, Harm Reduction Services,
One Community Health, Sacramento Sexual Health Clinic, Sierra Foothills AIDS Foundation, Sunburst Projects, UC Davis Pediatric Infectious Disease

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Most importantly, the Planning Council would like to thank each Person Living with HIV (PLWH) who took the time and effort to participate in the needs assessment process by completing the comprehensive survey. Without each person, the needs assessment would not have been possible. By learning more about PLWH, their unmet service needs and barriers to care, the TGA can more effectively focus its resources to enhance service delivery.

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A. METHODOLOGY

1. BACKGROUND

The Sacramento TGA's HIV Health Services Planning Council (Council) is responsible for allocation of funding under the Ryan White (RW) Comprehensive AIDS Resources Emergency (CARE) Act. A unique characteristic of this program is its requirements for local control of funding decisions and, very importantly, community input from People Living with HIV (PLWH) into those decisions.
The Council's Needs Assessment Committee (NAC) conducts a bi-annual assessment of PLWH in the Sacramento TGA, which includes the counties of Sacramento, El Dorado, and Placer. The HIV Needs Assessment collects and analyzes data on Service Demand, Unmet Needs and Barriers to Care to assist the Council with effective planning for service funding and delivery.

The Council has had many discussions over the years about the rising age of PLWH in the TGA and the impact the aging population is having on the region's HIV services. The majority of RW clients were ages 50 or older in 2022-23 (55%, (916/1,135). In addition, the number of RW clients over 60 was 44% higher than those ages 50-59 (669 vs. 466). Of the 191 RW clients who completed the TGA's 2022 Needs Assessment survey, 64% were aged 50+ and 36% were under age 50.

Given the increasing number and complex needs of older RW clients, NAC voted to conduct a targeted needs assessment of clients ages 50 and over in 2023-24. It was decided that a detailed analysis would be conducted by drilling down into the comprehensive data collected in 2022 to compare the demographics, social determinants of health, service demand, unmet needs, and barriers to care by subsets of RW clients ages 50+ and clients <50.

Financial Impact on RW program:
The fiscal impact of aging PLWH on the RW program continued to increase for clients over age 50, and even more so for clients ages 60 and older in 2022-23. The average cost per RW client was 24% higher for those ages 50 and older compared to clients under age 50 ($2,224 vs. $1,797). For clients over age 60, the costs are even higher. The average cost per client for those over age 60 was 11% higher than clients ages 50-59 ($2,318 vs. $2,089), and 29% higher than clients under age 50 ($2,318 vs. $1,797). Not only are the costs per client higher for clients over age 60, the number of RW clients over 60 was 44% higher than those ages 50-59 (669 vs. 466).

2. TARGETED NEEDS ASSESSMENT PROCESS

a. Client Survey

Council and HIV service provider agency staff conducted survey sessions, both in group and one-on-one settings. The Needs Assessment survey tool was created in English but was administered in Spanish during survey sessions as needed. All surveys were completed anonymously. Participants received a $20 grocery food certificate. Surveys with incentives such as gift cards are vulnerable to duplicate respondents who want to receive an additional incentive. To address this issue, staff kept a

list of the unique confidential identification code created for each survey participant to ensure that each identifier was never used twice.

Another quality control issue included a review of each survey by staff to ensure that each respondent completed all survey questions. While every effort was made to ensure that individuals completing the surveys fully understood the intent of the questions, responses were ultimately based on each respondent's individual interpretation of each question.

Data for all survey respondents have been analyzed by age cohort, including under age 50 compared to ages 50 and older, and ages 50-59 compared to ages 60+. The findings are presented in the tables and graphs throughout the narrative report. In addition, the complete anonymous data set and analytic comparison tables can be requested by contacting Paula Gammell, MPA, Sacramento County Human Services Program Planner, HIV Care Services Program, at (916) 876-5548.

b. Needs Assessment Survey Tool

The original HIV Needs Assessment survey tool for the TGA was approved in 2003 and has been periodically modified over the years by the Council and Needs Assessment Committee to clarify questions without changing the foundation of the survey so responses could be trended over time. The improvements have decreased the survey's length and increased usability (see Appendix, Attachment 1). Questions were revised to quantify service demand and unmet need for each RW service category to understand which services clients need most (demand), and which services they are having the most difficulty obtaining (unmet need) due to confronting barriers to care.

To help the TGA examine which level of the service system that the barriers to care exist, they are classified into five barrier categories which span from examining broad-based TGA-wide "Access" and "Knowledge" issues to more specific client-based "Financial", "Health", and "Personal" issues.

To allow for trending of findings over time, survey tool questions have remained fairly consistent for demographics (i.e., age, race, gender, mode of HIV transmission); social determinants of health (SDOH) (i.e., health insurance, income, substance use, housing, incarceration); and medical care history (i.e., stage of HIV infection, viral load, medication adherence and co-occurring conditions). However, several SDOH and co-morbidity questions have been removed over the years to reduce the survey's length and to inquire only about client information that is not collected from clients in other ways (i.e., client intake forms and SHARE database).

c. Drilldown Data Analysis

The 2023-24 Targeted HIV and Aging Needs Assessment was conducted using a variety of data sources. The primary data source was the full data set from the TGA's 2022-23 HIV Needs Assessment. 64% of the 191 RW clients who completed the survey were PLWH 50 years or older, the target population for the 2023-24 assessment. It was decided that an extensive analysis which drilled down into the large

amount of data collected was the most effective way to compare input from RW clients ages 50+ to those under age 50. The drill-down analysis allowed the Council to gain the most amount of information without over burdening the RW client population with an additional survey.

Needs Assessment data from each completed survey was entered by Council staff using Microsoft Excel. All open-ended questions and survey comments were compiled. Data was checked for consistency and skip patterns. Survey data were analyzed by Lili Carbone Joy, MPH, Community Health Impact, using Microsoft Excel. Data were stratified by age cohorts to identify meaningful distribution findings in demographics, social determinants of health, co-morbidities, service demand, unmet need and barriers to care.

The drilldown analysis found several significant differences between the survey cohorts. The data and analytic findings are presented through graphs and tables, as well as in narrative form. Numbers are rounded to the nearest integer (e.g., 16.7% rounded to 17%). In cases where multiple rounded numbers are added together, the total may not appear to equal the sum of the parts.

B. PARTICIPANT FINDINGS

1. DEMOGRAPHICS AND HIV EPIDEMIOLOGY

a. TGA's HIV Epidemiology

Of growing concern in the TGA is the aging PLWH population and increasing numbers transitioning into the senior population with an AIDS diagnosis. Based on HIV epidemiology data from the California State Office of AIDS for the three-year periods of 01/01/18-12/31/20 compared to 01/01/20–12/31/22, new AIDS cases (incidence) among people ages 45 and older were much higher than those under age 45. AIDS incidence among people ages 45 and older experienced a large increase of 73%, (from 48 to 83); and new AIDS cases for people ages 65+ increased 10% (from 10 to 11). For younger people, however, the number of new AIDS cases diagnosed among people under age 45 remained steady over both three-year periods (131 and 130 new AIDS cases).

The increasing number of aging PLWH in the TGA continues to disproportionately impact the RW program. 55% of RW clients were ages 50 and over in 2022-23, and the number of RW clients over 60 was 44% higher than those ages 50-59 (669 vs. 466).

Geographically, the Sacramento TGA is an over 4,000 square miles that includes the primarily urban and suburban County of Sacramento, and primarily rural El Dorado and Placer Counties. Although Yolo County isn't part of the RW Part A TGA, it receives RW Part B funds input from its RW clients is valuable to the survey. Sacramento County accounted for 72.2% of the TGA's population and 88.1% of the PLWH in the TGA as of 12/31/22. El Dorado County accounted for 8.8% of the TGA's population and 4.3% of the PLWH, while Placer accounted for 19.0% of the population and 7.6% of the PLWH. All TGA counties participated in the survey, although El Dorado County was underrepresented: 85% of respondents were from Sacramento, 8% Placer, 1% El Dorado, 9% Yolo and 2% unspecified.

b. Demographic Analysis and Trends

Growth in the TGA's HIV epidemic impacts the RW Program, especially when it comes to older adults. Over the last twenty years, the percentage of RW clients over age 50 has more than doubled, from 23% to 65%, between 2003 and 2022. The fiscal impact of aging PLWH on the RW program continues to be felt. In 2022-23, the average cost per RW client was 24% higher for those ages 50+ compared to clients <50. Further, the number of RW clients 60+ was 44% higher with an average cost per client 11% higher than clients ages 50-59. An analysis of demographic profiles of the 122 RW clients ages 50+ compared to the 67 clients under age 50 shows that the following subpopulations were over or underrepresented in each age cohort:

Age

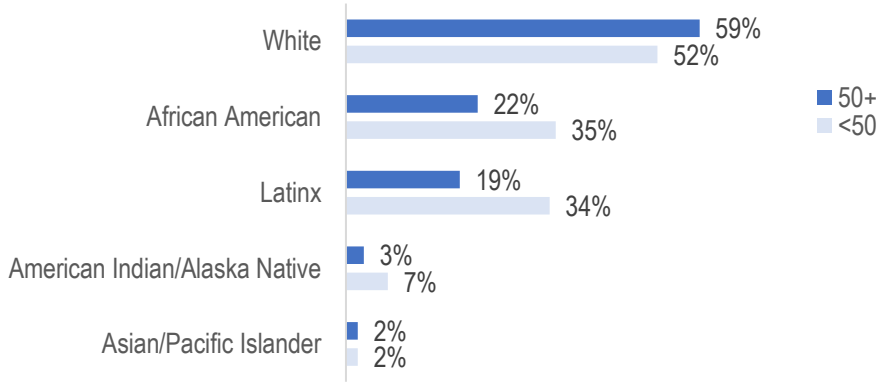
64% of the 191 RW clients who completed the needs assessment survey in 2022 were ages 50 or older, which is representative of the 55% of clients ages 50+ served by the RW program in 2022-23.

Gender

Gender		
Age	**<50**	**50+**
Male	69%	70%
Female	23%	25%
Transgender / Nonbinary / Unspecified	9%	1%

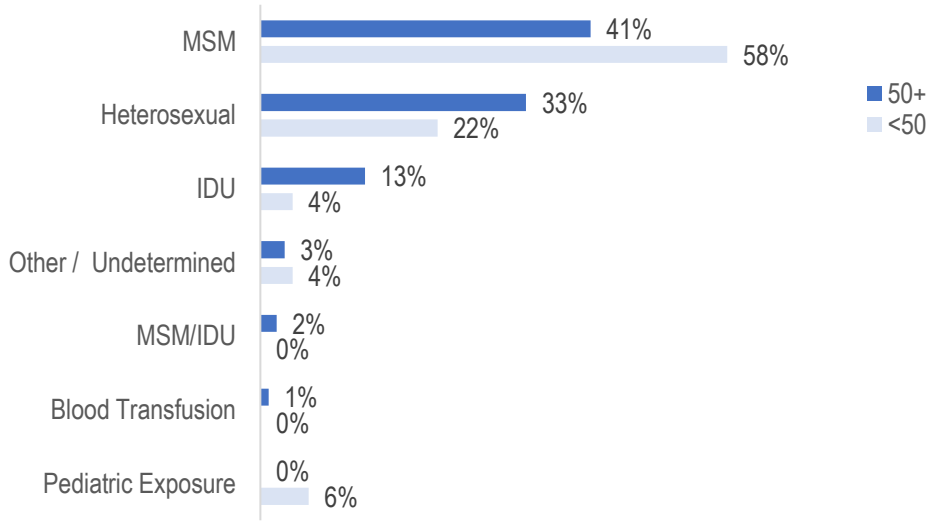
- Both the <50 and 50+ age groups had similar percentages of males and females represented among survey respondents. Transgender/non-binary survey respondents, however, were overrepresented in the <50 age group (9%) as compared to those ages 50+ (1%).

Race



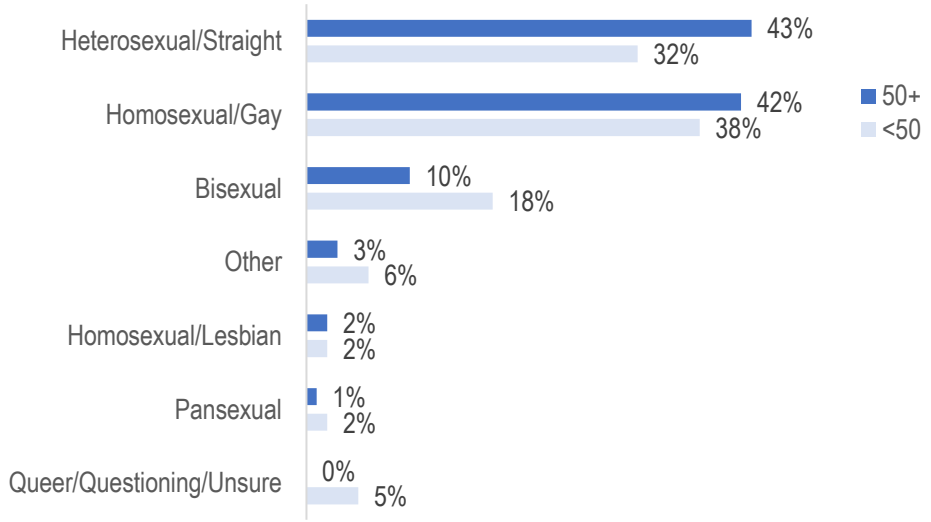
- The majority of older 50+ survey respondents were White (59%) compared to those <50 who were more likely to be African American, Latinx, American Indian/Alaskan Native
- Older adults 50+ were less likely to report more than one race (5%) compared to younger adults <50 (30%)

Mode of HIV Transmission



- Survey respondents ages 50+ were more likely to report their mode of HIV transmission as Heterosexual (33%) compared to those <50 (22%)
- Injection Drug Use as mode of HIV transmission was higher for older adults (13% vs. 4%).
- Survey respondents <50 reported MSM as their mode of transmission at higher rates than older adults 50+ (58% vs. 41%, respectively).
- 6% of clients <50 reported pediatric exposure transmission compared to 0% of PLWH 50+

Sexual Orientation



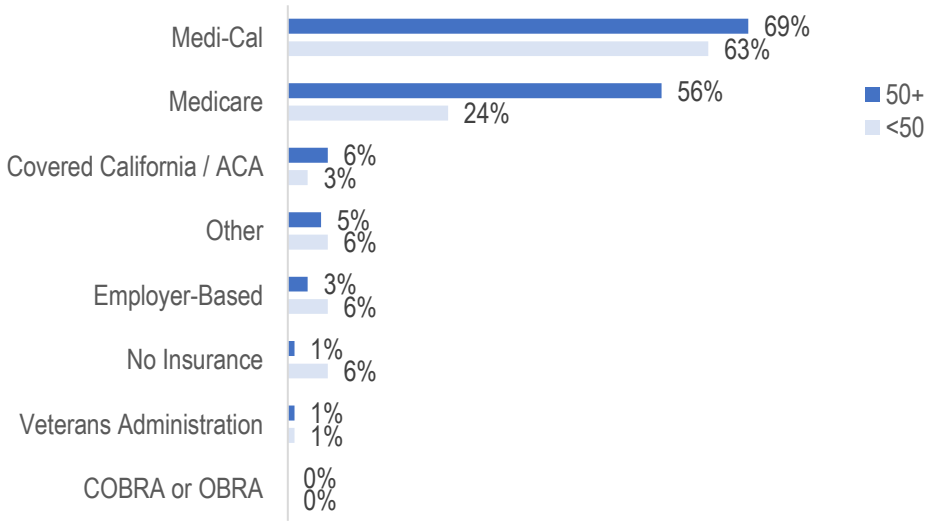
- PLWH ages 50+ were more likely to report their sexual orientation as Heterosexual (43%) or Homosexual/Gay (42%) than those <50 (32% and 38%, respectively)

- Survey respondents under age 50 were more likely to report their sexual orientation as Bisexual, Pansexual, Queer or other (31%) than older adults ages 50+ (14%)

2. SOCIAL DETERMINANTS OF HEALTH AND CO-OCCURRING CONDITIONS

The graphs and analyses below provide data on a range of social determinants of health and co-occurring conditions that add to the complexity of care for RW clients. Complicating factors such as homelessness, incarceration, poverty, insurance status, and income level were analyzed to determine where clients 50+ surveyed in 2022 reported being impacted at higher or lower rates than clients <50.

a. Health Insurance Coverage



- Older PLWH 50+ reported higher levels of health insurance coverage across all types of public insurance and only 1% had no insurance coverage.
- 6% of clients <50 reported that they were uninsured and 6% had employer-based insurance.

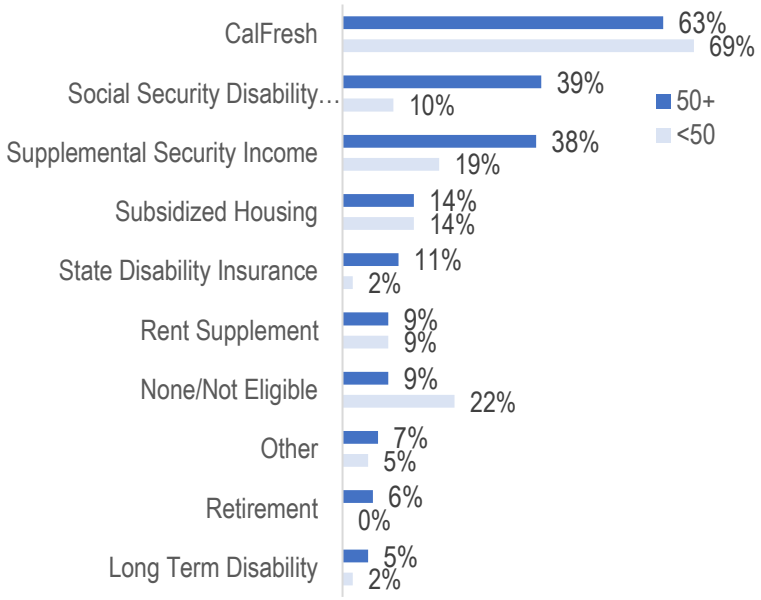
b. Income Status and Sources

Ryan White funded services are through a payor of last resort. To receive RW benefits each client must have no other means of paying for or obtaining services. The needs assessment found that more clients aged <50 were living under 100% of Federal Poverty Level than those ages 50+ (70% vs. 54%).

Supplementary Income

Given the low income of RW clients, the majority rely on supplementary income benefits. The graph below shows the top 10 supplementary income sources reported by survey respondents. Overall, older PLWH 50+ reported receiving more benefits than those <50.

NOTE: Unemployment wasn't on survey in 2022 but it's recommended for subsequent surveys.



- 36% of clients 50+ receive Social Security Disability vs. 10% of clients <50
- 38% of clients 50+ receive Supplemental Security Income vs. 19% of clients <50
- 11% of clients 50+ receive State Disability Insurance vs. 2% of clients <50
- Rent Supplement and Subsidized Housing were reported at equal rates by both age cohorts (9% and 14% respectively). Housing assistance is discussed in more detail below.
- RW clients under age 50 were more likely to report receiving NO supplemental income (22%) compared to older clients 50+ (9%)

Employment Income

Older clients ages 50+ were much less likely to be employed than younger clients <age 50, in part due to being disabled (55%) and retirement (11%):

- Among ages 50+, only 6% were employed full-time and 9% part-time, compared to 23% and 15% of those <50.
- 9% of unemployed PWLH 50+ were looking for work compared to 35% of those <50.
- 11% of PLWH 50+ were retired compared to 1% of those <50.
- PLWH 50+ reported being disabled at over twice the rate of those under age 50 (55% vs. 22%).

c. Previous Incarceration

Aging RW clients ages 50+ reported much fewer issues with incarceration or criminal record than RW clients under age 50. Only 1% of 50+ year old clients reported having been incarcerated in the previous 12 months compared to 6% of clients under age 50.

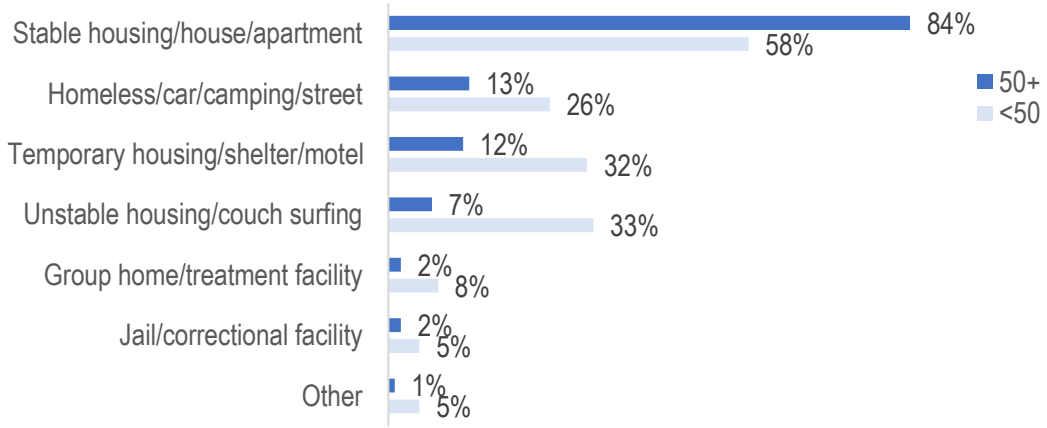
The survey asked about HIV medical care for PLWH who had been incarcerated over 48 hours in the past 12 months. 100% of those who had been incarcerated reported that the jail/prison knew their

HIV status and they continued HIV medical care after release. However, only 50% of those under age 50 got HIV medical care and medications while incarcerated, compared to 100% of those who were over age 50.

d. Housing

The 2022 survey asked RW clients which places they have lived over the prior 12-months. A large percentage (26.2%) reported they had been homeless (car, camping, street), or in temporary housing (shelter, motel). This extreme rate of homelessness/temporary housing among RW clients continues to be disproportionately high when compared to the TGA's general population, which was 0.48% based on the 2022 Point-in-Time homeless count coordinated by the US Department of Housing and Urban Development (HUD). It must be noted that HUD's count includes those who report being unsheltered, in emergency shelter or in temporary shelter on the day of being surveyed, rather than anytime during the prior 12-months as in the RW survey.

For this targeted Needs Assessment, comparison of older survey respondents ages 50+ to those <50 show the following*:*



- RW respondents 50+ were less likely to be homeless than those under age 50 (13% vs. 26%) or temporarily housed in a shelter or motel (12% vs. 32%)

- Older RW survey respondents ages 50+ are much more likely to be in stable housing than clients under age 50 (84% vs. 58%)

Housing Assistance

The needs assessment survey includes several questions about receipt of housing referrals and placements (at any previous time), as well as housing assistance, waiting lists, placements, and barriers to placement (during previous 12-months). Please see the barriers to care section (D3) of this report for the barriers to housing placement analysis. In addition, please see the future needs assessment recommendations section (E3) for input regarding potential revisions and additions to the housing section questions.

Subsidized Housing

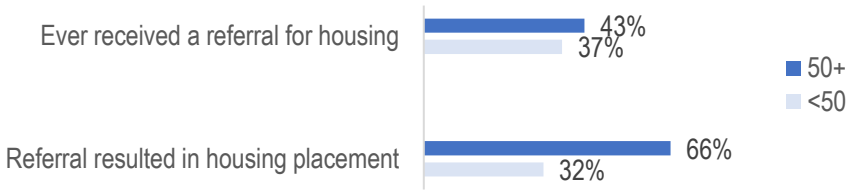
As can be seen below, PLWH 50+ were much less likely to have received a subsidized housing placement after being on a waiting list over the previous 12-months.

Subsidized Housing Waiting List and Placement		
Age	**<50**	**50+**
Been on a waiting list for subsidized housing over last 12-months	27%	31%
Waiting list resulted in subsidized housing placement	33%	8%

- PLWH 50+ were slightly more likely to be on a waiting list for subsidized housing over the last 12 months than respondents under age 50 (31% vs. 27%).
- PLWH 50+ were less likely to receive a subsidized housing placement than clients <50 (8% vs. 33%) over the previous 12-month period.

Housing Referral and Placement

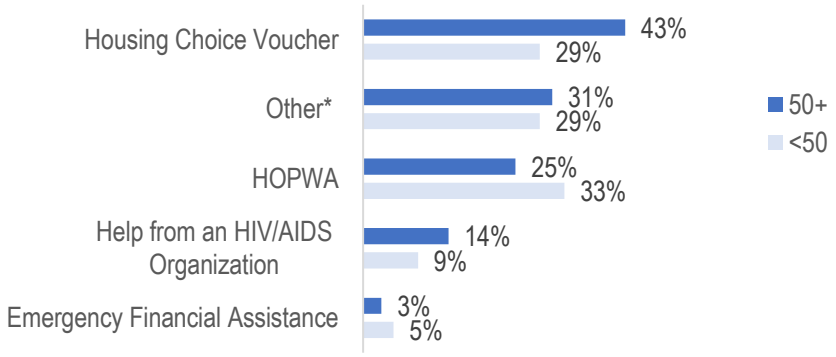
Note: See recommendations section regarding housing survey question #16 which asks "Have you ever received a referral for housing? If yes, did it result in housing placement?" The responses to this question are included below, even though they are skewed towards showing more success for older clients ages 50+ who have had many more years to receive those referrals and placements.



- 43% of PLWH ages 50+ had ever received a referral for housing, which was higher than PLWH <50 (37%).

- 66% of clients 50+ who received a housing referral secured a housing placement compared to 32% of clients <50.

Financial Housing Assistance



*Other sources included: Shelter Plus, Mercy Housing, SHRA

- Overall, PWLH 50+ reported currently receiving financial housing assistance at higher rates than those <50 (53% vs. 31%)

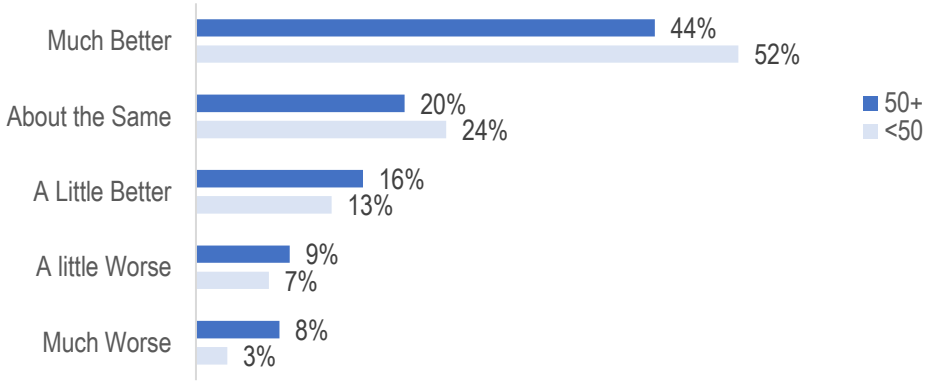
e. Hepatitis C Virus (HCV)

Survey respondents were asked," Has a medical or service provider ever told you that you have Hepatitis C? RW clients under age 50 were twice as likely to respond "yes" to this question than those ages 50+. Please see the future needs assessment recommendations section (E3) later in this report for input regarding potential revisions to this question to increase clarity and usefulness.

3. HIV HEALTHCARE STATUS AND ENGAGEMENT

a. Health Status Self Rating

The survey asked, "How would you rate your physical health now as compared to when you first sought treatment for your HIV infection?"



- Overall, these findings are very encouraging for both age cohorts, even more so for PWLH <50.
- 44% of PLWH 50+ and 52% of PLWH <50 reported that their health was "much better" now than when they first sought treatment for HIV.

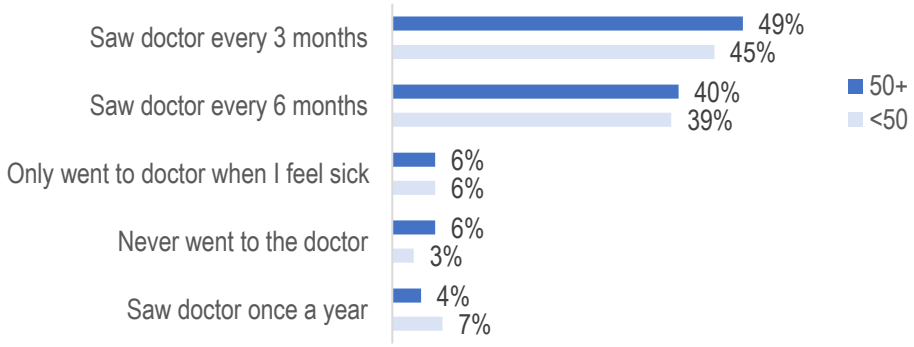
- Only 8% of PLWH 50+ and 3% of PLWH <50 reported that their physical health was much worse now than when they were first diagnosed.
- An additional 9% of PLWH 50+ and 7% of those <50 reported their health as "a little worse."

b. HIV Medical Care Engagement

The survey asked, "What HIV medical care have you received over the last 12 months?" Older PLWH 50+ reported receiving higher levels of HIV medical care during the past year than those <50 as shown below:

HIV Medical Care Engagement *Past 12 months*		
	<50	**50+**
Took HIV medication (HAART)	97%	99%
Had Viral Load test	93%	98%
Had CD4 test	93%	98%

Survey participants also were asked "How frequently do you see your HIV doctor?"



- Overall, PLWH 50+ saw their HIV doctor a bit more frequently than those <50; however, PLWH 50+ were more likely than those <50 to report never going to the doctor (6% vs. 3%)
- PLWH 50+ were more likely that those <50 to see their doctor every 3 months (49% vs. 45%)
- PLWH 50+ and <50 were almost equally likely to see their doctor every 6 months (40% vs. 39%)
- PLWH 50+ were less likely to see their doctor only annually compared to those <50 (4% vs. 7%)
- Aging 50+ were less likely to be out of care over a year compared to those <50 (17% vs. 22%)

c. Factors Decreasing HIV Medical Care Engagement

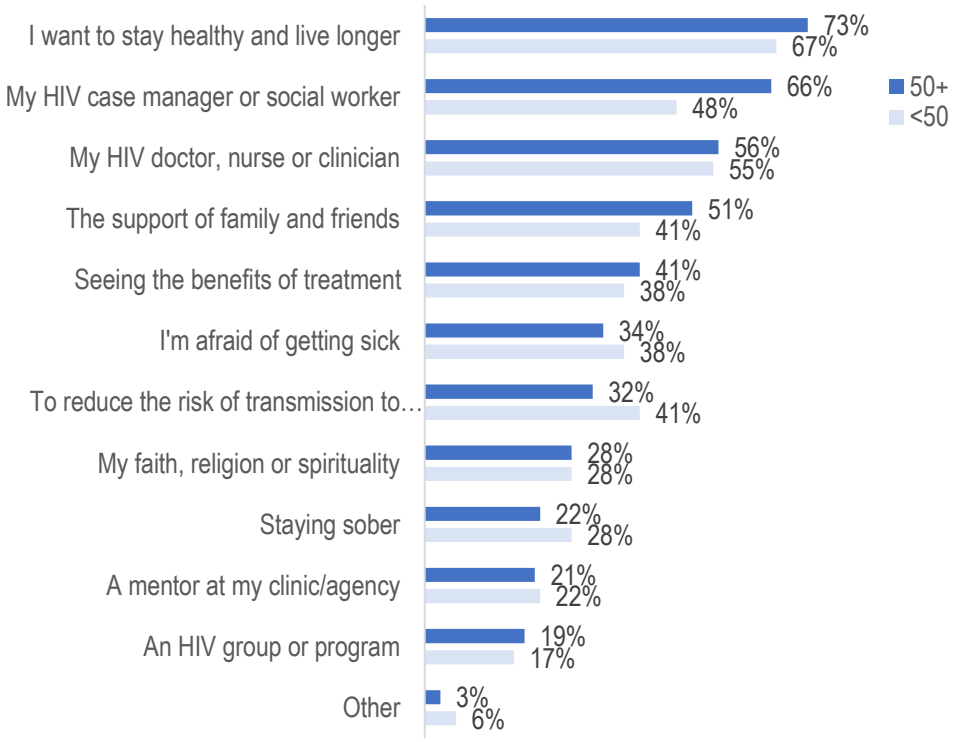
The survey asked "If you ever stopped seeing a doctor for 12 months or more [since your HIV diagnosis], why did you stop?

- Older PLWH 50+ were more likely than those <50 to report the following reasons they stopped seeing a doctor for over a year: felt fine; didn't want to take meds; side effects of medications; viral load was undetectable; and doctor or case manager left.

- PLWH 50+ were less likely that PLWH<50 to report they stopped seeing a doctor for over a year due to the following: lost health insurance; lost RW support services; substance use; mental health issue; no transportation; and overwhelmed.

d. Factors Increasing HIV Medical Care Engagement

PLWH were asked "What kinds of things help you keep up with your HIV medical care?"



Overall, PLWH 50+ reported factors that increased engagement for them at higher rates than those under age 50, particularly "my HIV case manager or social worker" (66% vs. 48%) and "the support of family and friends" (51% vs. 41%).

- 4 of the 5 top factors that PLWH reported kept clients in care were the same for both aging PLWH 50+ and those <50, although they were reported at higher rates by aging PLWH 50+, as follows:
  - I want to stay healthy and live longer (73% vs. 67%)
  - HIV case manager or social worker (66% vs. 48%)
  - My HIV doctor, nurse or clinician (56% vs. 55%)
  - Support of my family and friends (51% vs. 41%).

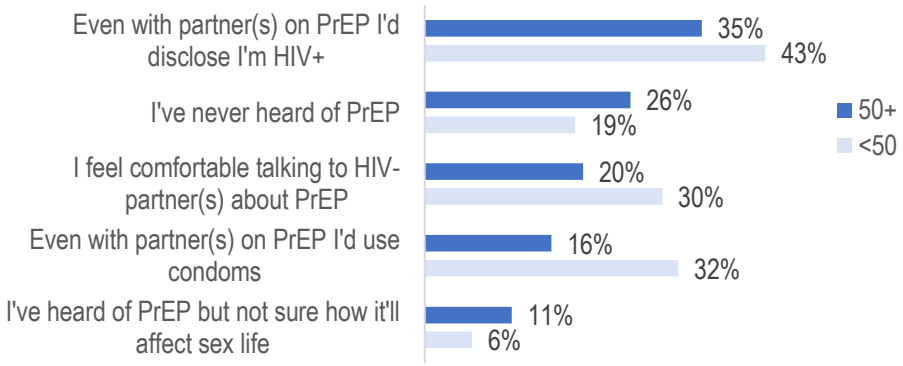
- Older PLWH reported the following in their top 5 reasons: "Seeing the benefits of treatment."
- PLWH under age 50 reported the following in their top 5: "To reduce the transmission to others".

4. HIV PREVENTION PRACTICES AND PARTNER SERVICES

The 2022 Needs Assessment includes questions about HIV Prevention and Partner Services. Although these services are not directly funded by the RW Part A Program, getting input from clients about their knowledge and use of HIV prevention strategies is imperative to improving outcomes along the HIV Continuum of Care.

a. Pre-Exposure Prophylaxis (PrEP)

PrEP is the use of anti-retroviral medications (ART) to keep HIV negative people from becoming infected with HIV. PLWH were asked "which of the following statements about PrEP are true for you"?



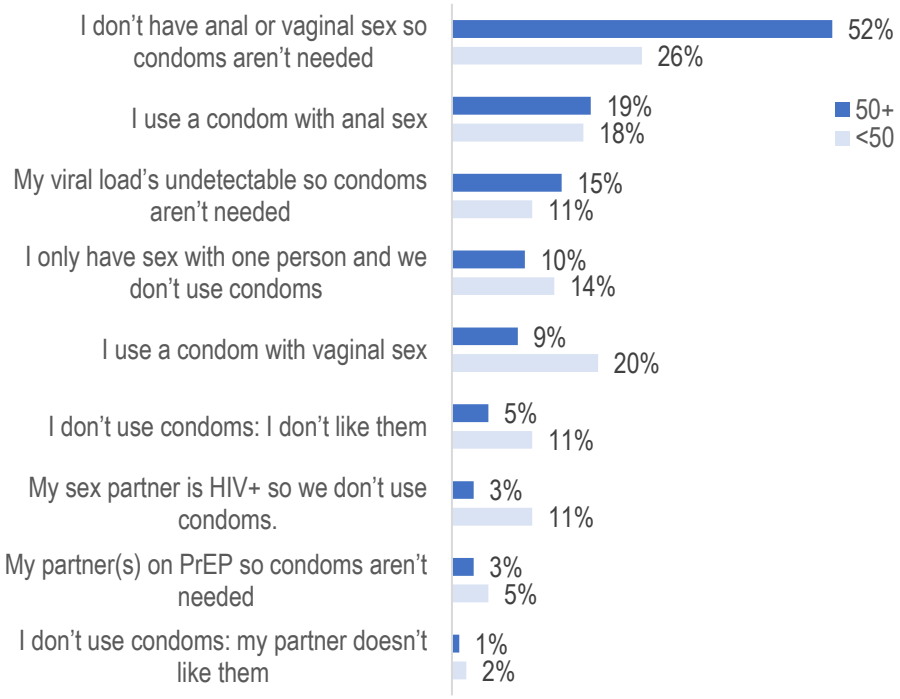
Aging PLWH ages 50+ reported themselves as less informed about PrEP than PLWH <50 as follows:

- 26% of aging PLWH 50+ had never heard of PrEP vs. 19% of those <50.
- 35% of older PLWH 50+ would disclose they are HIV+ compared to 43% of younger PLWH <50.
- Of PLWH 50+ who had heard about PrEP, 11% weren't sure how it would affect their sex life.
- 20% of PLWH 50+ felt comfortable talking to their HIV negative partner(s) about PrEP vs. 30% of those <50.
- 16% of PLWH 50+ would use condoms if their partner(s) was on PrEP vs. 32% of PLWH <50.

Sacramento County data for 2022 supports this needs assessment finding that older PLWH underutilize PrEP: PLWH 55+ had the lowest PrEP-to-Need ratio (number of PrEP users to number newly diagnosed with HIV) of any age group.

b. Condom Use

The survey asked, "Which of the following statements about condom use are true for you?"



Overall, the survey found that both age cohorts use condoms at fairly low rates, with aging PLWH 50+ using condoms at lower rates than those ages <50 as follows:

- 52% of PLWH 50+ reported they don't have anal or vaginal sex, so condoms aren't needed compared to 26% of PLWH <50.
- 15% of PLWH 50+ don't use condoms because viral load is undetectable vs. 11% of PLWH<50.
- 10% of PLWH 50+ and 14% <50 don't use condoms because they have sex with one person.
- 3% of PWLH 50+ and 5% of <50 don't use condoms because their partner is on PrEP.
- 6% of PLWH 50+ don't use condoms because either they or their partner don't like them compared to 14% of PLWH <50.
- Condom use for anal sex was low for both PLWH over and under age 50 (19% and 18%).
- Condom use for vaginal sex was lower for aging PLWH than those <50 (9% vs. 20%).

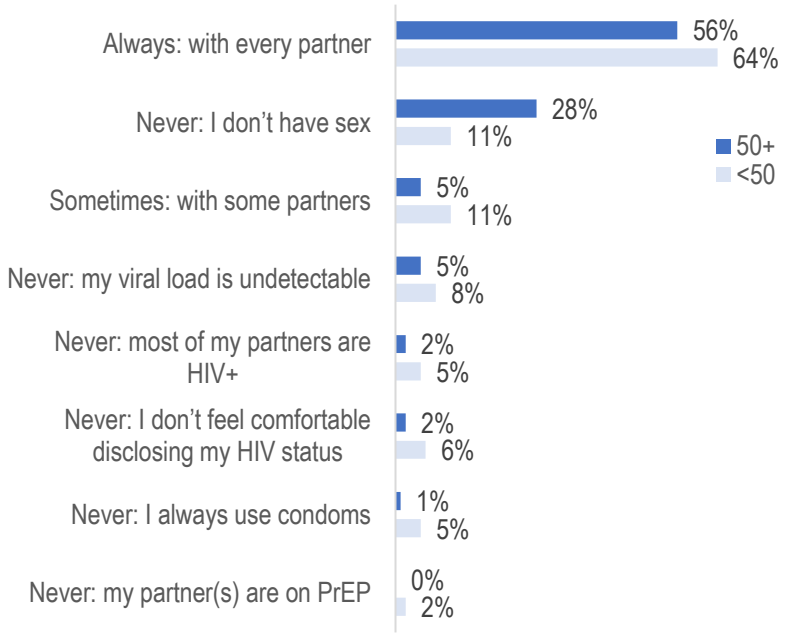
Other Sexual Health Practices

The survey asked about other sexual health practices during the previous 12 months that could increase the risk of HIV/STI transmission. Although the numbers were small, younger PLWH reported engaging in these risk behaviors at higher rates than aging PLWH 50+ as follows:

- 9% of PWLH <50 had sex to get money, drugs, housing compared to 3% of PLWH 50+
- 9% of PLWH <50 had sex with someone who shares syringes vs. 2% of aging PLWH 50+

d. HIV Disclosure

Survey participants were asked: "When do you choose to disclose your HIV status to sex partners?"

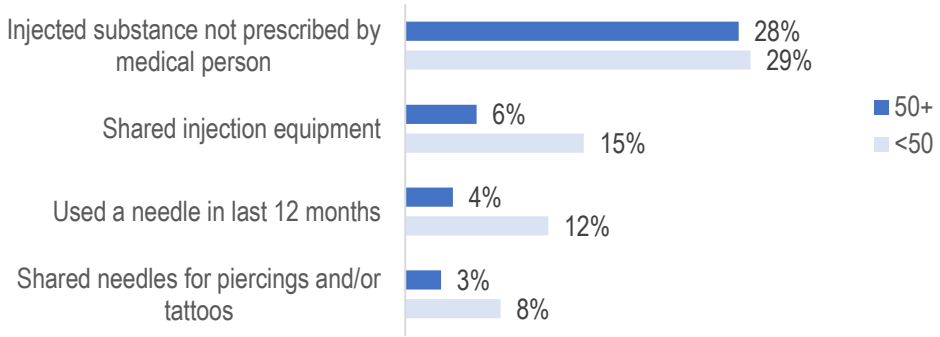


Overall, HIV disclosure rates are lower than needed to effectively reduce HIV transmission rates for both age cohorts and to effectively decrease the stigma associated with HIV/STIs, as follows:

- 56% of aging PLWH 50+ and 64% of PLWH <50 reported they always disclose their HIV status with every partner.
- 5% of aging 50+ and 11% of <50 reported sometimes, with some partners.
- 10% of aging 50+ and 26% of PLWH <50 never disclose their HIV status because of the at least one of the following: viral load is undetectable, partner(s) are HIV+, don't feel comfortable, always use condoms or their partner(s) are on PrEP.

d. Syringe Use and Practices

Survey participants were asked "Which statements about syringe use practices are true for you?"



Although both aging PLWH 50+ and those under age 50 reported injecting substances not prescribed by a medical person at similar rates (28% and 29%, respectively), older PLWH 50+ were less likely than PWLH <50 to have high risk behaviors around syringe use as follows:

- 6% of PLWH 50+ reported sharing injection equipment compared to 67% of PLWH <50.
- 4% of PLWH 50+ used syringes in the last 12 months vs. 12% of those <50.

e. Partner Services

The survey asked about Partner Services, which is a free service to assist HIV positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV.

Partner Services *Which of the following statements about Partner Services are true for you?*		
	<50	**50+**
Have you been informed of Partner Services before this survey?	47%	41%
Have you used Partner Services before?	14%	11%
Would you be willing to use Partner Services?	50%	46%

- PLWH 50+ were less likely than those <50 to have known about Partner Services prior to the survey (41% vs. 47%); have used Partner Servies before (11% vs. 14%) and be willing to use Partner Services (46% vs. 50%).

C. SERVICE DEMAND AND UNMET NEED FINDINGS

1. SERVICE DEMAND BY SERVICE CATEGORY

Service demand (total need) is the number of survey respondents who needed each RW service category. This includes both those who needed the service and received it (need met) plus those who needed the service but did not receive it due to barriers to care (unmet need).

a. Service Demand Findings: Clients Ages <50 Compared to 50+

Service (% Demand All Ages)	<50	50+
Medical Case Management (87%)	81%	91%
Case Management (Non-Medical) (77%)	78%	76%
Oral Health (75%)	67%	80%
Outpatient Ambulatory Care (69%)	63%	74%
Mental Health (64%)	58%	67%
AIDS Drug Assistance Program (61%)	58%	61%
Health Education/Risk Reduction (57%)	58%	56%
Food Bank/Home Delivered Meals (54%)	57%	53%
Medical Transportation (53%)	49%	56%
Psychosocial Support Services (53%)	54%	52%
AIDS Pharmacy Assistance (51%)	54%	49%
Housing (51%)	58%	46%
Health Insurance Premium Assistance (47%)	58%	42%
Early Intervention Services (46%)	54%	42%
Referral for Health Care & Support Services (44%)	48%	43%
Medical Nutrition (42%)	39%	43%
Emergency Financial Assistance (41%)	51%	35%
Outreach Services (40%)	46%	37%
Home/Community-Based Health Services (38%)	24%	46%
Substance Abuse Services – Outpatient (30%)	33%	29%
Rehabilitation Services (27%)	25%	27%
Home Health Care (18%)	15%	20%
Legal or Professional Services (16%)	22%	11%
Substance Abuse Services – Residential (16%)	18%	15%
Legal Services (15%)	13%	16%
Respite Care (13%)	13%	13%
Linguistic Services (6%)	9%	5%
Child Care (4%)	7%	2%
Hospice (3%)	4%	2%

- Aging PLWH 50+ reported at least 10% higher demand for the following services compared to clients under age 50:
  - Medical Case Management (91% vs. 81%)
  - Oral Health (80% vs. 67%)
  - Outpatient Ambulatory Care (74% vs. 63%)
  - Mental Health Services (67% vs. 58%)

- Home and Community Based Health Services (46% vs. 24%)

- Clients aged 50+ have at least a 10% lower demand for:
  - Housing (46% vs. 58%)
  - Health Insurance Premium Assistance (42% vs. 58%)
  - Early Intervention Services, Emergency Financial Assistance (42% vs. 54%)
  - Legal or Professional Services (11% vs. 22%)

To add to the comparison between survey respondents ages <50 and older clients ages 50+, the top ten ranked services with highest service demand for each age cohort are detailed below:

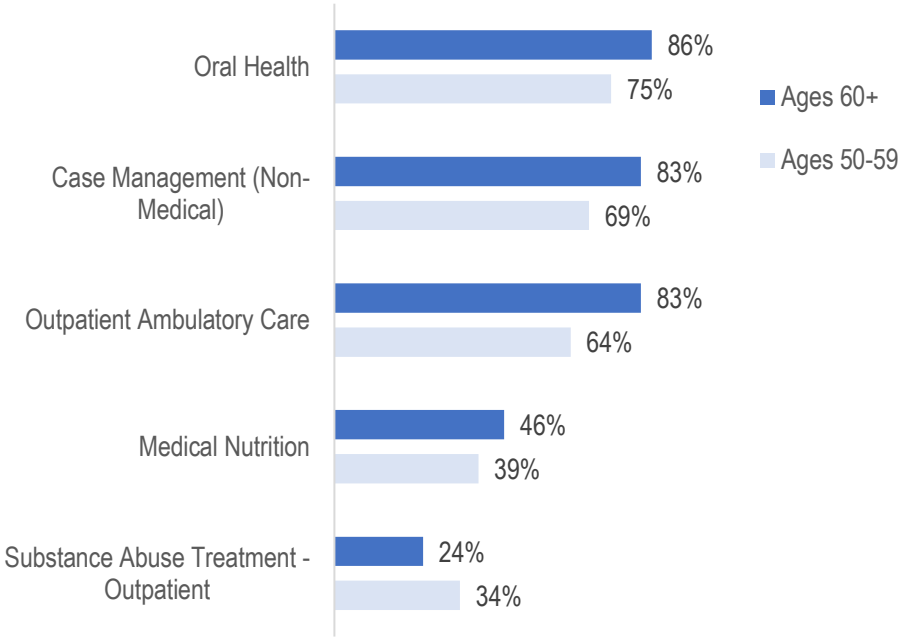
SERVICE DEMAND TOP TEN SERVICES Clients ages <50 compared to 50+			
	< 50		**Aging 50+**
1	Medical Case Management (81%)	1	Medical Case Management (91%)
2	Oral Health (67%)	2	Oral Health (80%)
3	Case Management Non-Medical (78%)	3	Case Management Non-Medical (76%)
4	Outpatient Ambulatory Care (63%)	4	Outpatient Ambulatory Care (74%)
5	Mental Healthcare (58%)	5	Mental Healthcare (67%)
5	AIDS Drug Assistance Program (58%)	6	AIDS Drug Assistance Program (61%)
5	Health Education/Risk Reduction (58%)	7	Health Education/Risk Reduction (56%)
5	Housing (58%)	7	Medical Transportation (56%)
5	Health Insurance Premium Assistance (58%)	8	Food Bank/Home-Delivered Meals (53%)
6	Food Bank/Home-Delivered Meals (54%)	9	Psychosocial Support Services (52%)

- 8 of 10 services that ranked in the top 10 for highest service demand were the same for aging PLWH 50+ and PLWH <50 with the following exceptions:
  - Medical transportation and psychosocial support services were in the top for PLWH 50+
  - Housing and health insurance assistance were in the top 10 for clients < age 50.

b. Service Demand Findings: Clients Ages 50-59 Compared to Ages 60+

To determine service demand disparities within the ageing 50+ population, a deeper analysis was conducted to compare clients 50-59 years old to those 60 years and older. Clients over age 60 had notably higher service demand for 4 of the top 5 services (oral health, non-medical case management, outpatient ambulatory care and medical nutrition). Only one service, outpatient substance use treatment, had a higher service demand for those 50-59 years old compared to those 60+.

Service Demand Ages 50-59 Compared to Ages 60+



2. UNMET NEED BY SERVICE CATEGORY

Services with high unmet need are critical to address because these are services that clients report that they need but are unable to receive due to various barriers that limit access to care.

Unmet Need Findings

Service (% Unmet Need All Ages)	<50	50+
Oral Health (14%)	16%	11%
Emergency Financial Assistance (14%)	21%	9%
Housing (13%)	12%	13%
Medical Nutrition (13%)	12%	12%
Mental Health (9%)	9%	8%
Medical Transportation (8%)	7%	7%
Home and Community-Based Health Services (7%)	9%	6%
Psychosocial Support Services (7%)	9%	7%
Food Bank/Home Delivered Meals (6%)	12%	2%
Legal or Professional Services (6%)	7%	5%
Legal Services (5%)	3%	6%
Substance Abuse Services – Outpatient (5%)	4%	5%
Respite Care (5%)	4%	5%
Health Education/Risk Reduction (4%)	6%	2%
Outreach Services (4%)	9%	2%
Outpatient Ambulatory Care (4%)	6%	2%
Case Management (Non-Medical) (4%)	7%	1%
Early Intervention Services (4%)	4%	2%
Medical Case Management (3%)	6%	2%
AIDS Drug Assistance Program (3%)	1%	3%
AIDS Pharmacy Assistance (3%)	4%	2%
Home Health Care (3%)	1%	3%
Referral for Health Care & Support Services (3%)	3%	3%
Rehabilitation Services (3%)	6%	2%
Health Insurance Premium Assistance (3%)	4%	2%
Substance Abuse Services – Residential (3%)	6%	1%
Child Care (2%)	3%	2%
Hospice (2%)	3%	1%
Linguistic Services (1%)	1%	1%

- Clients ages 50+ had a 12% lower unmet need for emergency financial assistance than those under age 50.
- These older respondents had a 10% lower unmet need for food bank/ home delivered meals.

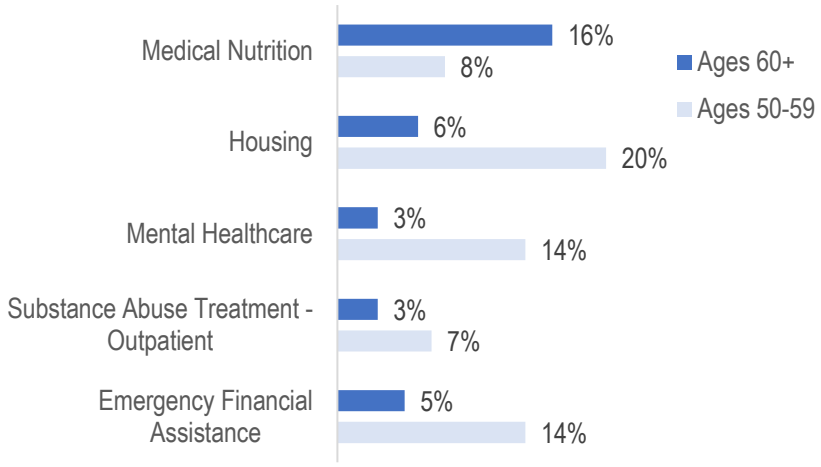
To add to the previous unmet need comparison between respondents ages <50 and older clients ages 50+, the top ten ranked services with highest unmet need for each age cohort are detailed below:

UNMET NEED - TOP TEN SERVICES Clients ages <50 compared to 50+			
	< 50		**Aging 50+**
1	Emergency Financial Assistance (21%)	1	Housing (13%)
2	Oral Health (16%)	2	Oral Health (11%)
3	Housing (12%)	3	Medical Nutrition (11%)
3	Medical Nutrition (12%)	4	Emergency Financial Assistance (9%)
3	Food Bank / Home Delivered Meals (12%)	5	Mental Healthcare (8%)
6	Mental Healthcare (9%)	6	Medical Transportation (7%)
6	Home/Community Based Health Services (9%)	6	Psychosocial Support Services (7%)
6	Psychosocial Support Services (9%)	8	Home/Community Based Health Services (6%)
9	Medical Transportation (5%)	8	Legal Services (6%)
9	Legal Services (5%)	8	Respite Care (6%)

- 9 of 10 services that ranked in the top for highest unmet need were the same among aging PLWH 50+ and PLWH <50 with the following exceptions:
  - respite care was in the top 10 for aging PLWH 50+
  - food bank / home delivered meals was in the top 10 for clients < age 50.

c. Unmet Need Findings: Clients Ages 50-59 Compared to Ages 60+

To determine unmet need disparities within the aging 50+ population, a deeper analysis was conducted to compare clients 50-59 years old to those 60 years and older. As shown below, clients ages 50-59 had notably higher unmet need for 4 of the top 5 services (housing, mental healthcare, emergency financial assistance, outpatient substance use treatment). Only one service, medical nutrition, had a higher unmet need for 60+ year olds compared to those 50-59.



3. HIGHEST RANKED SERVICES: DEMAND AND UNMET NEED

Services that have both a high service demand *and* a high unmet need are particularly important to focus on from a budgeting and programming perspective. These are the services that clients need at a high rate, but they also have not been able to receive them due to high rates of barriers to care.

The following seven services ranked in the top half of service categories for both service demand and unmet need. This targeted assessment drilled down further to figure out what disparities exist between clients ages 50+ and those under age 50 in these high priority services as follows:

HIGHEST RANKED SERVICES
TOP HALF OF SERVICE DEMAND AND UNMET NEED
Clients Ages <50 compared to 50+

Service Category	<50 Unmet Need	50+ Unmet Need	<50 Demand	50+ Demand
Oral Health	16%	11%	67%	80%
Mental Health	9%	8%	58%	67%
Food Bank / Home Delivered Meals	12%	2%	57%	53%
Housing	12%	13%	58%	46%
Medical Transportation	5%	7%	49%	56%
Psychosocial Support Services	9%	7%	54%	52%
Health Education/Risk Reduction	6%	2%	58%	56%

D. BARRIERS TO CARE

1. BARRIERS TO CARE CATEGORIES

Survey respondents were asked to complete the barriers to care section for each service they needed but had been unable to receive due to at least one barrier. Barriers were asked separately for each service category to clarify what barriers limited access to which services. To determine the level of the service delivery system where barriers exist for each service that clients reported an unmet need, they are classified into five categories to examine broad-based TGA-wide "Access" and "Knowledge" issues to more specific client-based "Financial", "Health", and "Personal" issues as follows:

- **Knowledge Barriers** include facts not known by the client that limit access to services, such as: "Didn't know service was available," "Didn't know I was eligible for service," "Didn't know how to get service," and "Didn't know where to receive service."

- **Access Barriers** include factors that limit a client's ability to obtain a service when they need it and include issues such as: "Appointments not soon enough", "Times not convenient," "No childcare," "Language barriers," and "No cell phone."

- **Financial Barriers** include issues such as: "Co-pay was too high," "Service costs too much," and "No insurance coverage."

- **Personal Barriers** include individual concerns such as: "Treated with disrespect," "Jail/Prison history," and "Wanted privacy of HIV status, mental health or substance use."

- **Health Barriers** include medical issues such as: "Didn't want to take medications," "Hard to navigate system due to physical, mental or substance use issues," and "Thought viral load was undetectable."

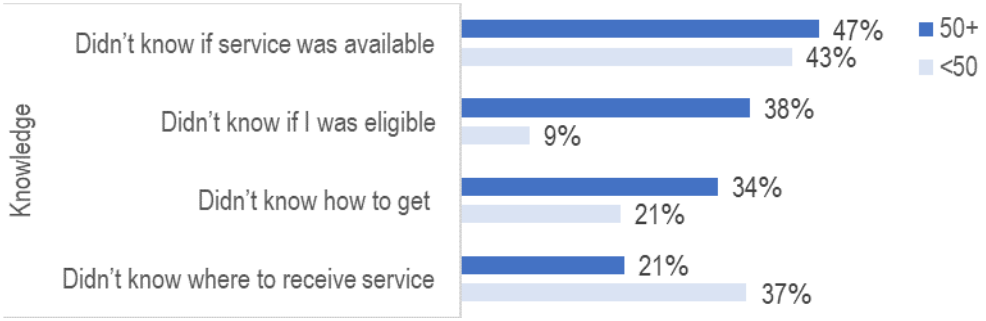
2. BARRIERS TO CARE RANKINGS

TOP 5 BARRIERS BY AGE COHORT

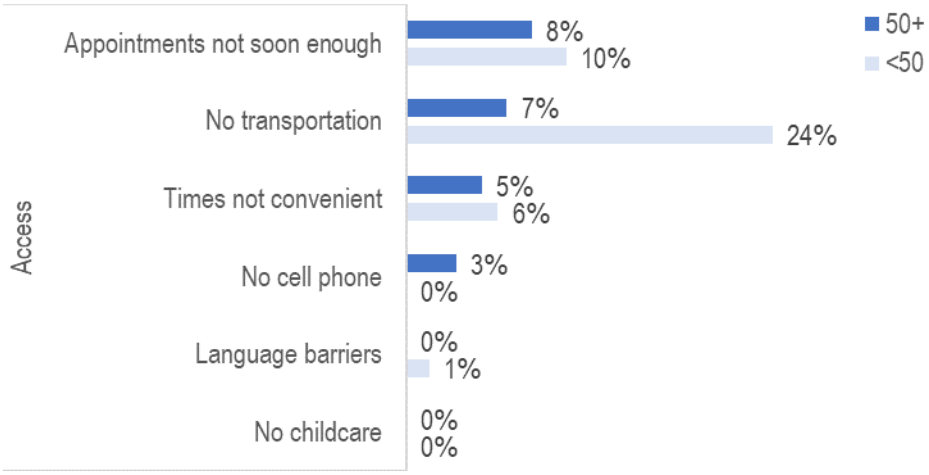
	Under 50		50 or older
1	Didn't know service was available (43%)	1	Didn't know service was available (47%)
2	Didn't' know where to receive service (37%)	2	Didn't know if I was eligible (38%)
3	Previous incarceration (25%)	3	Didn't know how to get (34%)
4	No transportation (24%)	4	Didn't know where to receive service (21%)
5	Didn't know how to get (21%)	5	Appointments not soon enough (8%)

- The top barrier to care for both age cohorts was "Didn't know service was available" (47% of PLWH 50+ and 43% PLWH <50).
- 4 of top 5 barriers for aging PLWH 50+ were knowledge barriers: 1) Didn't know service was available, 2) if I was eligible, 3) how to get or 4) where to receive service.
- 1 of top 5 barriers for PLWH ages 50+ was different than those <50: "Appointments not soon enough."
- 2 of top 5 barriers for PLWH under age 50 were different than PLWH 50+: "Previous incarceration" and "No transportation."

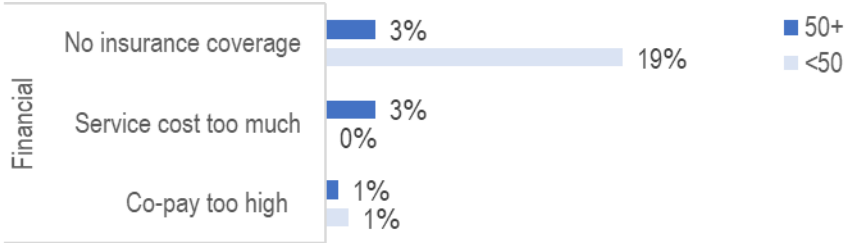
a. Knowledge Barriers by Age



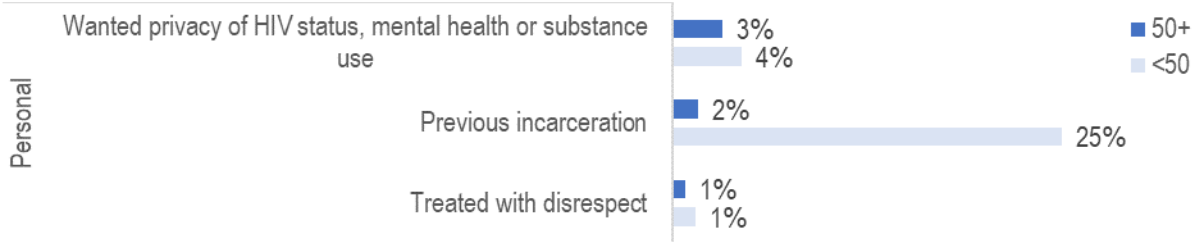
b. Access Barriers by Age



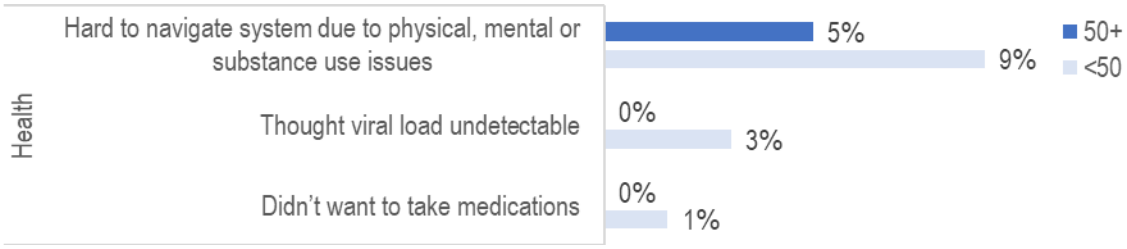
c. Financial Barriers by Age



d. Personal Barriers by Age



e. Health Barriers by Age



- Older PLWH 50+ were more likely than PWLH<50 to report that they stopped seeing a doctor for over a year for the following: felt fine; didn't want to take meds; side effects of medications; viral load was undetectable; and doctor or case manager left.

3. BARRIERS FOR SERVICES WITH HIGHEST UNMET NEED

Barriers to care for the top 5 services with the highest unmet need are shown below by survey respondent age group. With few exceptions, knowledge barriers were the greatest contributors to unmet need for most service categories. However, among those 5 services with the greatest unmet needs, Oral Health, Emergency Financial Assistance, Housing, Medical Nutrition and Housing Services, there were disparities between clients ages 50+ vs. those <50 in sub- barriers that limited access as follows:

Oral Health

- 14% of respondents ages 50+ with an unmet need for oral health services indicated transportation was a barrier to access, compared to none of the respondents under 50.
- 27% of respondents under 50 with an unmet need for oral health services had a financial barrier to obtaining those services compared to 7% of those 50 and older. The most common barrier among respondents under 50 was lack of insurance (18%), over twice the rate of older respondents (7%).

Emergency Financial Assistance

- Compared to clients under 50, a higher percentage of clients 50 and older with an unmet need for emergency financial assistance didn't know it was available (45% vs. 25%), didn't know they were eligible (36% vs. 7%), or didn't know where to get the assistance (27% vs. 7%).

Housing

- A slightly higher proportion of respondents 50 and older with unmet housing needs had knowledge barriers to obtaining housing (56%) compared to younger respondents (50%), with disparities in the types of sub-barriers that were greater for PWLH 50+, such as:
  - Not knowing they were eligible (31% vs. 12%)
  - Not knowing how to get help with housing (37% vs none)
  - Not know where to go to find housing (25% vs. 12%).

- Younger clients with unmet housing needs reported that the cost of housing was a problem more frequently than older respondents (25% vs. 12%).
- 25% of respondents under 50 with unmet housing needs indicated that previous incarceration was a barrier to obtaining housing compared 12% of respondents 50 and older.

Barriers to Receiving Housing Placement *(check all that apply)*		
	<50	**50+**
Previous incarceration/criminal record	17%	0%
Significant other's criminal record	8%	0%
Rental history	3%	0%
Not enough money	25%	27%
Housing location	8%	3%
Mental health	0%	3%
Physical health	0%	6%
Substance Use	0%	6%
Other	0%	12%

Medical Nutrition

- Both younger and older respondents with unmet medical nutrition needs indicated access barriers (25% vs. 20%). Younger respondents said inconvenient times were a problem at five times the rate of older respondents (37% s. 7%) and that childcare was more of an issue (25% vs. 7%).
- Personal barriers were a much greater problem for PLWH <50 with unmet medical nutrition needs compared to older PLWH 50+ (25% vs. 7%). One quarter of those <50 reported that previous incarceration with a problem compared to none of the respondents 50 and older.

Mental Health

- Half of respondents 50+ with unmet mental health service needs indicated knowledge barriers such as not knowing the service was available (30%), not knowing they were eligible (30%), and not knowing how to get mental health services (30%).
- No clients under age 50 with unmet mental health needs had knowledge barriers, but had many more access and personal barriers to care than older PLWH as follows:
- 33% of respondents under 50 with unmet mental health service needs had an access barrier compared to 10% of respondents over 50 (17% of clients <50 had a language barrier compared to no clients 50+).
- No older respondents with unmet mental health needs reported financial barriers to these services, however 17% of younger respondents did (all reported it was due to lack of insurance).
- One third of younger respondents with unmet mental health needs faced personal barriers (previous incarceration and privacy of sensitive health information were each 17%), however no older respondents indicated personal barriers accessing mental health services.

- 17% of younger respondents with unmet mental health needs faced health-related barriers compared to none of the respondents ages 50 and older. Top barriers were lack of desire to take medications (17%) and difficulty in navigating the system of care (17%).

E. OBSERVATIONS AND RECOMMENDATIONS

1. SERVICE SYSTEM IMPROVEMENTS FOR CONSIDERATION

It is important that the client input gained through this needs assessment be used to continue to decrease barriers to care that clients state have limited their ability to access needed HIV treatment and support services. Although not an exhaustive list of strategies, the following are examples of service system improvements the Council and HIV Care Services Program should continue to work on to meet client service need, reduce unmet need, and decrease barriers to care for PLWH 50+:

- ***Address Knowledge Barriers.*** 4 of top 5 barriers for aging PLWH 50+ were knowledge barriers. Models of care for outreach, education and case management should continue to be assessed and improved. For example, service providers should increase awareness of services through targeted strategies of direct client contact, tailored outreach, and social media campaigns. Case Managers and support staff should consistently contact clients directly to provide information and referrals to services needed. In addition, case managers should increase efforts to follow up with clients and providers to ensure services are received. In addition, cost-effective models of care that use peers to conduct outreach and education should be expanded.

- ***Medical Care Retention.*** To support retention in ongoing medical care, case managers and support staff should continue to increase efforts to contact patients directly to encourage and incentivize re-entry into medical care. All RW service agencies should continue to: 1) make appointment reminder calls, 2) facilitate transportation assistance; and 3) improve and implement "no-show" tracking and follow up protocols.

- ***Partner Services***. 61% of PLWH 50+ reported never being informed of partner services; 56% reported that they would be willing to use them; but only 6% had done so. The Planning Council and HIV Care Services Program should consider supporting efforts to increase education and provision of client incentives for partner services.

- ***PrEP*** was reported as underutilized: 26% of aging PLWH 50+ had never heard of PrEP vs. 19% of those <50. Strategies to continue to improve PrEP education, referrals, and navigation services, including client follow up and release of information between service providers, should be expanded.

- ***Technical Assistance/Capacity Building.*** The Council should continue to work with organizations across the TGA to share this and prior HIV needs assessments, as well as other local HIV data (see last bullet below). These data sharing efforts should be used to develop and implement technical

assistance and capacity building strategies to continue to improve services along the HIV continuum of care.

- ***Provider Access to Health Insurance Payments.*** HIV Care Services Subrecipients report difficulties with billing third party payors, including Medi-Cal and Medicare. If these barriers could be addressed, health insurance organizations could provide significant other sources of funding to HIV Care providers for the services they offer to PLWH. The Council should consider polling the HIV service provider community to assess barriers and needs related to health insurance provider enrollment and reimbursement. Based on provider input, the Council also should consider supporting strategies for funding and delivering various capabilities to maximize provider reimbursement from third party sources.

- ***Quality Improvement.*** The Council's Quality Advisory Committee should continue to expand efforts to get input from PLWH and service providers as part of its Continuous Quality Improvement (CQI) efforts. The HIV Care Services Program should consistently get input from PLWH in local planning, decision-making and service delivery improvements. For example, client and service provider focus groups should be facilitated to evaluate the TGA's overall service delivery system, including coordination of care and provider collaboration. These quality improvement strategies should continue to prioritize issues of racial equity and stigma reduction across all strategies of communication, program development and implementation.

- ***Leverage Local HIV Data.*** The HIV Care Services Program should continue to use its database, Sacramento HIV/AIDS Reporting Engine (SHARE), to generate "Clients Not in Care" reports to identify PLWH not in HIV medical care; to resolve data issues; to track progress of CQI projects; to identify areas for program improvement; and to assist with re-engaging clients in medical care. In addition, the HIV Care Services Program should continue to share data that reflect HIV epidemiology trends, client service utilization and community-based strategies used by other TGAs to improve the HIV care system and inform resource allocation.

2. FUTURE NEEDS ASSESSMENTS

Survey Tool

The HIV Needs Assessment Survey Tool was revised in 2022 to streamline the questions of Service Need, Need Met, and Unmet Need by RW service category. In addition, the survey collected data on Barriers to Care and Sub-Barriers by service category. This format resulted in more consistent answers from survey respondents compared to the TGA's past needs assessments. The survey was able to be completed in less time and with less confusion among survey respondents than in previous surveys.

Based on responses from the improved survey format in 2022, there are several additional improvements to the survey format and content that could help improve the reliability and utility of survey responses in the future. There are several questions on the current Needs Assessment Tool that the Council's Needs Assessment Committee may consider making adjustments to, as follows:

- **Benefits question 1b:** Unemployment should be added to the list.

- **Income question 2:** The number of dependents or children is not required to determine Federal Poverty Level so should be deleted and replaced with "how many people are in your household?" which is required.

- **Syringe use question 11a:** "Have you ever injected any substance NOT prescribed by a medical person?'" "Provider" should replace "person" and "syringe" should replace "needle."

- **Syringes add question 11d:** "Where do you *most often* get your clean syringes?" (check one) "I go to syringe exchange agency." I get from syringe exchange agency staff who bring them to me." I get them from another user of syringes who gets them from syringe access agency." "Other"

- **Syringes add question 11e**: "How do you *most often* dispose of your used syringes?" (check one) "Bring sterile syringe container back to syringe exchange agency." "I throw them away." "Other"

- **Hepatitis C question 12:** "Has a medical or service provider ever told you that you have hepatitis C?" The question should be narrowed to (a) Are you currently HCV positive? and (b) Were you newly infected in the last 12 months? (incidence).

- **Housing question 13:** "Over the last 12 months, have you lived in any of the following places (check all that apply). This data may not be comparable to other point-in-time housing figures for other local, state, and national programs. The Council should consider revising the survey tool to ask about current point-in-time housing status and require a single choice response.

- **Housing question 14:** "If you currently receive housing assistance, what assistance do you receive (check one option)". The following options should be added, since they've been written in as response under "other" over the years: Shelter Plus, Mercy Housing and Sacramento Housing and Redevelopment Agency (SHRA).

- **Housing question 16:** "Have you ever received a referral for housing? If yes, did it result in housing placement? This question should be specific to the year being surveyed to be consistent with the time period for housing question #15 which asks: "Have you been on a waiting list for housing over the last 12-months? If yes, did it result in housing placement?" If not, why not?"

- **HIV Transmission question 22:** "What is the most likely way that you contracted HIV"? It is intended to be a single selection of listed choices and should say "please check one" and remove MSM/IDU. Respondents could check "other" and write the risk categories that apply to them.

- **Barriers to Care** survey formatting for unmet needs sometimes resulted in inconsistent responses and data input in the "sub-barriers" section, which made analysis of response data for this section

challenging. The example below provides a suggested update to the survey tool to more clearly prompt respondents to select specific sub-barriers. Survey data input also would need to be updated to accommodate the increased specificity, including nineteen options/rows for each sub-barrier, indicating whether the respondent selected each specific sub-barrier or not.

BARRIERS TO CARE				
D	**E**	**F**	**G**	**H**
Knowledge Didn't know: 1) if service was available 2) if I was eligible 3) how to get 4) where to receive service 5) date/time of appointment	**Access** 1) Appointments not soon enough 2) times not convenient 3) no transportation 4) no childcare 5)language barriers 6) no cell phone	**Financial** 1) co-pay too high 2) service cost too much 3) no insurance coverage	**Personal** 1) treated with disrespect 2) previous incarceration 3) wanted privacy of HIV status, mental health or substance use	**Health** 1) didn't want to take medications 2) hard to navigate system due to physical, mental or substance use issues 3) thought viral load undetectable
Check all that apply:				
① ② ③ ④⑤	①②③④⑤⑥	① ② ③	① ② ③	① ② ③

Survey Process

In addition to the recommended changes to the HIV Needs Assessment survey tool, there are changes to the process that would help ensure that each participant's input is represented accurately and thoroughly. The quality and completeness of the data would be improved if each respondent's completed survey was reviewed by survey administration staff prior to providing the survey respondent with a gift card. Staff could answer any questions the client has about the instructions, format, or intent of the survey questions. This is particularly important for client's whose primary language is not English.

Sacramento County
Department of Health Services
HIV Health Services Planning Council
www.sacramento-tga.com

Meeting Agenda

June 26, 2024, 10:00 AM – 12:00 PM

Meeting Location –
4600 Broadway, Sacramento, CA 95820
2nd Floor Conference/Community Room 2020

Facilitator: Kristina Kendricks-Clark, Council Vice Chair

Scribe: Angelina Olweny, Council Staff

Meeting Invitees:

- HIV Health Services Planning Council Members
- Open to the Public

Public Comment: This provides opportunities for the public to address the Council as a whole in order to listen to opinions regarding matters within the jurisdiction of the Council during Regular meetings and regarding items on the Agenda at all other meetings. Public Comment time limit is three (3) minutes.

*Action Items

Topic	Presenter	Start Time and Length
Welcome, Introductions, & Housekeeping	Kendricks-Clark	10:00 am
Announcements	All	As Needed
Public Comments-Agenda Items 3 Minute Time Limit	All	
May 2024 Agenda*	Kendricks-Clark	
Minutes of April 2024*	Kendricks-Clark	

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State Office of AIDS June 2024 Update	Pulupa	As Needed
Homelessness and Housing	Rodriguez	
CPG/HIV/STI Prevention Updates	All	
Recipient Report: ➢ FY24 Part A Year Report* ➢ FY24 Part B Fiscal Report ➢ HRSA Ending the Epidemic Update	Gossett	
Committee/Work Group Updates ➢ Administrative Assessment Committee ➢ FY23 Year End Results ➢ Affected Communities Committee ➢ Community Presentations ➢ Reflectiveness ➢ Priorities and Allocations ➢ FY25 Allocations* ➢ Executive Committee ➢ Quality Advisory Committee ➢ Oral Health Service Standard* ➢ Housing Service Standard* ➢ EFA Service Standard* ➢ Needs Assessment Committee ➢ HIV & Aging Needs Assessment ➢ Ad Hoc Workgroup ➢ Governance	Willett Basler Bradley-Rowe Kendricks-Clark Gluckman Miranda Basler Bradley-Rowe	
Binder Updates	Caravella	
Public Comments-Non-Agenda Items	All	
Technical Assistance	Kendricks-Clark	

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Adjournment	Kendricks-Clark	12:00 pm

Attachments:

- Minutes of May, 2024*
- June 2024 OA Voice Update
- FY24 Part A Report*
- FY24 Part B Fiscal Report
- FY23 Year End AdAC Results
- FY25 Allocations*
- Oral Health Service Standard*
- Housing Service Standard*
- EFA Service Standard*
- HIV & Aging Needs Assessment

NEXT MEETING: August 28, 2024
September 25, 2024