

# RYAN WHITE C.A.R.E. ACT

SACRAMENTO REGION  
PART A APPLICATION  
2025 – 2026



SUBMITTED SEPTEMBER 27, 2024

Recipient/Administrative Agent  
County of Sacramento  
Department of Health Services  
Division of Public Health  
HIV Care Services Program  
7001-A East Parkway, Suite 600B  
Sacramento CA, 95823

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

**Application for Federal Assistance SF-424**

\* 1. Type of Submission:

- Preapplication
- Application
- Changed/Corrected Application

\* 2. Type of Application:

- New
- Continuation
- Revision

\* If Revision, select appropriate letter(s):

\* Other (Specify):

\* 3. Date Received:

Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

H89HA00048

**State Use Only:**

6. Date Received by State:

09/27/2024

7. State Application Identifier:

**8. APPLICANT INFORMATION:**

\* a. Legal Name:

County of Sacramento

\* b. Employer/Taxpayer Identification Number (EIN/TIN):

94-6000529

\* c. UEI:

YZL9FJW2J5H6

**d. Address:**

\* Street1:

7001A East Parkway, Suite 600A

Street2:

\* City:

Sacramento

County/Parish:

Sacramento

\* State:

CA: California

Province:

\* Country:

USA: UNITED STATES

\* Zip / Postal Code:

95823-2501

**e. Organizational Unit:**

Department Name:

Department of Health Services

Division Name:

Public Health

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

Prefix:

\* First Name:

Michelle

Middle Name:

\* Last Name:

Gossett

Suffix:

Title:

Senior Health Program Coordinator

Organizational Affiliation:

\* Telephone Number:

916-875-2776

Fax Number:

916-854-9459

\* Email:

gossettm@saccounty.gov

**Application for Federal Assistance SF-424**

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

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

\* Other (specify):

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

Health Resources and Services Administration

**11. Catalog of Federal Domestic Assistance Number:**

93.914

CFDA Title:

HIV Emergency Relief Project Grants

**\* 12. Funding Opportunity Number:**

HRSA-25-054

\* Title:

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

**13. Competition Identification Number:**

HRSA-25-054

Title:

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

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

Add Attachment

Delete Attachment

View Attachment

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

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

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

**Application for Federal Assistance SF-424**

**16. Congressional Districts Of:**

\* a. Applicant

\* b. Program/Project

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

Add Attachment

Delete Attachment

View Attachment

**17. Proposed Project:**

\* a. Start Date:

\* b. End Date:

**18. Estimated Funding (\$):**

* a. Federal	<input type="text" value="3,925,954.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="3,925,954.00"/>

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

a. This application was made available to the State under the Executive Order 12372 Process for review on .

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

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

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

Yes  No

If "Yes", provide explanation and attach

Add Attachment

Delete Attachment

View Attachment

**21. \*By signing this application, I certify (1) to the statements contained in the list of certifications\*\* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances\*\* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

\*\* I AGREE

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

**Authorized Representative:**

Prefix:  \* First Name:

Middle Name:

\* Last Name:

Suffix:

\* Title:

\* Telephone Number:

Fax Number:

\* Email:

\* Signature of Authorized Representative:

\* Date Signed:

## BUDGET INFORMATION - Non-Construction Programs

### SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Administrative (Part A + MAI)	93.914	\$ 0.00	\$ 0.00	\$ 392,594.00	\$ 0.00	\$ 392,594.00
2. COM (Part A + MAI)	93.914	0.00	0.00	196,297.00	0.00	196,297.00
3. HIV Services (Part A + MAI)	93.914	0.00	0.00	3,337,063.00	0.00	3,337,063.00
4.						
<b>5. Totals</b>		<b>\$ 0.00</b>	<b>\$ 0.00</b>	<b>\$ 3,925,954.00</b>	<b>\$ 0.00</b>	<b>\$ 3,925,954.00</b>

**SECTION B - BUDGET CATEGORIES**

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) Administrative (Part A + MAI)	(2) COM (Part A + MAI)	(3) HIV Services (Part A + MAI)	(4)	
<b>a. Personnel</b>	\$ 170,439.00	\$ 104,289.00	\$ 0.00	\$	\$ 274,728.00
<b>b. Fringe Benefits</b>	107,109.00	57,965.00	0.00		165,074.00
<b>c. Travel</b>	8,648.00	804.00	0.00		9,452.00
<b>d. Equipment</b>	0.00	0.00	0.00		0.00
<b>e. Supplies</b>	10,200.00	1,090.00	0.00		11,290.00
<b>f. Contractual</b>	25,811.00	0.00	3,337,063.00		3,362,874.00
<b>g. Construction</b>	0.00	0.00	0.00		0.00
<b>h. Other</b>	34,697.00	14,304.00	0.00		49,001.00
<b>i. Total Direct Charges (sum of 6a-6h)</b>	\$ 356,904.00	\$ 178,452.00	\$ 3,337,063.00	\$	\$ 3,872,419.00
<b>j. Indirect Charges</b>	35,690.00	17,845.00	0.00		53,535.00
<b>k. TOTALS (sum of 6i and 6j)</b>	\$ 392,594.00	\$ 196,297.00	\$ 3,337,063.00	\$	\$ 3,925,954.00
<b>7. Program Income</b>	\$ 0.00	\$ 0.00	\$ 0.00	\$	\$ 0.00

**Authorized for Local Reproduction**

**SECTION C - NON-FEDERAL RESOURCES**

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Administrative (Part A + MAI)	\$	\$	\$	\$
9. COM (Part A + MAI)				
10. HIV Services (Part A + MAI)				
11.				
12. TOTAL (sum of lines 8-11)	\$	\$	\$	\$

**SECTION D - FORECASTED CASH NEEDS**

	Total for 1st Year			
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 3,925,954.00	\$ 981,488.50	\$ 981,488.50	\$ 981,488.50
14. Non-Federal	\$			
15. TOTAL (sum of lines 13 and 14)	\$ 3,925,954.00	\$ 981,488.50	\$ 981,488.50	\$ 981,488.50

**SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT**

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Administrative (Part A + MAI)	\$ 392,594.00	\$ 392,594.00	\$	\$
17. COM (Part A + MAI)	196,297.00	196,297.00		
18. HIV Services (Part A + MAI)	3,337,063.00	3,337,063.00		
19.				
20. TOTAL (sum of lines 16 - 19)	\$ 3,925,954.00	\$ 3,925,954.00	\$	\$

**SECTION F - OTHER BUDGET INFORMATION**

21. Direct Charges:		22. Indirect Charges: 10%
23. Remarks:	Using the 10% de minimis charge for indirect	

## Key Contacts Form

**\* Applicant Organization Name:**

County of Sacramento

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

**\* Contact 1 Project Role:** HIV Care Services Program Coordinator

Prefix:

**\* First Name:** Michelle

Middle Name:

**\* Last Name:** Gossett

Suffix:

Title: Senior Health Program Coordinator

**Organizational Affiliation:**

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

**\* Street1:** 9616 Micron Ave, Suite 930

Street2:

**\* City:** Sacramento

County: Sacramento

**\* State:** CA: California

Province:

**\* Country:** USA: UNITED STATES

**\* Zip / Postal Code:** 95827-2625

**\* Telephone Number:** 916-875-2776

Fax: 916-854-9459

**\* Email:** gossettm@saccounty.gov

Next Person

### Project/Performance Site Location(s)

**Project/Performance Site Primary Location**  I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

\* Street1:

Street2:

\* City:  County:

\* State:

Province:

\* Country:

\* ZIP / Postal Code:  \* Project/ Performance Site Congressional District:

**Project/Performance Site Location 1**  I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

\* Street1:

Street2:

\* City:  County:

\* State:

Province:

\* Country:

\* ZIP / Postal Code:  \* Project/ Performance Site Congressional District:

**Additional Location(s)**

## CERTIFICATION REGARDING LOBBYING

### Certification for Contracts, Grants, Loans, and Cooperative Agreements

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

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

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

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

### Statement for Loan Guarantees and Loan Insurance

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

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

**\* APPLICANT'S ORGANIZATION**

County of Sacramento

**\* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE**

Prefix:  \* First Name: Paula Middle Name:

\* Last Name: Gammell Suffix:

\* Title: Human Services Program Planner

\* SIGNATURE: Completed on submission to Grants.gov

\* DATE: Completed on submission to Grants.gov

## RWHAP PART A BUDGET SUMMARY

RECIPIENT:

FISCAL YEAR: 2025

Object Class Categories	Part A			Minority AIDS Initiative (MAI)			Total
	Administration	CQM	HIV Services	Administration	CQM	HIV Services	
a. Personnel	\$ 157,592	\$ 98,215	\$ -	\$ 12,847	\$ 6,074	\$ -	\$ 274,728
b. Fringe Benefits	\$ 99,552	\$ 54,440	\$ -	\$ 7,557	\$ 3,525	\$ -	\$ 165,074
c. Travel	\$ 8,648	\$ 804	\$ -	\$ -	\$ -	\$ -	\$ 9,452
d. Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
e. Supplies	\$ 10,200	\$ 1,000	\$ -	\$ -	\$ 90	\$ -	\$ 11,290
f. Contractual	\$ 25,811	\$ -	\$ 3,133,594	\$ -	\$ -	\$ 203,469	\$ 3,362,874
g. Other	\$ 33,341	\$ 13,112	\$ -	\$ 1,357	\$ 1,192	\$ -	\$ 49,002

Direct Charges	\$ 335,143	\$ 167,571	\$ 3,133,594	\$ 21,761	\$ 10,881	\$ 203,469	\$ 3,872,419
Indirect Charges	\$ 33,514	\$ 16,757		\$ 2,176	\$ 1,088		\$ 53,535
<b>TOTALS</b>	<b>\$ 368,657</b>	<b>\$ 184,328</b>	<b>\$ 3,133,594</b>	<b>\$ 23,937</b>	<b>\$ 11,969</b>	<b>\$ 203,469</b>	<b>\$ 3,925,954</b>
Program Income							\$ -

FY 2024 Funding Ceiling:	
Part A Funding	\$ 3,686,579
MAI Funding	\$ 239,375
<b>Total:</b>	<b>\$ 3,925,954</b>

Administrative Budget 10%

Part A and MAI Within Limit

CQM Budget 5%

Part A and MAI Within Limit

Manually Enter HIV Services Allocation Percentages	
Core Medical Services	Support Services
86%	14%

**PART A ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

Personnel				
Salary	FTE	Name, Position	Budget Impact Justification	Amount
\$ 135,162	0.15	Sr. Health Program Coordinator (Gossett) 12 mos	Oversees daily operations of Part A. Monitors contractual obligations of contractors, MOU's with participating counties; Monitors expenditure rate and reallocation process, Negotiates yearly contract rates with contractors, Provides technical assistance, Coordinates functions of Part A program with other AIDS programs, including Part B, C and D program, AIDS Drug Assistance Program, and County STD, Public Health Surveillance and Prevention. Engage Planning Council in long-range planning. Keep Council apprised of strategic issues and trends in health and human services in the region. Facilitate collaboration in carrying out Planning Council activities. Develop performance improvement plans and monitor and report on Performance Outcomes. Identify and pursue opportunities for program enhancement. Run specialized data reports from Report Manager, special studies, and contractor monitoring visits. Position impact is to support all stages of HIV Care Continuum for our TGA. (.16 Part A CQM, .05 Part A MAI admin, 0.22 RW Part B admin, 0.11 Part B CQM, .26 HRSA ETE admin, .05 ETE CQM)	\$ 20,700
\$ 143,574	0.14	Human Services Program Planner, (Gammell) 12 mos	Assists the Sr. Health Program Coordinator in overseeing daily operations of Part A and Part A MAI Programs and contract monitoring as well as expenditure and utilization monitoring. Disseminates program changes and program reports to sub-recipients. prepares various mandatory program reports and Conditions of Award. Assists sub-recipients in accessing SHARE database and database issues and provides Technical Assistance on various issues. Run specialized data reports from Report Manager, special studies, and contractor monitoring visits. Position impact is to support all stages of HIV Care Continuum for our TGA. ( 0.31 Part A CQM, .03 Part A MAI admin, .04 Part A MAI CQM, .11 RW Part B admin, .18 Part B CQM, .19 HRSA ETE CQM)	\$ 19,900
\$ 103,562	0.14	Health Program Coordinator (Bunton) 12 mos	Assists the Sr. Health Program Coordinator in overseeing daily operations of Part A. Monitors contractual obligations of contractors, MOU's with participating counties; Monitors expenditure rate and reallocation process, Negotiates yearly contract rates with contractors, Provides technical assistance, Coordinates functions of Part A program with other AIDS programs, including Part B, C and D program, AIDS Drug Assistance Program, and County STD, Public Health Surveillance and Prevention. Engage Planning Council in long-range planning. Keep Council apprised of strategic issues and trends in health and human services in the region. Facilitate collaboration in carrying out Planning Council activities. Develop performance improvement plans and monitor and report on Performance Outcomes. Identify and pursue opportunities for program enhancement. Run specialized data reports from Report Manager, special studies, and contractor monitoring visits. Position impact is to support all stages of HIV Care Continuum for our TGA. (.03 RW Part B admin, .44 HRSA ETE admin, .22 HRSA ETE CQM, .17 HRSA ETE P&E)	\$ 14,742
\$ 78,602	0.54	Account Technician (Kincaid) 12 mos	Supports program by keeping track of sub-recipient expenditures with the SHARE data base, processes invoices for Sr. Health Program Coordinator to review, reconciles program spreadsheets, keeps program files accurate and in order, prepares and runs reports for the program as needed, works with sub-recipients who have program invoicing questions. Supports program objectives by ensuring RW funds are tracked and spent as budgeted. (.01 Part A MAI admin, .20 RW Part B admin, .25 HRSA ETE admin)	\$ 42,250
\$ 57,599	0.04	Sr. Office Assistant (Bishop) 12 mos	Position supports the HIV Care Services Unit. Answers phones, takes messages from clients, enter data into the State HIV database, distribute the mail to staff, organize important documentation. Work with the Sr. Managers to make sure tasks are completed in a timely manner that are relevant to grant. (.04 HRSA ETE admin, .04 HIV Surveillance, .88 HIV Prev.)	\$ 2,000
\$ 77,944	0.07	Dental Program Coordinator (Blanchard) 12 mos	Oversees pre-authorizations for Dental Project services to assure compliance with Dental Rate Schedule and Eligible Dental Procedures. Assists in achieving Oral Health services goals for clients within TGA and that funds are spent properly. (.80 Comp Oral Health, .13 First 5)	\$ 5,435
\$ 109,162	0.24	Admin. Services Officer II (Tu) 12 mos	Supports program through preparing direct services contracts and amendments, tracking their expenditures and related required documentation. Assist in the Ryan White claims process, drafts Board Letters, implements sub-recipient contract changes; and provides routine clerical support to Ryan White program staff. Program objectives are supported by assisting Coordinator with legislative requirements and service category objectives. (.09 RW Part B admin, .14 HRSA ETE P&E, .57 Realignment, .03 SAMHSA Navigator Program)	\$ 26,600
\$ 88,756	0.10	Admin. Services Officer 1 (Windmon) 12 mos	Liaison with Fiscal Department, travel and mileage claims, and Planning Council Member reimbursement expenses. Supports program objectives through routine clerical assistance. (.20 HIV Surveillance, .10 Realignment, .30 MCH Title V Funds, .30 Vital Statistics)	\$ 8,835
<b>Personnel Sub-Total with Rounding</b>				\$ 140,462
<b>Rounding Input Adjustment to Match SF-424A</b>				
<b>Personnel Total</b>				\$ 140,462
Fringe Benefits				
Percentage	Components			Amount
22.21%	Retirement			\$ 31,202
4.50%	Retirement Health Savings Account			\$ 6,320
4.45%	401K Match			\$ 6,247
7.66%	FICA/SSI			\$ 10,759
23.69%	Health Insurance			\$ 33,275
<b>Fringe Benefit Sub-Total with Rounding</b>				\$ 87,803
<b>Fringe Benefit Total</b>				\$ 87,803
Travel				
Local				
Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount

**PART A ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

0.670	646.68	Sr. Health Program Coordinator, Gossett	53.89mi/mo x 12 = 646.68 mi x .67 = \$433.28. Conduct site sub-recipient site visits; attend HIV Planning Council committee and other required meetings; provide TA to sub-recipients; attend off-site Training opportunities; participate in community continuum of care meetings and events. Travel impacts program goals so that staff can meet required steps to monitor subrecipients.	\$ 433
0.670	646.68	Human Services Program Planner, Gammell	53.89mi/mo x 12 = 646.68 mi x .67 = \$433.28. Conduct site sub-recipient site visits; attend HIV Planning Council committee and other required meetings; provide TA to sub-recipients; attend off-site Training opportunities; participate in community continuum of care meetings and events. Travel impacts program goals so that staff can meet required steps to monitor subrecipients.	\$ 433
0.670	646.68	Health Program Coordinator, Bunton	53.89mi/mo x 12 = 646.68 mi x .67 = \$433.28. Conduct site sub-recipient site visits; attend HIV Planning Council committee and other required meetings; provide TA to sub-recipients; attend off-site Training opportunities; participate in community continuum of care meetings and events. Travel impacts program goals so that staff can meet required steps to monitor subrecipients.	\$ 433
<b>Local Travel Sub-Total</b>				<b>\$ 1,300</b>
<b>Long Distance</b>				
<b>Type of Travel</b>	<b>Name, Position of Traveler(s)</b>	<b>Travel Expenses/Budget Impact Justification</b>		<b>Amount</b>
Air	1) Health Program Coordinator (Bunton)	Airfare = \$750, Hotel = \$176 + 20% taxes and fees x 4 nights = \$845, meals at per diem rates \$74 x 5 days = \$370; parking = \$19/day x 5 days = \$95, transportation to and from airport = \$45, incidentals \$5/day x 5 days = \$25; Attend US Conference on HIV/AIDS or RW Conference to obtain current information and best practices for administering HIV/AIDS programs x 1 staff. Program goals are impacted by conference travel so that staff can continue to keep current with the HIV Care Continuum and National HIV Strategy information.		\$ 2,130
<b>Long Distance Travel Sub-Total</b>				<b>\$ 2,130</b>
<b>Travel Total</b>				<b>\$ 3,430</b>
<b>Equipment</b>				
<b>List of Equipment</b>		<b>Budget Impact Justification</b>		<b>Amount</b>
				<b>Equipment Total</b>
				<b>\$ -</b>
<b>Supplies</b>				
<b>List of Supplies</b>		<b>Budget Impact Justification</b>		<b>Amount</b>
Copy Paper, Printer Cartridges, Pens, Highlighters, Pencils, Erasers, Post It Notes, Paper Clips, Pens, Flash Drives, Highlighters, Pencils, Erasers, Ink Refill, etc.		\$266/mo x 12 = \$3200. \$266 per month to be spent for misc. general consumable office supplies necessary to perform the work of administering the Ryan White Care Act funds to achieve goals of the National HIV Strategy.		\$ 3,200
<b>Supplies Total</b>				<b>\$ 3,200</b>
<b>Contractual</b>				
<b>List of Contract</b>	<b>Deliverables</b>	<b>Budget Impact Justification</b>		<b>Amount</b>
TBD	Part A Grant Application guidance review, original writing of application and editing of documents program creates.	Consultant for grant application; analyzes drafts of the application comparing to the Guidance to identify any missing components, and original writing. (141.89 hrs x \$100/hr) Costs estimated based on previous years total hours for this project. Meets program goals of compiling a successful application so that the TGA can provide services to our HIV+ clients.		\$ 14,189
<b>Contracts Total</b>				<b>\$ 14,189</b>
<b>Other</b>				
<b>List of Other</b>		<b>Budget Impact Justification</b>		<b>Amount</b>
Office Lease		Cost of rent per person for building. All rent charges are applied on a per FTE basis. 1.42 FTEs		\$ 8,138
Communication Services		Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals. 1.42 FTEs		\$ 9,395
Training		Cost of mandatory supervisory County training sessions for Sr. Health program Coordinator, Health Program Coordinator, Program Planner, and Health Educator; training on new software for staff. Health Equity training for RW staff. Trainings occur quarterly = \$500 per quarter.		\$ 2,000
OCIT-Data Processing/SHARE/MIS		SHARE is the unique client-level database for the Sacramento TGA. This expense includes data Processing for the RSR; Development and on-going maintenance of the data import program from sub-recipients; update of SHARE database reports; (IT programming \$100 per hour x 38.12 hours)		\$ 3,812
Postage		Routine postage, share of postage machine equipment and maintenance and federal Express charges postage = \$83.33/mo x 12 = \$1000		\$ 1,000
Printing/Duplicating		Printing of routine admin documents. Monthly print costs for large print jobs \$148 x 12 = \$1776.		\$ 1,776
Copy Machine Maintenance		Copy machine lease and maintenance agreements. Software license fees; Monthly copying fees \$166.67 x 12 = \$2000		\$ 2,000
<b>Other Costs Total</b>				<b>\$ 28,121</b>
<b>Total Direct Cost</b>				<b>\$ 277,204</b>
<b>Indirect Cost</b>				
<b>Type of Indirect Cost</b>	<b>Rate</b>	<b>Insert Base</b>		<b>Total</b>
Fixed	10% de minimis	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.		\$ 27,720

**PART A ADMINISTRATIVE BUDGET**

RECIPIENT:  
FISCAL YEAR: 2025

**Part A Administrative Total**

**PART A PLANNING COUNCIL/PLANNING BODY BUDGET**

RECIPIENT:  
FISCAL YEAR: 2025

**Personnel**

Salary	FTE	Name, Position	Budget Impact Justification	Amount
\$ 85,440	0.20	Health Educator Range B, (Caravella)	Manage operational staff support to the HIV Services Planning Council. Assist the council in how they need to meet their obligations which include adequate structure and governance, diverse and representative membership; annual priorities and allocations process; administrative assessment of the grantee; development of a comprehensive HIV Services Plan for the Sacramento TGA; increase access to services; Assessment of need for HIV services; assist the Sr. Health Program Coordinator and Health Services Program planner with programmatic aspects of Part A. This position impacts the program goals of meeting required Planning Council criteria. (.60 HRSA ETE core, .20 HRSA ETE P&F)	\$ 17,130

**Personnel Sub-Total with Rounding** \$ 17,130

**Personnel Total** \$ 17,130

**Fringe Benefits**

Percentage	Components	Amount
24.9000%	Retirement	\$ 4,265
5.8400%	Retirement Health Savings Account	\$ 1,000
4.9900%	401K Match	\$ 854
7.8900%	FICA/SSI	\$ 1,351
24.9800%	Health Insurance	\$ 4,279
<b>Fringe Benefit Total</b>		<b>\$ 11,749</b>

**Travel**

**Local**

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
0.670		Health Educator Range B, (Caravella)	119.15mi x 12/mo x 0.670 = \$958 for Local travel to Planning Council Committee meetings; other relevant travel for Planning Council activities to achieve program outcom Planning Council goals.	\$ 958

**Local Travel Sub-Total** \$ 958

**Long Distance**

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
Air	1)Health Educator (Caravella) 2) Planning Council Chairperson, (Benevitez)	Airfare = \$750, Hotel = \$176 +20% taxes and fees = \$845, meals at per diem rates \$74 x 5 days = \$370; parking = \$19/day x 5 days = \$95, transportation to and from airport = \$45, incidentals \$5/day x 5 days = \$25; Attend US Conference on HIV/AIDS or RW Conference to obtain current information and best practices for administering HIV/AIDS programs x 2 staff. Program goals are impacted by conference travel so that staff can continue to keep current with the HIV Care Continuum and National HIV Strategy information	\$ 4,260

**Long Distance Travel Sub-Total** \$ 4,260

**Travel Total** \$ 5,218

**Equipment**

List of Equipment	Budget Impact Justification	Amount
		\$ -

**Equipment Total** \$ -

**Supplies**

List of Supplies	Budget Impact Justification	Amount
Copy Paper, Printer Cartridges, Pens, Highlighters, Pencils, Erasers, Post It Notes, Paper Clips, Pens, Flash Drives, Highlighters, Pencils, Erasers, Ink Refill, etc.	\$250/mo x 12 = \$3000. \$250 per month to be spent for misc. general consumable office supplies necessary to perform the work of administering the Ryan White Care Act funds to achieve goals of the National HIV Strategy.	\$ 3,000
Client Survey Cards	200 clients x \$20 card - \$4000. Cards provided to clients for completing Needs Assessment survey.	\$ 4,000

**Supplies Total** \$ 7,000

**Contractual**

List of Contracts	Deliverables	Budget Impact Justification	Amount
TBD	Planning Council Website Design	The HIV Planning Council has decided that they would like to redesign the current website that we have. The concern is the website is out of date, lacking the options such as maps of local providers, electronic membership application, and possibly a chat bot. The website looks outdated so there would be a refresh of photos and buttons to use for easy navigation to meeting agendas, minutes, calendar, and local resources. Overall, the website would be more user-friendly and appealing.	\$ 4,999
Consultant (TBD)	Ryan White Statistical Analysis reports; Needs Assessment data analysis. Prepare Client Needs Assessment Tools.	Consultant for needs assessment tools for clients; evaluations of data research; prepares summaries of data reports; analyzes needs assessment data and quality measurement outcome data. Information the Planning Council uses in their decision making processes. (62.34 hrs x \$100/hr.) Meets program outcome goals by compiling and analyzing outcome information for required Needs Assessments.	\$ 6,623

**Contracts Total** \$ 11,622

**Other**

List of Other	Budget Impact Justification	Amount

**PART A ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals. (.20 FTE)	\$ 1,530
Leases	Cost of rent per person for building. All rent charges are applied on a per FTE basis. .20 FTE Additional charges are included for Planning Council Outreach event fees to participate in community events (table rentals, etc.) in order to promote the Council and recruit new members.	\$ 850
Postage	Routine postage, share of postage machine equipment and maintenance and federal Express charges postage = \$100/mo x 12 = \$1200	\$ 1,200
Copy Machine Maintenance	Copy machine lease and maintenance agreements. Software license fees; Monthly copying fees \$33.33 x 12 = \$400	\$ 400
Planning Council Expenses	Various fees incurred by the Planning Council, including legal fees. \$50/mo x 12 = \$600.	\$ 600
Printing	Printing of routine admin documents. Monthly print costs for large print jobs \$53.33 x 12 = \$640.	\$ 640
<b>Other Costs Total</b>		<b>\$ 5,220</b>
<b>Total Direct Cost</b>		<b>\$ 57,939</b>

**Indirect Cost**

Type of Indirect Cost	Rate	Insert Base	Total
Fixed	10% de minimis	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead; Personnel Svc;	5,794

**Part A Planning Council/Planning Body Total**

**PART A CLINICAL QUALITY MANAGEMENT BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

**Personnel**

Salary	FTE	Name, Position	Budget Impact Justification	Amount
\$ 135,162	0.16	Sr. Health Program Coordinator, (Gossett)	Coordinates outcome measures of Part A CQM program with other RW CQM programs; Assist as the CQM Program Manager with the on-going recruitment of the CQM Committee, development of CQM Performance measures, and provision of technical assistance to sub-recipients on CQI activities and site visits. Oversees subrecipients quality projects. This position impacts the goals of our program by following CQM requirements. (.15 Part A admin, .05 Part A MAI admin, .22 RW Part B admin, .11 Part B CQM, .26 HRSA ETE admin, .05 HRSA ETE CQM)	\$ 21,750
\$ 143,574	0.31	Human Services Program Planner, (Gammell)	Oversees daily operation of the CQM program by providing leadership to guide, plan, implement and evaluate the Continuous Quality Improvement Plan; tracks client-level and contractor level data; provides technical assistance to sub-recipients on CQI Performance measures; assists the CQM Committee with the development and analysis of Performance measures and outcomes; standards and expectations; performs fiscal and programmatic CQM site visits to improve patient care health outcomes and client satisfaction. Runs Report Manager reports and Access queries for Quality Management reviews. This position impacts the goals of our program by following CQM requirements. (.14 Part A admin, .03 Part A MAI admin, .04 Part A MAI CQM, .11 RW Part B admin, .18 Part B CQM, .10 HRSA ETE CQM)	\$ 44,800
\$ 105,566	0.30	Epidemiologist, (Vacant)	Supports the CQM program by preparing Epidemiological reports, studies and tracking systems. Codes and prepares Access queries designed and developed by the CQM Committee to track new Performance measures. Downloads and analyzes statewide and national epidemiological data for local comparison on selected CQM Performance Measures. This position impacts the goals of our program by following CQM requirements. (.20 HIV Surveillance, .50 ELC Enhancing Expansion)	\$ 31,665
<b>Personnel Total</b>				<b>\$ 98,215</b>

**Fringe Benefits**

Percentage	Components	Amount
21.0630%	Retirement	\$ 20,687
2.4900%	Retirement Health Savings Account	\$ 2,445
2.7300%	401K Match	\$ 2,681
7.6600%	FICA/SSI	\$ 7,523
21.4880%	Health Insurance	\$ 21,104
<b>Fringe Benefit Total</b>		<b>\$ 54,440</b>

**Travel**

**Local**

Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
0.670	1200	Human Services Program Planner, (Gammell)	Local travel to Continuous Quality Management Committee meetings; travel to sub-recipient sites to perform CQI site visits and other relevant travel for CQM activities. 100mi/mo x 12 = 1,200 mi x .67 = \$804.	\$ 804
<b>Local Travel Sub-Total</b>				<b>\$ 804</b>

**Long Distance**

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
<b>Long Distance Travel Sub-Total</b>			<b>\$ -</b>
<b>Travel Total</b>			<b>\$ 804</b>

**Equipment**

List of Equipment	Budget Impact Justification	Amount
<b>Equipment Total</b>		<b>\$ -</b>

**Supplies**

<b>Supplies Total</b>		<b>\$ -</b>
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**PART A ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

List of Supplies		Budget Impact Justification	Amount
General Consumable office supplies		Supplies necessary to provide qtrly reports to the CQM committee; file folders for CQI documentation; Refreshments for qtrly CQM Committee meetings. \$250/quarter x 4 = \$1000.	\$ 1,000
		<b>Supplies Total</b>	<b>\$ 1,000</b>
Contractual			
List of Contracts	Deliverables	Budget Impact Justification	Amount
		<b>Contracts Total</b>	<b>\$ -</b>
Other			
List of Other	Budget Impact Justification		Amount
Office Lease	Cost of rent per person for building. All rent charges are applied on a per FTE basis. .77 FTEs		\$ 4,322
Copy Machine Maintenance	Copy machine lease and maintenance agreements. Software license fees; Monthly copying fees \$24.16 x 12 = \$290		\$ 290
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals. .77 FTEs		\$ 2,500
OCIT-Data Processing/SHARE/MIS	Maintenance of Sacramento HIV/AIDS Reporting Engine (SHARE) to provide CQI committee with on-going progress in achieving selected Performance Indicators. Costs to update and maintain SHARE. (IT programming \$100 per hour x 60 hours)		\$ 6,000
		<b>Other Costs Total</b>	<b>\$ 13,112</b>
<b>Total Direct Cost</b>			<b>\$ 167,571</b>
Indirect Cost			
Type of Indirect Cost	Rate	Insert Base	Total
Fixed	10% de minimis	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.	\$ 16,757
<b>Part A Clinical Quality Management Total</b>			<b>\$ 184,328</b>

**PART A HIV SERVICES BUDGET  
RECIPIENT:  
FISCAL YEAR: 2025**

Personnel				
Salary	FTE	Name, Position	Budget Impact Justification	Amount
<b>Personnel Total</b>				\$ -
Fringe Benefits				
Percentage	Components			Amount
<b>Fringe Benefit Total</b>				\$ -
Travel				
Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
<b>Travel Total</b>				\$ -
Equipment				
List of Equipment	Budget Impact Justification			Amount
<b>Equipment Total</b>				\$ -
Supplies				
List of Supplies	Budget Impact Justification			Amount
<b>Supplies Total</b>				\$ -
Contractual				
List of Contracts	Deliverables	Budget Impact Justification		Amount
Sierra Foothills AIDS Foundation - El Dorado County (LOI)	Outpatient Amb Care; EFA; Health Insurance; Medical CM; Transportation; Mental Health; Oral Health	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.		\$ 203,454
Sierra Foothills AIDS Foundation - Placer County (LOI)	Outpatient Amb Care; EFA; Health Insurance; Medical CM; Transportation; Mental Health; Oral Health	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.		\$ 213,511
U.C. Davis Pediatric Infectious (LOI)	Outpatient Pediatric Ambulatory Care; Medical CM; Transportation	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.		\$ 103,981
Cares Community Health DBA One Community Health	Ambulatory/Outpatient Medical Care, Oral Health, Medical CM, Mental Health, Substance Abuse Outpatient, Substance Abuse Residential, Transportation, Non-Medical Case Management, Food Bank, Health Insurance, Housing, Outreach Services	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.		\$ 1,235,983
Golden Rule Services	Non-Medical Case Management	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.		\$ 53,848
Harm Reduction Services	EFA; Food Bank; Medical CM; Transportation	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.		\$ 331,510

**PART A ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

Sacramento Sexual Health Clinic	Ambulatory/Outpatient Medical Care, Transportation, EFA	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.	\$ 48,873
Sunburst Projects	Child Care; EFA; Food Bank; Medical CM; Transportation; Mental Health; Non-Medical CM	Provision of direct client services. Costs estimated based on prior utilization figures and comparable community rates.	\$ 942,434
<b>Contracts Total</b>			<b>\$ 3,133,594</b>
<b>Other</b>			
<b>List of Other</b>	<b>Budget Impact Justification</b>		<b>Amount</b>
<b>Other Costs Total</b>			<b>\$ -</b>
<b>Total Direct Cost</b>			<b>\$ 3,133,594</b>
<b>Indirect Cost</b>			
<b>Type of Indirect Cost</b>	<b>Rate</b>	<b>Insert Base</b>	<b>Total</b>
<b>Part A HIV Services Total</b>			<b>\$ 3,133,594</b>

**MAI ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

<b>Personnel</b>				
<b>Salary</b>	<b>FTE</b>	<b>Name, Position</b>	<b>Budget Impact Justification</b>	<b>Amount</b>
\$ 135,162	0.05	Sr. Health Program Coordinator, (Gossett)	Oversees daily operations of Part A MAI Program. Monitors contractual obligations of contractors, MOU's with participating counties. Monitors expenditure rate and reallocation process. Monitors programmatic functions of MAI program and sub-recipient adherence to MAI requirements; Negotiates yearly contract rates with contractors; Provides technical assistance; Coordinates functions of Part A MAI program with other AIDS programs, including Ryan White Parts B, C, D; HIV AIDS Education and Testing programs, and county Surveillance programs. This position impacts the program goals so we can implement the National HIV Strategy. (0.15 Part A admin, .16 Part A CQM, .22 RW Part B admin, .11 Part B CQM, .26 HRSA ETE admin, .05 HRSA ETE CQM)	\$ 7,155
\$ 143,574	0.03	Human Services Program Planner, (Gammell)	Assists the Sr. Health Program Coordinator in overseeing daily operations of Part A MAI Program. Continuous improvement/development of Quality Plan, tracking of individual and contractor data, provides technical assistance, develops with HIV Health Services Planning Council outcomes measures and standards/expectations for MAI program; monitors monthly charges to MAI program and prepares annual MAI program reporting functions. This position impacts the program goals so we can implement the National HIV Strategy. (.14 Part A admin, .31 Part A CQM, .04 Part A MAI CQM, .11 RW Part B, .18 Part B CQM, .19 HRSA EE CQM)	\$ 4,975
\$ 78,602	0.01	Account Technician, (Kincaid) 12 mos	Supports program by keeping track of sub-recipient expenditures with the SHARE data base, processes invoices for Sr. Health Program Coordinator to review, reconciles program spreadsheets, keeps program files accurate and in order, prepares and runs reports for the program as needed, works with sub-recipients who have program invoicing questions. This position impacts the program goals so we can implement the National HIV Strategy. (.54 Part A admin, .20 RW Part B admin, .25 HRSA ETE admin)	\$ 717
<b>Personnel Total</b>				<b>\$ 12,847</b>
<b>Fringe Benefits</b>				
<b>Percentage</b>	<b>Components</b>			<b>Amount</b>
21.0050%	Retirement			\$ 2,698
3.4900%	Retirement Health Savings Account			\$ 448
3.7300%	401K Match			\$ 479
7.6600%	FICA/SSI			\$ 984
22.9500%	Health Insurance			\$ 2,948
<b>Fringe Benefit Total</b>				<b>\$ 7,557</b>
<b>Travel</b>				
<b>Mileage Rate</b>	<b>Number of Miles</b>	<b>Name, Position of Traveler(s)</b>	<b>Travel Expenses/Budget Impact Justification</b>	<b>Amount</b>
<b>Travel Total</b>				<b>\$ -</b>
<b>Equipment</b>				
<b>List of Equipment</b>	<b>Budget Impact Justification</b>		<b>Amount</b>	
			<b>Equipment Total</b>	
			<b>\$ -</b>	
<b>Supplies</b>				
<b>List of Supplies</b>	<b>Budget Impact Justification</b>		<b>Amount</b>	
			<b>Supplies Total</b>	
			<b>\$ -</b>	
<b>Contractual</b>				
<b>List of Contracts</b>	<b>Deliverables</b>	<b>Budget Impact Justification</b>		<b>Amount</b>
				<b>Contracts Total</b>
				<b>\$ -</b>
<b>Other</b>				
<b>List of Other</b>	<b>Budget Impact Justification</b>		<b>Amount</b>	
Office Lease	Cost of rent per person for building. All rent charges are applied on a per FTE basis. .09 FTEs		\$ 744	
Communication Services	Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals. .09 FTEs		\$ 613	

PART A ADMINISTRATIVE BUDGET					
RECIPIENT:					
FISCAL YEAR: 2025					
				Other Costs Total	\$ 1,357
Total Direct Cost					\$ 21,761
Indirect Cost					
Type of Indirect Cost	Rate	Insert Base		Total	
Fixed	10% de minimis	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.		\$ 2,176	
MAI Administrative Total					\$ 23,937
MAI CLINICAL QUALITY MANAGEMENT BUDGET					
RECIPIENT:					
FISCAL YEAR: 2025					
Personnel					
Salary	FTE	Name, Position	Budget Impact Justification	Amount	
\$ 143,574	0.04	Human Services Program Planner, (Gammell)	Oversees daily operation of the MAI CQM program by providing leadership to guide, plan, implement and evaluate the Continuous Quality Improvement Plan; tracks client-level and contractor level data; provides technical assistance to sub-recipients on MAI CQM Performance measures; assists the CQM Committee with the development and analysis of MAI Performance measures and outcomes; standards and expectations; performs fiscal and programmatic MAI CQM site visits to improve patient care health outcomes and client satisfaction. Position impact is to support all stages of HIV Care Continuum for our TGA. (.14 Part A admin, .31 Part A CQM, .03 Part A MAI admin, .11 RW Part B admin, .18 Part B CQM, .19 HRSA ETE CQM)	\$ 6,074	
				Personnel Total	\$ 6,074
Fringe Benefits					
Percentage	Components			Amount	
22.1600%	Retirement			\$ 1,345	
3.4600%	Retirement Health Savings Account			\$ 210	
3.6100%	401K Match			\$ 219	
7.6500%	FICA/SSI			\$ 464	
21.1990%	Health Insurance			\$ 1,287	
				Fringe Benefit Total	\$ 3,525
Travel					
Mileage Rate	Number of Miles	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount	
				Travel Total	\$ -
Equipment					
List of Equipment	Budget Impact Justification			Amount	
				Equipment Total	\$ -
Supplies					
List of Supplies	Budget Impact Justification			Amount	
Copy Paper, Printer Cartridges, Pens, Highlighters, Pencils, Erasers, Post It Notes, Paper Clips, Pens, Flash Drives, Highlighters, Pencils, Erasers, Ink Refill, etc.	\$7.50/mo x 12 = \$90. \$90 per month to be spent for misc. general consumable office supplies necessary to perform the work of administering the Ryan White Care Act funds to achieve goals of the National HIV Strategy.			\$ 90	
				Supplies Total	\$ 90
Contractual					
List of Contracts	Deliverables	Budget Impact Justification		Amount	
				Contracts Total	\$ -
List of Other					
		Budget Impact Justification		Amount	
Office Lease		Cost of rent per person for building. All rent charges are applied on a per FTE basis. .04 FTEs		\$ 500	
Communication Services		Monthly IT staff charges, server charges, network charges, cell phones and telecomm charges, VPN charges based on FTE totals. .04 FTEs		\$ 637	
Printing/Duplicating		Printing of routine admin documents Monthly printing costs for large print jobs \$4.66 x 12 = \$56.		\$ 56	
				Other Costs Total	\$ 1,192
Total Direct Cost					\$ 10,881
Indirect Cost					
Type of Indirect Cost	Rate	Insert Base		Total	
Fixed	10% de minimis	Dept overhead charges include Security Svc; Data Processing General; Software, System Dev Svc; WAN Allocation, Alarm Services; GS Purchasing; GS Warehouse, GS Surplus property Svc; GS Store Charges; GS Equip Rental; Water; Dept/Agency Overhead: Personnel Svc; Safety Program.		\$ 1,088	
MAI Clinical Quality Management Total					\$ 11,969
MAI HIV SERVICES BUDGET					
RECIPIENT:					
FISCAL YEAR: 2025					
Personnel					

**PART A ADMINISTRATIVE BUDGET**

**RECIPIENT:  
FISCAL YEAR: 2025**

Salary	FTE	Name, Position	Budget Impact Justification	Amount
<b>Personnel Total</b>				\$ -
<b>Fringe Benefits</b>				
Percentage	Components			Amount
<b>Fringe Benefit Total</b>				\$ -
<b>Travel</b>				
<b>Travel Total</b>				\$ -
<b>Equipment</b>				
List of Equipment	Budget Impact Justification			Amount
<b>Equipment Total</b>				\$ -
<b>Supplies</b>				
List of Supplies	Budget Impact Justification			Amount
<b>Supplies Total</b>				\$ -
<b>Contractual</b>				
List of Contracts	Deliverables	Budget Impact Justification		Amount
Sunburst Projects; Harm Reduction Services;	Medical Case Management Services-MAI	Service category amount calculated from Appendix B in NOFO Instructions		\$ 203,469
<b>Contracts Total</b>				\$ 203,469
<b>Other</b>				
List of Other	Budget Impact Justification			Amount
<b>Other Costs Total</b>				\$ -
<b>Total Direct Cost</b>				\$ 203,469
<b>Indirect Cost</b>				
Type of Indirect Cost	Rate	Insert Base		Total
<b>MAI HIV Services Total</b>				\$ 203,469

### Project Abstract

**Project Title:** Ryan White (RW) CARE Act Part A Grant Application - FY 2025  
**Applicant Name:** Sacramento Transitional Grant Area (TGA) **HRSA Grant #:** H89HA00048  
**Address:** County of Sacramento Department of Health Services  
7001 A. East Parkway, Suite 600B, Sacramento, CA 95823-2501  
**Contact Phone #s:** 916.875.6211 (voice); 916.875-5888 (fax)  
**E-Mail:** [GossettM@SacCounty.gov](mailto:GossettM@SacCounty.gov) **Web:** [www.sacramento-tga.com](http://www.sacramento-tga.com)

**a) HIV Epidemic in Sacramento TGA:** The Sacramento TGA is a large three-county area of 4,287 square miles, with a geography that presents unique challenges to efficient delivery of health care to People Living with HIV or AIDS (PLWH). As of 12/31/23, Sacramento County accounted for 88.3% of PLWH in the TGA, and the rural counties of El Dorado and Placer accounted for 4.2% and 7.4%, respectively. Since the TGA's RW Part A Program began in 1997, the HIV epidemic has had an increasingly disproportionate impact on People of Color. Over these 26 years, the proportion of new AIDS cases more than doubled, from 27.0% to 54.8%, and Hispanics had the largest increase in new AIDS cases, from 6.0% to 20.2%. Heterosexuals also experienced a disproportionate increase since 1997, from 6% of PLWH to 22.5% as of 12/31/23. In the last 10 years, the number of PLWH in the TGA rose 43%, from 4,080 to 5,833 as of 12/31/23.

As of the current reporting period ending 12/31/23, African Americans continue to be the racial group most disproportionately affected by HIV. African Americans were only 7.5% of the TGA's general population, but were 22.9% of AIDS prevalence, 20.9% of HIV prevalence, and 18.7% of HIV Incidence as of 12/31/23. Regarding mode of HIV transmission, Men who have Sex with Men (MSM) continue to be the majority of PLWH (55.2%), followed by Heterosexuals (22.5%) and Injection Drug Users (IDUs) (7.8%) as of 12/31/23. Regarding increases in the number of PLWH by age since the last reporting period ending 12/31/20, the highest increase was among ages 25-44 (62.3%), followed by ages 45-64 (21.9%), ages 20-24 (11.1%), ages 13-29 (2.4%), ages 65+ (1.6%) and youth under age 13 (0.7%).

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

**c) Overall HIV Viral Suppression Rate for TGA:** The RW Program's 2023 viral suppression rate (89%) was higher than the 2023 rate in other jurisdictions: overall TGA (71%); California (67%), and National (65%). Among FY23 RW clients, MSM were less likely to be virally suppressed (55.7%) than IDUs (65.7%) or Heterosexuals (60.9%). American Indians/Alaskan Natives (57.1%) and African Americans (57.2%) were less likely to be virally suppressed than Whites (57.7%), Asians (57.7%) and Hispanics (59.5%). Male RW clients were less likely to be virally suppressed (56.5%) than females (65.1%). RW clients ages 20-44 were less likely to be virally suppressed (50%) than those ages 25-44 (54.9%); 45-59 (57.3%) or 65+ (62.1%), ages 3-12 (100%) or ages 13-19 (100%).

## **SECTION 1: INTRODUCTION**

The Sacramento Transitional Grant Area (TGA) has been a Ryan White (RW) Part A Recipient since 1996 and consists of three counties, the urban county of Sacramento, as well as the rural counties of El Dorado and Placer. The Recipient of RW Part A funds is the County of Sacramento's HIV Care Services (HCS) Program, which also oversees the RW Part-B program funded by the California State Office of AIDS (SOA), for the three Transitional Grant Area (TGA) counties (as well as Yolo County, which is not part of the TGA). In addition, the HCS oversees the HRSA Ending the HIV Epidemic (EHE) program.

The impact of the HIV epidemic has continued to grow in the TGA over the last ten years, with 43.0% more People Living with HIV/AIDS (PLWH) in 2023 as there were in 2013 (from 4,080 to 5,833 cases). During the same period, the population of the TGA's general population has increased by 10.2%, from 1,996,242, to 2,200,064 based on data from the US Census Bureau. During Fiscal Year (FY) 2023, which runs from 3/1/23 to 2/29/24, there were 195 new clients, who had never been served by the TGA's RW system of care. Not only has there been growth in both the number of PLWH in the TGA and the RW Program over the years, there also have been changes in the sociodemographic composition of the HIV epidemic.

In response to the growth and changes in the HIV epidemic, the TGA's HIV Continuum of Care has evolved to meet the increasing and divergent needs of newly emerging subpopulations of PLWH. The TGA has a strong base of service providers in the region that are dedicated to working together to provide high quality services that meet the needs of PLWH at all levels of the Care Continuum and ultimately to end the HIV epidemic. Throughout this application, it will become clear that the development and implementation of all aspects of the HCS Program in the Sacramento TGA are data-driven; and that all planning decisions are based on information, much of which comes directly from PLWH. These sources include HIV/AIDS epidemiology data; HCS Program service utilization data; service utilization data from other sources of HIV/AIDS funding; Continuous Quality Management (CQM) indicator data; Needs Assessment data and Client Satisfaction survey data collected directly from consumers of HIV services.

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

## **SECTION 2: ORGANIZATIONAL INFORMATION**

### **2.A. GRANT ADMINISTRATION**

#### **2.A.1) Program Organization**

##### **2.A.1)a) Administration of Part A and MAI Funds within TGA (Attachments 1 and 2)**

The Chair of the Sacramento County Board of Supervisors, as the Chief Elected Official (CEO) for RW Part A funds, has delegated authority to Timothy Lutz, MBA, Director of the Sacramento County Department of Health Services (DHS), to administer the RW Part A Program, through the County of Sacramento's HCS Program, as the Recipient. See **Attachment 1** for Program Organizational Chart and **Attachment 2** for Staffing Plan, Job Descriptions and Biographical Sketches for Key Personnel.

The STI/HIV Health Program Manager, Staci Syas, a Master of Public Health (MPH) and directly supervises the Sr. Health Program Coordinator and AIDS Director, Michelle (Chelle) Gossett, who runs the day-to-day

operations of the HCS Program. Ms. Syas has over 28 years' experience with Sacramento County Public Health and provides oversight and development of programs addressing the continuum of Sacramento County HIV and STI service efforts; coordinates the integration of efforts between HIV/STI Prevention Program, HIV/STI Surveillance Unit, HCS Program, Epidemiology Unit, and the County STI Controller. Ms. Syas facilitates the development and implementation of a Community STI/STI Prevention Action Plan through engagement with community stakeholders, health care providers, and school staff and state agencies. Ms. Syas is a member of the California STI Controllers Association and National Coalition of STI Directors.

Michelle (Chelle) Gossett holds the Sacramento County AIDS Director and Sr. Health Program Coordinator positions. Ms. Gossett has over 25 years' experience working with the Ryan White (RW) CARE program as a Part C and D Program Director, as a subrecipient for RW Parts A and B, and Director of Grants Management for the TGA's largest FQHC that specializes in HIV specialty care. In her current position with the County of Sacramento, which she has held for over 5 years, Ms. Gossett is responsible for fiscal and programmatic oversight of the HCS Program, including coordinating/facilitating collaborative efforts among multi-faceted organizations; administering program objectives, activities, staffing needs and funding allotments; writing grant applications; preparing/monitoring program budgets; subrecipient program monitoring; coordinating functions of Continuous Quality Management (CQM) activities; acting as a liaison/resource to subrecipients, HIV Health Services Planning Council (HHSPC), County Departments and State and other funding sources; as well as other responsibilities (see Attachment 2 for more detail). The AIDS Director and Sr. Health Program Coordinator position is allocated to Part A RW program 36% FTE as follows: Part A Administration (15%), CQM (16%), and MAI Administration (5%).

The Human Services Program Planner, Paula Gammell, has a Master of Public Health, MPH. and over 21 years' experience in management of the TGA's Ryan White program, now part of the HCS Program. As the Continuous Quality Management (CQM) Program Manager, Ms. Gammell oversees operations of the CQM Program including tracking of client-level and contractor level data in the program's client-level database; provides technical assistance to subrecipients on CQM measures; develops CQM outcomes and measures, standards/expectations, and performs fiscal and programmatic CQM site visits/audits. Ms. Gammell also provides data and assistance required for Community Needs Assessments, compiles and analyzes data for grant proposals, HIV/AIDS Comprehensive Work Plans, HRSA reports, and epidemiological studies. Ms. Gammell responds to the needs of the HHSPC and its committees to assist them in achieving and improving their work plans and goals. The RW Program Coordinator and Human Services Program Planner position is allocated to RW Part A program 52% FTE as follows: Administration (14%), Part A CQM (31%), Part A MAI Admin (3%), and Part A MAI CQM (4%).

The Health Program Coordinator, Alexa Bunton, has a Bachelor of Science in Food, Nutrition and Wellness studies and a Master of Public Health. She is also a Certified Health Education Specialist (CHES) and Certified Phlebotomy Technician (NHA-CPT) (CHES). Ms. Bunton assists the Sr. Health Program Coordinator with HCS Program planning, program and subrecipient evaluation, developing performance improvement plans, monitoring and reporting on performance outcome and contractual updates and evaluates required documentation for successful program implementation. This position oversees program Health Educator and Senior Office Assistant positions. This position is 14% FTE to Part A Administration.

The Health Educator, Danielle Caravella, began her career with Sacramento County Public Health with an internship in 2018 while completing her Bachelor Degrees in both Psychology and Public Health with a concentration in Policy and Management. Future positions included an Office Assistant with the County's Sexual Health Clinic and COVID Specimen Testing Coordinator. Upon completing her Master of Public Health, she became a Communicable Disease Investigator with a primary role of investigating HIV cases and conducting partner notifications. Ms. Caravella now assists the HCS Program by working closely with the HHSPC, attending Council and Committee meetings, and providing epidemiological, demographic, needs assessment, financial and service utilization data to the Council. This position is 20% FTE to Part A Council.

The Account Technician position is held by John Kincaid, who has 19 years' experience working in a governmental capacity. Mr. Kincaid is responsible for processing subrecipients' invoices, reconciling internal grant workbooks, assisting with subrecipient budget revisions, reconciliation between program and fiscal departments and assisting the Senior Health Program Coordinator with the fiscal oversight of the HCS Program. This position is allocated to RW Part A program 63% FTE as follows: Administration (54%) and Part A MAI Admin (9%).

Administrative Services Officer II is held by Larry Tu who has a Bachelor Degree and over 10 years' combined experience in accounting/tax/audit/fiscal. Mr. Tu is a liaison with Human Resources, Information Technology (IT), Contracts, and Fiscal departments. Responsibilities includes assistance with board letters, contracts, budget amendments, providing hiring support, preparing and updating organization charts, as well as other support including processing travel and mileage claims. Supports program through routine clerical assistance. This position is 24% FTE to Part A Administration.

The Epidemiologist position is currently vacant. This position provides epidemiology data to the HCS Program for grant writing and other reporting purposes, assists with HIV cluster, programmatic information, supports the CQM program by preparing epidemiological reports, studies and tracking systems. This individual will code and prepare access queries designed and developed by the CQM Committee to track new performance measures, downloads and analyze statewide and national epidemiological data for local comparison on selected CQM Performance Measures. The Epidemiologist position is allocated 30% FTE to Part A CQM.

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

Amber Windmon, Administrative Services Officer I: With a Master Degree in Public Health and over 18 years' experience working for Sacramento County, Ms. Windmon's responsibilities include providing hiring support such as job postings and job offers, preparing and updating organization charts, as well as other support including processing travel and mileage claims and Planning Council Member reimbursement expenses. Ms. Windom also supports the program through routine clerical assistance. This position is 10% FTE to the Part A Administration.

The Sr. Office Assistant position is filled by Emitai Bishop, who has worked with the Sexual Health Promotion

Unit for 9 years. Ms. Bishop is responsible for supporting the HCS Program with various administrative duties such as answering phones, taking client messages, enter data into State HIV database, documentation organization, and mail distribution. This position is 4% FTE to the Part A Administration.

All staff vacancies are filled through an established civil service system or filled by contracts with temporary employment agencies during the recruitment process when expediency is necessary. Thankfully, as can be noted above by the long-term commitment of staff allocated to the HCS Program, vacancies have been extremely infrequent since the HCS Program began in the TGA in 1996.

### **2.A.1)b) Administration of Part A and MAI Funds by Contractor**

The Sacramento TGA does not utilize contractors to administer the Part A funds.

### **2.A.2) Grant Recipient Accountability**

#### **2.A.2)a) Subrecipient Monitoring Process for FY 2025-2027**

The Recipient's ongoing fiscal and programmatic monitoring protocol includes both off-site monitoring procedures, conducted at the Recipient office. Unless granted an off-site exemption waiver, the Recipient conducts annual on-site monitoring visits at each HCS Program subrecipient's service organization, to review all fiscal policies and procedures, audits, and to review completeness and accuracy of financial records. Using a standard Contract Analysis Report (CAR), the Recipient compares financial performance indicators to each subrecipient's actual performance measures on a monthly basis. The protocols for off-site monitoring of programmatic performance are similar to those for fiscal monitoring, with additional protocol reports that assess quality of care data collected in SHARE. Subrecipients also are required to submit monthly, semi-annual program narratives and a cumulative year-end report to the Recipient.

#### **Site Visit Process**

The Recipient's annual on-site programmatic monitoring includes investigations of CQM through client chart reviews, agency policies and procedures, and agency evaluation systems. Annual performance outcomes are reviewed by the Recipient to determine if service quality is within acceptable ranges. The Recipients' monitoring tools have been revised to incorporate the new CQM activities, as well as the new processes that are available through the updated data collection system. Additional changes in the monitoring tools have also been added to incorporate new areas identified by HRSA's National Monitoring Standards and new Service Standards adopted by the RW Part B Program.

#### **Corrective Action Procedures**

If significant fiscal or programmatic deficiencies are noted for any subrecipient based on the Recipient's monitoring procedures, the Recipient notifies the subrecipient and requires, within two weeks, a written Corrective Action Plan describing: 1) specific activities the contractor will take to remedy the deficiencies; 2) a timeline for completing all activities of correction; and 3) a request for technical assistance as needed. If the Corrective Action Plan sufficiently addresses the Recipient's concerns, the Recipient provides follow-up contact with the subrecipient to monitor progress and provides any necessary technical assistance until all deficiencies are corrected. Contract language allows the Recipient to terminate services within 30 days if corrections aren't made for any fiscal or programmatic concerns that would result in an audit exception. Where appropriate, the Recipient provides TA to assist the subrecipient with corrective action.

#### **Technical Assistance (TA) Process**

As part of its Annual Administrative Efficiency Assessment process, the Part A Recipient and HIV Health

Services Planning Council have discussed developing a survey for the TGA's subrecipients to assess how well they feel their TA needs are currently being met by the Recipient, as well as what additional TA needs they may have. This effort is still in the planning stage but will be beneficial to determine the scope of each subrecipient's TA needs, as well as the effectiveness of TA provided by the Recipient during each grant cycle.

The TA provided by the Recipient covers a wide range of issues. For example, the most common TA consists of responding to inquiries about entries into the web-based data system (SHARE), either on client intake forms, invoice data entry, or inquiries related to access user requests and password updates. TA also is provided for invoice / payment issues, CQM issues, HCS Program service issues, site visit inquiries and other grant issues. TA also is provided for subrecipient contract documentation issues; assistance in identifying client resources, medication co-payments and specialty medical care; contract document related requests; subrecipient site visit inquiries and assistance; HIV/AIDS statistics and health outcome inquiries; provision of information regarding ADAP; assistance in developing revised budgets; interpretation of service standards, HAB information and AAHIV National advocacy updates. Additional TA is provided by the recipient to all subrecipients through the Service Providers Caucus, a mandatory monthly meeting. Updates regarding HRSA Policy Guidelines/Updates, TGA Service Directives, CQM/CQI, Client Barriers, Waitlists, Poverty Guidelines, and Provider Orientation Manual updates are examples of topics covered for all subrecipients.

### ***Oversight of Subrecipient Compliance with Audit Requirements***

All subrecipients must submit financial audits to the HCS Program Coordinator and the DHS Fiscal Services within sixty days of the end of each fiscal year. Notices are sent by the Department's contract unit reminding each subrecipient of their audit due date. If audits are not received on a timely basis, the County discontinues payment to the contractor until they reach compliance with the audit submission requirement. Four of the eight (50%) FY24 RW Part A subrecipients receive enough Federal funding to fall under the OMB Single Audit guideline requirements. Audits first are reviewed by the HCS Program Coordinator and the Sacramento County DHS' Chief Financial Services Officer to ensure that no audit exceptions or audit concerns exist. In addition, all current subrecipients also have undergone rigorous financial testing at the time of the RFP review process prior to contract awards.

If major audit exceptions are noted, the Sacramento County Auditor-Controller conducts its own audit of subrecipients and makes recommendations to the Department Director. If the problem appears to be correctable, Sacramento County requires a corrective action plan within a specific time frame. If the problem appears beyond the subrecipient's ability for correction, the Department's contract language allows the County to immediately terminate the subrecipient's HCS Program contract.

### ***2.A.2)b) Payer of Last Resort***

#### ***Processes to Ensure Monitoring of Third-Party Reimbursement by Subrecipients***

Contract language between the recipient and each subrecipient includes requirements for screening for payer of last resort and application of the TGA's Eligibility standards. In addition, all subrecipients are required to attend a comprehensive training on Benefits Eligibility Determination at the start of their contract term. The recipient sends out updated eligibility information on Federal and State programs as they change throughout the year, including annual updated poverty guidelines. TA sessions are provided at mandatory monthly HCS Program Service Provider Caucus meetings when those changes require more in-depth training. An Annual Eligibility Checklist is distributed to all subrecipients to assist them in identifying all RW Part A eligibility documentation required for client files and documentation of identifying payer of last resort efforts and this checklist is available as a resource within the TGA's Electronic Database (SHARE).

### ***Eligibility Documentation to Ensure RW is Payer of Last Resort***

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

Each RW client must be recertified at a minimum of annual intervals to qualify for continued RW assistance and to ensure that the RW program continues to be each client's payer of last resort. To verify that each RW subrecipient is compliant with this requirement, client charts are pulled randomly during subrecipient site visits to validate appropriate recertification documentation of RW eligibility for each client. To provide RW funded services to eligible RW clients, case files must include denials from all other potential funding sources as well as documentation of the lack of an alternative service provider. Through the SHARE database, the Recipient provides quarterly reports to subrecipients indicating Client Intake Forms requiring updating. This process allows the Recipient to ensure that RW remains each client's payor of last resort by regularly monitoring subrecipient adherence to eligibility requirements and client recertification procedures.

### ***Monitoring and Tracking of Program Income at Recipient and Subrecipient Levels***

To monitor appropriate tracking and use of program income, the Recipient reviews subrecipient program income records during site visits to ensure that schedule of charges systems remain in place, conform to HRSA guidelines, and program fees are taken into consideration during contract negotiations.

### ***2.A.2)c) Fiscal Oversight***

#### ***Fiscal Activity Coordination and Accountability***

The HIV Services Program Sr. Health Program Coordinator has responsibility for reporting, reconciliation and tracking program expenditures; and the County systems have crosscheck methods to ensure accurate payment and claiming of expenditures. The Comprehensive Online Management Personnel and Accounting System for Sacramento (COMPASS) County's accounting system, records and tracks all expenditures by order number (i.e., RW Part A has order numbers for administrative, quality improvement, MAI, and direct service expenses). Each service category has an order number for formula, supplemental, and MAI funds. The HIV Services Program Coordinator reviews each claim to ensure that appropriate order numbers are entered into the County's COMPASS system. Direct services are reconciled against the SHARE database to ensure accuracy of provider claims. While Sacramento County DHS has its own Fiscal Department, all reconciliations and tracking of expenditures are the HIV Services Program Coordinator's responsibility, using the HCS Program's database (SHARE) which includes tracking of direct service expenditures. The Final Financial Report (FFR) is prepared by the HCS Program Coordinator and the County's Fiscal Manager reviews and authorizes the FFR after ensuring it matches the County's Payment Management system figures.

### ***Tracking of Formula, Supplemental, MAI and Carryover Funds***

Sacramento County DHS maintains a coding system that charges expenditures to each specific program and grant. Order numbers are assigned to separately track formula, supplemental, unobligated and MAI funds for each grant, as well as programs within those grants. The HIV Services Program Sr. Health Program Coordinator assigns order numbers to each grant's budget and reviews provider invoices and grant claims to verify accuracy of order number assignment for all expenditures. The database system, COMPASS,

provides a clear and up-to-date audit trail of all grant-funded expenditures. In addition, the TGA has procedures to ensure that funds are redirected to service categories most in need throughout the year. The HIV Services Program Coordinator has authority to transfer funds between service categories during the year, up to 10% or \$70,000, whichever is less, as long as the transfer does not substantially change the intent of the Council's Annual Service Category Plan. Only the HHSPC has the authority to change this.

In addition to the fund transfer, the TGA employs a "Rapid Reallocation" process. After the fifth month of service, the Recipient notifies subrecipients that all funds invoiced less than 40% of budget by service category will be redirected unless the affected subrecipients can substantiate the anticipated expenditure of all allocated funds by fiscal year end. The Priorities and Allocations Committee (PAC) reviews recipient reports to identify funds available for reallocation by service category, as well as justification for additional funds requests. The recipient makes adjustments to subrecipient contracts based on the identified needs and allocations adopted by the Council. This process has been effective in reducing carryover each fiscal year.

### ***Subrecipient Reimbursement Process***

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

Once the subrecipient submits signed invoices, the recipient reviews and approves payment, indicating the order number to be charged. The HCS Program Accounting Technician logs all invoices sent to the County's Fiscal Department for payment along with a log of the date the checks were cashed. Before claims are submitted to the funding sources, the recipient reconciles the logs and the SHARE database, ensuring that checks have been issued for correct amounts. Invoices are processed within ten days of receipt of each signed approved invoice and paid within 30 days.

### ***2.B. MAINTENANCE OF EFFORT (MOE) and MOE BUDGET ELEMENTS (Attachment 3)***

See Attachment 3 for the Maintenance of Effort (MOE) table that identifies the baseline aggregate for FY23 TGA expenditures for HIV-related services, FY24 estimate of these expenditures, as well as an explanation of the process and elements used to determine the amounts in the MOE table calculations.

## **SECTION 3: NEEDS ASSESSMENT**

### ***3.A. DEMONSTRATED NEED***

#### ***3.A.1) Epidemiologic Overview (Attachment 4)***

##### ***3.A.1)a) Summary of HIV Epidemic in Sacramento TGA (Attachment 4-HIV/AIDS Demographics Table)***

The California State Office of AIDS (SOA) supplies the data sets for HIV and AIDS Incidence (new cases) and Prevalence (existing cases) and Unmet Need data. The HIV Continuum of Care data was supplied by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. The requirements for these data sets do not match exactly due to differences in date ranges, definitions and formats for each database and jurisdiction, resulting in a few discrepancies in figures when used for direct comparative analyses across measurement and reporting tools. Given these caveats, the TGA remains diligent in its efforts to conduct a data driven process to understand the HIV/AIDS epidemic overtime.

The TGA is a large three-county area in California comprised of 4,287 square miles, with a geography that

presents unique challenges to efficient delivery of healthcare to PLWH. Sacramento County is geographically the smallest of the three counties, but the most populous, accounting for 72.0% of the TGA's general population and 88.3% of the HIV/AIDS Prevalence (People Living with HIV/AIDS – PLWH) as of 12/31/23. In the rural counties, Placer accounted for 19.3% of the TGA's population and 7.4% of PLWH, while El Dorado accounted for 8.7% of the population and 4.2% of PLWH as of 12/31/23.

Over the last ten years, from 12/31/13-12/31/23, there has been a 43.0% increase in the number of PLWH in the TGA, from 4,080 to 5,833 cases. This rise in HIV/AIDS Prevalence over the last decade has been much higher than the growth of the TGA's general population. Over the 10-year period of 12/31/13-12/31/23, the TGA's population only increased by 10.2%, from 1,996,242 to 2,200,064, based on US Census Bureau data. The increase in PLWH between 12/31/12 and 12/31/23 was experienced throughout the TGA, in the large urban County of Sacramento (+41.2%, from 3,648 to 5,152 PLWH), as well as the two rural counties of Placer (+69.5%, from 256 to 434 PLWH) and El Dorado (+42.0%, from 174 to 247 PLWH).

The following is an analysis of more recent trends over the last three years (reporting periods ending 12/31/20 compared to the current reporting period ending 12/31/23). See Attachment 4, HIV/AIDS Incidence (new cases) over the three-year period of 1/1/21 - 12/31/23 and HIV/AIDS Prevalence (existing cases) as of 12/31/23). This more recent trend analysis found that overall, across the TGA, HIV/AIDS Prevalence increased 9.1% (from 5,347 PLWH as of 12/31/20 to 5,833 PLWH as of 12/31/23). Further prevalence analysis shows a higher increase in the number people living with HIV, as compared to the increase in the number of people living with AIDS, as follows: HIV prevalence increased 15.7% (from 2,624 to 3,036) and AIDS prevalence increased 2.7% (from 2,723 to 2,797). This increase in HIV/AIDS prevalence was found in all three counties of the TGA, Sacramento (+9.0%, from 4,725 to 5,152), as well as two rural counties of Placer (+10.2%, from 394 to 434) and El Dorado (+8.3%, from 228 to 247).

Regarding HIV incidence (number of *new* HIV cases) between the reporting periods of 1/1/18 - 12/31/20 compared to 1/1/21-12/31/23, the TGA experienced an increase of 0.2% (from 459 to 460 new HIV cases), including Sacramento County (+1.7%, from 409 to 416), and El Dorado County (+25%, from 12 to 15). In Placer County there was a decrease of 23.7%, from 38 to 29 new HIV cases. The TGA experienced an increase of 7.4% in new AIDS cases (from 189 to 203) between the reporting periods of 1/1/18-12/31/20 and 1/1/21-12/31/23, including Sacramento County. The increase in AIDS incidence occurred only in Sacramento County, a 16.1% increase, from 161 to 187 new AIDS cases. El Dorado remained stable, with 5 new AIDS cases during both reporting periods, while Placer County had a 52% decrease from 23 to 11 new AIDS cases.

### **3.A.1)b) Socio-Demographic Characteristics of HIV Epidemic in TGA**

To better understand the socio-demographic characteristics of persons newly diagnosed, living with HIV and at higher risk for HIV in the TGA, the following includes an analysis of demographic data (e.g., race, age, sex, gender identity) and socioeconomic data (e.g., income, education, employment, language housing).

#### **3.A.1)b)i. HIV Epidemic: Demographic Data Analysis**

##### **Racial Disparities in the TGA's HIV Epidemic**

**African Americans** continue to be disproportionately impacted by HIV across the TGA. African Americans were 21.9% of PLWH, 18.7% of new HIV cases and 20.2% of new AIDS cases as of 12/31/23. All these statistics are more than 3 times higher than the percentage of African Americans in the TGA's general population in 2023 (7.5%). Longer term trends in the TGA's HIV epidemic further highlight the disproportionate impact among African Americans over the last 10 years. There was a 31.5% increase in the number of African American PLWH (from 970 to 1,276) even though there was only a 1.2% increase in the

number of African Americans in the TGA's general population between 2013 to 2023.

**Hispanics.** The number of Hispanic PLWH in the TGA has grown by over 2 times during the last ten years, from 649 in 2013 to 1,408 PLWH in 2023, which is 6 ½ times higher than the growth in Hispanics among the TGA's general population of 18.3% (from 416,753 to 493,088) during the same time period. Between 12/31/20 12/31/23, the number of new AIDS cases among Hispanics increased by 17.0% (from 53 to 62), AIDS Prevalence by 17.0% (536 to 627) and HIV Prevalence by 29.1% (from 605 to 781).

**Whites.** As of 12/31/23, Whites were underrepresented among PLWH in the TGA (43.3%) compared to their representation in the TGA's 2022 general population (51.4%). The number of White PLWH increased by 1.6%, from 2,486 to 2,525, between 12/31/20 and 12/31/23. new HIV cases increased by 10.1%, from 138 to 152 cases. Ten-year trends in the TGA show that although the number of White PLWH increased from 2,489 to 2,525 between 2013 and 2023 and the percentage of White PLWH decreased from 44.4% to 43.3% as the impact of HIV among people of color continued to increase.

#### **Age Disparities in New HIV Cases and PLWH between 12/31/20 and 12/31/23\***

\*Number of PLWH in the TGA by age in this section is from Unmet Need line list data provided by State Office of AIDS (which includes current age) rather than the State Office of AIDS epidemiology data (which includes age at HIV diagnosis) used throughout the rest of this application Therefore, total PLWH as of 12/31/23 differs slightly in this section (5,686) than the rest of the epidemiology section (5,833).

- **Age <13.** No new HIV cases. 2 PLWH <age 13 as of 12/31/23
- **Ages 13-19.** New HIV cases was 12 during both reporting periods. 0.3% of PLWH as of 12/31/23 (17/5,686)
- **Ages 20-24.** 25.6% decrease from 78 to 58 new HIV cases. 1.6% of PLWH as of 12/31/23 (93/5,686)
- **Ages 25-44.** 63.5% of new HIV cases (up from 54.2%) and 17.3% increase from 249 to 292 new HIV cases. 32.6% of PLWH as of 12/31/23 (1,854/5,686)
- **Ages 45-64.** Decrease from 106 to 91 new HIV cases. 47.8% of PLWH as of 12/31/23 (2,717/5,686)
- **Ages 65+.** Decrease from 14 to 7 new HIV cases. 17.6% of PLWH as of 12/31/23 (1,003/5,686)

#### **Mode of Transmission Disparities in TGA's HIV Epidemic**

There has not been a significant change in the HIV epidemiology in terms of modes of HIV transmission between the reporting periods ending 12/31/20 and 12/31/23. However, the longer ten-year trend analysis, reporting period ending 12/31/13 compared to 12/31/23, shows recent trends among PLWH by mode of transmission as follows, with the most significant impact among Heterosexuals:

- **Heterosexuals** increased by 55.9%, from 843 to 1,314 PLWH, or 15.8% to 22.5% of PLWH
- **Men who have Sex with Men (MSM)** stabilized at 55.0% and 55.2% of PLWH
- **Injection Drug Users (IDUs)** stabilized at 7.9% and 7.8% of PLWH
- **MSM and IDUs** decreased from 7.4% to 6.9% of PLWH
- **Perinatal Transmission.** In CY23 there were 4 newly diagnosed HIV+ pregnant women in Sacramento County, the largest number in one year. HIV Surveillance and the HIV Care Program worked to ensure all women were in prenatal care and on medications. As of June 2024, two of the babies were born uninfected; one baby is taking preventative ART, and the third baby and mother are lost to follow-up.

**Gender Identity.** Analysis of trends by gender identify between the reporting periods ending 12/31/20 and 12/31/23 showed the highest increases were among Transgender Male-to-Female PLWH, who experienced a 7.5 times increase (from 7 to 62), followed by a 5-times increase among Transgendered Female-to-Male

PLWH (from 2 to 10). The next highest increases were among Female PLWH, 8.9% (from 874 to 952), followed by Male PLWH, 7.7%, (from 4,464 to 4,809).

**3)a.1)b.ii. HIV Epidemic: Socioeconomic Data Analysis (see Co-Occurring Conditions - Attachment 5) Poverty and Income Status.** RW clients have poverty rates that are much higher than the TGA's general population. 57.9% (1,256) of FY23 clients had annual incomes at or below 100% of the Federal Poverty Level (FPL), or reported no income, which is over 5 times the rate of the TGA's general population (11.1%). The percentage FPL used to determine RW Program eligibility changed from 300% to 500% of poverty beginning in 2023, at which time 99% of HCS Program clients met the 500% criteria.

**Justice Involved.** PLWH surveyed in the 2022-23 TGA's Needs Assessment reported having current involvement with the justice system at higher rates than the TGA's general population: 2.6% vs. 0.58%.

**Education.** FY23 RW clients were much less likely to be college educated than the general population: 13% reported they had college degrees (AA, BA/BS or Graduate) compared to 62% of the TGA.

**Language Barriers.** 29.9% of FY23 RW clients were Hispanic and may experience language barriers when navigating the healthcare system at higher rates than the general population with 20.7% Hispanics.

**Unhoused / Unstable Housing.** FY23 RW clients (12.2%) are much more likely to be unhoused or living in unstable housing (homeless shelter, motel) than the TGA's general population (0.32%). Further, only 80.4% of RW clients were in stable/permanent housing (house or rent).

**Employment.** RW clients surveyed in the 2022-23 Needs Assessment reported being employed (either full or part-time) at less than half the rate than the TGA's general population (23% vs. 59%).

### **3.A.1)d) Healthcare Coverage Among PLWH**

There was a slight improvement in healthcare coverage among RW clients served through the HIV Care Services Program between FY22 and FY23. Of the RW clients who indicated an insurance source in FY23, 91.1% had a third-party payer while 8.9% had no insurance. Of those with healthcare coverage in FY23, 8.8% had employer-based private insurance and 80.4% had some form of public insurance through Medicare, Medicaid, or other local governmental programs. In comparison, in FY22, 90.4% of the RW clients reported a third-party payer while 9.4% had no insurance. Of those with coverage, 8.4% had employer-based private insurance and 82.0% had coverage through Medicare, Medicaid, or local other governmental programs.

With the end of the Continuous Coverage Requirement for Medi-Cal in response to the end of the COVID-19 pandemic, California enacted Senate Bill 184 (Chapter 47, Statutes of 2022) on January 1, 2024. Under this requirement, California state funded full scope Medi-Cal is provided to individuals aged 26 through 49, regardless of immigration status if otherwise eligible. While this bill was intended to increase access to healthcare coverage for many Californians, issues have still arisen for individuals trying to get coverage. For example, the application continues to request a social security number which creates fear for many applicants who do not have one. In addition, other barriers exist such as confusion about eligibility policies, difficulty navigating the enrollment process, as well as language and literacy challenges.

Beginning December 1, 2023, Medi-Cal Dental changed from managed care to fee-for-service for newly enrolled clients. Previously enrolled clients had the opportunity to change from managed care to fee-for-

service if they filed the appropriate paperwork. Medi-Cal dental providers remain a challenge to find and secure for services in the TGA, especially for specialty care.

### ***Coordination of Health Insurance Enrollment Efforts***

There was a higher percentage of FY23 RW clients who were uninsured compared to the TGA's 2022 general population (8.9% vs. 4.1%) and a lower percentage of FY23 RW clients on Medi-Cal than the TGA's 2022 general population (53.5% vs. 71.9%) according to the University of California Los Angeles (UCLA) California Health Interview Survey (CHIS). The balance of those RW clients (minus approximately 5% of undocumented clients) are eligible to enroll in a private Covered California insurance plan with tax subsidy assistance, or the ADAP and California SOA Health Insurance Premium Payment Program (OA-HIPP). OA-HIPP provides payment of health insurance premiums and medical deductibles and co-pays for PLWH who have lost their employment and their private health insurance coverage. Two of the RW Part A subrecipients have OA-HIPP certified staff to assist PLWH in maintaining their private health insurance by directly enrolling eligible clients in the State's premium assistance program. The TGA's rural counties also have certified ADAP and OA-HIPP enrollment workers. In the TGA's rural counties there are five Covered California private health insurance plans in Placer County and there are two in El Dorado (CA Health and Wellness Plan).

With the Affordable Care Act (ACA), low-income clients who are dually enrolled in both ADAP and the OA-HIPP programs get assistance with private insurance premiums, medication co-payments and medical insurance deductibles. While this program has reduced the need for RW dollars to be spent on medical co-pays and deductibles, the RW program still assists clients with the first month of insurance premiums until their OA-HIPP application is approved and processed. Reimbursements that clients receive from OA-HIPP for that first month of service are returned to the RW program.

### ***3.A.2) Unmet Need (Framework: Attachment 6)***

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

In reporting each component of the Unmet Needs Framework the TGA did not use linked databases but used HIV surveillance data, the required format. The data used was a Data-to-Care (DtC) line list provided by the California State Office of AIDS (SOA). This data format varied from the HIV Surveillance data used for the HIV/AIDS Epidemiology data, (Attachment 4) and numbers vary slightly as described prior. The HIV Data-to-Care (DtC) Line List is an Excel spreadsheet containing all HIV/AIDS cases reported to be alive and still residing in the state of California based on the most currently available data in the Enhanced HIV/AIDS Reporting System or Surveillance database (eHARS). The cases are grouped by the most recent residence address into separate spreadsheets for each TGA. The monthly line lists are generated based on the prior end-of-month frozen eHARS data set, and therefore reflect the most up-to-date information about each HIV/AIDS case. Cases are deemed to be "out-of-care" if they do not have an updated CD4 or viral load in eHARS during the last calendar year of the evaluation period. The evaluation period for this framework is for CY23 with PERSON-based HIV surveillance data reported through 06/30/23.

### ***3.A.2)a) Service Needs of PLWH Based on Unmet Need Estimate***

#### ***3.A.2)a)i. Service Needs of Late Diagnosed PLWH***

Late Diagnosed PLWH are defined as the number of late HIV diagnoses based on first CD4 test performed or documentation of an AIDS-defining condition less than or equal to three months after a new HIV diagnosis. The Sacramento TGA's Unmet Need Framework shows an 11% reduction in the percentage of late diagnosed PLWH between 2020 and 2023. 19.6% of newly diagnosed PLWH were defined as late diagnosed in CY23 compared to 30.8% in CY20. Since the impact of the COVID-19 pandemic has decreased across the TGA, HIV testing activities have increased and more people are getting diagnosed in a timely matter resulting in fewer late diagnoses. The availability of testing and linkage-to-care activities for newly diagnosed persons across the TGA remain critical in reducing late diagnoses and improving health outcomes.

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

### **3.A.2)a)ii. Service Needs of PLWH with Unmet Need**

PLWH with Unmet Need is defined as the number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year. The Sacramento TGA's Unmet Need Estimate calculates 1,269/22.3% of PLWH with unmet need. The service needs of PLWH who are diagnosed with HIV but not in medical care include a need for improvement of linkages between supportive services and primary care services. Expanded services for PLWH who have dropped out of care also are needed to include improvements to provider-patient partnerships and collaborations with peers. Service needs of PLWH who have never been in care include peer facilitated linkages between points of service entry, counseling and primary medical care. Collaboration between the three TGA counties also is necessary to ensure rural patients are linked to and retained in medical care.

There are also patients who have been diagnosed with HIV but were never made aware of their diagnosis. Commonly patients who rely solely on the ED for their medical care are experiencing other hardships that make it extremely difficult to locate and contact them to disclose their positive test results after they leave the ED. Common barriers in disclosing to these patients include phone numbers no longer in service or being unstably/unhoused with no additional contact or locating information available.

To address the service needs of PLWH with Unmet Need and to engage and re-engage them in HIV medical care, the TGA's RW service providers continue to work closely with Sacramento County DHS HIV Prevention and Testing providers to provide outreach to communities living in those zip codes with the highest number of clients not in care. The RW Program funds several subrecipients that provide services including non-medical case management to enhance efforts to get PLWH in care. For example, getting RW clients enrolled in the AIDS Drug Assistance Program (ADAP), Covered California and OA-HIPP (State Health Insurance Premium) programs all increase access to care for PLWH who have fallen out of care due to lapses in securing benefits. A Linkage to Care Coordinator housed in the Sexual Health Promotion Unit, funded

partially by the County and with SAMHSA funding, assists with linking newly diagnosed and out-of care PLWH to medical and support services.

To help address the large number of PLWH with unmet need, Sacramento County's Sexual Health Promotion Unit launched a Multidisciplinary HIV Response Team in early 2024. This team is primarily responsible for identifying, linking and engaging/re-engaging PLWH with unmet need into care. Having a dedicated team, consisting of staff from across the HIV continuum, including Sexual Health Clinic and HIV Care Services staff and Prevention and Surveillance staff. With greater capacity, the team will be able to utilize more resources to engage and locate clients, including field visits, the mobile medical van, partnerships with local mental health and substance use disorder programs, housing case managers, etc.

These complex unmet needs of the out-of-care population, as summarized above, are projected to have an increased fiscal impact of over \$1M on the RW Program in FY25. To determine the potential increased annual cost to meet the needs of the out-of-care population, the Unmet Need Estimate data was applied to the average cost per FY23 RW client. These calculations show that the FY23 RW caseload represents 38.2% (2,171/5,686) of the TGA's PLWH as of 12/31/23. Applying 38.2% to the 1,269 PLWH out-of-care, an additional 485 persons will likely need access to the RW care system in FY25. This data analysis shows a potential increased cost to the RW program of \$1,090,765 annually if 38.2% of the anticipated out-of-care clients accessed the RW program in FY25, given that the average cost per RW client in FY23 was \$2,249. This potential increased dollar figure is based on FY23 RW cost figures and doesn't factor in the rising cost of living in California, which would increase this average cost per client figure further in FY25.

#### ***Subpopulations of Focus and Unmet Need***

The first out-of-care population is MSMs. In terms of race, African American MSMs represented 10.1% of the unmet need population as of 12/31/23 and Hispanic MSMs represented 13.4% of the unmet need population as of 12/31/23. White MSMs represented 23.4% of the unmet need population.

The Heterosexual category represented the second largest percentage of PLWH in the TGA as of 12/31/23 (22.5%); and represented the second highest population out-of-care in 2023 (24%). Within the heterosexual transmission category, African American women accounted for 19.3% of those with unmet need and 6.5% of total African American women represent the overall unmet need population. African American women accounted for 6% of those who had a late diagnosis as of 12/31/23. 16% of late diagnoses were among heterosexual females while 32% of late diagnosis were among heterosexual males. The third highest population out-of-care was Injection Drug Users (IDU) at 10.2% as of 12/31/23. African American, Hispanic, and White IDUs represented 1.7%, 1.1%, and 3.4% of unmet need respectively.

#### ***3.A.2)a)iii. Service Needs of PLWH In Care Without Viral Suppression***

PLWH in care but not virally suppressed is defined as the number of PLWH in the jurisdiction who are in care with a viral load test result in the most recent calendar year of  $\geq 200$  copies/mL. The TGA's Unmet Need Estimate calculates that 462/10.5% of PLWH are in care but are without viral suppression. The needs of PLWH without viral suppression include services that address barriers to HIV medical care and gaps in support services such as mental healthcare, substance use services, emergency financial assistance, housing, transportation and food assistance services. These wrap-around support services have

demonstrated their effectiveness in establishing housing stability and improving clients' ability to stay retained in medical care and improve the outcome of viral suppression.

In addition to wrap around mental health, substance use and housing services, transportation services funded with RW Part A funds continue to be expanded and enhanced. While transportation assistance has been available to clients in the form of bus vouchers, the RW field-based medical case management system also provides mileage reimbursement for RW case managers to escort clients to appointments when necessary. The TGA also has expanded transportation to include monthly rather than daily bus passes for RW clients with documented service needs to attend multiple appointments. Transportation assistance also includes Uber and Lyft rides as well as gas cards for clients with access to a vehicle. Many people in the TGA's rural counties use gas cards to get to their medical appointments, as public transportation is extremely limited.

### 3.A.3) HIV Care Continuum

#### 3.A.3)a). Graphic Depiction of HIV Care Continuum

The TGA's RW Program's successes and challenges are documented in the following bar graph in which the baseline rates of RW clients are compared not only to the National and California (CA) rates, but to the TGA's general HIV+ population rates for the following five measures that comprise the National HIV/AIDS Strategy (NHAS) HIV Care Continuum: 1) Diagnosis of HIV Infection; 2) In Medical Care; 3) Retention in Care; and 4) Viral Suppression; 5) Linkage to care

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



#### HIV Care Continuum Data Sources

- CY23 Ryan White client data for the HIV Continuum of Care are from the RW Program's Sacramento TGA HIV/AIDS Reporting Engine (SHARE)
- CY22 Sacramento TGA data are from Centers for Disease Control HIV Surveillance data as of December 31, 2023 \\cdc.gov\Locker\NCHHSTP\_HICSB\_STORE02\SBPGMS\xah2\Supplemental Report\HIV

*Indicators\Year2023\Table 1 (HIV\_Dx\_Prev).sas*

- *CY22 National data and CY22 California (CA) data are from CDC and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—US and 6 territories and freely associated states, 2022. HIV Surveillance Supplemental Report 2024;29(No. 2). <https://www.cdc.gov/hiv-data/nhss/national-hiv-prevention-and-care-outcomes.html>. Published May24*

**Diagnosing HIV Infection** is defined as number of persons aged > 13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. This grant application is based on a diagnosed-based HIV Care Continuum, which is defined as all PLWH in the jurisdiction who have been diagnosed with HIV. Therefore, all jurisdictions that conduct HIV testing, including the TGA, State and National, have HIV diagnosed indicators that are at 100%. The RW Program does not conduct HIV testing and therefore this indicator is not applicable. By comparison, a prevalence-based HIV Care Continuum includes both people whose HIV infection has been diagnosed plus those PLWH that have not yet been diagnosed.

**Linkage to HIV Medical Care** is defined as newly diagnosed with HIV during the year with at least one CD4 or viral load test within one month of diagnosis. **Receipt of Care** is defined as persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year. **Retained in Care**. Is defined as persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year. **Viral Suppression** is defined for the RW Program, Sacramento TGA, California and the Nation as PLWH whose most recent HIV viral load test result in during the calendar year was  $\leq 200$  copies/ml.

### **3.B. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)**

#### **3.B.1) Planned Activities in TGA's EIIHA Plan for FY 2025-2027 Period of Performance**

##### **3.B.1)a) Overall EIIHA Strategies and Adjustments from Prior Period**

The Sacramento County Department of Health Services, Division of Public Health has fully integrated its HIV and STI programs (HIV/STI Prevention Program, HIV/STI Surveillance, and HCS Programs) into the Sexual Health Promotion Programs Unit (SHPU) and an HIV/STI Health Programs Manager coordinates and oversees the integrated programs. This united structure has enhanced the TGA's efforts to identify HIV+ individuals and to provide risk reduction counseling. The Sacramento County SHPU relies on the expertise of the Sacramento Workgroup to Improve Sexual Health (SacWISH) to support HIV/STI prevention, testing and treatment efforts in the TGA. To further facilitate this integration, each HIV/STI program has moved into the same office suite to facilitate coordination of staff and implementation strategies that address the full range of HIV and STI services. These services include HIV/STI prevention and testing, surveillance, disease intervention, Partner Services, HIV/STI linkage to care and treatment; as well as re-engagement to care and treatment. This structure has supported implementation of the TGA's EIIHA Plan.

The HCS Program, Sacramento County Division of Public Health and participating government and private testing providers have agreed to common data elements are tracked to monitor the impact of the EIIHA Plan. Through analysis of TGA-wide HIV surveillance epidemiological data through 12/31/23, National, State and TGA HIV Continuum of Care data through 12/31/22, and RW Continuum of Care data from the TGA's RW program (3/1/23-2/28/24). The FY25 EIIHA plan targets those subpopulations overrepresented in the TGA's HIV/AIDS epidemic (PLWH) through 12/31/23, as well as those subpopulations with the highest newly diagnosed positivity rates over the most recent three-year period (1/1/21-12/31/23).

While the government funded test sites and those in the RW care system have a coordinated approach to testing the highest risk populations and reporting those results, data collection from private testers is more challenging. Although data collection and reporting has improved among private testing sites, these efforts

often are costly processes, and despite their willingness to cooperate, these private testers often have limited resources to generate the data to provide a more expansive picture of the TGA's success in reaching high risk populations. The TGA's private testers do, however, cooperate well with the HCS Program to get HIV+ clients into medical care; and provide clients with outreach materials to get free or low-cost care. Most HIV testing providers in the Sacramento TGA make immediate contact with the County Public Health Surveillance Team to initiate Partner Services, confirmatory tests, and access to HIV medical providers.

Since the TGA's privately funded HIV testing providers are already members of SacWISH, the Sacramento Prevention Coalition (SPC), and the HIV Test Counselors/PrEP Navigators Coalition, they cooperate in the development and implementation of the EIIHA Plan. These coalitions are comprised of certified HIV Test Counselors, PrEP Navigators, representatives from community-based organizations and health care facilities to network, collaborate, and support one another in their efforts to end the HIV epidemic. SacWISH members collaborate on ways to eliminate disparities and address gaps in STI/HIV prevention and care; the SPC topics include how to address barriers to vital HIV prevention and treatment services; and the HIV Test Counselors/PrEP Navigators Coalition discusses current policy related to PrEP, best practices for Status Neutral approaches, and strategies to troubleshoot challenges with insurance coverages. With years of extensive community collaboration and coordination, the TGA has a solid framework for implementing its EIIHA Plan by targeting specific demographic groups and specific needs of people most at risk for HIV, and by limiting barriers to HIV testing and care for the TGA's most at risk populations.

Despite all these coordinated efforts, the Centers for Disease Control (CDC) data reports that in Sacramento County in 2023 there were an estimated 956 PLWH who are unaware of their HIV status. Although HIV testing is available in numerous locations throughout the TGA, community engagement data suggests that HIV messaging and outreach is not adequately reaching several vulnerable populations, or if it is, the message is not resonating as needed. These populations include people of color (including women), transgender persons, youth, injection drug users, other substance abusing individuals, people experiencing homelessness, and people who have English as a second language or are Spanish speaking only.

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

The Sacramento TGA has used all the available resources, both internal and external, in its efforts to produce favorable outcomes in its effort to continue to achieve the EIIHA Plan's target outcomes. Lessons learned from the FY22 EIIHA plan factored into the development of the FY25 plan. Some of the activities were so closely aligned that the decision was made to combine them to streamline outcomes. One activity that was added to the plan, which has been an on-going challenge in the TGA, is ROOT. This expanded effort is intended to increase opportunities to diagnose many PLWH who are unaware of their HIV status. There is strong consensus among community engagement participants, Sacramento County staff and the Planning Council that, to end the TGA's HIV epidemic, community-based testing needs to be widely accessible throughout the TGA and tailored to the needs of people not currently being reached, and that the addition of ROOT to the EIIHA plan needs to be widely implemented throughout the Sacramento TGA.

**3.B.1)b) EIIHA Plan Summary Table: Identify, Inform, Refer and Link Newly Diagnosed**

The following tables provides a summary of the activities, anticipated outcomes and primary collaborators for each of the four EIIHA components:

- 1) Identification of individual unaware of their HIV status;
- 2) Informing individuals that tested positive of their HIV diagnosis;
- 3) Referral to care of newly diagnosed individuals; and
- 4) Linkage to care of newly diagnosed individuals.

<b>Activities to <u>IDENTIFY</u> Individuals Unaware of HIV Status</b>	<b>Anticipated Outcomes</b>	<b>Primary Collaborators</b>
Provide HIV testing to high-risk populations to make them aware of their HIV status, including same day result options	Increase in number of high-risk clients knowing their HIV status	SHPU HIV Prevention team; SHPU Surveillance staff; SHC staff; CBO HIV certified test counselors
Conduct testing at venues accessible to high-risk populations through venues associated with their culture, geography, and lifestyle to maximize testing efforts	Increase in number of rapid HIV tests administered in field-based settings  Increase availability/easy access to testing for high-risk populations	SHPU HIV Prevention team; SHPU Surveillance staff; SHC staff; CBO HIV certified test counselors
Educate medical providers on HIV testing and referral resources to increase routine testing of population at large	Increase in routine HIV testing and reporting from medical providers	SHPU HIV Prevention team; SHPU Surveillance staff
Certify and train new HIV testers on rapid HIV testing to expand TGA's capacity	Increased number of trained and certified HIV testers in TGA  Increased number of rapid HIV tests completed in TGA	SHPU staff
Maintain the Sacramento Workgroup to Improve Sexual Health (SacWISH) in order to focus on ending the HIV epidemic	Successful completion of four (4) coalition meetings, annually, disseminating HIV education and resources	SHPU staff; Community stakeholder participants
Expand number of nontraditional testing partners who reach more of the targeted populations by increasing the number of individuals who know their status	Increase number of partnerships with nontraditional testing partners that offer HIV/STI services  Increase reach to target populations by partnering with organizations offering other services  Increase in HIV/STI tests completed by target population	SHPU staff; Community organizations
<b>Activities to <u>INFORM</u> Newly Diagnosed of HIV Status</b>	<b>Anticipated Outcomes</b>	<b>Primary Collaborators</b>
Provide HIV testing to high-risk populations to make them aware of their HIV status, including same day result options	Increase in number of high-risk clients knowing their HIV status	SHPU HIV Prevention team; SHPU Surveillance staff; SHC staff; CBO HIV certified test counselors
Conduct testing at venues accessible to high-risk populations through venues	Increase in number of clients getting tested and receiving test results	SHPU HIV Prevention team; SHPU Surveillance staff; SHC

associated with their culture, geography, and lifestyle to maximize testing efforts	Increase availability/easy access to testing & providing immediate results for high-risk populations	staff; CBO HIV certified test counselors
Decrease barriers that may prevent individuals from each target population from returning for test follow-up, including results, confirmatory testing, and/or treatment.	Increase in number of individuals receiving test results from completed tests  Increase number of individuals knowing their status	SHPU HIV Prevention team; SHPU Surveillance staff: SHC staff; CBO HIV certified test counselors
Make Routine-Opt-Out Testing (ROOT) more widely practiced throughout Sacramento County	Increase in number of Emergency Rooms using ROOT	SHPU staff
<b><i>Activities to <u>REFER</u> Newly Diagnosed to HIV Care</i></b>	<b><i>Anticipated Outcomes</i></b>	<b><i>Primary Collaborators</i></b>
Provide prevention and harm reduction education information, including PrEP and PEP information and referrals, to individuals at testing	Increase number of PrEP referrals, condoms distributed, and educational materials provided to TGA residents	SHPU HIV Prevention team; SHPU Surveillance staff: SHC staff; CBO HIV certified test counselors
Educate medical providers on HIV testing and referral resources to increase routine testing of population at large	Increase in HIV testing referrals and PrEP referrals from medical providers	SHPU HIV Prevention team; SHPU Surveillance staff
<b><i>Activities to <u>LINK</u> Newly Diagnosed to HIV Care</i></b>	<b><i>Anticipated Outcome</i></b>	<b><i>Primary Collaborators</i></b>
Increase percent of newly diagnosed HIV+ people linked to medical care within one month of diagnosis through targeted, TGA-wide referrals.	Increased number of newly diagnosed HIV+ linked to medical care in one month or less of diagnosis	SHPU Linkage to Care Coordinator; SHPU HIV Prevention team; SHPU Surveillance staff: SHC staff; CBO HIV certified test counselors
Increase the number of TGA residents at high risk for infection who are on PrEP	Increase in high-risk individuals on PrEP	SHPU Linkage to Care Coordinator; SHPU HIV Prevention team; SHPU Surveillance staff: SHC staff; CBO HIV certified test counselors

**3.B.1)b)i. EIIHA Plan Activities**

**Activities to Identify Individuals Unaware of HIV Status.** Since Sacramento County Department of Health Services, Division of Public Health’s integration of HIV/STI prevention, surveillance, care and treatment programs, many additional efforts have been implemented to identify individuals unaware of their HIV status, and to ensure that they are immediately referred to and provided care and treatment. While HIV/STI testing is available through public entities, the TGA also has a broad range of private organizations conducting activities to identify individuals unaware of their HIV status. The variety of private agencies involved in HIV testing allows for multi-level strategies targeting various high-risk populations. The HIV testing services offered at these public entities and private organizations include Rapid Finger Stick HIV tests which result in clients receiving test results within 20 minutes. This HIV testing process involves both pre- and post-test

counseling, incorporating both assessment and discussion of HIV risk factors. Clients who test negative receive risk reduction counseling and educational materials; referrals to agencies providing testing, free condoms, PrEP, PEP; as well as other support services. For individuals who test positive for HIV, all TGA subrecipient agencies have contractual language requiring providers to refer all newly diagnosed individuals to the County Linkage to Care Coordinator and Partner Services Program. This service works to obtain the names of sex and/or needle-sharing partners from clients testing HIV positive. This process enables the County surveillance team to notify partners of their HIV exposure and offer free testing and follow up.

To reduce barriers to testing, the Sacramento County Sexual Health Prevention Unit (SHPU), in collaboration with Sacramento County Primary Health Care, utilize a mobile testing van which brings HIV/STI testing, as well as certain primary health care services, directly to the target population. This mobile testing van, called Wellness Without Walls (W3), travels to locations heavily populated by the unhoused community three days per week to offer health services to those individuals who may not seek out services otherwise.

***Activities to Inform Newly Diagnosed Individuals of HIV Status.*** All activities to inform individuals of their HIV status are implemented by public and private test sites. Once completing the Rapid Finger Stick HIV test, results are available within 20 minutes and provided to clients immediately by certified test counselors. For individuals who receive a negative test result, they are given post-test counseling, risk reduction education and referrals for PrEP/PEP, further testing and support services. For individuals who receive a positive or inconclusive test result, a more extensive counseling session, along with resource and referral information for medical care, is provided. All clients are transitioned immediately to the Sacramento County Sexual Health Clinic (SHC) or other preferred or established medical care provider to receive a confirmatory blood test, linkage to medical care as well as RW case management. For clients who consent, a Partner Service session is completed by either the County Linkage to Care Coordinator or a County Communicable Disease Investigator to anonymously contact their sex and/or needle sharing partners to inform them of their risk and encourage them to get tested.

The Sacramento County HIV/STI Prevention programs are an integral part of the TGA's plan to inform individuals of their HIV status and works cooperatively with government-funded programs and private testing organizations to develop coordinated strategies, plans and activities. The County SHC began offering services in 2019 with the goal of further reducing the spread of HIV and other STIs. The Prevention and Disease Control branches of the TGA's two rural counties both coordinate services with the Sierra Foothills AIDS Foundation (SFAF), which is headquartered in Placer County with field offices in El Dorado County. SFAF participates in TGA activities related to informing rural individuals of their HIV Status. SFAF contracts with Sacramento County testing providers to continue testing in the TGA's rural counties and has been successful in encouraging HIV testing in rural county primary care centers as well as the county jails.

***Activities to Refer Newly Diagnosed Individuals to HIV Care.*** Protocols have been put in place to ensure that newly diagnosed individuals are referred to as quickly as possible. While the TGA covers a large geographic area for HIV testing, HIV specialty medical providers are relatively limited. All testers are familiar with the HIV medical providers in the area, including the County SHC, One Community Health, WellSpace Health, and SFAF, as well as government funded testing sites. All public and private HIV testing sites currently refer 100% of newly diagnosed clients to medical care.

Persons receiving a preliminary HIV+ test result are provided more extensive counseling and are immediately

referred to medical care and psychosocial support services. All testing sites distribute resource and referral information to all clients who are first diagnosed with HIV, or if results are inconclusive. The resource and referral information is used to identify sources for HIV care and treatment, as well as educational materials for HIV+ individuals. The Sacramento HIV/STI Prevention program is an integral part of the TGA's plan to refer individuals to appropriate services, and both HIV+ and HIV- individuals receive referrals that are custom designed to meet their specific needs. All HIV testing sites send clients to either their established or preferred care provider for confirmatory tests, or to the County SHC or One Community Health Federally Qualified Health Center (FQHC). One Community Health, which was established in 1989 as the Center for AIDS Research, Education and Services (CARES), transitioned to become an FQHC in 2015, is now named One Community Health and has been a RW subrecipient since 1996. Referrals for confirmatory HIV testing are only made to organizations that provide free or low-cost confirmatory HIV testing to all individuals regardless of their insurance, county of residence, immigration or income status.

***Activities to Link Newly Diagnosed Individuals to HIV Care.*** All public and private testing locations in the TGA, who collaborate with SHPU, are required to report any positive HIV result to the Sacramento County Linkage to Care Coordinator. This position is filled by a staff member of the SHPU who is responsible for ensuring all HIV+ clients in the Sacramento TGA are linked to medical care and treatment. Along with the efforts of the Linkage to Care Coordinator, each public and private testing location immediately link the individual to either the County SHC, One Community Health, or other established or preferred provider for confirmatory testing. Each client also is linked to a RW case manager, which can help the individual in a large variety of ways. Providers offer a wide variety of services to help the client overcome barriers to receiving treatment and care. Providers offer transportation services from the test site to their clinic to get confirmatory testing, and from there assist clients with additional appointment scheduling/transportation and linkage to a case manager. In addition, Sacramento County HIV/STI Prevention is integral to the TGA's plan to link individuals to treatment. SFAF carries out these activities for the TGA's two rural counties.

The TGAs client-level database (SHARE) tracks whether clients are "in medical care" or have "dropped out of" care. Each RW subrecipient, regardless of services provided, is given a monthly report of their clients who are not in medical care and agencies are contractually obligated to follow-up with out-of-care clients and help get them back into care. At the time of intake, RW clients are encouraged to sign the Universal Release of Information Form, so that RW agencies unable to locate their out-of-care client can refer that client's name to OCH's Outreach team, who collaborates with the County HIV response Team, to locate out-of-care clients and provide them with the assistance necessary to return to medical care.

Several RW funded agencies operate a "field-based medical case management model" where case managers go directly to the clients to provide services, rather than requiring clients to go to a service site. Public testing sites are familiar with these agencies and arrange for a medical case manager to meet with each newly diagnosed person. The case managers assist the individual with various services including scheduling, transportation and ensuring attendance at medical appointments. While the field-based case management system is more expensive than office-based, client health outcomes demonstrate this model's effectiveness in linking clients to medical care and achieving viral suppression. In CY23, 80.7% of RW clients who received RW medical case management (1,228/1,522) met the definition of "In Medical Care" by receiving a minimum of one medical visit in CY23 including a CD4 or viral load test. However, only 25.1% (382/1,522) met the definition of "Retained in Medical Care" by receiving at least two medical visits at least three months apart in CY23. The percent of CY23 RW clients who received medical care and were prescribed HAART was 94.1%, a significant improvement over CY22 (89.8%). The percent of RW clients in medical care

in CY23 who achieved viral suppression was 72.7%, similar to the CY22 rate of 73.8%.

**3.B.1)b)ii. Anticipated Outcomes of EIIHA Strategy**

The TGA's FY25 EIIHA Goals, which include those for the government funded agencies, are identified in the first column of the table below; with the responsible parties/timeframes noted in the final column:

<b>FISCAL YEAR 2025 EIIHA PERFORMANCE INDICATORS</b>	
<b>Responsible Parties/Timeframes</b>	
<b>Strategies to Improve EIIHA</b>	<b>Responsible Parties/Timeframes</b>
1. Conduct testing in at least 40 venues accessible and familiar to high-risk populations to maximize number of high-risk individuals who become aware of their status.	<u>Parties/Timeframes:</u> Testing Providers 1/1/25-12/31/25
2. Certify and train new testers on Rapid Finger Stick HIV testing to expand the region's ability to administer a minimum of 1500 tests and inform individuals of their HIV status.	<u>Parties/Timeframes:</u> Testing Providers 1/1/25-12/31/25
3. Provide Rapid HIV testing, PrEP referrals, and linkage to care to the following risk populations and make them aware of their HIV status: <ul style="list-style-type: none"> <li>▪ IDUs and other Substance Using Individuals: at least 10% of tests will be administered to IDUs.</li> <li>▪ Men having Sex with men (MSMs): at least 30% of total tests will be administered to MSM.</li> <li>▪ Other High-Risk Groups: approximately 55% of total tests will be administered to individuals at higher risk of acquiring HIV, such as: people with an HIV+ Sex Partner; Sex Workers; IDU Partner; MSM Partner; Sex Worker Partner; previous Syphilis/Gonorrhea Diagnosis; Stimulant User; as well as members of disproportionately impacted groups, such as: Black/AA, Latinx, low- income communities, and those who are unhoused.</li> <li>▪ Transgender Individuals: 5% of those tested will be transgender men, transgender women, genderqueer or non-binary</li> </ul> <p><u>Target Population Goals by Race:</u></p> <ul style="list-style-type: none"> <li>▪ 30% of total clients tested will be White</li> <li>▪ 20% of total clients tested will be African American</li> <li>▪ 30% of total clients tested will be Hispanic</li> <li>▪ 10% of total clients tested will be Asian/Pacific Islander</li> <li>▪ 2% of total clients tested will be American Indian/Alaskan Native</li> <li>▪ 8% of total clients tested will be Other/Undeclared</li> </ul>	<u>Parties/Timeframes:</u> Testing Providers and 1/1/25-12/31/25
Increase routine HIV testing, referrals, and reporting from medical providers by partnering with UC Davis emergency room navigators	<u>Parties/Timeframes:</u> <u>Testing Providers, ER Staff</u> 1/1/25 - 12/31/25
Successful completion of four (4) coalition meetings disseminating HIV education and resources	<u>Parties/Timeframes:</u> <u>Testing Providers, Community Stakeholders, Healthcare Representatives</u> 1/1/25 - 12/31/25

FISCAL YEAR 2025 EIIHA PERFORMANCE INDICATORS	
Responsible Parties/Timeframes	
Strategies to Improve EIIHA	Responsible Parties/Timeframes
Increase avenues for clients to access test results, follow-up testing, and treatment services by increasing the number of tests ordered through TakeMeHome.org program by 5% (from 690 in CY23 – 725), within Sacramento TGA; and utilizing the Chexout test tracking and patient portal software	<u>Parties/Timeframes:</u> <u>Testing Providers</u> <u>1/1/25 - 12/31/25</u>
Expand number of Emergency Room's using Routine Opt-Out Testing (ROOT)	<u>Parties/Timeframes:</u> <u>County Staff, Testing Providers, ER Staff</u> <u>1/1/25 - 12/31/25</u>

**Contribution of EIIHA Plan to Improvements in HIV Care Continuum Outcomes**

The TGA's FY25 EIIHA goals correlate with several of the National HIV/AIDS Strategy (NHAS) strategies, several of the are described below: Continuum of Care Performance Indicators, a few of which are described below:

"Increase knowledge of HIV-positive status to 95%. The TGA's efforts target youth and young adults, in particular young men who have sex with men (MSM), to get tested. In CY23, 15.5% of tests administered through the TGA's EIIHA providers were for clients ages 24 and younger. Of the tests completed by these providers, 8% of the newly diagnosed cases were under age 24, as of 12/31/23. To maximize opportunities for HIV testing for youth and young adults, the TGA offers a wide range of testing sites accessible to various target populations of youth through venues associated with each subpopulation's culture, geography, lifestyles, and sexual orientations. Once tested, comprehensive efforts are made to ensure that youth and young adults are contacted directly, made aware of their HIV status, and linked to care as soon as possible.

In addition to youth and young adults, the TGA targets the United States' most at risk populations for transmission of HIV: Men who have Sex with Men (MSM) and Intravenous Drug Users (IDUs). The TGA's efforts of providing testing at needle exchange sites, and offering incentives to clients who get tested, are proving successful at increasing the number of IDUs in the TGA who are aware of their HIV status.

Analysis of the TGA's HIV epidemiology data shows that the Heterosexual HIV transmission category surpassed the IDU transmission category, in both absolute numbers and percentages, in 2018. This trend has continued into 2023. Longer term trends show the total number of PLWH among the heterosexual population increased 52.1% over the last ten years (from 793 to 1,314 PLWH) between 12/31/13 and 12/31/23 and the representation of Heterosexuals grew from 19.4% to 22.5% of PLWH. The Sacramento County community-based organizations have continued to offer HIV testing services to heterosexuals, and while the Office of AIDS no longer specifically tracks "high-risk heterosexuals" this population is included in the "low priority/unknown" which accounts for 57.9% of HIV tests completed in 2023.

"Increase linkage of newly diagnosed persons to HIV medical care within one month to 95%." The TGA's and HCS Program's service providers implementing the EIIHA Plan coordinate efforts to link each client to care when they test positive for HIV, ensuring they get a confirmatory test; and providing each client with access to Partner Services. Surveillance teams follow up with all positive tests to ensure that clients promptly access medical care and are linked to a RW Case Manager to access services such as benefits counseling and transportation. The HCS Program's CY23 rate of 91% linkage to HIV medical care within 30-days for newly

diagnosed PLWH is higher than the TGA's CY22 rate of 84%, California's CY22 rate of 82%, the National CY22 rate of 82%, but slightly lower than the NHAS goal of 95%.

### ***Addressing Gaps Along the HIV Care Continuum***

Analysis of RW client data from FY23 allows the TGA to determine which subpopulations are less likely to be meeting targets across the HIV Care Continuum. Follows are examples of some of these variations and strategies in the EIIHA Plan to work to reduce these gaps. In Medical Care (receipt of at least one CD4 or viral load) for the FY23 RW was 77% overall. However, MSMs (62.6%) and IDUs (65.7%) were less likely than Heterosexuals (66.5%) to be in medical care. African Americans (63.7%) were less likely to be in medical care than Whites (63.9%) or Hispanics (65.3%). Males (63.01%) were slightly less likely to be in care than females (69.5%). RW clients ages 20-24 (61.5%) were slightly less likely to be in medical care than ages 25-44 (63.2%), ages 45-59 (63.9%), clients ages 60 and over (65.5%) and clients ages 3-19 (100%).

Follows are examples of the TGA's EIIHA Plan to address gaps along the HIV Care Continuum:

- Expanded "field-based" case management which allows medical case management (MCM) to be offered in settings of the client's choice, rather than only in an office. This model began in 2003 with the MAI program. Health outcomes improved so substantially that the Council increased allocations to field based MCM from 30% in 2003 to 63% in 2023. In addition, the HCS Program allocates funding to outreach workers for the growing target populations, such as youth MSM who are persons of color.
- All RW agencies, regardless of services provided, are required to track each client's progress related to that service's linkage to the Continuum of Care (i.e., ambulatory care providers must track all NHAS Performance Indicators, while transportation providers must track their clients' linkage to care). All RW subrecipients must document each client's viral load suppression regardless of the service provided.

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

### ***3.B.1)b)iii. EIIHA Plan Collaborations***

A major achievement in the implementation of the EIIHA Plan has involved the integration of the HIV and STI Programs into one unit within the Sacramento County Division of Public Health - SHPU. These efforts have enhanced the TGA's efforts to provide risk reduction education counseling to those at highest risk, to identify HIV+ individuals, and to fast track them into care and support services. Currently, the SHPU Prevention Program and its community subcontractors provide State funded HIV testing activities. When staff or community subcontractors identify HIV positive individuals, they link them directly to appropriate medical providers. Upon linking individuals to care and treatment, testing staff notify the County Linkage to Care Coordinator so that they can monitor whether or not each HIV positive individual is engaged in care and follow up accordingly. SHPU Surveillance staff also provide Partner Services, including third party anonymous notification of HIV exposure to the partners, when requested; and can link partners to get tested as well. Staff from SHPU and the HCS Program work with the Epidemiology Unit, to determine best practices for tracking client retention and to maximize opportunities for data sharing.

To further these efforts, the Sacramento County HIV/STI Programs Manager is responsible for oversight of the SacWISH community group, which is comprised of representatives from community medical clinics, health care plans, HIV/STI testing agencies, school districts, state and local public health departments, and nonprofit agencies. The purpose of SacWISH is to coordinate and enhance the TGA's HIV/STI prevention, testing and treatment efforts and to assist with determining best practices for client retention and data sharing. The EIIHA Plan is disseminated to SacWISH to provide regional goals and objectives, and to elicit their support in providing the HCS Program with annual HIV/STI testing results. SacWISH also provides its members with promotional materials to increase community awareness of free testing sites and referral locations to link individuals to low-cost or free treatment; and provides epidemiological data and technical assistance to guide local HIV prevention efforts.

Sacramento County Public Health also expanded its capability to identify HIV+ clients and link them to care by opening a new Sexual Health Clinic (SHC) in May of 2019. The clinic provides a variety of sexual health services including contraception services, extragenital testing for chlamydia and gonorrhea, rapid HIV, HCV, and syphilis screening, as well as STI treatment and referral services. In CY23 the SHC provided 1,181 office visits. There has been a significant reduction in the number of uninsured SHC patients since the last reporting period. 43.7% of SHC patients from 5/1/19-2/24/24 were uninsured compared to 72% uninsured from 5/1/19-6/8/21. Ensuring each client's access to health insurance and providing comprehensive STI care is crucial to ending the HIV epidemic. It is well documented that contracting Syphilis and/or Gonorrhea significantly increases the chances of contracting HIV, particularly among MSM. In January 2021 the Sacramento County DHS SHC began offering RW services such as HIV ambulatory care and transportation and has served 114 HIV clients between 1/1/21 and 12/31/23. In CY23, the SHC served 91 HIV clients which represents an HIV positivity rate of 1.6% indicating that the clinic is drawing high risk clients.

***Organizations Responsible for Implementation of EIIHA Activities.*** Sacramento County SHPU, County Sexual Health Clinic (SHC), One Community Health (OCH), Golden Rule Services (GRS), Safer Alternatives through Networking and Education (SANE), Gender Health Center (GHC), Harm Reduction Services (HRS), Sacramento LGBT Center, Wind Youth Services (Wind), Community Against Sexual Harm (CASH), Sacramento Native American Health Center (SNAHC), Sacramento County HIV/STI Prevention Program, CommuniCare Health Centers (CCHC), Sunburst Projects, El Dorado County DPH, Placer County DPH, WellSpace Health, and Sierra Foothill AIDS Foundation (SFAF) identify HIV+ individuals in the TGA.

Many organizations throughout the TGA are currently funded by public sources and are responsible for ensuring that activities to inform, refer and link individuals are implemented. Each of these providers has one of the TGA's three target populations as part of its contract with the County SHPU. OCH has access to high-risk individuals and their partners who come for low-cost STI testing and treatment. HRS targets its services for people who are homeless and/or substance users, including injection drug users and conducts free HIV and Hepatitis C testing, a syringe exchange program which provides clients with case management services, food, clean syringes, overdose prevention medications and transportation. GRS targets African American MSM, offering free or low-cost HIV/STI testing, Hepatitis C testing, risk reduction services, counseling, case management and social support services. SANE targets the IDU and substance using community and provides IDUs with clean syringes, risk reduction counseling, referral to partner services and medication assisted substance abuse treatment. The Sacramento County SHPU Prevention Program and testing partners target MSM by providing testing at venues where high risk communities congregate.

### ***EIHA Plan Community Collaborations to Strengthen Outcomes Across the HIV Care Continuum***

In addition to the County's integration efforts and collaborations with the SacWISH community stakeholder group, the Sacramento Prevention Coalition, comprised of community organizations dedicated to ending HIV in the TGA, meets monthly to provide feedback on strategies that have proved effective in reaching people most at risk for HIV infection. In the TGA's rural counties, SFAF conducts HIV testing in Placer and El Dorado County and has increased HIV testing done in community clinics. These community collaboration efforts are instrumental in development, implementation, and oversight of the TGA's EIHA Plan. Examples of additional efforts currently provided throughout the TGA follow:

- Sacramento County Department of Health Services (DHS) Sexual Health Promotion Unit (SHPU) opened its Sexual Health Clinic in May 2019, providing services to high-risk patients and their partners, including low/no-cost HIV/STI testing, treatment and comprehensive PrEP services
- SHPU has convened a monthly HIV Test Counselor/ PrEP Navigator workgroup to coordinate efforts across Sacramento County and support coordination of various programs, services and organizations.
- SHPU surveillance staff conduct ongoing analysis to monitor the number of individuals prescribed PrEP.
- SHPU Communicable Disease Investigators provide services to partners of those testing HIV+ to ensure they get tested. Those testing negative are educated on PrEP, PEP, and other harm reduction strategies.
- SHPU is continuing to implement and strengthen its STI/HIV Prevention, education and testing activities.
- SacWISH provides PrEP education and resources to providers to distribute to their clients.
- Rural county RW providers are disseminating PrEP and prevention materials to rural providers.
- Rural county testers are providing Risk Reduction/Partner Services to their clients testing negative.
- RW providers are conducting Risk Reduction/Partner Services with negative partners of their HIV+ clients implement referral agreements for partner services, PrEP, PEP, and harm reduction services for all clients.

### **3.C. SUBPOPULATIONS OF FOCUS**

#### ***3.C.1) Three Subpopulations with Health Outcome Disparities and Unique Service Needs***

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

1. HIV Health Services Planning Council HIV/AIDS Needs Assessments
2. State of California TGA epidemiological data through 12/31/23
3. FY23 RW service utilization, client demographic and cost data
4. Co-Occurring Conditions Data
5. Social Determinants of Health Data
6. Other Public Health Threat Data (i.e., Covid-19 pandemic)
7. RW Unmet Need Estimate
8. Continuum of Care data for HCS Program, TGA, State and Nation
9. 2023 HIV testing data provided by participating local government-funded testing sites
10. HCS Program's FY25-27 Early Identification of Individuals with HIV/AIDS (EIHA) Plan

Based on analysis of these data sources, the TGA's HIV Health Services Planning Council determined that the following subpopulations have health outcome disparities and unique service needs that qualify them as the TGA's "Subpopulations of Focus" for 2025: Men who Have Sex with Men (MSM), Heterosexuals and

Intravenous Drug Users (IDUs). As noted in the bullets in the table below, each subpopulation is comprised of the races, ages, genders, and HIV transmission modes most disproportionately affected.

<b>Sacramento TGA FY25-FY27 SUBPOPULATIONS OF FOCUS</b>		
<b><i>Men who have Sex with Men (MSM)</i></b>	<b><i>Heterosexuals</i></b>	<b><i>Intravenous Drug Users (IDU) (Includes MSM/IDU)</i></b>
<ul style="list-style-type: none"> <li>• African American MSM</li> <li>• Hispanic MSM</li> <li>• Youth and Young Adult MSM</li> <li>• White MSM</li> </ul>	<ul style="list-style-type: none"> <li>• African Americans</li> <li>• Youth and Young Adults</li> <li>• Hispanics</li> <li>• Whites</li> <li>• Asian Females</li> </ul>	<ul style="list-style-type: none"> <li>• African American IDUs</li> <li>• Hispanic Male IDUs</li> <li>• White IDUs</li> <li>• African American MSM/IDU</li> <li>• White MSM/IDU</li> </ul>

The following narrative describes the data used from the sources listed above to support the Planning Council’s decisions for each Subpopulation of Focus. It should be noted that all viral suppression figures discussed below are for those clients in medical care.

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

Overall, the unique needs of the MSM subpopulation are complicated by issues such as stigma regarding homosexuality, particularly within the African American, Hispanic, and Asian/Pacific Islander populations, including homophobia by religious communities that leads to isolation of MSM of color. These issues result in many MSM staying “closeted” which inhibits their ability to reach out for care and treatment services, including PrEP. Follows is analysis of recent epidemiological trends among the MSM population, including African Americans, Hispanics, Whites, and Youth and Young Adult MSMs living with HIV.

Between the last two reporting periods (ending 12/31/20 and 12/31/23), increases occurred among MSMs in most epidemiologic categories. New HIV cases (incidence) increased by 13.7% (212 to 241), AIDS prevalence increased by 1.8% (1,449 to 1,475), HIV prevalence increased by 17.2% (1,491 to 1,747) and total PLWH increased by 9.6% (2,940 to 3,222). Further analysis of target populations within the MSM transmission category follow:

**3.C.1)a)i African American MSM**

African Americans continue to be disproportionately impacted by HIV and were 23.9% of PLWH, 20.4% of new HIV cases and 21.4% of new AIDS cases as of 12/31/23, which is over 3 times higher than their rate in the TGA’s general population in 2022 (7.5%). Longer term trends in the TGA’s HIV epidemic further highlight the disproportionate impact among African Americans. Specific to the FY23 RW program 47.9% of African American RW clients were MSMs. This subpopulation underutilized RW services in FY23 with a 14.6% lower cost per client than RW clients overall (\$1,921 vs. \$2,249).

This finding is consistent with 2023 Unmet Need Data that African Americans MSMs were less likely to be in medical care than other subpopulations, accounting for 10.1% of the total out of care population and 20.3% of out of care MSMs. African American MSMs (75%) were less likely to be in medical care than Hispanics (80%) or Whites (80%). Of those in medical care (75%) only 87% of African American MSMs were virally suppressed compared to 91% of Hispanic MSMs and 94% of White MSMs. African American MSMs accounted for 4% of new diagnosis in CY23 and 11% of new MSM diagnoses. 3% of late diagnoses were among African American MSMs and 9% of late MSM diagnoses.

### **3.C.1)a)ii. Hispanic MSM**

Hispanics continue to be disproportionately affected by HIV. Between reporting periods ending 12/31/20 and 12/31/23, the number of new AIDS cases among Hispanics increased by 17.0% (from 53 to 62), AIDS Prevalence increased by 17.0% (536 to 627), HIV Prevalence increased by 29.1% (from 605 to 781) and total Hispanic PLWH increased by 23.4% (1,142 to 1,408). In FY23, the majority of Hispanic RW clients reported MSM as their mode of HIV transmission (68%) which is higher than Whites (59.1%) and Blacks (47.9%). Hispanic MSMs were disproportionately represented among MSMs (31.2%, 397/1274) compared to Hispanic representation among RW clients overall (26.9% 584/2171).

Analysis of FY23 RW client service utilization and cost data found that Hispanic RW clients with MSM as mode of transmission did not access RW services to the same degree as other racial groups, which points to more barriers to care among this population. Hispanic MSM RW clients had a 27.5% lower average cost per client (\$1,636) than RW clients overall (\$2,249). Hispanics MSM had lower costs per client (\$1,635) than African American MSM (\$1,921) and White MSM (\$2,333). In FY23, Hispanic RW clients had an overall viral suppression rate of 65.3%, which was lower than RW clients overall (87.7%). However, there was improvement in the percentage of Hispanic RW MAI clients on HAART between FY22 and FY23, from 89.5% to 97.6%. Regarding the Hispanic MSM subpopulation of focus, Hispanics were 59.5% of RW MSM clients that achieved viral suppression as compared to Hispanics being 37.9% of RW MAI clients overall.

HIV Care Continuum data show that Hispanic MSM account for 13.3% of the total out of care population and 26.7% of the out of care MSM population. While Hispanic MSM were equally as likely to be in medical care (80%) as Whites (80%), only 91% were virally suppressed compared 94% of Whites. Hispanic MSM accounted for a substantial amount of new diagnosis (23%) in CY23 and 55% of new MSM diagnoses. They also represented a large portion of total late diagnoses (16%) and 45% of late MSM diagnoses. Hispanic MSM aged 25-34 accounted for 12% of total new diagnoses and 13% of total late diagnoses.

### **3.C.1)a)iii. Youth and Young Adult MSM**

52.7% of FY23 RW clients ages 13-24 reported MSM as their mode of HIV transmission. Hispanics represented the highest percentage RW clients ages 13-24 (38.2%), followed by Blacks (36.4%) and Whites (14.5%). An important finding is that young adult MSM RW clients significantly underutilized services and have substantial barriers to care. In FY23, the average cost per MSM client ages 20-24 was less than half the average cost per RW client overall (\$800 vs. \$2,171). Youth and young adults were overrepresented among the MSM RW clients in FY23: 65.0% of RW clients ages 13-24 reported MSM transmission compared to 52.8% of RW clients ages 45 and older.

RW clients ages 20-24 (66.7%) were less likely to be virally suppressed than RW clients overall (87.7%). Moreover, RW clients ages 13-19 were more likely to be virally suppressed (100%) than in the Sacramento TGA (71%), California (67%) or the Nation (65%). While Youth and Young MSMs accounted for 2% of the total MSM population, they were 6% of new diagnoses and 6% of late diagnoses, representing 15% of new MSM diagnoses and 18% of late MSM diagnoses. While youth and adult MSM had slightly higher rates of being in medical care (83%) than MSM overall (80%), only 88% were virally suppressed compared to 92% of MSM. African Americans (35%) and Hispanics (35%) were overrepresented among Youth and Young

Adult MSM compared to their representation among MSM overall (16% and 27%, respectively).

### **3.C.1)a)iii. White MSM**

White MSM represented the largest subgroup of PLWH in the TGA as of 12/31/23 at 26% of total PLWH and 47% of MSM. They are equally as likely to be in care (80%) as all MSM (80%) and have slightly higher viral suppression rates (94% vs. 92%). While in medical care and viral suppression rates are higher than other subpopulations of focus, White MSM continue to represent a significant portion of new diagnoses (10%), diagnoses among MSM (25%), and late diagnoses (6% overall and 18% of late diagnosed MSM). White MSMs account for 23.5% of out of care PLWH in the TGA and 47.2% of MSM out of care. Among RW clients, Whites made up the highest percentage of clients with MSM as their mode of HIV transmission (42.9%), followed by Hispanics (31.1%) and African Americans (20.1%). White MSM also had the highest cost per RW client (\$2,333), followed by African American MSM (\$1,921) and Hispanic MSM (\$1,635).

### **3.C.1)b) Heterosexuals – African Americans, Youth and Young Adults, Hispanics, Whites and Asian Females**

Unique needs of the Heterosexual subpopulation (which includes High-Risk Heterosexuals) mirrors those of other risk categories: stigma regarding homosexuality and bisexuality; hesitancy to seek substance use treatment due to fear of arrest; addiction focused behaviors challenging concern for personal health and well-being; and other high-risk behaviors including unprotected sex with multiple partners. Analysis of the TGA's HIV/AIDS epidemiology since RW Part A funding began in 1996 shows that PLWH with Heterosexual mode of transmission grew by more than 3 times, from 7% in 1995 to 22.5% as of 12/31/23. Epidemiology analysis of the most recent reporting period ending 12/31/20 compared to 12/31/23 shows that the percentage of PLWH with a Heterosexual transmission increased from 15.8% to 22.5% (843 to 1,314 PLWH). In addition, increases occurred among Heterosexuals in all HIV epidemiologic categories. New HIV cases increased by over 2 ½ times (35 to 127); new AIDS cases increased by almost 1 ½ times (27 to 65); AIDS Prevalence increased by 32.0% (494 to 652); HIV Prevalence increased by 90% (349 to 662); and total PLWH increased by 55.9% (843 to 1,314). 28.5% of FY 23 RW clients were infected with HIV via heterosexual contact, which is higher than the representation of heterosexuals among PLWH in the TGA as of 12/31/23 (22.5%). Further analysis of Subpopulations of Focus within the heterosexual transmission category follow:

### **3.C.1)b)i. African American Heterosexuals**

African Americans continue to be disproportionately impacted by HIV and were 23.9% of PLWH, 20.4% of new HIV cases and 21.4% of new AIDS cases as of 12/31/23, which is over 3 times higher than their rate in the TGA's general population in 2022 (7.5%). Analysis of data by mode of HIV transmission and race shows that heterosexual African American males accounted for 15% of all heterosexual PLWH and 31% of all heterosexual male PLWH in 2023. They made up 4% of all new diagnoses, 12% of heterosexual diagnoses, and 25% of heterosexual male diagnoses. Regarding late diagnosis, heterosexual African American males were 6% of late diagnoses, 13% of heterosexual late diagnoses, and 25% of late heterosexual male diagnoses. While African American and White heterosexual males account for the same proportion of heterosexual males, African American males are more likely to be out of care than White heterosexual males as follows: (4.5% of total PLWH out of care, 18.7% of heterosexuals out of care, and 35% of heterosexual males out of care compared to 3.9%, 16.1%, and 30% respectively. African American heterosexual Males are less likely to be in care (70%) than heterosexual males overall (73%) but have slightly better viral suppression rates among those in care (87%) compared to heterosexual males overall (86%).

Females continue to be overrepresented among heterosexuals in all aspects. 41.5% of female FY23 RW

clients were African American, which is much higher than the 24.6% of RW clients who were African American and 7.5% of African Americans in the TGA's 2022 general population. Among FY23 RW clients, females are disproportionately African American compared to males (41.5%) of female RW clients were African American compared to 20.7% of males.

Of concern is that in 2023 there were 4 newly diagnosed HIV+ pregnant women in Sacramento County, the largest number in one year. HIV Surveillance and the HIV Care Program worked to ensure all women were in prenatal care and on medications. As of June 2024, two of the babies were born uninfected; one baby is taking preventative ART, and the third baby and mother are lost to follow-up.

Among female RW clients in FY23, 82.3% reported heterosexual as their mode of HIV transmission and 41.5% were African American. Within the 2023 RW Program's Continuum of Care, linkage-to-care rates were the lowest for Heterosexuals (40%) compared to MSMs (51%) and IDUs (50%). Further, African American RW clients had the lowest viral suppression rate (74%) compared to other racial groups including Hispanics (81%), Whites (79%), Asians (86%), NH/PI (79%) and AI/AN (77%). Regarding females, there were several indicators across the HIV Care Continuum in which women had lower than average outcomes compared to the jurisdiction overall. For example, 82% of female RW clients achieved viral suppression in 2023 vs. 85% overall; 52% of females were retained in the TGA vs. 54% overall; and 74% of females were in medical care in California vs. 75% overall. African American heterosexual women are disproportionately affected and made up 5% of total PLWH, 23% of heterosexuals, and 43% of heterosexual women. They made up 6% of total new diagnoses, 16% of new heterosexual diagnoses, 31% of new heterosexual female diagnoses, and 6% of total late diagnoses. African American heterosexual females account for 4.6% of all out of care PLWH, 19.3% of all heterosexuals out of care, and 41% of heterosexual females out of care.

### **3.C.1)b)ii. Youth and Young Adult Heterosexuals**

The number of youth and young adult RW clients has continued to climb since the TGA's RW Program began in 1997. RW clients ages 13-24 increased by 57.2% between 1997 to 2017; and increased another 14.1% between 2017 to 2020. In FY23, the age group of 20-24 had the lowest viral suppression rates among RW clients (50%) and heterosexual HIV mode of transmission was the second highest, under MSM contact as of 12/31/23. Heterosexual RW clients ages 13-24 had very low cost per client in FY23 compared to RW clients overall (\$198 vs. \$1,535). The following age groups were less likely to be virally suppressed than RW clients overall (84.5%); ages 13-19 (81.3%) and ages 20-24 (66.7%). Moreover, youth and young adults ages 13-24 in the RW Program were less likely to be virally suppressed in 20203 (60%) than in the Sacramento TGA (95%), California (81%) or the nation (79%) in 2022. While the overall representation of Youth and Young Adult heterosexuals is low (less than 1% of all PLWH) Care Continuum indicators among this critical subpopulation are lower (75% in medical care and 67% virally suppressed) than PLWH overall (78% vs. 90%) and lower than Heterosexuals overall (77% vs. 89%).

### **3.C.1)b)iii. Hispanic Heterosexuals**

Hispanics continue to be disproportionately affected by HIV. Between the reporting period ending 12/31/20 compared to 12/31/23, among Hispanics, the number of new AIDS cases increased by 17.0% (from 53 to 62), AIDS Prevalence increased by 17.0% (536 to 627), HIV Prevalence increased by 29.1% (from 605 to 781) and total Hispanic PLWH increased by 23.4% (1,142 to 1,408). Hispanic heterosexual males made up 3% of all PLWH in the TGA, 12% of all heterosexuals, and 27% of heterosexual males. They represented 6% of all new diagnoses, 16% of new diagnoses among heterosexuals, and 32% of new heterosexual male diagnoses. Hispanic heterosexual males accounted for a significant number of late diagnoses at 13% of all late diagnoses. 28% of Hispanic heterosexual males are not in care and represent 3.5% of the total out of care

population. Of the 73% of Hispanics in medical care, 88% are virally suppressed, which is slightly higher than 70% of African American Heterosexual males in care, with a viral suppression rate of 87%, but they are below the overall 77% heterosexual males in medical care rates with 89% virally suppressed.

Hispanic Heterosexual females make up 17% of heterosexual female cases. They accounted for 3% of total new diagnoses, 9% of new heterosexual diagnoses, and 17% of new heterosexual female diagnoses. They made up 6% of total late diagnoses, and 13% of late heterosexual diagnoses. 24% of Hispanic Heterosexual females are not in care and represent 2.2% of total PLWH out of care. 76% of Hispanic heterosexual females are in medical care (76%) and 90% of those have a viral suppression lower, not only than other heterosexual female subpopulations such as the 80% of African American in medical care with a viral suppression rate of 92% and 79% of White in medical care with a viral suppression rate of 92%, but lower than the 79% overall heterosexual female subpopulation with a viral suppression rate of 91%.

### **3.C.1)b)iii. White Heterosexuals**

White Heterosexual Males were overrepresented among new and late HIV diagnoses in 2023. This subpopulation made up 4% of PLWH and 33% of heterosexual males but accounted for 7% of total new diagnoses and 19% of new heterosexual diagnoses. They accounted for 13% of total late diagnoses and 25% of late diagnoses among heterosexuals. White heterosexual males between the ages of 35-44 accounted for 4% of total new diagnoses and 10% of total late diagnoses. 25% of White heterosexual males were not in care and represented 3.9% of all out of care PLWH in the TGA. While White heterosexual males have higher in medical care rates (76%) than other subpopulations, their viral suppression (82%) numbers are lower compared to African American (87%) and Hispanic (88%) Heterosexual males. Particularly concerning is that 67% of youth and young adult White heterosexual males are not in medical care.

White heterosexual females represent 4% of PLWH in the TGA and 30% of heterosexual females as of 12/31/23. They made up 6% of new diagnoses, 18% of new heterosexual diagnoses, and 3% of late diagnoses. White heterosexual females account for 3.4% of the total out of care population and 30% of out of care heterosexual women. Those aged 35-44 represented 4% of all new diagnoses. Among all White heterosexual females, those aged 65+ had the greatest amount out of care at 28%.

### **3.C.1)b)iii. Asian Heterosexual Females**

While Asian heterosexual females make up a relatively small portion of heterosexual females at 5%, they are more likely to be out of care medical care (26%) than all other races of heterosexual females as follows: African American (20%), White (21%), Hispanic (24%), and overall (21%). While they account for 5% of all heterosexual women, they accounted for 10% of new diagnoses among heterosexual Women in 2023.

### **3.C.1)c. Injection Drug Users (IDU) – African American, Hispanic Males, and White**

Unique needs of the IDU subpopulation include issues such as: limited ability to form trusting relationships due to fear of arrest and incarceration; mental health issues leading to substance use and self-medication; addiction behaviors that challenge concern for personal health and well-being; use of infected syringes; being under-the influence of drugs which limits follow through with appointments and medication regimens including PrEP and PEP; unprotected sex and other high-risk behaviors.

There were several indicators across the HIV Care Continuum where Injection Drug Users had outcomes lower than the average for each jurisdiction (RW, TGA, CA, Nation). For example, 50% of IDUs were linked to care in RW program compared to 84% of the TGA; 82% in California; and 82% in the Nation. IDUs also

were less likely to meet the HIV Care Continuum indicator of in medical care in the RW program (65.7%) compared to PLWH in TGA (74.0%), California (75%) and the Nation with 76% of PLWH in medical care. Similarly, IDUs were less likely to be retained in care in the TGA (19.5% RW vs. 50% TGA), CA (52%) overall and the Nation (54%).

Between the most recent reporting periods ending 12/31/20 and 12/31/23, the percentage of PLWH with IDU as their mode of HIV transmission stabilized from 7.9% to 7.8% of the TGA's PLWH. However, in terms of the numbers of new and existing cases, HIV incidence among IDUs increased by 48.1% (27 to 40), AIDS incidence increased by 16.9% (18 to 21); and HIV prevalence increased by 19.9% (141 to 169). Overall IDUs had low rates of being in medical (71%) and virally suppressed (79%). With Male IDU's having 71% in medical care and 77% of those being virally suppressed. Female IDUs had slightly better in medical care rates at 72% but higher viral suppression rates at 83%. Further analysis within the IDU transmission category follow:

### **3.C.1)c)i. African American MSM/IDUs**

African American MSM/IDUs make up 1% of the total PLWH and 11% of the total MSM/IDU population as of 12/31/23. 22% of African American MSM/IDUs were not in medical care and accounted for 10.2% of the total out of care MSM/IDU population. 78% of African American MSM/IDU's are in medical care, of those 91% are virally suppressed. 50% of African American MSM/IDUs aged 35-44 are out of care and represent 44% of the total out of care African American MSM/IDU population.

### **3.C.1)c)ii. African American IDUs**

African Americans IDUs are a target population within the RW Program, the MAI portion of the program, as well as EIIHA. In FY23, 37.0% of RW clients ages 13-24 were African American (30/81) compared to 24.6% of RW clients being African American overall (535/2,171). Further, African Americans are increasingly overrepresented among FY23 RW clients who are unhoused, unstable or in temporary housing (21.9%) compared to African American representation in the TGA overall (7.5%). FY23 RW Program data show that African Americans were 92% of RW MAI clients with IDU transmission that were virally suppressed compared to 93% of MAI clients overall. Among FY23 RW MAI clients in the IDU HIV transmission category, African Americans represented 52% of RW MAI clients, followed by Hispanics (34.7%) and American Indian/Alaska Natives (2.6%). As discussed above, African Americans, as well as IDUs, have HIV Care Continuum indicators that are behind RW, TGA, California and National outcomes overall, including linkage to care, in medical care, retained in care and viral suppression. While African American male IDUs only make up 1% of PLWH in the TGA, they are disproportionately represented among RW male IDU clients at 26% of male IDUs. They accounted for 3% of total new diagnoses in 2023 and 25% of new IDU diagnoses. African American Male IDUs are in medical care (70%) at a slightly higher rate than White Male IDUs (68%) but are significantly less virally suppressed at 62% compared to Whites at 82%.

Similarly, African American female IDU's made up 1% of total PLWH, but accounted for 25% of Female IDUs. They account for 1.2% of the total out of care population and 29% of out of care female IDUs. African American females are more likely to be out of care than Whites, Hispanics, and overall female IDUs with in medical rates at 67%, 73%, 70%, and 72% respectively. While they are more likely to be out of care, those that are in care have better viral suppression rates, with 97% of African American female IDUs being virally suppressed compared to Whites (79%), Hispanics (75%), and overall female IDUs (83%).

### **3.C.1)c)iii. Hispanic Male IDUs**

In 2023, Hispanic male IDUs continued to represent a significant number of IDU cases and represented 18% of male IDUs. They accounted for 15% of new male IDU diagnoses and 3% of total late diagnoses. 18% of out of care Male IDUs were Hispanic and 28% of Hispanic IDUs were not in medical care. Of those in medical care (72%) Hispanic IDUs had higher viral suppression rates compared to other subpopulations of IDU males, as follows: 89% of Hispanic Male IDUs were virally suppressed compared to African Americans (62%), Whites (82%), and overall Male IDUs (77%). Of particular concern is the high percentage of Hispanic male IDUs aged 65+ who were out of care. This aging population accounted for 16% of Hispanic male IDUs, but were 63% of out of care in this subpopulation.

### **3.C.1)c)iii. White IDUs**

White male IDUs represent a majority of the male IDU cases at 50% and 2% of PLWH in the TGA as of 12/31/23. In 2023, they accounted for 4% of total new diagnoses and 38% of new IDU diagnoses. They represented a significantly larger percent of total people out of care (3.4%) compared to African American (1.7%) and Hispanic (1.1%) IDUs. White male IDUs accounted for 54% of male IDUs out of care and had lower rates of being in medical care (68%) than African American (70%), Hispanic (72%), and overall male IDUs (71%). White male IDUs aged 45-54 made up 22% of this subpopulation but 47% of them were out of care, and represented 33% of total White male IDUs out of care.

White female IDUs similarly represented a majority of the female IDU cases at 50% and 2% of total PLWH in the TGA as of 12/31/23. While they accounted for 2% of total new diagnoses in 2023 they represented all new cases among female IDUs. White female IDUs represent 1.9% of the total out of care population and 47% of out of care female IDUs. White female IDUs aged 35-44 made up 16% of this subpopulation but 36% of them were out of care.

### **3.C.1)c)v. White MSM/IDU**

White MSM/IDUs represented 4% of total PLWH in the TGA and 62% of MSM/IDUs as of 12/31/23. While they only accounted for 1% of total new diagnoses in 2023 they represented 3% of late diagnoses. White MSM/IDUs accounted for 4.3% of out of care PLWH and 62.5% of MSM/IDUs out of care. While they had similar out of care rates (77%) as African American (78%), Hispanic (77%), and overall MSM/IDUs (77%), they had lower rates of viral suppression at 85% compared to 91%, 87%, and 86%, respectively.

### **3.C.2) EIIHA Data, Activities and Subpopulations of Focus**

The disparate needs and costs of PLWH who are aware of their diagnosis but who are out-of-care (Unmet Needs population), as well as the population who is unaware of their HIV diagnosis (EIIHA), is important to analyze in determining priorities, allocations, and targeted activities for Subpopulations of Focus. The RW Planning Council uses the demographics of the aware but out-of-care population (Unmet Needs) to presume similar demographics of the HIV unaware population (EIIHA) and its corresponding needs. Demographic information on newly diagnosed individuals also aids in determining the success of selected outreach efforts to determine if additional funding is needed to expand efforts to reach each target population.

Tracking the annual goals of the EIIHA Strategy and Plan, the Council has updated the demographics of the targeted high-risk populations for testing, as well as the linkage and clinical Continuum of Care outcomes of newly diagnosed populations. This information is incorporated into the Council's Priorities and Allocations process to ensure that the RW services are designed to meet the needs of newly diagnosed and targeted high-risk populations that are overrepresented in the TGA's HIV epidemic. Although most of the activities for each objective of EIIHA are implemented across all target populations, many are tailored to each specific

population, with the following examples of tailored activities.

**Objectives for Each Component of EIIHA for Subpopulations of Focus.** For each Subpopulation of Focus, several EIIHA activities are implemented by the TGA's private and public partners. Since each subgroup has advisory committees and peer advisory groups, the list of strategies for each target population is extensive. Follows are examples of EIIHA strategies customized for each target subpopulation:

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

Examples of EIIHA activities targeted on this Subpopulation of Focus include the following: 1) Provide HIV testing to high-risk populations to make them aware of their HIV status, including same day result options; 2) Provide prevention and harm reduction education information, including PrEP and PEP information and referrals, to individuals at testing; 3) Educate medical providers on HIV testing and referral resources to increase routine testing of population at large; 4) Certify and train new HIV testers on rapid HIV testing to expand TGA's capacity; 5) Expand number of nontraditional testing partners who reach the targeted populations and increase the number of individuals who know their HIV status; 6) Decrease barriers that prevent individuals in each population from returning for test follow-up, including results, confirmatory testing, and/or treatment; 7) Increase the number of TGA residents at high risk for HIV infection who are on PrEP; 8) Make Routine Opt-Out-Testing (ROOT) more widely practiced throughout the Sacramento TGA.

**3.C.2)b. Heterosexuals – African American Females, Youth and Young Adults, Hispanic Males, and Whites**

Examples of EIIHA activities targeted on this Subpopulation of Focus include the following: 1) Provide HIV testing to high-risk populations to make them aware of their HIV status, including same day result options; 2) Provide prevention and harm reduction education information, including PrEP and PEP information and referrals, to individuals at testing; 3) Increase percent of newly diagnosed HIV+ people linked to medical care within one month of diagnosis through targeted, TGA-wide referrals; 4) Educate medical providers on HIV testing and referral resources to increase routine testing of population at large; 5) Certify and train new HIV testers on rapid HIV testing to expand TGA's capacity; 6) Maintain the Sacramento Workgroup to Improve Sexual Health (SacWISH) in order to focus on ending the HIV epidemic; 7) Decrease barriers that may prevent individuals from each target population from returning for test follow-up, including results, confirmatory testing, and/or treatment; 8) Increase the number of TGA residents at high risk for HIV infection who are on PrEP; 9) Make ROOT more widely practiced throughout the TGA.

**2.C.2)c. Heterosexuals – African American Females, Youth and Young Adults, Hispanic Males, and Whites**

Examples of EIIHA activities targeted on this Subpopulation of Focus includes: 1) Provide HIV testing to high-risk populations to make them aware of their HIV status, including same day result options; 2) Conduct testing at venues accessible to high-risk populations through venues associated with their culture, geography, and lifestyle to maximize testing efforts; 3) Provide prevention and harm reduction education information, including PrEP and PEP information and referrals, to individuals at testing; 4) Increase percent of newly diagnosed HIV+ people linked to medical care within one month of diagnosis through targeted, TGA-wide referrals; 5) Educate medical providers on HIV testing and referral resources to increase routine testing of population at large; 6) Certify and train new HIV testers on rapid HIV testing to expand TGA's capacity; 7) Maintain the Sacramento Workgroup to Improve Sexual Health (SacWISH) in order to focus on ending the HIV epidemic; 8) Expand number of nontraditional testing partners who reach more of the targeted populations by increasing the number of individuals who know their HIV status; 9) Decrease barriers that may prevent individuals from each target population from returning for test follow-up, including results,

confirmatory testing, and/or treatment; 10) Increase the number of TGA residents at high risk for HIV infection who are on PrEP; 11) Make ROOT more widely practiced throughout the TGA.

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

### **SECTION 4: APPROACH**

#### **4.A. PLANNING RESPONSIBILITIES**

##### **4.A.1) Letter of Assurance from Planning Council Chair (Attachment 7)**

See Attachment 7 for Letter of Assurance from Planning Council Chair confirming that the following activities were conducted in current FY22-24 period of performance and will be continuing through FY25-27: a) TGA-wide program planning process including Needs Assessment and Comprehensive Plan for TGA and Statewide Coordinated Statement of Need; b) Priority Setting and Resource Allocation (PSRA) with involvement of PLWH; c) Council Membership Training; and d) Assessment of the Efficiency of the Administrative Mechanism.

##### **4.A.2) Resource Inventory**

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

Medicaid expansion and implementation of the Affordable Care Act (ACA), inflation, increased service demand and client need were factors that contributed to changes in funding within the TGA's service categories over the last several years. For example, the Council increased emergency financial assistance, non-medical case management, health insurance premium and cost sharing assistance and medical transportation allocations in response to the demographics and client needs. Health insurance premium and cost sharing assistance expenditures increased by 99% from FY21 to FY23. The allocation for outpatient ambulatory care was moderately reduced over the last several years to accommodate for these increases in other support services, as the Council believed some additional revenue from third party payers would provide a resource shift.

Further, in FY23 funding was received from RW Part B, so Part A was able to redirect some funds to service categories that had client waiting lists. For example, funds were redirected to non-medical case management, which saw a 120% increase in clients from 2021 to 2023, including benefits and enrollment counseling which also provides clients with assistance in applying for the State OA-HIPP and AIDS Drug Assistance Program (ADAP). The expansion of this service category is critical to assist clients not only in enrolling in new health care plans, but in maintaining coverage during re-enrollment periods. Food bank/home delivered meals was previously funded by Part B. With additional Part A funding, food bank/home delivered meals experienced an 18% increase in clients. Additionally, nutrition services experienced a 419% increase in clients from 32 in FY21, to 166 clients in FY23.

While some insurance plans offer "medical case management," this is only limited to a referral coordinator who assists with the cumbersome process of getting a client an authorization to see a specialist. The RW medical case management program, however, offers a full range of services to clients, including medication adherence services, advocacy, and assistance with a broad range of barriers to care. The service category

experienced a 25% increase in clients from FY21 to FY23. In addition, the RW program continues to assist PLWH with Core Services such as mental health and outpatient substance use services which have limited coverage under ACA plans, as well as Medi-Cal. These plans require that Mental Health Counselors be Licensed Clinical Social Workers (LCSWs) resulting in clients being placed on waiting lists due to shortages of these professionals. The RW Program has counseling professionals (MFTs, MFCCs, MSWs, ACSWs) who continue to provide mental health counseling to RW clients on ACA waiting lists as long as these professionals are supervised by the appropriately licensed mental health professional.

#### ***Impact of Marketplace Plans on Medications for PLWH***

California has legislation in place that authorizes the SOA and its contractors, including ADAP enrollment workers, to share RW client data with “qualified entities” solely for the purpose of facilitating enrollment and maintaining access to Medi-Cal Expansion and Covered California health coverage. This State law has expanded the TGA’s ability to coordinate enrollment efforts with other agencies and community partners.

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

The TGA’s RW Part A program has consistently made certain that its allocations for non-medical case management was high enough to ensure that RW clients receive assistance enrolling in public benefits, such as ACA coverage, Medi-Cal, Office of AIDS Health Insurance Premium Assistance Programs (OA-HIPP) and ADAP. The RW Program’s FY24 Request for Proposal (RFP) process ensured that enrollment services continue through an expanded number of subrecipients receiving Part A funding for non-medical case management. These agencies also have the enrollment services augmented with Part B funding which maximizes the TGA’s use of resources.

The resource shifts resulting from the ACA also allowed the RW Council to increase allocations overtime to the State OA-HIPP) to assist clients with premiums, deductibles and medical co-payments. A challenge for PLWH is that assistance under a Covered California plan is available from the State OA-HIPP program, but the approval wait-time averages six weeks, so clients seek assistance from the RW Part A to cover premiums during that time. OA-HIPP provides premium assistance with a monthly cap for combined medical, dental and vision coverage. Dental co-payments are provided if the dental insurance is included as part of the medical plan. The program also assists with co-pays and deductibles up to each client’s annual out-of-pocket maximum. Clients with full Medi-Cal coverage are not eligible for ADAP or OA-HIPP, so the RW program is their only source of assistance for non-covered procedures and co-payments. These resource shifts in the TGA have allowed the Council to allocate additional funding over the years to services such as transportation, emergency financial assistance, childcare, residential substance abuse treatment and emergency housing, although client needs continue to far outpace the TGA’s ability to respond.

#### ***4.A.2)a. Coordination of Services and Funding Streams (Attachment 8)***

See Attachment 8 for the TGA’s HIV Resources Inventory table that includes: 1) public funding sources for HIV prevention, care and treatment; 2) total dollar amount and percent of total available funds in the FY24 period of performance for each funding source; and 3) use of resources including services delivered.

## **SECTION 5: WORKPLAN**

### ***5.A. HIV CARE CONTINUUM SERVICES TABLE AND NARRATIVE***

#### ***5.A.1) FY 2025-2027 HIV Care Continuum Table (Attachment 9)***

See Attachment 9 for the FY 2025-2027 HIV Care Continuum Table comprised of the diagnosed-based HIV Care Continuum Service Table; baseline indicators for each stage; the desired target outcomes for the three-year period of performance; and RW Part A funded service categories to support desired outcomes.

### **5.A.2) HIV Care Continuum Services Narrative**

#### **5.A.2)a) Service Needs and Issues Addressed by HIV Care Continuum Services Table**

The HIV Care Continuum is used to improve engagement of PLWH, and to improve outcomes at each stage of the continuum throughout the TGA. The TGA's HIV Care Continuum Plan addresses the issues and core service needs identified in the California State Integrated HIV Prevention and Care Plan and they align with the National HIV Strategic Plan. By utilizing the HIV care continuum in planning, prioritizing, targeting and monitoring available resources in response to the needs of PLWH in the TGA, the region has had numerous and continual successes in linking and retaining clients in care, and ultimately achieving viral suppression. These successes are documented by the RW Program's current baseline rates compared not only to the National and California rates, but to the TGA's general population of HIV/AIDS rates for the five HHS measures that comprise the NHAS Continuum. Examples from this analysis follow.

The RW Council addresses these disparities along the HIV Care Continuum by allocating funds to services identified as having the greatest unmet needs for the populations with the greatest health disparities. For example, over the last several years, between 2021 and 2023, the Planning Council has increased funding for emergency financial assistance, food, and transportation. non-medical case management, field-based medical case management, and outreach funding has increased over the last three years. Expansions in funding for these services were maintained by the Council for FY25, as these services are most effective at increasing access along the HIV Care Continuum and are more highly utilized by minority demographic groups within the TGA. The Council will continue to monitor service utilization and implement mechanisms to ensure that RW funding continues to reduce health disparities among demographic groups.

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

A significantly higher proportion of PLWH with a new HIV diagnosis were linked to HIV care within 30 days following diagnosis in the RW program in FY23 (91%) than FY22 (37%). In addition, the linkage to care rates for the 2023 RW program (91%) were above TGA (84%), State (82%) and National (82%) rates for 2022. Although FY23 RW clients were slightly less likely to be in medical care (74%) than PLWH in California in CY22 (75%) or the Nation (76%) it was further behind the TGA rate (80%). FY23 RW clients were slightly less likely to be retained in care (49%) than PLWH in the TGA during CY22 (50%), the State (52%) or the Nation (54%). It must be noted that the retained in care statistics are skewed by the fact that the RW program is still in the process of improving its reporting methodology to capture a RW client's second visit in the retention in care report when that second visit falls outside the 12-month reporting period. The RW Program is further analyzing data on this effort, as it continues to be an issue. Evidence that the lower retention in care figures likely are more of a reporting problem than a service provision problem is demonstrated by the high viral load suppression rates of RW clients in FY23. It should also be noted that patients who are virally suppressed and do not have other emergent health issues are less likely to be seen by a medical provider and have labs completed more than once per year. A greater proportion of RW clients in FY23 were virally suppressed (89%) than PLWH nationwide during CY22 (65%), the TGA (71%) and California (67%) in CY22.

The most common challenge in the TGA's development of its Continuum of Care roadmap has been in identifying and obtaining data sources for the same time periods as other jurisdictions in its efforts to monitor the TGA's successes and to identify areas in need of improvement. This challenge is most apparent when it comes to analyzing demographic disparities, such as age categories, which vary between the RW Program,

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

Another data issue surrounds the State Office of AIDS surveillance data reporting of unknown/unreported viral load counts. The SOA supplies as much data as it has available from its data systems to the TGA's RW and HCS Programs; however, that data is restrained by backlogs that occur at State and local health jurisdiction levels. It also takes State surveillance systems more than a year to mature, so real-time progress is not always possible to monitor. The SOA also supplies the data sets used for Attachment 4: HIV and AIDS Incidence, HIV and AIDS Prevalence and the data for Attachment 6: Unmet Needs table.

The RW Council continues to analyze numerous relevant data sources and Continuum of Care performance indicators to assess changes in client utilization, emerging high-risk populations, and the specific needs of each subpopulation. In addition, the Council analyzes best practices used at the state and national level to improve the TGA's Care Continuum and integrate those findings into the RW Program. For example, the TGA coordinates efforts with the California Department of Public Health, Office of AIDS, on several large-scale projects: California's Needs Assessment for HIV, California's Integrated HIV Prevention and Care Plan, as well as the State of California's Integrated Statewide Strategic Plan "Ending the HIV/STI/HCV Syndemic Plan: Addressing HIV, HCV, and STI's in CA" The Integrated HIV, Prevention and Care Plan not only incorporates the NHAS Continuum of Care indicators, but assesses the needs identified by the most high-risk populations in California's HIV Needs Assessment. It also develops statewide plans and TGA level strategies to address barriers to care for PLWH.

The TGA's HIV Health Services Planning Council's Needs Assessment Committee conducted a comprehensive HIV Needs Assessment in FY22 using an updated survey tool. The findings of the FY22 Needs Assessment were analyzed and used throughout this application and assist with development of programmatic changes across the Continuum of Care to improve services for each subpopulation of PLWH. In addition, the TGA conducted a Targeted HIV Needs Assessment of Aging PLWH 50+ in FY23, by comparing Service Demand, Unmet Needs and Barriers to Care for RW clients ages 50+ to clients under age 50, to assist the Planning Council in service category priority ranking and allocations for the coming years. The Council continues to work diligently to continue to improve outcomes along the HIV Care Continuum for all subpopulations of PLWH, specifically improving linkage to care and retention in care efforts. Much of the RW Program's successes are due to the cooperative outreach, HIV prevention, treatment and wrap-around support services conducted by numerous nonprofit agencies across the TGA.

California's Integrated HIV Prevention and Care Plan and Ending the HIV/STI/HCV Syndemic Plan have identified barriers to patients accessing medical care. Those include difficulties navigating the healthcare system, housing instability, and mental health challenges. To address these barriers the TGA FY25 Service Category Plan will fund medical case management, housing, and mental health services. Medical case management helps patients to navigate the healthcare system by serving as patient advocates, supporting, guiding, and coordinating care for patients as they navigate their health and wellness journeys. They serve as the center of communication, connecting patients with members of the healthcare team and community to impact acute and chronic disease management. 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 people from becoming unhoused and to increase stability for clients, allowing them to gain or maintain access to medical care. Mental health services include outpatient psychological and psychiatric treatment and counseling services for individuals living with HIV who have mental health issues, and include medical, psychosocial and support services to ensure client access to and continuity of care. A comprehensive medical plan of care is individualized to client needs consistent with intervention services that promote an optimal state of wellness.

In addition, California's Integrated HIV Prevention and Care Plan identified barriers to patients achieving HIV viral suppression. Those included difficulties with transportation and substance use. To address these barriers the TGA FY25 Service Category Plan will fund transportation and residential & outpatient substance abuse services. Transportation services funding is designed to significantly improve client access and adherence to HIV medical resources and are provided to meet healthcare or other critical needs. Substance abuse services are designed to assist clients in reducing and/or eliminating use of alcohol, legal, and/or illegal drugs through harm reduction strategies in order to improve the overall health and social wellness of PLWH.

**5.A.2)a)ii. Targeted Impact Along Steps of HIV Care Continuum**

The Sacramento County Department of Health Services has made major contributions to linking HIV clients to care and retaining them in care. Follows are examples of several of these efforts, and the collaborative approaches used by many organizations, both public and private, to improve the outcomes along each step of the HIV Care Continuum throughout the TGA:

**Diagnosis of HIV Infection.** The Sacramento County Department of Health Services, Division of Public Health has integrated its HIV prevention and treatment programs to operate under the same unit, the SHPU (Sexual Health Promotion Unit), which includes the HCS Program which oversees the RW Parts A & B Programs, Minority AIDS Initiative Program, Ending the HIV Epidemic Program, and other funding sources used to provide HIV services. To further streamline and coordinate efforts for persons living with, or at risk for HIV in the TGA, planning bodies for HIV prevention and treatment programs were successfully consolidated by merging the Sacramento Alliance to Prevent AIDS (SAPA) into the RW HIV Health Services Planning Council (the Council) in 2010. With the HCS Program operating as Recipient for both Part A and B funding, all services, planning efforts and implementation strategies continue to improve coordination and efficiency.

As RW funds do not support testing, there are no planned service categories that directly aid in the diagnosis of HIV infection and cannot be reported on within the RW System. In addition to various hospitals and private labs, the TGA has numerous HIV testing, education and prevention sites that the HCS Program relies on to identify HIV positive individuals throughout the TGA. One Community Health (OCH), which was established in 1989 as the Center for AIDS Research, Education and Services (CARES), transitioned to become an FQHC in 2015 and is now called One Community Health. Through this transition, it has maintained itself as a provider of services to PLWH in the Sacramento Region and has continued its HIV testing and education services. Government-funded testing sites and community-based organizations which rely on both public and private funding, work together to ensure that activities to identify HIV positive individuals throughout the TGA are implemented.

The TGA's current strategy, which will continue to be implemented in the TGA's FY25 Service Category Plan, includes enlisting the support of the private and public testing providers to collaborate with OCH and the Sacramento County SHPU in its testing efforts. Private testing agencies have strong working relationships

with government-funded entities. All public and private testing providers distribute HIV+ service information to newly diagnosed clients; provide or refer clients to post-test counseling; and facilitate the immediate transition of newly diagnosed preliminary positive clients to their private provider if insured, or to OCH or the Sacramento County Sexual Health Clinic for confirmatory tests if uninsured.

***Linkage of HIV Clients to Care and Receipt & Retention in HIV Care.*** The Council has established and continues to refine mechanisms in its Service Category Plan that enable newly infected and underserved persons, including disproportionately impacted communities of color, to access and remain in HIV medical care. Services vital to linkage to care that have been prioritized by the Council include outreach, non-medical case management, and transportation services. The TGA's care providers that conduct HIV testing (noted above) work closely with the Sacramento County DHS HIV Prevention and Testing outreach providers to serve communities located in those zip codes with the highest number of clients with Unmet Need. When clients are newly diagnosed with HIV, many care providers, as well as testing sites, refer clients to OCH where they are screened for eligibility for RW medical services and receive Partner Services, a program which provides immediate access to resource referrals. Services vital to retention in care established by the Council include medical case management, mental health and outpatient ambulatory care services. Mental health services spending increased 5% from FY21 to FY23, to further meet the needs of clients to keep them retained in medical care. Due to the TGA's successes in bringing high acuity HIV+ clients into care using a field-based Medical Case Management (MCM) model, the Council has steadily adjusted its Implementation Plan to increase the percentage of core service funds allocated to MCM from 30% in FY 2003 to 48% in FY23.

While the field-based case management system is more expensive than office-based, client health outcomes demonstrate this model's effectiveness in linking clients to medical care, retaining clients in care, and achieving viral suppression. In CY23, 80.7% of RW clients who received RW Medical Case Management services (1,228/1,522) met the definition of "In Medical Care" by receiving a minimum of one medical visit in CY23 including a CD4 or viral load test. However, only 25.1% (382/1,522) met the definition of "Retained in Medical Care" by receiving at least two medical visits at least three months apart in CY23. The Continuum of Care indicator of "Retained in Medical Care" decreased from 28.6% in CY22 to 25.1% in CY23. The percent of RW clients who received medical care in CY23 prescribed HAART was 94.1%, which is a significant improvement over CY22 (89.8%). The percentage of RW clients in medical care in CY23 who achieved viral suppression was maintained at a rate of 72.7%, similar to the CY22 rate of 73.8%.

These efforts are proving successful in increasing the number of new RW clients in care over the years, especially among historically underserved communities, however, more work continues to be needed across the Continuum of Care for all subpopulations of PLWH. The FY25 Service Category Plan builds on the TGA's successes over the years and focuses efforts in those areas most in need of improvement. In two of four Continuum of Care indicators, the RW program exceeded National, California and TGA rates. RW clients were more likely to be linked to care (91%) in FY23 than PLWH in California during (82%) or in the Nation (82%) in 2022. A greater proportion of FY RW clients were virally suppressed (91%) in 2023 than PLWH in the TGA in 2022 (71%); California in 2022 (67%), and the United States in 2022 (65%).

In two of four Continuum of Care indicators, however, the RW program had outcomes that were lower than TGA, State and National rates. For example, a smaller proportion of PLWH were in medical care in the RW program in FY 2023 (74%) than the TGA (80%), California (75%), and Nation (76%) in 2022. In addition, the RW program had lower outcomes for retention in care in 2023 (49%) than in the TGA (50%), California (52%) or the Nation (54%) in 2022. The HCS Program believes that these figures are being reported by the

program's data system are not an accurate reflection of these continuum of care indicators due to several factors. The TGA's internal tracking database requires the manual input of lab tests by subrecipients. For clients that receive their medical care outside of the RW system of care, obtaining updated lab tests has become a barrier as clients are being charged to obtain copies of these labs. The HCS Program is working on addressing these barriers so that the data systems can better reflect the improvements being made throughout the TGA to link and retain clients in medical care.

***Access to Antiretroviral Therapy and Viral Load Suppression.*** The RW Council continues to prioritize HIV outpatient ambulatory care, medical case management and HIV prescription medications to ensure that RW clients not only access HIV care but remain in care and maintain access to antiretroviral therapy. The TGA's web-based system, SHARE, collects basic medical service utilization data from RW providers. This system tracks clients who receive a service, but are not in ongoing primary medical care, and each provider receives a monthly report with the unique client identifier for all clients out of medical care. Providers are contractually obligated to follow up with these clients to ensure that they overcome barriers and receive primary medical care for their HIV. This integrated service model has been achieving successful health outcomes throughout the TGA. For example, in FY23, 89% of RW medical care patients were virally suppressed, which is much higher than PLWH nationwide (65%) in 2022.

Medical Case Management (MCM) is the gateway to all other funded services in the RW Program and is vital to clients in accessing care, being retained in care, and ultimately reaching viral suppression. Medical Case Managers work with clients to identify their needs to help them meet their health goals. For FY25 the Planning Council has funded outpatient ambulatory care services, health insurance premium assistance, emergency financial assistance, medical case management, transportation, oral health, childcare, housing, mental health, outreach, MAI case management, substance abuse Outpatient & residential, and medical nutritional therapy as services essential for clients to access care and reach viral suppression.

## **5.B. FUNDING FOR CORE AND SUPPORT SERVICES**

### **5.B.1) FY24 and FY25 Service Category Plan**

#### **5.B.1a) Service Category Plan Table (Attachment 10)**

The TGA's Service Category Plan (Attachment 10), lists the TGA's core medical services and support services, covering all of Part A and MAI funded services for FY24 and FY25. For each service, the Plan describes one or more service goals with time-limited and measurable program objectives which define service units; number of persons to be served; units of service to be delivered; and estimated cost of meeting each objective. The Service Category Plan Table also lists separately the Minority AIDS Initiative (MAI) funded service category of medical case management; the only core service funded with MAI funds. The MAI Service Category table provides a breakdown of the category by target populations.

#### **5.B.1b) MAI Service Category Plan Narrative**

##### **5.B.1b)i. MAI Services Plan to Address Subpopulations of Focus**

Services funded through the MAI grant operate street-side and home-based medical case management services targeted to the TGA's emerging high-risk populations: African American and Hispanic men and women who are substance users; unhoused; justice involved; and women who are pregnant or at risk of dropping out of care. Demographics of MAI clients in FY23 show that 52.2% were African American; 37.9% Hispanic; 2.8% American Indian/Alaskan Native; 5.7% Asian, and 1.5% Native Hawaiian/Pacific Islanders. Care Continuum outcomes for FY23 RW MAI clients show that 84.9% achieved viral suppression. In FY23, Asians had the highest viral suppression rate (94.6%), followed by American Indian/Alaska Natives (94.4%), Hispanics (93.9%), African Americans (92.3%) and Native Hawaiian/Pacific Islanders (90.0%).

As the MAI figures show, RW subrecipients have been able to continue to build trust within the community to reach the targeted minority populations and forge the working relationships necessary with clients and other agencies to ensure that ongoing medical services are received for these vulnerable populations. The subrecipients use a combination of several types of medical case management, including in-home, street-side and pre/post incarceration services, to reach those in need. Based on the MAI data, the time and effort provided to serve these high-risk clients is proving effective in many ways. However, affordable housing is reported as MAI clients' greatest barrier to care and transportation is the second most reported barrier. Although bus and light-rail systems are available in the greater Sacramento metropolitan area, they are inadequate to meet the large area covered by the TGA, including the rural counties which have little to no public transportation systems.

**5B.1)b)ii. MAI Services Plan to Decrease Health Disparities and New HIV Infections**

Since the inception of the TGA's RW program, the MAI funded subrecipients often have overspent their federal MAI allocations, so the TGA's RW Part A funds have been allocated by the Council to MAI funded subrecipients to maintain essential MAI programs. The primary goal of the TGA's MAI Plan is to enhance access to ambulatory medical care and provide ongoing assistance to link and retain high risk minority clients in medical care. Programs funded through the MAI grant operate street-side, home-based and pre/post incarceration medical case management services targeted to the TGA's emerging high-risk populations: African American and Hispanic men and women who are substance users/IDUs; unhoused; formerly or about to be incarcerated; and women who are pregnant or at risk of dropping out of care. As of 12/31/23, the combined number of African Americans (21.9% of PLWH) and Hispanics (24.1% of PLWH) accounted for 46.0% of PLWH in the TGA, while their prevalence in the general population was 7.5% and 22.8%, respectively, based on 2022 US Census figures.

One of the main goals of the TGA's MAI Plan is to help clients with medication adherence where appropriate for clients on HAART. This goal is achieved by using "field-based" Medical Case Managers who serve as client advocates to fast-track clients into specialty medical care and other intensive support services throughout the Sacramento Region's service area as needed. In previous years, Medical Case Managers spent many hours in a client's place of residence or in their homeless encampment to encourage clients to seek and maintain medical care. Telehealth also has been implemented in the TGA and is extremely important, especially for the rural counties.

Harm Reduction Services (HRS), a RW MAI case management subrecipient, targets its services to people who are unhoused and/or substance users, including injection drug users. Through multiple funding sources HRS conducts free HIV and Hepatitis C testing, a syringe exchange program, and provides clients with case management services, food, clean syringes, overdose prevention medications and transportation. HRS staff are familiar with the unique service needs of IDU's, unhoused, and justice involved individuals. Through MAI case management services, they are able to assist high risk minority clients in accessing and engaging in medical care to ultimately reach viral suppression.

Follow-up with patients occurs on a regular basis through the medical case management system using an electronic medical record combined with a continuous quality improvement tracking system. Numerous strategies and services are used to ensure that the client's access to medical care is not jeopardized by their mental health. The Medical Case Managers throughout the HIV system of care follow each client closely for a minimum of six months or until the client successfully demonstrates consistent independence and is compliant with their medical care regimen.

MAI funds were allocated by the RW Program's Planning Council according to the overall HIV Services Plan which documents needs for each subpopulation of PLWH as described throughout this RW Application.

Overall, since the inception of the MAI program in the Sacramento TGA, the field-based medical case management model has demonstrated its effectiveness in keeping clients in care and improving their health outcomes. The health outcomes of the MAI clients through FY23 as compared to earlier years, show that the percentage of RW MAI clients that achieved viral load suppression increased from 84.9% in FY20 to 93.1% in FY23. These FY23 viral suppression rates among RW MAI clients are well above the most recent 2022 National viral suppression rate (65%) and 2022 State viral suppression rate (67%).

In addition to the MAI program that targets high-risk communities of color, all service standards developed and adopted by the Council include mechanisms to assure parity of services across subpopulations of PLWH throughout the TGA. These service standards ensure that comprehensive, geographically feasible, culturally appropriate and high-quality services are provided by all RW subrecipients to all eligible PLWH. The RW Program's FY25 Service Category Plan calls for "100% of all RW subrecipients to comply with the adopted service standards." To ensure geographic parity of HIV services, the Plan mandates that all services be delivered in the TGA's rural counties. In addition, the rural counties may apply RW allocations to any Council-approved service categories to meet client needs. To ensure parity of services across all demographics, objectives are included in each service category that "the percentage of clients accessing services will be reflective of TGA's PLWH population for race/ethnicity."

The TGA's subrecipient contracts also include requirements that ensure all services are culturally and linguistically appropriate to the TGA's various subpopulations. RW providers have bilingual staff and offer translation services to address the needs of non-English speaking clients. Many subrecipients have staff that reflect the cultural and lived experienced needs of the communities they serve. A Spanish-speaking case management collaborative has been established among the RW providers in the TGA to better understand and meets the needs of Spanish-speaking clients. In addition, the RW Recipient provides RW subrecipients with resource information on free and low-cost cultural competency training opportunities.

### **5.B.2) Unmet Need**

#### **5.B.2)a) Interventions to Improve Outcomes for PLWH with Unmet Need**

By analyzing the Unmet Needs found in the TGA's HIV Needs Assessments, out-of-care, epidemiology and cost data, the Council developed four strategies to increase access to get PLWH into medical care, and to keep them in care: 1) strategies for Newly Diagnosed PLWH (improved linkages between prevention and care); 2) strategies for PLWH receiving non-primary medical care services (improved linkages between supportive and primary care services); 3) strategies for PLWH who have dropped out of care (improved provider-patient partnerships and collaborations with peers); and 4) strategies for PLWH never in care (peer facilitated linkages between points of entry, testing, counseling and primary care).

In addition, the TGA's HIV service providers work closely with Sacramento County DHS HIV Prevention and Testing providers to outreach to communities located in those zip codes with the highest number of clients who are not in care. When clients are newly diagnosed with HIV, care providers, as well as testing sites, refer clients for RW eligibility screening and health education/risk reduction (partner services), which provides immediate access to counseling and resource referrals. The Partner Services Program not only assists clients with issues of disclosure but provides referrals to the Sacramento County Surveillance Partner Services Program which provides anonymous notification of HIV+ sex and needle sharing partners regarding their

exposure and assist them in getting tested. All RW medical case management subrecipients are contractually required to document referrals to Partner Services.

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

### ***Activities to Improve Outcomes for Late Diagnosed PLWH***

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

### ***Activities to Re-engage in Care PLWH with Unmet Need***

To further address service gaps and barriers to care, transportation services funded with RW Part A funds have been enhanced. While transportation assistance has been available to clients in the form of bus vouchers, the RW field-based medical case management system also provides mileage reimbursement for RW case managers to escort clients to appointments when necessary. In addition, the TGA has expanded its transportation program to provide monthly bus passes, rather than daily passes, to RW clients with documented service needs to attend multiple appointments within a given week or month. The TGA also has added a transportation coordinator to arrange alternative transportation services for clients with mobility issues. Further, due to the increased barriers to public transportation during the COVID-19 pandemic, the RW Program has added Uber or Lyft services as an option for PLWH to be transported to medical visits and support services. This service has continued even as COVID has decreased, because ride share services have reduced the need for RW case managers to provide client transportation, increasing their capacity to provide direct case management services to clients.

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

To help address the large number of PLWH with Unmet Need, the Sexual Health Promotion Unit launched a Multidisciplinary HIV Response Team in early 2024. This team is primarily responsible for identifying, linking and engaging/re-engaging PLWH with unmet need into care. Having a dedicated team from across the HIV continuum, including Sexual Health Clinic, HCS staff and Prevention and Surveillance staff, will ideally

improve the response rate for clients we attempt to reach for Partner Services. In addition, this team approach will increase Sacramento County’s Sexual Health Promotion Unit’s capacity to engage with clients who have fallen out of HIV care or who have never been in care. With greater capacity the team will be able to utilize more resources to engage and locate clients, such as field visits, use of the mobile medical van, partnerships with local mental health and substance use disorder programs, housing case managers, and other services.

**Activities to Increase Viral Suppression among PLWH who are in care but not virally suppressed**

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

**5.B.3) Core Medical Services Waiver See Attachment 11**

**SECTION 6: RESOLUTION OF CHALLENGES**

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

Implementation of RW Part A Program and HIV Care Continuum Resolution of Challenges			
Continuum of Care Data Definitions and Tracking Across Jurisdictions			
Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status
<p>Variations in Continuum of Care definitions across jurisdictions decrease the integrity of comparative findings as follows:</p> <p><b>Retained in Care</b> This measure for RW and the TGA is defined as PLWH with =&gt;2 visits per year at least three months apart during the 12-month reporting year; for CA, it is defined as two or more CD4 or viral load tests, performed at least 3 months apart during the year; for the Nation, it is defined as ≥2 tests (CD4</p>	<p>The RW Program took much time and effort to revise local tracking and database systems to utilize the HRSA/HAB “retained in care” definition and these efforts have been completed.</p> <p>The Planning Council’s CQM Program would like HRSA to consider amending the “retained in care” measure requirement. The inconsistency in the definitions across jurisdictions (RW, TGA</p>	<p>All local tracking system reports were re-coded to track the Continuum of Care according to HRSA and CDC guidelines.</p> <p>Since the State Office of AIDS revised their definition of “in medical care” to reflect only those visits where a viral load or CD4 count test was conducted, the Sacramento TGA has re-coded its tracking system to reflect this measure as “in medical care”.</p>	<p>The TGA’s RW Program has new reports for “retained in care” which are provided to each RW provider monthly and reported to the Planning Council quarterly. These reports use the “retained in care” definition of at least two viral load/CD4 tests at least 3 months apart in a 12-month period. This definition does not capture the true picture of a client’s status if their first or second visit falls outside the reporting period.</p> <p>Annual statistics for the RW</p>

<p>or VL) ≥3 months apart during year.</p> <p>The “retained in care” measure is not very informative for the TGA’s RW Program, as many clients with suppressed viral loads (89% in 2023) are only seen by their medical provider once every 12 months due to stable health status.</p>	<p>State, Nation) make comparisons difficult.</p> <p>The true measure of quality care is viral suppression rates.</p> <p>Viral suppression is consistently measured across jurisdictions and can be tracked using specific measurement tools (lab tests).</p>		<p>Program are skewed to reflect lower than actual results for “retained in care”. Viral suppression rates for the TGA’s RW Program exceed TGA, CA and National rates in 2023 and more accurately reflect RW clients’ health status.</p>
<p><b>HIV Diagnosed</b></p> <p>Continuum of Care indicator at the local level is challenging because RW does not fund HIV testing. The private testing agencies, while cooperative, do not always have resources to track demographic data on HIV testing clients and State surveillance data has reporting delays.</p>	<p>The TGA’s RW Program has established collaboration and coordination between government funded HIV testing agencies and two of the largest HIV private testers in the area (One Community Health and Planned Parenthood).</p>	<p>Through the HIV/STI Stakeholders group (SacWISH), the TGA is gaining access to more data from non-government funded HIV testers.</p>	<p>The RW Recipient and Planning Council continue their outreach efforts to obtain HIV testing data from non-government funded testers in the TGA.</p>
<b>Continuum of Care Data Issues for RW Subrecipients</b>			
<b>Challenges/Barriers</b>	<b>Proposed Resolutions</b>	<b>Intended Outcomes</b>	<b>Current Status</b>
<p>Care Continuum data with RW Subrecipients (Subs) is challenged by staff turnover at the service provider level; lack of staff training; and limited staff time to ensure data integrity.</p>	<p>RW program staff has provided technical assistance to Subs. Much progress has been made to get all data updated in SHARE, but work is still ongoing to continue to improve processes and procedures. Data reports have been distributed and trainings are occurring, not only at individual Sub provider levels, but also at Service Provider Caucus meetings.</p>	<p>There have been improvements to RW Program data integrity across service providers. Agencies are working with staff on “retention in care” efforts and are making data integrity a priority. RW Subs have participated in decisions and development of reports that benefit them most.</p>	<p>RW Subs receive monthly reports showing the progress of their clients along the Continuum of Care. Included with each indicator is a list of unique client identifiers for clients served at their agency. This procedure gives providers the means to follow up on clients whose indicators are under target. These reports will continue to be monitored and improved to be most useful to RW Subs and the TGA as a whole.</p>
<b>Continuum of Care Integration into RW Program Service Improvement</b>			
<b>Challenges/Barriers</b>	<b>Proposed Resolutions</b>	<b>Intended Outcomes</b>	<b>Current Status</b>
<p>The process of integrating the full HIV Continuum of Care into the RW Part A</p>	<p>California State Office of AIDS has worked hard to reach a point</p>	<p>The RW Program has a quarterly client level data import, resulting in</p>	<p>Full integration of the Continuum of Care into the Part A program will continue</p>

<p>program has been challenging at the TGA's RW Program level, but even more so at the State level.</p>	<p>where the State and local health jurisdictions will be using the same surveillance data and NHAS indicators, including demographic categories, to track the Continuum.</p>	<p>RW client health information which is more current than State HIV data. RW Program and Sacramento County Public Health Unit managers are developing strategies to conduct ongoing reconciliation of the RW Program's HIV lab reports with the SOA reports to identify additional PLWH who are out of care and engage them back in medical care.</p>	<p>to be modeled at the TGA's RW Program level and integrated at the State level.</p>
<p><b>Access Barriers to HIV Care Continuum Services</b></p>			
<p><b>Challenges/Barriers</b></p>	<p><b>Proposed Resolutions</b></p>	<p><b>Intended Outcomes</b></p>	<p><b>Current Status</b></p>
<p><b>People of Color.</b> African American and Hispanic communities continue to be disproportionately impacted by HIV/AIDS and are more likely to be behind target indicators across HIV Care Continuum than other racial groups.</p>	<p>Outreach, HIV prevention messaging and testing resources need to be expanded and continue to be targeted to reach Black and Brown communities.  Continue to increase telehealth services to provide direct patient care.</p>	<p>Continue to increase the percentage of MAI clients that achieve viral suppression. Increase efforts across TGA to build trust within minority populations to increase contact with target population and increase linkage to HIV care.</p>	<p>Field-based medical case management system, which includes both in-home, street side and per/post incarceration services, has been implemented through Minority AIDS Initiative (MAI) Program. Percentage of RW MAI clients that reached viral suppression increased from 84.9% in FY20 to 93.1% in FY23.</p>
<p><b>Transportation</b> continues to be cited as a barrier to care for clients on Needs Assessments, Annual Client Satisfaction Surveys, and through Planning Council and other meeting forums where clients have a voice. This barrier increased during the COVID-19 pandemic due to more limitations and challenges with public transportation options.  The need for increased access to transportation does not appear to be solely due to limited</p>	<p>The TGA has adequately funded transportation services; however, strategies are needed to improve the quantity and quality of the public transit system. Because the TGA is large tri-county geographic region with two rural counties, and primary HIV medical care is centrally located in Sacramento County transportation services are challenging for PLWH to access.  Increased telemedicine</p>	<p>Continue to adjust support of transportation services to meet client demand.  For example, provide expanded use of Uber and Lyft to ease transportation barriers since public transportation is not easily accessed by all. This was beneficial during the COVID-19 pandemic when public transportation was limited and posed a health risk for immunocompromised individuals and should continue even as the COVID pandemic has subsided.</p>	<p>A transportation coordinator was integrated into the RW program to assist with arranging transportation and ride share services.  Additional Subs applied for and received transportation services in the recent RW Program's Request for Proposal.  Clients relying on RW Funded transportation services increased 20% since FY21, from 468 clients to 562 clients in FY23.</p>

funding, and proposed resolutions are broader in scope.	opportunities to address the transportation barrier, and primarily for rural county clients.		
<p><b>Housing</b> continues to be cited as a barrier to care for clients on Needs Assessments, Annual Client Satisfaction Surveys, and through Council and other meeting forums where clients have a voice.</p> <p>Housing has become an even greater barrier to care over the last couple of years, further impacted by the COVID-19 pandemic as well as a major housing shortage in the greater Sacramento TGA with extremely high housing prices.</p>	<p>The Sacramento and Placer County Board of Supervisors, and Sacramento City Council, have initiated projects to assist unhoused individuals.</p> <p>With 19.6% RW clients homeless or unstably housed in FY23, compared to 0.32% in the TGA, these proposed resolutions are in need of increased funding.</p>	Continue to advocate for increased funding and services for the homeless and unstably housed PLWH, especially during the pandemics when health risks issues are so high for HIV clients.	The housing coordinator continues to assist clients with this service. More Subs applied for and received housing service and case management funds in most recent RW Request for Proposal.

## SECTION 6: EVALUATION AND TECHNICAL SUPPORT CAPACITY

### 7.A. CLINICAL QUALITY MANAGEMENT (CQM)

#### 7.A.1) FY25 CQM Project Example

<p>Methodology: The CQM program will plan, implement, and document QI activities using the Model for Improvement (MFI). Plan, Do, Study, Act (PDSA) cycles will be used to deliver improvements in client health outcomes through structured and iterative changes based on performance measurement data.</p>			
<p>Service Category: Outpatient Ambulatory Care</p>			
<p>Overall Impact: To increase viral suppression by 10% among all Outpatient Ambulatory Care clients by improving viral load (VL) monitoring &amp; data capture processes</p>			
Key Activities	Timeline	Person(s)/Organization Responsible	Intended Outcome/Impact
Continue conducting MFI and PDSA trainings to expand QI capacity across the RW network	Ongoing	CQM Manager	Increased QI and MFI/PDSA knowledge across the RW network Maximized health outcomes for PLWH
Review, stratify, and analyze network wide Outpatient Ambulatory Care, viral suppression, and VL testing data to identify deficiencies and disparities	Spring 2025	Epidemiologist	QI activities informed and enhanced by performance measurement data Reduced disparities in VL testing & viral suppression

Survey clients and RW agencies to identify barriers to viral load testing and data entry	Spring 2025	CQM Manager	Increased awareness about the barriers and facilitators for VL monitoring Increased % of clients with a VL test every 6 months during the measurement year
Explore expanding laboratory services & clinical hours through field-based phlebotomy	Spring 2025	RW Program Coordinator	Increase % of clients linked to care Increase % of clients retained in care Increase % of clients virally suppressed
Conduct network training on VL monitoring including steps for entering VL data for clients and tips for collecting and obtaining accurate information	Summer 2025	CQM Manager & RW Program Coordinator	Standardized operating procedures for VL monitoring Increased # of clients with a "complete" intake status Increased # of clients retained in care Increased # of clients virally suppressed
Conduct agency training on how to bill for administrative tasks & hire for data entry staff	Fall 2025	CQM Manager & RW Program Coordinator	Increased # of clients properly reported in RSR Increased # of clients with a "complete" intake status & retained in care
Review & distribute regular QM reports to identify individuals & RW providers without updated VL test	Summer 2025	CQM Manager, Epidemiologist	Increased # of clients linked to care Increased # of clients receiving viral load testing Increased # of clients retained in care Increased # of clients virally suppressed
Outline processes for using newly developed data bridge for lab batch data entry	Ongoing	RW Program Coordinator, RW Providers	Reduced data entry time Increased # of clients with a "complete" intake status Increased # of clients retained in care
Analyze patient care, health outcomes and satisfaction data to evaluate & monitor QI activities	Ongoing	Epidemiologist, CQM Manager, RW Program Coordinator	Completed assessment of whether CQM program activities are making changes that positively affect outcomes

During FY23, the RW Program continued to focus on its Continuous Quality Improvement efforts to assure conditions for optimal health for people living with HIV across the TGA. An updated CQM Plan was developed in March 2020, updated June 2020, September 2021, and again in June 2023. The purpose of the CQM Plan is to systematically plan for, measure, evaluate and improve the quality of RW funded services delivered to its current clients and PLWH eligible for its services. The plan is a "living" document designed to be updated as part of the continuous quality improvement process and is reviewed annually at a minimum.

The RW Program's CQM Manager works directly with the Sacramento RW Program Coordinator and is

responsible for coordinating the RW CQM Program, including reviewing progress from all RW subrecipients' CQM activities. The CQM Manager also serves as the RW liaison to external quality improvement work groups throughout the TGA and, for example, coordinates webinars and training opportunities around quality improvement for CQM committee members and RW subrecipients. The CQM Manager also facilitates the activities of the Planning Council's CQM efforts which provides input to and oversight of the CQM Plan. Each CQM committee member serves an important role in ensuring accountability and standardization of CQM efforts, identifying gaps in RW services, and fostering collaboration among service providers. The CQM Work Plan, which is part of the CQM Plan, delineates activities, with specific timelines and responsible parties, to be implemented in order to achieve CQM goals and objectives. The CQM Work Plan also is reviewed annually and revised as needed.

To support the RW Program's CQM efforts, the Recipient has been ahead of the curve in data collection and analysis of client level data by developing the Sacramento Eligible Metropolitan Area System (SEMAS - renamed the Sacramento HIV/AIDS Reporting Engine – SHARE). The SHARE database is a sophisticated system that stores RW client-level data at service category and point-of-service levels. This data, along with EHR/Client Chart Reviews and on-site subrecipient reviews, is thoroughly analyzed by the Recipient and Planning Council and is compared to State and National benchmark data.

In FY08, the Recipient went further in its analysis of its client-level data and developed a detailed series of reports identified as the RW Annual Statistical Summary Project (RASSP). These comprehensive statistical reports provide multi-level cross-tabulations of the RW Program's client-level data to determine cost and service utilization by multiple fields such as gender, race, transmission, age, income, insurance, housing, co-occurring conditions, etc. These detailed reports are instrumental to the CQM Program which is based on past outcomes and experiences to identify where improvements can be made, for which subpopulations of RW clients, to improve health outcomes along the HIV Care Continuum.

To provide an example of the TGA's extensive CQM activities particular to the RW program in FY23, the following provides information about the ongoing improvement efforts for the Minority AIDS Initiative (MAI) aspect of the RW Program. MAI funding has been instrumental in evaluating and addressing the impact of HIV/AIDS on disproportionately affected minority populations. The RW Program's CQM outcomes data show that the RW MAI Program continues to address disparities among PLWH throughout the TGA and improve access to clinical care. In FY23, the percentage of MAI clients that met the definition of "Viral Suppression" follows: 75.0% of Native Hawaiian/Pacific Islanders (up from 73.7% in FY19); 93.0% of Asians (up from 81.5% in FY19); 87.5% of Hispanics (up from 82.2% in FY19); 83.1% of African Americans (up from 77.5% in FY19); and 85.7% of American Indian/Alaskan Natives (up from 85.7% in FY19). The chart below provides a summary of HIV Care Continuum Measures for each minority served in FY23 MAI Program.

As can be noted, Viral Load Suppression and on HAART were two of the Sacramento TGA's Planned CQI Outcome measures for FY23 MAI Program. Overall, the Viral Load Suppression target was met (93.1% Virally Suppressed, 85% goal); as well as the HAART outcome measure (96.4% on HAART, 90% goal).

FY23 HIV CQM Outcomes – RW Minority AIDS Initiative (MAI)							
	American Indian Alaskan Native	Asian	African American	Hispanic	Hawaiian/ Pacific Islander	Total	RW MAI Goal
MAI Clients	18	37	339	246	10	650	n/a
In Medical Care	88.9%	67.6%	66.9%	63.5%	60%	66.1%	n/a
Virally Suppressed	94.4%	94.6%	92.3%	93.9%	90%	93.1%	85%
On HAART	100%	64.9%	98.6%	97.6%	100%	96.4%	90%

### CQI Data to Improve Patient Care, Outcomes, Service Delivery and Long-Range Planning

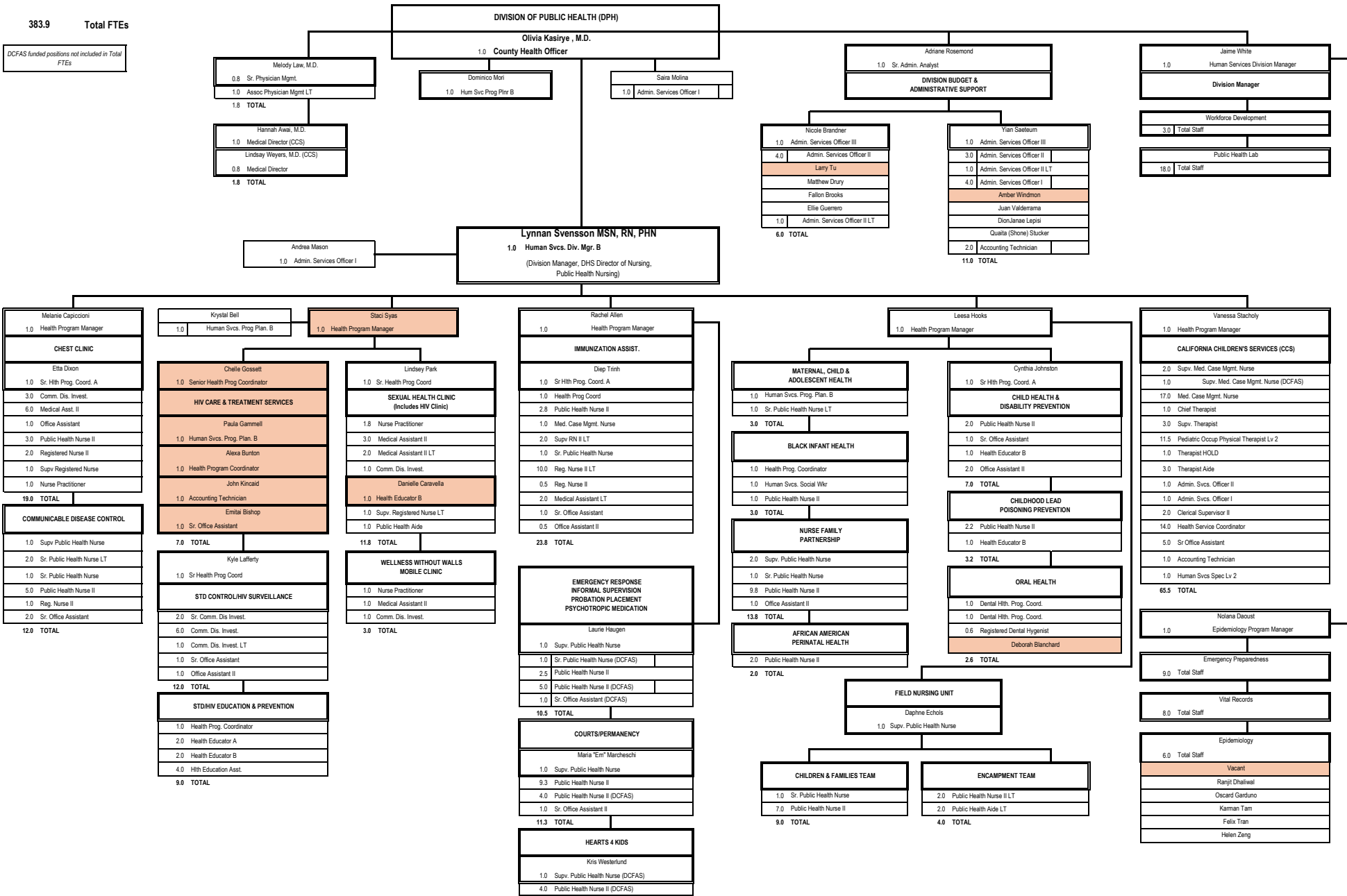
These ongoing Continuous Quality Improvement efforts assist the Recipient and RW Planning Council in evaluating disparities in care within the RW Program and inform the development of strategies and coordination efforts with service providers to reduce and eliminate disparities. CQM data is used by the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

As part of the CQM Program, Performance Indicators have been established and updated for the RW Program to be consistent with State and National efforts across the HIV Care Continuum. Follows is RW baseline data for FY22 and FY23 as compared to National HIV/AIDS Strategy (NHAS) targets for FY22:

RW CARE Program Continuous Quality Management Indicators FY22 Baseline, FY23 Outcomes and FY22 Targets					
Indicator	Performance Measure	Data Source	RW Program Baseline FY22	RW Program Outcomes FY23	NHAS Target FY22
Linkage to HIV Medical Care	% of newly diagnosed clients who attend a routine HIV medical care visit within 1 month of diagnosis	SHARE	86.8%	91.3%	85%
Prescribed HAART*	% of still active clients prescribed HIV/AIDS antiretroviral therapy (HAART) for treatment of HIV	SHARE	78.5%	96.5%	90%
In Medical Care	% of still active clients with at least one medical visit during 12-month period (one CD4 count or Viral Load Test)	SHARE	81.6%	73.1%	90%
Retained in Medical Care	% of still active clients with at least two medical visits at least 3 months apart in 12-month period (visit include CD4 or Viral Load Test)	SHARE	55.7%	45.5%	82.5%
Viral Load Suppression	% of still active clients with viral load < 200 copies/ml with viral load test recorded in 12-month period	SHARE	81.6%	88.1%	90%
Housing	% of still active clients with HIV who were stably housed in 12-month measurement period	SHARE	71.18%	81.2%	54%

383.9 Total FTEs

DCFAS funded positions not included in Total FTEs



Name	Education/ Credentials	Title	Project Role	Experience	% FTE				
					Admin	CQM	Planning Council	MAI Admin	MAI CQM
Staci Syas	MPH	Health Program Manager	Provides oversight and development of programs addressing the full continuum of Sacramento County HIV and STD service efforts	25+ years with Sac. Co. Public Health including Health Program Manager, Human Services Program Planner, Health Program Coordinator, and Health Educator.	-	-	-	-	-
Michelle (Chelle) Gossett	AGWA Certified Grant Writer	Senior Health Program Coordinator	Oversight of RWHAP award and project implementation	25+ years' experience with Parts A, B, C, D & also EHE, Sect. 330, CDC, SAMHSA	15%	16%	-	5%	-
Paula Gammell	MPA	Human Services Program Planner	Assists the Senior Health Program Coordinator with daily operations of the HIV Care Services Program	20+ years serving as the HIV Care Program's Planner	14%	31%	-	3%	4%
Alexa Bunton	MPH, CHES	Health Program Coordinator	Assists HIV Care Services Program with planning, program and subrecipient evaluation, and developing improvement plans.	4 years with Sacramento County Public Health including Health Program Coordinator and Health Educator	14%	-	-	-	
Danielle Caravella	MPH	Health Educator B	Assists HIV Care Services Program with programmatic needs.	5+ years working in Sac Co. including Health Educator, Disease Intervention Specialist, COVID-19 Specimen Testing Coordinator, Office Assistant I & II, and Intern	-	-	20%	-	-

John Kincaid	BA Degree in Accounting in Process; AA In Business Administration	Account Technician	Assists the Senior Health Program Coordinator with the fiscal oversight of the RWHAP Award	19+ years in a government capacity incl. Account Clerk II and Account Clerk III in Stanislaus County	54%	-	-	9%	-
Larry Tu	BA	Administrative Services Officer II	Liaison with Fiscal, Contracts and Board of Supervisors preparing claims, contracts, and board letters.	10+ years' experience in accounting, tax, audit, and/or fiscal	24%	-	-	-	-
Vacant	MPH	Epidemiologist	Provides epidemiological data; assists with HIV Cluster; other relevant information for grant writing and reports.	TBD	-	30%	-	-	-
Deborah Blanchard	Registered Dental Hygienist; MPA	Dental Program Coordinator	Oversees pre-authorizations for Dental services	40+ years clinical experience concurrent with 20+ years in public health	7%	-	-	-	-
Amber Windmon	MPH	Administrative Services Officer I	Liaison with Fiscal, and Travel Depts processing claims, mileages and travel.	18 years with Sac Co including Admin Services Officer, Disease Intervention Specialist, Health Educator, Senior Office Assistant, and Office Assistant	10%	-	-	-	-
Emitai Bishop		Senior Office Assistant	Administrative duties including entering data in databases, organization documentation, and answering phones	9 years' experience in the Sexual Health Promotion Unit	4%	-	-	-	-

**MAINTENANCE OF EFFORT**

**Core Medical Service and Support Service Budget Elements to Document MOE**

**MOE Expenditures Based on Core Medical Services and Support Services**

<b>Item No.</b>	<b>Item Description</b>	<b>Agency/Department/Other Government Unit</b>	<b>FY 23 Actual Expenditures</b>	<b>FY 24 Estimated Expenditures</b>
1	Outpatient Ambulatory Care-Ryan White CARE Program	Department of Health Services, Ryan White CARE Program	\$250,000	\$250,000
		<b>Total</b>	<b>\$250,000</b>	<b>\$250,000</b>

**Process Used to Determine Amount of Expenditures in MOE Table**

The Maintenance of Effort (MOE) computations are made in accordance with Section II, Chapter 4: Maintenance of Effort of the Ryan White CARE Act, of the Part A manual. MOE computations for the Sacramento TGA include actual expenditures for HIV-related core and support services from all sources in Sacramento, Placer and El Dorado counties. All counties operate on a July 1 through June 30 Fiscal Year. MOE funding is used to fund HIV outpatient ambulatory care and medical case management services for the Sacramento County Sexual Health clinic. This contract was the only budget in DHS that has not been reduced because of the Maintenance of Effort requirement by the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (and reauthorized in October of 2010). While the three counties of the TGA do have other State funding for HIV, that funding is for surveillance, and HIV Prevention and testing, service categories that do not fall within the Part A eligible service categories. MOE computations for all expenditures for FY23 were compiled using a coding system that applies each of the expenditures to the applicable program in each of the County’s accounting and reporting systems (COMPASS). For FY24, all HIV related expenditures funded locally in the Sacramento TGA are spent in Sacramento County, by the Sacramento County DHS, which has a line-item budget that funds HIV related activities. Sacramento County DHS incurs additional expenditures to supplement the revenues from grants that do not pay for indirect expenses or are under-funded. Total HIV/AIDS expenditures minus HIV/AIDS revenues determine the locally funded HIV/AIDS related expenditures.

As the basis for the Maintenance of Effort, the Sacramento County Board of Supervisors authorizes general funds in the amount of \$250,000 *annually* to support needed Core services in the Ryan White CARE Program. For Fiscal Year 2023, MOE funds were expended on Outpatient Ambulatory Care services to PLWH. This action has ensured annual Maintenance of Effort at previous levels. The Sacramento County Board of Supervisors has already authorized the \$250,000 for the current FY24 and it is anticipated that these funds will be expended by June 30, 2025.

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

Demographic Group/Exposure Category	HIV Incidence*: 01/01/21 to 12/31/23		AIDS Incidence*: 01/01/21 to 12/31/23		AIDS Prevalence ** as of 12/31/23		HIV (not aids) Prevalence ** as of 12/31/23		PLWH Prevalence ** as of 12/31/23	
	<i>HIV incidence is defined as the number of <u>new</u> HIV cases reported during the period specified.</i>		<i>AIDS incidence is defined as the number of <u>new</u> AIDS cases reported during the period specified.</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>		<i>PLWH Prevalence is defined as the estimated number of diagnosed people living with HIV or AIDS as of the date specified.</i>	
<b>Race/Ethnicity</b>	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
White, not Hispanic	152	33.0	80	39.4	1,302	46.5	1,223	40.3	2,525	43.3
Black, not Hispanic	86	18.7	41	20.2	641	22.9	635	20.9	1,276	21.9
Hispanic	133	28.9	62	30.5	627	22.4	781	25.7	1,408	24.1
Asian/Pacific Islander	36	7.8	8	3.9	107	3.8	175	5.8	282	4.8
American Indian/Alaska Native	3	0.7	0	1.4	7	0.3	15	0.5	22	0.4
Multi-Race	10	2.2	4	1.4	99	3.5	112	3.7	211	3.6
Not Specified/Other	40	8.7	8	3.9	14	0.5	95	3.1	109	1.9
<b>Total</b>	460	100.0	203	100.0	2,797	100.0	3,036	100.0	5,833	100.0
<b>Gender</b>	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
Male	364	79.1	166	81.8	2,297	82.1	2,512	82.7	4,809	82.4
Female	83	18.0	36	17.7	467	16.7	485	16.0	952	16.3
TG:MTF	12	2.6	1	0.0	30	0.0	32	0.0	62	1.1
TG:FTM	1	0.2	0	0.0	3	0.0	7	1.0	10	0.2
<b>Total</b>	460	100.0	203	100.0	2,797	100.0	3,036	100.0	5,833	100.0
<b>Age at Diagnosis (Years)</b>	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total	Number	% of Total
<13	0	0.0	0	0.0	16	0.6	26	0.9	42	0.7
13-19	12	2.6	3	1.5	32	1.1	107	3.5	139	2.4
20-24	58	12.6	8	3.9	164	5.9	481	15.8	645	11.1
25-44	292	63.5	112	55.2	1,812	64.8	1,823	60.0	3,635	62.3
45-64	91	19.8	66	32.5	715	25.6	561	18.5	1,276	21.9
>65	7	1.5	14	6.9	58	2.1	38	1.3	96	1.6
<b>Total</b>	460	100.0	203	100.0	2,797	100.0	3,036	100.0	5,833	100.0

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

Demographic Group/ Exposure Category	HIV Incidence*: 01/01/21 to 12/31/23		AIDS Incidence*: 01/01/21 to 12/31/23		AIDS Prevalence ** as of 12/31/23		HIV (not aids) Prevalence ** as of 12/31/23		PLWH Prevalence ** as of 12/31/23	
	<i>HIV incidence is defined as the number of new HIV cases reported during the period specified.</i>		<i>AIDS incidence is defined as the number of new AIDS cases reported during the period specified.</i>		<i>AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.</i>		<i>HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.</i>		<i>PLWH Prevalence is defined as the estimated number of diagnosed people living with HIV or AIDS as of the date specified.</i>	
<b>Adult/Adolescent AIDS Exposure Category</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>
Men who have sex with men	241	52.4	81	39.9	1,475	53.0	1,747	58.0	3,222	55.2
Injection drug users	40	8.7	21	10.3	288	10.4	169	5.6	457	7.8
Men who have sex with men and inject drugs	14	3.0	11	5.4	237	8.5	168	5.6	405	6.9
Heterosexuals	127	27.6	65	32.0	652	23.4	662	22.0	1,314	22.5
Other***	38	8.3	25	12.3	129	4.6	264	8.8	393	6.7
<b>Total</b>	<b>460</b>	<b>100.0</b>	<b>203</b>	<b>100.0</b>	<b>2,781</b>	<b>100.0</b>	<b>3,010</b>	<b>100.0</b>	<b>5,791</b>	<b>99.3</b>
<b>Pediatric AIDS Exposure Categories</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>
Mother with/at risk for HIV infection	0	N/A	0	N/A	14	87.5	21	80.8	35	0.6
Other/hemophilia/blood transfusion	0	N/A	0	N/A	1	6.3	0	0.0	1	0.0
Risk not reported or identified	0	N/A	0	N/A	1	0.0	5	19.2	6	0.1
<b>Total</b>	<b>0</b>	<b>N/A</b>	<b>0</b>	<b>N/A</b>	<b>16</b>	<b>100.0</b>	<b>26</b>	<b>100.0</b>	<b>42</b>	<b>0.7</b>

Data source: E-Hars Data system, Office of AIDS, California State.

\*Includes cases diagnosed and reported to Sacramento, El Dorado and Placer County's eHars database by December 31, 2023

\*\*People living with HIV/AIDS current living in Sacramento, El Dorado and Placer County by December 31, 2023

\*\*\* Unknown/Other includes perinatal exposure, blood exposure, other types of exposures, and no identified/reported risk (unknown risk).

**CO-OCCURRING CONDITIONS**

Condition	Ryan White Clients-Prevalence Fiscal Year 2023			TGA General Population 2022			Source for General Population Numerator (Latest Available)
	Rate	Numerator <sup>1</sup>	Denominator	Rate	Numerator <sup>1</sup>	Denominator <sup>2</sup>	
Tuberculosis	0.9%	30	2,171	0.004%	82	2,162,665	2021 California Department of Public Health, TB Control Branch
Hepatitis C*	4.0%	87		0.09%	1,999		2018 California Department of Public Health, STD Control Branch
Syphilis **	8.3%	159		0.06%	1,338		2021 California Department of Public Health, STD Control Branch
Gonorrhea	5.0%	109		0.22%	4,826		2021 California Department of Public Health, STD Control Branch
Chlamydia	4.9%	106		0.41%	8,874		2021 California Department of Public Health, STD Control Branch
Intravenous Drug Use	9.5%	207		0.33%	7,137		2022 SAMHSA National Survey on Drug Use and Health <sup>3</sup>
Mental Illness ***	21.9%	476		22.2%	479,895		2022 SAMHSA National Survey on Drug Use and Health <sup>3</sup>
Homeless / Unstable Housing	12.3%	266		0.46%	9,957		2023 Business, Consumer Services and Housing Agency; Homeless Data Integration System
Uninsured	8.9%	122		4.1%	88,714		2022 U.S. Census Bureau American Community Survey 1-Year Estimates
Under 100% FPL (incl no Income)	57.9%	1,256		10.6%	229,356		2022 U.S. Census Bureau American Community Survey 1-Year Estimates
Recently Incarcerated****	23.9%	583		0.49%	10,613		2022 Board of State and Community Corrections
American Indian or Alaskan Native	1.3%	28		0.40%	8,651		2022 U.S. Census Bureau American Community Survey 5-Year Estimates
Black or African-American (not Hispanic)	24.6%	535		7.5%	162,200		2022 U.S. Census Bureau American Community Survey 5-Year Estimates
Hispanic/Latinx	26.9%	584		22.8%	493,088		2022 U.S. Census Bureau American Community Survey 5-Year Estimates
More than One Race/ Other	0.0%	0		4.9%	105,971		2022 U.S. Census Bureau American Community Survey 5-Year Estimates
Asian / Pacific Islander	4.7%	101		13.0%	281,146		2022 U.S. Census Bureau American Community Survey 5-Year Estimates
White (not Hispanic)	42.5%	923		51.4%	1,111,610		2022 U.S. Census Bureau American Community Survey 5-Year Estimates

Footnotes

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

2. TGA denominator based on 2022 U.S. Census Bureau American Community Census 5-Year Estimates Data Profiles

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

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

\*\* 159 of 1909 FY23 RW clients with reported results were treated for Syphilis in past 12 months

\*\*\* 476 FY23 RW clients received mental health services in FY23

\*\*\*\* RW client reported release from correctional facility within last 12 months

Reporting Template A - Unmet Need						
Jurisdiction Name: Sacramento TGA			Approach?	Required		
Definition/Description			Number	Percent	Data Source	Year(s) of Data
A	B	C	D	E	F	
<b>HIV SURVEILLANCE DATA</b>						
<b>Late Diagnosed</b>						
1	<b>Late diagnoses:</b> Number of people with late diagnosed HIV in the most recent calendar year in the jurisdiction based on residence at time of diagnosis. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition $\leq$ 3 months after a diagnosis of HIV infection	31	19.6%	HIV Surveillance data	2023	
2	<b>New diagnoses:</b> Number of people in the jurisdiction with HIV diagnosed in the most recent calendar year based on residence at time of diagnosis	158				
<b>Unmet Need</b>						
3	<b>Unmet need:</b> Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year	1,269	22.3%	HIV Surveillance data; if linked databases are used please specify <sup>1</sup>	2023	
4	<b>Population size:</b> Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or any other HIV-related lab data (e.g., CD4, VL, genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period	5,686		HIV Surveillance data	2019 -2023	
<b>In Care, Not Virally Suppressed</b>						
5	<b>Not virally suppressed:</b> Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was $\geq$ 200 copies/mL in the most recent calendar year	462	10.5%	HIV Surveillance data; if linked databases are used please specify <sup>1</sup>	2023	

Reporting Template B - Priority Populations												
Jurisdiction Name: Sacramento TGA										Approach?	Required	
Category	Totals	Numerical Inputs					Auto-Calculated Percentages					
	# of People Living with Diagnosed HIV infection	# New Diagnoses	# Late Diagnosed	# Unmet Need	# In Care, Not Virally Suppressed	Within Categories			Across Categories			
						% Late Diagnosed	% Unmet Need	% In Care, Not Virally Suppressed	% Late Diagnosed	% Unmet Need	% In Care, Not Virally Suppressed	
A	B	C	D	E	F	G	H	I	J	K	L	M
<b>HIV SURVEILLANCE DATA</b>												
1	Total	5,686	158	31	1,269	462	19.6%	22.3%	10.5%	100.0%	100.0%	100.0%
<b>2 PRIORITY POPULATIONS (Determined by Jurisdiction)</b>												
	Men Who have Sex with Men (MSM)	3,127	65	11	632	196	16.9%	20.2%	7.9%	35.5%	49.8%	42.4%
	Heterosexuals- including	1,300	57	16	305	111	28.1%	23.5%	11.2%	51.6%	24.0%	24.0%
	Injection Drug Users (IDU)	455	16	1	130	68	6.3%	28.6%	20.9%	3.2%	10.2%	14.7%

## HIV Health Services Planning Council

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(916) 875-5881



July 29, 2024

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

RE: Letter of Concurrence from Planning Council Chair

Dear Mr. Lutz:

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

- a) The Sacramento TGA conducted a comprehensive *HIV Needs Assessment of HIV Care Services clients* in 2022 as well as a targeted *HIV Needs of Assessment for Aging PLWH* in 2023 and a *Young Adult Targeted Needs Assessment* in 2021. In December 2022 the *California Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, CY 2022-2026* was published by the California State Office of AIDS with input from the TGA's RW Program.
- b) Priority Setting and Resource Allocation
  - i) Priority Setting and Resource Allocations (PSRA) for FY 2025 were determined by the Council using the Council approved priority setting process outlined in policy document PAC 01 – PRSA Processes. This included review of the HIV needs assessments; TGA-wide epidemiology and demographic data; RW client utilization data; cost per RW client data; and financial data, such as increases or decreases in other funding streams.  
In addition, Unmet Need framework estimates, HIV Care Continuum and Early Identification of Individuals with HIV/AIDS (EIIHA) data also were reviewed to address the needs of the populations with HIV with unmet need and those unaware of their HIV status. Through this data driven PSRA process, the Council works to maximize access to services for historically underserved communities, including subpopulations and women, infants, children and youth.
  - ii) There is seated non-aligned PLWH and one seated aligned PLWH who are consumers of the RW Program involved in planning on the Priorities and Allocations Committee. Additionally, final decisions are determined by the Planning Council which includes an additional nine seated non-aligned consumers. Consumer input is highly valued and instrumental in the PSRA process.
  - iii) According to year end expenditure reports, the Ryan White FY 2023 Part A Formula, MAI, and Supplemental funds awarded to the Transitional Grant Area (TGA) were expended according to the priorities and allocations established by the Council. According to monthly expenditure reports, the Ryan White FY 2024 Part A Formula, MAI, and Supplemental funds

awarded to the Transitional Grant Area (TGA) are being expended according to the priorities and allocations established by the Council.

- c) In addition to all Priorities and Allocation Committee (PAC) members receiving an annual PAC process training (5/1/24), the Council received annual membership training on the Mechanics of the Planning Council on 5/29/24. The Council also receives ongoing monthly trainings which include presentations from community-based organizations, Recipient training on administrative and legislative mandates; and issues and trends as they relate to local, state, and federal HIV issues.
- d) The Administrative Assessment was conducted on June 13, 2024, and all standards were “met and exceeded” including PSRA, fiscal and program monitoring and timeliness of allocation and contracting of funds and payments to contractors.

Thank you for your time and attention,

A handwritten signature in blue ink, appearing to read 'Kristina Kendrick-Clark', is centered on the page.

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



### Diagnosis-Based HIV Care Continuum Services Table using CDC Data

#### Stages of the HIV Care Continuum

I. Diagnosed: Percentage of persons aged ≥13 years with HIV infection who know their serostatus.					Diagnosed Service Category <i>(List service categories that tie to target goal as described in Part A and/or MAI Service Category Plan Table)</i>
Goal	Prevent new HIV infections.	Objective	By 2030, increase the percentage of people with HIV infection who know their serostatus to at least 95 percent. (Source: NHSS, Indicator HIV02***)		
<b>2022 CDC Baseline</b>					The Ryan White Program Part A and Part A MAI does not fund testing activities.
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		208	Denominator: Number of persons aged ≥13 years with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year. ****		
			208	100%	
Percentage Change from Baseline to Target					
<b>FY 2027 Three-Year Period of Performance Target</b>					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection in the jurisdiction at the end of the calendar year. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		240	Denominator: Number of persons aged ≥13 years with HIV infection (diagnosed or undiagnosed) in the jurisdiction at the end of the calendar year. ****		
			240	100%	
Percentage Change from Baseline to Target					<b>0%</b>
II. Receipt of Care: Percentage of persons with diagnosed HIV who had at least one CD4 or viral load test during the calendar year.					Receipt of Care Service Category
Goal	Improve HIV-related outcomes for people with HIV.	Objective	By 2030, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: NHSS, Indicator HIV05***)		
<b>2022 CDC Baseline</b>					Outpatient Ambulatory Care Services, Health Ins. Premium Asst, Emergency Financial Asst., Transportation, Oral Health, Child Care, Housing, Mental Health, Outreach, MAI Case Management, Substance Abuse Outpatient, Substance Abuse Residential
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: HPPR, 2019**).		4092	Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.		
			5104	80%	
Percentage Change from Baseline to Target					
<b>FY 2027 Three-Year Period of Performance Target</b>					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had a care visit during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: HPPR, 2019**).		4415	Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.		
			5247	84%	
Percentage Change from Baseline to Target					<b>4%</b>
III. Retained in Care: Percentage of persons with documentation of 2 or more CD4 or viral load tests performed at least 3 months apart during the calendar year.					Retained in Care Service Category
Goal	Improve HIV-related outcomes for people with HIV.	Objective	By 2030, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: NHSS, Indicator HIV05).		
<b>2022 CDC Baseline</b>					Medical Case Management, Mental Health, Ambulatory Care Services
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		2566	Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.		
			5104	50%	
Percentage Change from Baseline to Target					
<b>FY 2027 Three-Year Period of Performance Target</b>					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection who had two care visits that were at least 90 days apart during the calendar year, as measured by documented test results for CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		2651	Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.		
			5247	51%	
Percentage Change from Baseline to Target					<b>0%</b>
IV. Viral Suppression: Percentage of persons with diagnosed HIV infection whose most recent HIV viral load test in the past 12 months showed that HIV viral load was suppressed.					Viral Suppression Service Category
Goal	Improve HIV-related outcomes for people with HIV.	Objective	By 2030, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 95%. (Source: HNSS, Indicator HIV05***)		
<b>2022 CDC Baseline</b>					Outpatient Ambulatory Care, Medical Case Management, Case Management-Non-Medical, Substance Abuse-Outpatient, Substance Abuse-Residential, MAI Medical Case Management, Mental Health, Medical Nutritional Counseling
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200 copies/mL at the most recent viral load test. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		3642	Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.		
			5104	71%	
Percentage Change from Baseline to Target					
<b>FY 2027 Three-Year Period of Performance Target</b>					
Numerator: Number of persons aged ≥13 years with diagnosed HIV infection whose most recent viral load test in the calendar year showed that HIV viral load was suppressed. Viral suppression is defined as a viral load test result of <200 copies/mL at the most recent viral load test. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		3718	Denominator: Number of persons aged ≥13 years with HIV infection diagnosed by previous year-end and alive at year-end.		
			5247	71%	
Percentage Change from Baseline to Target					<b>0%</b>
V. Linkage to Care: Percentage of persons with newly diagnosed HIV infection who were linked to care within one month after diagnosis as evidenced by a documented CD4 count or viral load.					Linkage to Care Service Category
Goal	Improve HIV-related outcomes for people with HIV.	Objective	By 2030, increase the percentage of persons with newly diagnosed HIV infection who are linked to HIV medical care within one month of diagnosis to at least 95%. (Source: NHSS, Indicator HIV04***)		
<b>2022 CDC Baseline</b>					Medical Transportation, Outreach, Non-Medical Case Management
Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		174	Denominator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.		
			208	84%	
Percentage Change from Baseline to Target					
<b>FY 2027 Three-Year Period of Performance Target</b>					
Numerator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year who were linked to care within one month of their diagnosis date as evidenced by a documented test result for a CD4 count or viral load. Data Source: NHSS 202012 (Reference Source: Vol 5 No 1*).		177	Denominator: Number of persons aged ≥13 years with newly diagnosed HIV infection during the calendar year.		
			240	74%	
Percentage Change from Baseline to Target					<b>-10%</b>
Describe methodology utilized to calculate the Target to be achieved during the three-year period of performance:		<p style="color: red;">We used the data provided in the NOFO by HRSA and the CDC.</p> <p style="color: red;">For the numerator, we calculated the percentage of change of alive clients between 2020 and 2022 and applied it to the number of alive clients who attained the required goal/outcome during the reporting period.</p> <p style="color: red;">For the denominator, we calculated the percentage of change of alive clients between year 2020 and 2022 and applied it to the total number of alive clients in 2022 to project the increase of clients over a three year period.</p>			

RWHAP Part A Service Category Plan Table									
Service Categories	FY 2024 Allocated				FY 2025 Estimated				
	Priority #	Allocated Amount	Unduplicated Clients	Service Units	Priority #	Estimated Amount	Unduplicated Clients	Service Units	Average Cost per Service Unit
<b>Core Medical Services</b>									
AIDS Drug Assistance Program (ADAP) Treatment	29		Not Presently Funded ☐		28		Not Presently Funded ☐		
AIDS Pharmaceutical Assistance (LPAP)	2		Not Presently Funded ☐		18		Not Presently Funded ☐		
Early Intervention Services	30		Not Presently Funded ☐		29		Not Presently Funded ☐		
Health Insurance Premium & Cost Sharing Assistance	3	\$ 21,897.00	14	19906.37	10	\$ 22,225	14	20204.55	\$1.10
Home & Community Based Health Service	21		Not Presently Funded ☐		20		Not Presently Funded ☐		
Home Health Care	22		Not Presently Funded ☐		21		Not Presently Funded ☐		
Hospice	23		Not Presently Funded ☐		22		Not Presently Funded ☐		
Medical Case Management (Incl. Treatment Adherence)	5	\$ 1,141,541.00	954	58227.12	1	\$ 1,217,034	1036	59642.04	\$20.41
Medical Nutrition Therapy	16	\$ 28,296.00	50	1886.4	12	\$ 39,711	70	2647.4	\$15.00
Mental Health Services	8	\$ 472,518.00	496	5283.62	4	\$ 525,143	546	5874.08	\$89.40
Oral Health Care	4	\$ 273,965.00	735	54642.74	5	\$ 286,872	772	55162.42	\$5.20
Outpatient/ Ambulatory Health Services	1	\$ 448,269.00	1077	6127.68	3	\$ 423,826	1018	5789.9	\$73.20
Substance Abuse Outpatient Care	11	\$ 181,888.00	170	6272	11	\$ 180,982	169	6240.8	\$29.00
<b>CORE MEDICAL TOTAL</b>		\$ 2,568,374				\$ 2,695,793			
<b>Support Services</b>									
Child Care Services	14	\$ 21,341.00	7	19400.91	14	\$ 12,408	4	11280	\$1.10
Emergency Financial Assistance	15	\$ 87,943.00	154	79948.18	9	\$ 92,341	162	83946.36	\$1.10
Food Bank/ Home Delivered Meals	7	\$ 33,383.00	257	30348.18	6	\$ 55,052	424	50047.27	\$1.10
Health Education/ Risk Reduction	17		Not Presently Funded ☐		17		Not Presently Funded ☐		
Housing	13	\$ 23,134.00	15	21030.91	7	\$ 24,291	16	22082.73	\$1.10
Linguistics Services	20		Not Presently Funded ☐		19		Not Presently Funded ☐		
Medical Transportation	10	\$ 108,529.00	540	71833.59	8	\$ 113,955	567	75970	\$1.50
Non-Medical Case Management Services	6	\$ 97,780.00	423	6518.66	2	\$ 123,669	535	8244.6	\$15.00
Other Professional Services	24		Not Presently Funded ☐		23		Not Presently Funded ☐		
Outreach Services	18		Funded by Part B Only		13		Funded by Part B Only		
Psychosocial Support	9		Not Presently Funded ☐		16		Not Presently Funded ☐		
Referral For Health Care Supportive Services	26		Not Presently Funded ☐		25		Not Presently Funded ☐		
Rehabilitation Services	27		Not Presently Funded ☐		26		Not Presently Funded ☐		
Respite Care	28		Not Presently Funded ☐		27		Not Presently Funded ☐		
Substance Abuse-residential	12	\$ 43,890.00	17	171.45	15	\$ 16,085	6	62.83	\$256.01
<b>SUPPORT SERVICES TOTAL</b>		\$ 416,000				\$ 437,801			
<b>GRAND TOTAL</b>		\$ 2,984,374				\$ 3,133,594			

FY 2024 Part A Allocated		
	Core Medical Services	Support Services
<b>FY 2024 Percentages</b>	86.06%	13.94%

FY 2025 Part A Estimated		
	Core Medical Services	Support Services
<b>FY25 Percentages</b>	86.03%	13.97%

FY 2024 Part A + MAI Allocated		
	Core Medical Services	Support Services
<b>FY 2024 Percentages</b>	86.91%	13.09%

FY 2025 Part A + MAI Estimated		
	Core Medical Services	Support Services
<b>FY25 Percentages</b>	86.88%	13.12%

Core Medical Services Waiver Requested  Yes

Recipient Name: Sacramento TGA  
 Grant Number: H89HA00048

Attachment 10: FY25 Part A Service Category Plan  
 RWHAP Part A Emergency Relief Grant

### MAI Service Category Plan Table

Service Categories	FY 2024 Allocated					FY 2025 Estimated					
	Priority #	Allocated Amount	Unduplicated Clients	Service Units	Subpopulation(s) of Focus	Priority #	Estimated Amount	Unduplicated Clients	Service Units	Subpopulation(s) of Focus	Average Cost per Service Unit
<b>Core Medical Services</b>											
Medical Case Management (Incl. Treatment Adherence)	5	\$ 127,953	281	10179	Black/African American	5	\$ 134,350	294	10688	Black/African American	\$12.57
Medical Case Management (Incl. Treatment Adherence)	5	\$ 53,850	204	3918	Hispanic/Latino	5	\$ 56,542	214	4114	Hispanic/Latino	\$13.74
Medical Case Management (Incl. Treatment Adherence)	5	\$ 5,627	30	259	Asian	5	\$ 5,908	32	272	Asian	\$21.72
Medical Case Management (Incl. Treatment Adherence)	5	\$ 5,646	15	517	American Indian/Alaskan Native	5	\$ 5,928	16	543	American Indian/Alaskan Native	\$10.92
Medical Case Management (Incl. Treatment Adherence)	5	\$ 704	8	33	Native Hawaiian/Pacific Islander	5	\$ 741	9	35	Native Hawaiian/Pacific Islander	\$21.17
<b>CORE MEDICAL TOTAL</b>		\$ 193,780					\$ 203,469				
<b>Support Services</b>											
<b>SUPPORT SERVICES TOTAL</b>		\$ -					\$ -				
<b>GRAND TOTAL</b>		\$ 193,780					\$ 203,469				

FY 2024 MAI Allocated		
	Core Medical Services	Support Services
FY 2024 Percentages	100.00%	\$ -

FY 2025 MAI Estimated		
	Core Medical Services	Support Services
FY25 %	100.00%	

### Service Unit Definitions

Provide service unit definitions. You may have multiple unit definitions for a service category. Indicate funding stream (RWHAP Part A or MAI), when applicable

RWHAP Service Category	Comments
AIDS Drug Assistance Program (ADAP) Treatment	Not Presently Funded
AIDS Pharmaceutical Assistance (LPAP)	Not Presently Funded
Early Intervention Services	Not Presently Funded
Health Insurance Premium & Cost Sharing Assistance	1 unit = 1 Vendor Paid Insurance, Medical Visit or Deductible Co-pay dollar
Home & Community-Based Health Service	Not Presently Funded
Home Health Care	Not Presently Funded
Hospice	Not Presently Funded
Medical Case Management (Incl. Treatment Adherence)	1 unit = 1 face to face or other encounter OR 1 unit = 1 face to face Medication Adherence Session (Part A & MAI)
Medical Nutrition Therapy	1 unit = 1 Medical Nutritional Therapy face-to-face encounter
Mental Health Services	1 unit = 1 face to face or other encounter
Oral Health Care	1 unit = 1 visit or vendor dollar
Outpatient/Ambulatory Health Services	1 unit = 1 visit or vendor dollar
Substance Abuse Outpatient Care	1 unit = 1 face to face or other encounter
Child Care Services	1 unit = 1 Vendor Child Care Dollar
Emergency Financial Assistance	1 unit = 1 Vendor Paid Other Critical Need
Food Bank/Home Delivered Meals	1 unit = 1 Vendor paid food dollar
Health Education/Risk Reduction	Not Presently Funded
Housing	1 unit = 1 Vendor paid lodging dollar
Linguistics Services	Not Presently Funded
Medical Transportation	1 unit = 1 One-Way trip or Vendor transportation dollar
Non-Medical Case Management Services	1 unit = 1 Non-medical case mgmt face to face or other encounter
Other Professional Services	Not Presently Funded
Outreach Services	Funded by Part B Only
Psychosocial Support	Not Presently Funded
Referral For Health Care and Support Services	Not Presently Funded
Rehabilitation Services	Not Presently Funded
Respite Care	Not Presently Funded
Substance Abuse-residential	1 unit = 1 Detox Hour

OMB Number: 0906-0065

## HRSA Ryan White HIV/AIDS Program (RWHAP) Core Medical Services Waiver Request Attestation Form

This form is to be completed by the Chief Elected Official, Chief Executive Officer, or a designee of either.

Please initial to attest to meeting each requirement after reading and understanding the explanation.

Name of Recipient Sacramento County Department of Health Services

RWHAP Part A recipient     RWHAP Part B recipient     RWHAP Part C recipient

Initial request     Renewal request

Year of request FY25

REQUIREMENT	EXPLANATION
<b>No ADAP waiting lists</b>	By initialing here and signing this document, you attest there are no AIDS Drug Assistance Program (ADAP) waiting lists in the service area. <input checked="" type="checkbox"/>
<b>Availability of, and accessibility to core medical services to all eligible individuals</b>	By initialing here and signing this document, you attest to the availability of and access to core medical services for all HRSA RWHAP eligible individuals in the service area within 30 days. Such access is without regard to funding source, and without the need to spend on these services, at least 75 percent of funds remaining from your RWHAP award after reserving statutory permissible amounts for administrative and clinical quality management. You also agree to provide HRSA HAB supportive evidence of meeting this requirement upon request. <input checked="" type="checkbox"/>
<b>Evidence of a public process</b>	By initialing here and signing this document, you attest to having had a public process during which input related to the availability of core medical services and the decision to request this waiver was sought from impacted communities, including clients and RWHAP funded core medical services providers. You also agree to provide supportive evidence of such process to HRSA HAB upon request. <input checked="" type="checkbox"/>

*Olivia Kasirye MD*

**SIGNATURE OF CHIEF ELECTED OFFICIAL OR CHIEF EXECUTIVE OFFICER (OR DESIGNEE)**

Olivia Kasirye  
**PRINT NAME**

Public Health Officer  
**TITLE**

9/18/24  
**DATE**

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0906-0065 and is valid until 09/30/2024. Public reporting burden for this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

Expiration Date 09/30/2024

## Appendix: A

### FY 2025 AGREEMENTS AND COMPLIANCE ASSURANCES

#### Ryan White HIV/AIDS Program

#### *Part A HIV Emergency Relief Grant Program*

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

**Pursuant to Section 2602(a)(2)<sup>5, 6</sup>**

The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

**Pursuant to Section 2602(a)(2)(B)**

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

**Pursuant to Section 2602(b)(4)**

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

**Pursuant to Section 2603(c)**

The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds and will comply with any cancellation of unobligated funds.

**Pursuant to Section 2603(d)**

The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

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<sup>5</sup> All statutory references are to the Public Health Service Act, unless otherwise specified.

<sup>6</sup> TGAs are exempted from the requirement related to Planning Councils but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

**Pursuant to Section 2604(a)**

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

**Pursuant to Section 2604(c)**

The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

**Pursuant to Section 2604(f)**

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

**Pursuant to Section 2604(g)**

The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

**Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)**

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

**Pursuant to Section 2604(h)(5)**

The EMA/TGA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or \$3 million.

**Pursuant to Section 2604(i)**

The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

**Pursuant to Section 2605(a)**

With regard to the use of funds,

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

A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and  
d. documentation of this MOE will be retained.

**Pursuant to Section 2605(a)(3)**

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

**Pursuant to Section 2605(a)(5)**

The EMA/TGA will participate in an established HIV community-based continuum of care if such continuum exists within the EMA/TGA.

**Pursuant to Section 2605(a)(6)**

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

**Pursuant to Section 2605(a)(7)(A)**

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

**Pursuant to Section 2605(a)(7)(B)**

Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

**Pursuant to Section 2605(a)(7)(C)**

A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

**Pursuant to Section 2605(a)(8)**

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

**Pursuant to Section 2605(a)(9)**

The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

**Pursuant to Section 2605(a)(10)**

The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

**Pursuant to Section 2605(e)**

The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

**Pursuant to Section 2681(d)**

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

**Pursuant to Section 2684**

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

Signature           *Oliver J. [unclear]*          

Date           8/19/2024