SCOPE OF WORK – MAI

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE

Contract Number:	
Contractor:	Desert AIDS Project dba DAP Health (DAP)
Grant Period:	March 1, 2024 – February 28, 2025
Service Category:	Early Intervention Services (MAI)
Service Goal:	Quickly link HIV infected individuals to testing services, core medical services, and support services necessary to support treatment adherence and maintenance in medical care. Decrease the time between acquisition of HIV and entry into care and decrease instances of out-of-care to facilitate access to medications, decrease transmission rates, and improve health outcomes.
Service Health Outcomes:	If RW-funded testing: maintain 1.1% positivity rate or higher (targeted testing); Link newly diagnosed HIV+ to medical care in 30 days or less; Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate.

BLACK / AFRICAN AMERICAN	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 24/25 TOTAL**
Number of Clients	0	0	10	0	5	5	**20**
Number of Visits = Regardless of number of transactions or number of units	0	0	100	0	20	50	**170**
Number of Units = Transactions or 15 min encounters	0	0	200	0	150	200	**550**

HISPANIC / LATINO	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 24/25 TOTAL**
Number of Clients	0	0	90	0	15	15	**120**
Number of Visits = Regardless of number of transactions or number of units	0	0	900	0	180	200	**1280**
Number of Units = Transactions or 15 min encounters	0	0	1800	0	300	800	**2900**

TOTAL MAI (sum of two tables above)	**SA1** West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 24/25 TOTAL**
Number of Clients	0	0	100	0	20	20	**140**

Number of Visits = Regardless of number of transactions or number of units	0	0	1000	0	200	250		**1450**
Number of Units = Transactions or 15 min encounters	0	0	2000	0	450	1000		**3450**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Identify/locate HIV+ unware and HIV+ that have fallen out of care; **Element #4:** Coordination with local HIV prevention programs; **Element #9:** Utilize the "Bridge" model to reconnect those that have fallen out of care; and **Element #10:** Establish and maintain formal linkages with traditional (prisons, homeless shelters, treatment centers, etc.) AND non-traditional (faith-based organizations, community centers, hospitals, etc.) entry points. **Activities:** Employing educated staff who are offered training to remain informed about epidemiology and target populations trends revealing characteristics of high-risk individuals so that efforts to identify/locate can be focused; Conducting advertising and promotion to those groups to make them aware of services; Tracking missed appointments and other indicators of poor treatment adherence such as declining mental health in shared electronic health records (EHR) so that reports can be generated of those who have fallen out of care and case manager can be aware of those at high risk; Case Conferencing; Establishing regular contact with local HIV prevention programs to avoid duplication of services, coordinating training opportunities, linking clients to partner counseling and referral services, implementing data-to-care efforts and conducting mandated disease reporting; Training new staff and updating current staff on The Bridge and similar interventions that can be adapted to our service area; and Employing Community Partner Liaison to support EIS team and Leadership Team to maintain relationships with diverse group of both traditional and non-traditional collaborating partners who can provide access to high risk populations.	3,5,6	03/01/24-02/28/25	• Resumes of staff and staff training records. • Advertising/Promotion collateral. • No-Show reports and other functions of the EHR. • Case Conference logs. • MOU/Letters of Support/Contracts/Agreements with County of Riverside and State of California. • List of active EIS partners showing mix of traditional and non-traditional sites and schedule of partner activities (e.g. hosting our team to conduct regular testing and education, coordinating services with our mobile testing van, etc.). • Service deliveries in ARIES and documentation in EIS Logs and electronic databases. • Progress notes in ARIES. • EIS Enrollment Forms and Counseling Information Forms. • EIS logs showing documentation, when available, of the profile of individuals served as evidence of targeting efforts at high risk populations.
Element #2: Provide testing services and/or refer high-risk unaware to testing; and **Element #6:** Provide education/information regarding availability of testing and HIV care services to HIV+, those at-risk, those affected by	3,5,6	03/01/24-02/28/25	• EIS logs and Counseling Information Forms. • Records showing positivity rate of 1.1% or higher for targeted testing.

HIV, and caregivers. Activities that are exclusively HIV prevention education are prohibited. **Activities:** Conducting HIV testing on-site, at stationary sites throughout the community, via mobile testing unit and at special events; Delivering education/information in conjunction with testing tailored for audience age, gender, race/ethnicity/gender/sexual orientation, risk group, immigration status, addiction history, etc.; Maintaining partnership with on-site laboratory for confirmatory testing; Hosting State of California HIV testing training program for certification of new test counselors; Recruiting and retaining volunteer test counselors; and Maintaining walk-in Sexual Health Clinic on-site at DAP			• EIS Schedule showing education sessions utilizing Ryan White Part A funds were accompanied by testing. • List of partners welcoming DAP to provide testing and education services to the populations they serve. • Lease with LabCorp and evidence of interface between EHR and LabCorp. • Staff training logs. • Volunteer files. • Record of testing services provide through DAP's Sexual Health Clinic, The DOCK.
Element #3: One-on-one, in-depth encounters; **Element #5:** Identify and problem-solve barriers to care; **Element #7:** Referrals to testing, medical care, and support services; **Element #8:** Follow-up activities to ensure linkage; **Element #11:** Utilize standardized, required documentation to record encounters, progress; and **Element #12:** Maintain up-to-date, quantifiable data to accommodate reporting and evaluation. **Activities:** Through one-on-one sessions, working collaboratively with the client to identify greatest barriers that if addressed will expedite linkage to medical care (e.g. insurance status, income, transportation, fear and concern, etc.); Case Conferencing; Co-locating medical clinic, dental clinic, behavioral health, home health programs and other social services such as housing, food assistance and case management; Ensuring shared medical records review health indicators to include medical visits and viral load; Maintaining network of community clinic referral options to ensure client can link to care at most convenient and preferred provider; Documenting follow-up efforts such as phone calls, emails, social media connections, in-person sessions, mail or communication with collaborating partners per client consent; Adhering to using Inland Empire HIV Planning Council and local Ryan White Program published Standards of Care and EIS policies, procedures and forms; and Maintaining Ryan White Program-approved spreadsheets and support ongoing data entry in electronic databases.	3,5,6	03/01/24-02/28/25	• EIS data showing rate of linkage to medical within 30 days. • Past and present medical appointment history and most recent lab results in on-site EHR or in ARIES. • EIS Enrollment Forms. • Needs assessments as appropriate documented in ARIES or client chart. • Case Conference logs. • Referrals and outcomes recorded in ARIES. • Progress notes in ARIES documenting encounters as well as reduced incidence of falling out of care after EIS discharge. • Functions of EpicCare and LEO customized to record required data and generate reports.
Element #13: Develop and implement specific, evidence-based strategies proven effective for African American and/or Hispanic populations. **Element #14:** Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enroll staff in annual C&L Competency training; Provide care compatible with client culture, health beliefs, practices, preferred language, and in a manner that reflects and respects gender and sexual diversity of community served; Recruiting, retaining and promoting	3,5,6	03/01/24-02/28/25	• Staff development documentation and personnel files. • Client Satisfaction Survey results. • Staff race/ethnicity/gender/sexual orientation survey results. • C&L Competency Plan and All-Staff Meeting agenda. • C&L Competency Self-Assessment and plan to address deficiencies.

diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retain additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• Race, ethnicity and language proficiency recorded in ARIES. • Staff language proficiency survey results. • "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.