

## SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

<b>Contract Number:</b>	<i>Leave Blank</i>
<b>Contractor:</b>	TruEvolution, Inc.
<b>Grant Period:</b>	March 1, 2024 – February 28, 2025
<b>Service Category:</b>	Non-Medical Case Management
<b>Service Goal:</b>	Facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals.
<b>Service Health Outcomes:</b>	<ul style="list-style-type: none"> <li>• Improve retention in care (at least 1 medical visit in each 6-month period)</li> <li>• Improve viral suppression rate</li> </ul>

	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
<b>Proposed Number of Clients</b>	15	15	N/A	5	5	N/A	40
<b>Proposed Number of Visits</b> = Regardless of number of transactions or number of units			N/A			N/A	*
<b>Proposed Number of Units</b> = Transactions or 15 min encounters (See Attachment P)	240	240	N/A	80	80	N/A	640

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
• N/A								
•								
•								

\*Goal numbers for clients, visits, and units may be impacted due to the current COVID-19 pandemic.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:

SERVICE  
TIMELINE  
AREA

PROCESS OUTCOMES

<p>Activities:</p> <ul style="list-style-type: none"> <li>• Initial assessment of service needs</li> <li>• Initial and ongoing assessment of acuity level</li> <li>• Development of a comprehensive, individualized care plan</li> <li>• Continuous client monitoring to assess the efficacy of the care plan</li> <li>• Re-evaluation of the care plan at least every 6 months with adaptations as necessary</li> <li>• Ongoing assessment of the client's and other key family members' needs and personal support systems</li> <li>• Provide education, advice and assistance in obtaining medical, social, community, legal, financial (e.g. benefits counseling), and other services</li> <li>• Discuss budgeting with clients to maintain access to necessary services</li> <li>• Case conferencing with Medical Case Management Staff on behalf of the client</li> <li>• Benefits counseling (assist with obtaining access to other public and private programs for which clients are eligible (e.g. Medi-Cal, Medicare, Covered CA, ADAP, Premium Assistance, etc.).</li> <li>• Services are provided based on established C&amp;L Competency Standards</li> </ul>	<p>SA1, SA2, SA4 and SA5</p>	<p>03/01/24-02/28/25</p>	<p>We will use the following outcome indicators to measure either aspects of the process (client's care, # of visits and linkage to care or health outcomes (VLS). These indicators will be:</p> <ul style="list-style-type: none"> <li>– Linkages to HIV Medical Care – 90%</li> <li>– HIV Viral Load Suppression – 90%</li> </ul> <p>Benchmark rates will be recorded at the beginning of cycle and there after every three months to determine areas in need of improvement.</p>
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### USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

<b>Contract Number:</b>	<i>Leave Blank</i>
<b>Contractor:</b>	TruEvolution, Inc.
<b>Grant Period:</b>	March 1, 2024 – February 28, 2025
<b>Service Category:</b>	Early Intervention Services (EIS)
<b>Service Goal:</b>	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.
<b>Service Health Outcomes:</b>	<ul style="list-style-type: none"> <li>– Maintain 1.1% positivity rate or higher</li> <li>– Link new diagnosed HIV+ to HIV Medical Care - (appointment scheduled w/24 hours for an appointment w/in 72 hours)</li> <li>– Retention in medical care (at least two medical visits in a 12-month period) and</li> <li>– Improved or maintained viral load suppression rates.</li> </ul>

	<b>SA1</b> West Riv	<b>SA2</b> Mid Riv	<b>SA3</b> East Riv	<b>SA4</b> San B West	<b>SA5</b> San B East	<b>SA6</b> San B Desert		<b>FY 24/25 TOTAL</b>
<b>Proposed Number of Clients</b>	25	25	N/A	25	25	N/A		100
<b>Proposed Number of Visits</b> = Regardless of number of transactions or number of units			N/A			N/A		*
<b>Proposed Number of Units</b> = Transactions or 15 min encounters (See Attachment P)	100	100	N/A	100	100	N/A		400

<b>Group Name and Description (must be HIV+ related)</b>	<b>Service Area of Service Delivery</b>	<b>Targeted Population</b>	<b>Open/ Closed</b>	<b>Expected Avg. Attend. per Session</b>	<b>Session Length (hours)</b>	<b>Sessions per Week</b>	<b>Group Duration</b>	<b>Outcome Measures</b>
• N/A								
•								
•								

\*Goal numbers for clients, visits, and units may be impacted due to the current COVID-19 pandemic.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
<b>Activities:</b> <ul style="list-style-type: none"> <li>• Identify/locate HIV+ unaware and HIV+ that have fallen out of care</li> <li>• Provide testing services and/or refer high-risk unaware to testing</li> <li>• One-on-one encounters</li> <li>• Coordination with local HIV prevention programs</li> <li>• Identify and problem-solve barriers to care</li> <li>• Provide education/information regarding availability of testing and HIV care services to HIV+, those at-risk, those affected by HIV, and caregivers</li> <li>• No HIV prevention education.</li> <li>• Referrals to testing, medical care, support services</li> <li>• Follow-up activities to ensure linkage</li> <li>• Utilize “Bridge” model to reconnect those that have fallen out of care</li> <li>• 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</li> <li>• Utilize standardized, required documentation to record encounters, progress</li> <li>• Maintain up-to-date, quantifiable data to report and evaluate service.</li> <li>• Maintain services based on C&amp;L Competency Standards</li> </ul>	SA1, SA2, SA4 and SA5	03/01/24-02/28/25	<p>We will use the following outcome indicators to measure either aspects of the process (client’s care, # of visits and linkage to care or health outcomes (VLS). These indicators will be:</p> <ul style="list-style-type: none"> <li>– HIV Positivity Rate – 1.1%</li> <li>– Linkages to HIV Medical Care – 90%</li> <li>– Decrease Unmet Need – 75%</li> <li>– HIV Viral Load Suppression – 90%</li> </ul> <p>Benchmark rates will be recorded at the beginning of cycle and there after every three months to determine areas in need of improvement.</p>