SCOPE OF WORK – RYAN WHITE PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2024 - February 28, 2025
Service Category:	**NON-MEDICAL CASE MANAGEMENT SERVICES**
Service Goal:	The goal of Case Management (non-medical) is to facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved or maintained viral suppression rate Improve retention in Care (at least one medical visit each 6-month period)

	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**
Proposed Number of Clients	650	175	125	0	0	0	**950**
Proposed Number of Visits = Regardless of number of transactions or number of units	750	300	200	0	0	0	**1,250**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1,250	500	250	0	0	0	**2,000**

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**
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: The HIV Nurse Clinic Manager is responsible for ensuring Case Management (Non-Medical) Services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activities:**	1, 2, & 3	03/01/24-02/28/25	• Patient Assessments • Care Plans • Case Management Tracking Log • Case Conferencing Documentation • Referral Logs • Progress Notes

• Case Manager will work with patient to conduct an initial intake assessment within 3 days from referral.			• Cultural Competency Plan • ARIES Reports
Element #2: Initial and on-going of acuity level **Activities:** • Case Manager will provide initial and ongoing assessment of patient's acuity level during intake and as needed to determine Case Management or Medical Case Management needs. Initial assessment will also be used to develop patient's Care Plan. • Case Manager will discuss budgeting with patients to maintain access to necessary services and Case Manager will screen for domestic violence, mental health, substance abuse, and advocacy needs.	1, 2, & 3	03/01/24- 02/28/25	
Element #3: Development of a comprehensive, individual care plan. **Activities:** • Case Manager will refer and link patients to medical, mental health, substance abuse, psychosocial services, and other services as needed and Case Manager will provide referrals to address gaps in their support network. • Case Manager will be responsible for eligibility screening of HIV patients to ensure patients obtain health insurance coverage for medical care and that Ryan White funding is used as payer of last resort. • Case Manager will assist patient to apply for medical, Covered California, ADAP and/or OA CARE HIPP etc. • Case Manager will coordinate and facilitate benefit trainings for patients to become educated on covered California open enrollment, Medi-Cal IEHP, OA- CARE HIPP etc.	1, 2, & 3	03/01/24- 02/28/25	
Element #4: Case Manager will provide education and counseling to assist the HIV patients with transitioning if insurance or eligibility changes. **Activities:** • Case Manager will assist patients with obtaining needed financial resources for daily living such as bus pass vouchers, gas cards, and other emergency financial assistance.	1, 2, & 3	03/01/24- 02/28/25	

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD
Grant Period:	March 1, 2024 - February 28, 2025
Service Category:	**Medical Case Management (MCM)**
Service Goal:	The goal of providing medical case management services is to ensure that those who are unable to self-manage their care, struggling with challenging barriers to care, marginally in care, and/or experiencing poor CD4/Viral load tests receive intense care coordination assistance to support participation in HIV medical care.

Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved or maintained viral load Improved retention in care (at least 1 medical visit in each 6-month period) Reduction of Medical Case Management utilization due to client self-sufficiency.

	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**
Proposed Number of Clients	455	130	65	0	0	0	**650**
Proposed Number of Visits = Regardless of number of transactions or number of units	665	390	195	0	0	0	**1,250**
Proposed Number of Units = Transactions or 15 min encounters	1,250	500	250	0	0	0	**2,000**

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								

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: The HIV Nurse Clinic Manager is responsible for ensuring MCM services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activities:** • Management and MCM staff will attend Inland Empire HIV Planning Council Standards of Care Committee meetings to ensure compliance. • MCM staff will receive annual training on MCM practices and best practices for coordination of care, and motivational interviewing.	1, 2, & 3	03/01/24-02/28/25	• Medical Case Management Needs Assessments • Patient Acuity Assessments • Benefit and resource referrals • Comprehensive Care Plan • Case Conferencing Documentation • Referral Logs • Progress Notes

Element #2: Medical Case Managers will provide Medical Case Management Services to patients that meet TGA MCM service category criteria: **Activities:** • Benefits counseling, support services assessment and assistance with access to public and private programs the patient may qualify for. Make referrals for: home health, home and community-based services, mental health, substance abuse, housing assistance as needed	1, 2, & 3	03/01/24-02/28/25	• Cultural Competency Plan • ARIES Reports
Element #3: Medical Case Managers will conduct an initial needs assessment to identify which HIV patients meet the criteria to receive medical case management. **Activities:** Initial patient, family member and personal support system assessment. Re-assessments will be conducted at a minimum of every four months by MCM staff to determine ongoing or new service needs.	1, 2, & 3	03/01/24-02/28/25	
Element #4: Medical Case Managers will conduct initial and ongoing assessment of patient acuity level and service needs. **Activities:** • If patient is determined to not need intensive case management services, they will be referred and linked with case management (non-medical) services.	1, 2, & 3	03/01/24-02/28/25	
Element #5: The MCM staff will develop comprehensive, individualized care plans in collaboration with patient, primary care physician/provider and other health care/support staff to maximize patient's care and facilitate cost-effective outcomes. **Activities:** • The plan will include the following elements: problem/presenting issue(s), service need(s), goals, action plan, responsibility, and timeframes.	1, 2, & 3	03/01/24-02/28/25	

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2024 - February 28, 2025
Service Category:	**OUTPATIENT/AMBULATORY HEALTH SERVICES**
Service Goal:	To maintain or improve the health status of persons living with HIV/AIDS in the TGA. NOTE: Medical care for the treatment of HIV infection includes the provision of care that is consistent with the United States Public Health Service, National Institutes of Health, American Academy of HIV Medicine (AAHIVM).
Service Health Outcomes:	Improved or maintained CD4 cell count; as a % of total lymphocyte cell count. Improved or maintained viral load. Improve retention in care (at least 1 medical visit in each 6-month period). Link newly diagnosed HIV+ to care within 30 days: and Increase rate of ART adherence

	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**
Proposed Number of Clients	275	100	75	0	0	0	**450**
Proposed Number of Visits = Regardless of number of transactions or number of units	500	300	150	0	0	0	**950**
Proposed Number of Units = Transactions or 15 min encounters	1,800	800	400	0	0	0	**3,000**

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								

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**

Element #1: DOPH-HIV/STD medical treatment team will provide the following service delivery elements to PLWHA receiving * HIV Outpatient/Ambulatory Health Services at Riverside Neighborhood Health Center, Perris Family Care Center, and Indio Family Care Center. Provide HIV care and treatment through the following: **Activities:** • Development of Treatment Plan • Diagnostic testing • Early Intervention and Risk Assessment • Preventive care and screening • Practitioner examination • Documentation and review of medical history • Diagnosis and treatment of common physical and mental conditions • Prescribing and managing Medication Therapy • Education and counseling on health issues • Continuing care and management of chronic conditions • Referral to and provision of Specialty Care • Treatment adherence counseling/education • Integrate and utilize ARIES to incorporate core data elements.	1, 2, & 3	03/01/24- 02/28/25	• Patient health assessment • Lab results • Treatment plan • Psychosocial assessments • Treatment adherence documentation • Case conferencing documentation • Progress notes • Cultural Competency Plan • ARIES reports • Viral loads • Reduction in unmet need • Prescription of/adherence to ART
Element #2: The HIV/STD Branch Chief, Medical Director, and HIV Clinic Manager are responsible for ensuring Outpatient/Ambulatory Health Services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activity:** • Management staff will attend Inland Empire HIV Planning Council Standard of Care Meetings. • Management/physician/clinical staff will attend required CME training and maintain American Academy of HIV Medicine (AAHIVM) Certification.	1, 2, & 3	03/01/24- 02/28/25	
Element #3: Clinic staff will conduct assessments including evaluation health history and presenting problems. Those on HIV medications are evaluated for treatment adherence. Assessments will consist of: **Activities:** • Completing a medical history • Conducting a physical examination including an assessment for oral health care • Reviewing lab test results • Assessing the need for medication therapy • Development of a Treatment Plan. • Collection of blood samples for CD4 Viral load, Hepatitis, and other testing • Perform TB skin test and chest x-ray	1, 2, & 3	03/01/24- 02/28/25	

Element #4: Clinicians will complete a medical history on patients, including family medical history, psycho-social history, current medications, environmental assessment, diabetes, cardiovascular diseases, renal disease, GI abnormalities, pancreatitis, liver disease, and hepatitis. **Activities:** • Conducting a physical examination • Reviewing lab test results • Assessing the need for medication therapy • Development of a Treatment Plan.	1, 2, & 3	03/01/24- 02/28/25	

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2024 - February 28, 2025
Service Category:	**MEDICAL NUTRITION THERAPY**
Service Goal:	Facilitate maintenance of nutritional health to improve health outcomes or maintain positive health outcomes.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate.

	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**
Proposed Number of Clients	143	46	22	0	0	0	**211**
Proposed Number of Visits = Regardless of number of transactions or number of units	250	125	75	0	0	0	**450**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	300	175	125	0	0	0	**600**

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**

Element #1: Medical Nutrition Therapist will develop a Nutrition Screening Tool to identify patients who need Medical Nutrition Therapy Assessments. Risk factors could include but are not limited to: weight loss, wasting, obesity, drug use/abuse, hypertension, cardiovascular disease, liver dysfunction etc. **Activities:** • HIV patients to be screened at every medical appointment by the physician or nursing staff to identify nutrition related problems. Patients will be referred to MNT based on the following criteria: o HIV/AIDS diagnosis o Unintended weight loss or weight gain o Body mass index below 20 o Barriers to adequate intake such as poor appetite, fatigue, substance abuse, food insecurity, and depression	1, 2, & 3	03/01/24-02/28/25	• MNT schedules/logs • MNT encounter logs • Nutrition Screening and MNT assessment • MNT Referrals Progress/treatment notes • ARIES Reports • Cultural Competency Plan • Academy of Nutrition and Dietetics Standards • Viral loads
Element #2: HIV patients will be assessed by MNT based on the following criteria: • High risk - to be seen by an RDN within 1 week	1, 2, & 3	03/01/24-02/28/25	

• Moderate risk - to be seen by an RDN within 1 month • Low risk - to be seen by an RDN at least annually **Activities:** Initial MNT assessment and treatment will include the following: • Gathering of baseline information. Routine quarterly or semi-annually follows- up can be scheduled to continue education and counseling. • Nutrition-focused physical examination; anthropometric data; client history; food /nutrition-related history; biochemical data, medical tests, and procedures. • Identify as early as possible new risk factors or indicators of nutritional compromise. • Discuss plan of treatment with treating physician. Treating physician will RX food and/or nutritional supplements. • Participate in bi-weekly case conferences to discuss treatment planning and coordination with the medical team			
Element #3: HIV patients who are identified for group education based on MNT assessment and treatment will be referred to MNT group/educational classes **Activities:** • MNT will develop educational curriculum. • HIV patient will attend MNT group/educational class as recommended by MNT and treating physician.	1, 2, & 3	03/01/24-02/28/25	

SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY	
Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2024 - February 28, 2025
Service Category:	EARLY INTERVENTION SERVICES (PART A)
Service Goal:	Quickly link HIV infected individuals to testing services, core medical services, and support services necessary to support treatment adherence and maintain in medical care. Decreasing the time between acquisition of HIV and entry into care will facilitate access to medications, decrease transition rates, and improve health outcomes.
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved retention in care (at least 1 medical visit in each 6 month period) Improved viral suppression rate Targeted HIV Testing-Maintain 1:1% positivity rate or higher

	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**
Proposed Number of Clients	75	40	35	0	0	0	150
Proposed Number of Visits = Regardless of number of transactions or number of units	225	100	50	0	0	0	375
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	250	175	75	0	0	0	500

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**
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE	TIMELINE	PROCESS OUTCOMES
Element #1: Identify/locate HIV+ unaware and HIV + that have fallen out of care **Activities:** EIS staff will work with grass-roots community-based and faith-based agencies, local churches and other non-traditional venues to reach targeted communities to perform targeted HIV testing, link unaware populations to HIV Testing and Counseling and Partner Services and newly diagnosed and unmet need to HIV care and treatment. EIS staff will work with prisons, jails, correctional facilities, homeless shelters and hospitals to perform targeted HIV testing, linking newly diagnosed to HIV care and treatment. EIS staff will work with treatment team staff to identify PLWHA that have fallen out-of-care and unmet need population to provide the necessary support to bring back into care and maintain into treatment and care. EIS staff will provide the following service delivery elements to PLWHA receiving EIS at Riverside Neighborhood Health Center, Perris Family Care Center and Indio Family Care Center. Services will also be provided in the community throughout Riverside County based on the Inland Empire HIV Planning Council Standards of Care.	1, 2, & 3	03/01/24-02/28/25	▪ Outreach schedules and logs ▪ Outreach Encounter Logs ▪ LTC Documentation Logs ▪ Assessment and Enrollment Forms ▪ Reporting Forms ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ARIES Reports
Element #2 Linking newly diagnosed and unmet need individuals to HIV care and treatment within 30 days or less. Provide referrals to systems of care (RW & non-RW) **Activities:** EIS staff will coordinate with HIV Care and Treatment facilities who link patient to care within 30 days or less.	1, 2, & 3	03/01/24-02/28/25	

Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi- Cal, Insurance Marketplace, OA-Care HIPP, etc.) Interventions will also include community-based outreach, patient education, intensive case management and patient navigation strategies to promote access to care.			
Element #3 Re-linking HIV patients that have fallen out of care. Perform follow-up activities to ensure linkage to care. **Activities:** Link patients who have fallen out of care within 30 days or less. Coordinate with HIV care and treatment. Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi- call, Insurance Marketplace, OA-Care HIPP, etc.) Link patient to non-medical case management, medical case management to assist with benefits counseling, transportation, housing, etc. to help patient remain in care and treatment. Link high-risk HIV positive EIS populations to support services (i.e., mental health, medical case management, house, etc.) to maintain in HIV care and treatment. Participate in bi-weekly clinic care team case conferencing to ensure linkage and coordinate care for patient.	1, 2, & 3	03/01/24- 02/28/25	
Element #4: EIS staff will utilize evidence-based strategies and activities to reach high risk MSM HIV community. These include but are not limited to: **Activities:** Developing and using outreach materials (i.e., flyers, brochures, website) that are culturally and linguistically appropriate for high risk communities-Utilizing the Social Networking model	1, 2, & 3	03/01/24- 02/28/25	

asking HIV + individuals and high risk HIV negative individuals to recruit their social contacts for HIV testing and linkage to care services.			
Element #5: EIS staff will work with HIV Testing & Counseling Services to bring newly diagnosed individuals from communities of color to Partner Services and HIV treatment and care at DOPH- HIV/STD as well as other HIV care and treatment facilities throughout Riverside County. **Activities:** EIS staff will meet with DOPH Prevention on a weekly basis to exchange information on newly diagnosed patients ensuring that the person is referred to EIS and linked to HIV care and treatment within 30 days or less Senior Communicable Disease Specialist (CDS) will review all data elements to ensure linkage and retention of patient.	1, 2, & 3	03/01/24- 02/28/25	
Element #6: EIS staff will coordinate with local HIV prevention /outreach programs to identify target outreach locations and identify individuals not in care and avoid duplication of outreach activities. **Activities:** EIS staff will coordinate with prevention and outreach programs within the TGA to strategically plan service areas to serve. EIS staff will work with the DOPH-Surveillance unit to target areas in need of services.	1, 2, & 3	03/01/24- 02/28/25	
Element #7: EIS staff will assist patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-Cal, Insurance Marketplace, OA Care HIPP, etc.).	1, 2, & 3	03/01/24- 02/28/25	

EIS staff will coordinate with non-medical case management services to assist with benefits counseling and rapid linkage to care and support services.			
Element #8: Senior CDS and Clinic Supervisor will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activities:** Senior CDS and Clinic Supervisor will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards. Training to be obtaining through the AIDS Education and Training Center on a semi-annual basis. Training elements will be incorporated into policies/plans for the department.	1, 2, & 3	03/01/24- 02/28/25	
Element #9: EIS Staff will utilize standardized, required documentation to record encounters and progress. **Activities:** EIS staff will maintain documentation on all EIS encounters/activities including demographics, patient contacts, referrals, and follow-up, Linkage to Care Documentation Logs, Assessment and Enrollment Forms and Reporting Forms in each patient's chart. Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators, continuum of care data and provide opportunities for improvement in care and services,	1, 2, & 3	03/01/24- 02/28/25	

improve desired patient outcomes and results can be used to develop and recommend “best practices.			