SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE	
Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Case Management – Non-Medical
Service Goal:	Facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals.
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 23/24 TOTAL
Number of Clients	0	0	1601	0	48	76	**1725**
Number of Visits = Regardless of number of transactions or number of units	0	0	9708	0	104	1188	**11000**
Number of Units = Transactions or 15 min encounters	0	0	28983	0	396	621	**30000**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Initial assessment of service needs; **Element #2:** Initial and ongoing assessment of acuity level; and **Element #6:** Ongoing assessment of the client's and other key family members' needs and personal support systems. **Activities:** Screening for Payer of Last Resort with support from on-site central registration; Through communication via email, phone or in-person sessions, working collaboratively with client to identify need for services and providing guidance and assistance in improving access to needed services. Referring clients to co-located (to include shared electronic health records) with medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as food, housing, transportation and psychosocial support programs; and Referring clients to needed services provided by community referral partners.	3,5,6	03/01/23-02/29/24	• Eligibility documentation complete at least every six months. • Needs Assessment results in ARIES and dates and content of changes noted a well as record of communication dates and type. • Progress notes in ARIES. • Referrals documented in Progress Notes, ARIES and electronic health records (EHR). • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners

SCOPE OF WORK for Program Year 2022-23

Element #3: Development of a comprehensive, individualized care plan;	3,5,6	03/01/23-02/29/24	• Care plan documented in ARIES. • Treatment adherence counseling documented in ARIES.

Element #4: Continuous client monitoring to assess the efficacy of the care plan; **Element #5:** Re-evaluation of the care plan at least every 6 months with adaptations as necessary; **Element #7:** Provide education, advice and assistance in obtaining medical, social, community, legal, financial (e.g. benefits counseling), and other services; **Element #8:** Discuss budgeting with clients to maintain access to necessary services; and **Element #10:** 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.). **Activities:** In alignment with client's needs, barriers to care, eligibility, motivation and capacity, developing an ISP with goals and objectives signed by both the client and case manager to indicate commitment to implementation; Ensuring shared access to EHR and electronic dental records (EDR); Reviewing health indicators to include medical visits and viral load; and Updating Care Plan as needed in collaboration with client.			• Benefits counseling documented in ARIES. • Progress notes in ARIES. • Insurance status documented in ARIES and proof of insurance on record. • Quality Improvement Plan.
Element #9: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	3,5,6	03/01/23-02/29/24	• Case Conference logs. • ARIES Progress Notes.
Element #11: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing care compatible with client culture, health beliefs, practices, preferred language, and reflecting and respecting gender and sexual diversity of community served; Recruiting, retaining and promoting 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 retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/23-02/29/24	• 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. • 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.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE	
Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Emergency Financial Assistance (EFA)
Service Goal:	The overall goal of Emergency Financial Assistance is to prevent negative client outcomes as a result of emergency financial difficulties and to assist the client in securing s financially stable living situation.
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 23/24 TOTAL
Number of Clients	0	0	25	0	5	5	**35**
Number of Visits = Regardless of number of transactions or number of units	0	0	25	0	5	5	**35**
Number of Units = Transactions or 15 min encounters	0	0	175	0	35	355	**565**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Direct payment to an agency. **Element #2:** Current local limit = Maximum of three months to pay their utility bills (electricity, water, gas). **Activities:** Ensuring funds are not in the form of direct cash payments to recipients or services; and ensuring shared access to EHR to monitor medical visits and viral load as well as living situation/housing status.	3,5,6	03/01/23-02/29/24	• Service deliveries in ARIES. • Completed RW Emergency Financial Assistance Referral Form. • Check and/or utility bill requests and cancelled checks and/or utility bill from vendor.

SCOPE OF WORK for Program Year 2022-23

Element #3: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L	3,5,6	03/01/23-02/29/24	• 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.

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 retaining 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.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – MAI

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
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 23/24 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 23/24 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 23/24 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	03/01/23-02/29/24	• 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	03/01/23-02/29/24	• 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	03/01/23-02/29/24	• 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	03/01/23-02/29/24	• 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.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
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 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.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 23/24 TOTAL**
Number of Clients	0	0	100	0	40	49	**189**
Number of Visits = Regardless of number of transactions or number of units	0	0	1000	0	330	400	**1730**
Number of Units = Transactions or 15 min encounters	0	0	3000	0	500	550	**4050**

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

SCOPE OF WORK for Program Year 2022-23

Element #1: Identify/locate HIV+ unaware 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	3, 5, 6	03/01/23-02/29/24	• 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.).

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.			• 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 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	3,5,6	03/01/23-02/29/24	• EIS logs and Counseling Information Forms. • Records showing positivity rate of 1.1% or higher for targeted testing. • 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 provided 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	3,5,6	03/01/23-02/29/24	• 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.

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.			• Functions of EpicCare and LEO customized to record required data and generate reports.
Element #13: N/A			
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 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.	3,5,6	03/01/23-02/29/24	• 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. • 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.

SCOPE OF WORK for Program Year 2022-23

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Food Services
Service Goal:	Supplement eligible HIV/AIDS consumer's financial ability to maintain continuous access to adequate caloric intake and balanced nutrition sufficient to maintain optimal health in the face of compromised health status due to HIV infection in the TGA.
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 23/24 TOTAL**
Number of Clients	0	0	545	0	15	40		**600**
Number of Visits = Regardless of number of transactions or number of units	0	0	6540	0	180	600		**7320**
Number of Units = Transactions or 15 min encounters	0	0	32700	0	900	3000		**36600**

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

SCOPE OF WORK for Program Year 2022-23

Element #1: Food vouchers, actual food, and/or hot meals; **Element #2:** Licensure and Food Handling certification required if applicable; and **Element #3:** Current local limit = $50 per client per month. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Renewing food handling certification; Distributing food vouchers once a month on a regular basis, and as needed for emergency assistance, ensuring that every client receives an equal number of food vouchers each month; Securing vouchers from an accessible grocery store chain making every effort to purchase quantities that provide for discounts; Case Conferencing; Co-locating with case managers support review of health indicators to include medical visits and viral load; Ensuring shared access to electronic health records (EHR) and electronic dental records (EDR); Referring clients to co-located (to include shared electronic health records) with	3,5,6	03/01/23-02/29/24	• Eligibility documentation is completed at least every six months. • Current Food Handler license from the County of Riverside Department of Environmental Health. • Food voucher eligibility lists are produced monthly. • Food voucher distribution receipts. • Invoices showing discount from Stater Bros. • Service deliveries in ARIES. • Case Conference logs. • Referrals documented in Progress Notes, ARIES and EHR. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners.

medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as housing, transportation and case management; and Referring clients to needed services provided by community referral partners.			
Element #4: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 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 retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/23-02/29/24	• 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. • 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.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Home & Community-Based Health Services
Service Goal:	To keep consumers out of inpatient hospitals, nursing homes, and other long-term care facilities as long as possible during illness.
Service Health Outcomes:	Reduction in inpatient, nursing home, long-term care instances; 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 23/24 TOTAL**
Number of Clients	0	0	13	0	5	5	**23**
Number of Visits = Regardless of number of transactions or number of units	0	0	676	0	260	260	**1196**
Number of Units = Transactions or 15 min encounters	0	0	10248	0	768	768	**11784**

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

SCOPE OF WORK for Program Year 2022-23

Element #1: Development of written care plan signed by case manager and clinical health care professional responsible for client's HIV care and indicating need for this service. Care plan must also specify the types of services needed and quantity/duration. **Element #2:** Documentation signed by professional that indicates services provided: types, dates, locations. **Element #3:** Address the medical, social, mental health, and environmental needs. **Element #4:** On-going activities to promote self-reliance. **Element #5:** Assist client in becoming actively engaged in their health care. **Element #6:** Assist with referrals and linkages to needed services. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Maintaining, and	3,5,6	03/01/23-02/29/24	• Eligibility documentation complete at least every six months. • Care plan signed by case manager and clinical health care professional responsible for client's HIV care and indicating need for this service, the types of services needed and quantity/duration. • Chart notes documenting types, dates and locations of services provided. • Needs Assessment and home care plan in ARIES and/or paper charts. • Health indicator trends/flowsheets/reports. • Case Conference logs. • Quality Improvement Plan. • Employment records.

documenting in, paper charts and/or ARIES; Establishing initial assessment to include assessing needs and evaluating home environment; Developing home care plan to include activities to promote self-reliance and self-management; Co-locating (to include shared electronic health records) with medical clinic, dental clinic, behavioral health and social services including case management and early intervention teams; Maintaining community referral partners; Case Conferencing; Tracking of hospitalization records, medical visits, viral loads, and assessment tools/outcomes; Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.			• MOUs/Contracts/Agreements/Letters of support from partners. • Hospitalization records • Medical visits • Viral loads
Element #7: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and update as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/23-02/29/24	• 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. • Race, ethnicity and language proficiency recorded in ARIES. • Staff language proficiency survey results. • "Interpreter Needed" alert in electronic health record (EHR) as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED GRANT AND SERVICE	
Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Housing Services
Service Goal:	To provide shelter, on an emergency or temporary basis, to eligible clients throughout the TGA at risk for homelessness or with unstable housing to ensure that they have access to and/or remain in medical care.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate; Improve stable housing rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 23/24 TOTAL**
Number of Clients	0	0	415	0	15	25	**455**
Number of Visits = Regardless of number of transactions or number of units	0	0	4,980	0	60	300	**5340**
Number of Units = Transactions or 15 min encounters	0	0	9960	0	360	600	**10920**

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

SCOPE OF WORK for Program Year 2022-23

Element #1: Housing Case Management: Housing referral services defined as assessment, search, placement, and advocacy services must be provided by case managers or other professional(s) who possess a comprehensive knowledge of local, state, and federal housing programs and how these programs can be accessed. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Collaborating with client to identify need for services and conducting searches on behalf of client for best match; Reviewing client's eligibility for local, state, federal and private sources of housing assistance and assist with applications or renewals for enrollment; Offering counseling, self-management strategies, training, and education that will support client's housing stability; Referring to needed services provided by community partners to	3,5,6	03/01/23-02/29/24	• Eligibility documentation complete at least every six months. • Housing Needs Assessment results in client chart. • Housing Plan available for review including causes of housing crises and a strategy to identify, relocate and/or ensure progress towards long-term, stable housing or a strategy to identify an alternate funding source for housing assistance • Progress notes in ARIES. • Referrals documented in Progress Notes and/or ARIES. • Housing status recorded in ARIES. • Case Conference logs. • Employment records.

include, shelters, transitional housing, sober living, and group quarters that have supportive environments; Case Conferencing; Ensuring shared access to electronic health records (EHR) to monitor medical visits and viral load as well as living situation/housing status; and Referring to co-located medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as food, transportation and case management as needed.			• MOUs/Contracts/Agreements/Letters of support from partners. • Quality Improvement Plan.
Element #2: Housing Services (financial assistance): Short-term or emergency housing defined as necessary to gain or maintain access to medical care; and **Element #3:** Current local limit = 90 days per client per grant year. **Activities:** Ensuring funds are not in the form of direct cash payments to recipients or services; and Ensuring shared access to EMR to monitor medical visits and viral load as well as living situation/housing status.	3,5,6	03/01/23-02/29/24	• Service deliveries in ARIES. • Completed RW Emergency Housing Assistance/Referral Form. • Check requests and cancelled checks to/from motels, landlords, etc.
Element #4: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 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 retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/23-02/29/24	• 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. • 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.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Medical Case Management
Service Goal:	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 test results receive intense care coordination assistance to support participation in HIV medical care. MCM services are best delivered when co-located in facilities that provide HIV/primary medical care.
Service Health Outcomes:	Improved retention in care (at least 1 medical visit in each 6-month period), Improved 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 23/24 TOTAL**
Number of Clients	0	0	535	0	8	57	**600**
Number of Visits = Regardless of number of transactions or number of units	0	0	4240	0	32	228	**4500**
Number of Units = Transactions or 15 min encounters	0	0	10510	0	128	912	**11550**

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	**SERVICE AREA**	**TIMELINE**	**PROCESS OUTCOMES**
Element #1: Initial assessment of the client's service needs; **Element #7:** Ongoing assessment of the client's and other key family members' needs and personal support systems; and **Element #9:** Client-specific advocacy and/or review of utilization of services. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; and Through communication via email, phone or in-person sessions, working collaboratively with client to identify need for services that would alleviate or remove barriers and support engagement in care.	3,5,6	03/01/23-02/29/24	• Eligibility documentation complete at least every six months. • Needs Assessment results in ARIES and dates and content of changes noted a well as record of communication dates and type. • Progress notes in ARIES.

SCOPE OF WORK for Program Year 2022-23

Element #2: Development of a comprehensive Individualized Care Plan (ICP) with the client;	3,5,6	03/01/23-02/29/24	• ICP documented in ARIES. • Treatment adherence counseling documented in ARIES. • Benefits counseling documented in ARIES.

Element #5: Continuous client monitoring to assess the efficacy of the care plan; **Element #6:** Re-evaluation of the care plan at least every 6 months with adaptations as necessary; **Element #8:** Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and **Element #11:** 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.). **Activities:** In alignment with client's needs, barriers to care, eligibility, motivation and capacity, developing an ISP with goals and objectives signed by both the client and case manager to indicate commitment to implementation; Ensuring shared access to electronic health records (EHR) and electronic dental records (EDR); Reviewing health indicators to include medical visits and viral load; and Updating ICP and Care Plan as needed in collaboration with client.			• Progress notes in ARIES. • Insurance status documented in ARIES and proof of insurance on record. • Quality Improvement Plan.
Element #3: Timely and coordinated access to medically appropriate levels of health and support services and continuity of care; **Element #4:** Coordination and follow-up of medical treatments; and **Element #12:** Provide or refer clients for advice, support, counseling on topics surrounding HIV disease, treatments, medications, treatment adherence education, caregiver bereavement support, dietary/nutrition advice and education, and terms and information needed by the client to effectively participate in his/her medical care. **Activities:** Co-locating (to include shared electronic health records) with medical clinic, dental clinic, behavioral health, early intervention programs and other social services; Maintaining community referral partners; Providing referrals and advocacy for linkage to needed services; and Maintaining ongoing communication with community partners and internal departments receiving referrals.	3,5,6	03/01/23-02/29/24	• Referrals and outcomes documented in Progress Notes, ARIES and EHR. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners.
Element #10: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	3,5,6	03/01/23-02/29/24	• Case Conference Attendance Logs. • ARIES Progress Notes.
Element #13: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 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	3,5,6	03/01/23-02/29/24	• 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. • Race, ethnicity and language proficiency recorded in ARIES. • Staff language proficiency survey results.

client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• "Interpreter Needed" alert in EHR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Medical Transportation Services
Service Goal:	To enhance clients' access to health care or support services using multiple forms of transportation throughout the TGA.
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 23/24 TOTAL
Number of Clients	0	0	739	0	62	149	**950**
Number of Visits = Regardless of number of transactions or number of units	0	0	3436	0	620	1596	**5652**
Number of Units = Transactions or 15 min encounters	0	0	8868	0	744	1428	**11040**

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

SCOPE OF WORK for Program Year 2022-23

Element #1: Bus pass (monthly pass only when justified, otherwise day pass); **Element #2:** Gasoline vouchers; **Element #3:** Van trip; **Element #4:** Urgent taxi trip; **Element #5:** Collect and maintain data to document that funds are used only for medical appointments and to obtain support services to maintain participation in medical care (origin, destination, method, etc.); and **Element #6:** Restricted to pick-up and drop-off points within the TGA. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Educating clients on how to fill out mileage logs to document eligible mileage including purpose, starting point, destination, and signature of medical or social service provider visited; Ensuring that no cash payments are made to clients by securing gas cards from locally accessible gas station chain; Case Conferencing; Co-locating	3,5,6	03/01/23-02/29/24	• Eligibility documentation is completed at least every six months. • Mileage logs. • Invoices and check requests and cancelled checks to/from Valero. • Service deliveries in ARIES. • Case Conference logs. • Referrals documented in Progress Notes. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners. • Medical visits. • Viral loads.

with case managers to support review of health indicators to include medical visits and viral load; Ensuring shared access to electronic health records (EHR); Referring clients to co-located medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as housing, food and case management; and Referring clients to needed services provided by community referral partners.			
Element #7: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 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 retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/23-02/29/24	• 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. • 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.

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – PART A

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Oral Health Care
Service Goal:	Improve or maintain the oral health of HIV+ clients throughout the TGA to sustain proper nutrition and positive health outcomes.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate; Improve oral health.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 23/24 TOTAL**
Number of Clients	0	0	464	0	15	30		**509**
Number of Visits = Regardless of number of transactions or number of units	0	0	1920	0	58	122		**2100**
Number of Units = Transactions or 15 min encounters	0	0	9280	0	232	488		**10000**

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

SCOPE OF WORK for Program Year 2022-23

Element #1: Comprehensive oral exam; **Element #2:** Development/update of a treatment plan; **Element #3:** Development of oral hygiene plan; **Element #4:** Treatment visit; **Element #5:** Preventive visit; and **Element #6:** Emergency care visit. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Maintenance of, and documentation in, electronic dental record (EDR) customized to track all required data and generate reports; Conducting oral X-rays; Providing initial, follow-up and urgent care appointments; Co-locating (to include shared electronic health records) with medical and other social services including case management and early intervention teams; Case Conferencing; Tracking of medical visits, viral loads, and reduction non-	3,5,6	03/01/23-02/29/24	• Eligibility documentation complete at least every six months. • Progress notes and radiographs in EDR. • Diagnoses and procedure codes, treatment plan signed by client, oral hygiene plans, prescriptions, medical history, lab orders/results, referrals in EDR. • Past and future appointment history in EDR. • Health indicator trends/flowsheets/reports. • Case Conference logs. • Quality Improvement Plan. • Employment records.

preventative visit rate; Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.			
Element #7: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 diverse staff and management representative of the demographic characteristics of the service area; Reviewing C&L Competency Plan annually and update as needed; Assessing C&L Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.	3,5,6	03/01/23-02/29/24	• 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. • Race, ethnicity and language proficiency recorded in ARIES. • Staff language proficiency survey results. • "Interpreter Needed" alert in EDR as well as accounting of payment to interpretive service vendors. • Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	Psychosocial Support Services
Service Goal:	To provide psychosocial support services to persons living with HIV/AIDS in the TGA to maintain them in the HIV system of care.
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 23/24 TOTAL
Number of Clients	0	0	72	0	5	5		**82**
Number of Visits = Regardless of number of transactions or number of units	0	0	3744	0	260	260		**4264**
Number of Units = Transactions or 15 min encounters	0	0	14976	0	1040	1040		**17056**

SCOPE OF WORK for Program Year 2022-23

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Initial individual needs assessment; **Element #2**: Individual support/counseling session; **Element #3:** Group support/counseling session. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Through one-on-one sessions, working collaboratively with the client to identify need for services that would support engagement in care and prevent falling out of care; Providing counseling regarding the emotional and psychological issues related to living with HIV and to promote problem solving, service access, and steps towards diseases self-management; Providing peer, volunteer, and staff-led groups on a regular schedule various days a week; Case Conferencing; Co-locating with case managers to support review of health indicators to include medical visits and viral load as well as reduced incidence of becoming aware but not in care (unmet need); Ensuring shared access to electronic health records (EHR); Referring clients to co-located medical clinic, dental clinic, early intervention programs and other social services such as housing, food and case management; and Referring clients to needed services provided by community referral partners.	3,5,6	03/01/23-02/29/24	• Eligibility documentation complete at least every six months. • Needs Assessment in ARIES. • Service deliveries in ARIES. • Case Conference logs. • Progress Notes in ARIES. • Published group schedules. • Attendance Logs. • Documentation of topics/focus, group duration, group type (open/closed), general group goals. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners. • Quality Improvement Plan.
Element #4: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	3,5,6	03/01/23-02/29/24	• Case Conference logs. • ARIES Progress Notes.
Element #5: Referral to mental health professional. **Activities:** Employing referral specialist to navigate insurance; Maintaining co-located substance abuse specialists, psychiatrists and therapists; and Maintaining relationship with community partners.	3,5,6	03/01/23-02/29/24	• Progress notes in EHR, ARIES and/or paper charts. • Employment records. • MOUs/Contracts/Agreements/Letters of support from partners.
Element #6: Services are provided based on Cultural and Linguistic (C&L) Competency Standards. **Activities:** Enrolling staff in annual C&L Competency training; Providing 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 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	3,5,6	03/01/23-02/29/24	• 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. • Race, ethnicity and language proficiency recorded in ARIES.

Competency and reflectiveness of client and target populations; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			• 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.