SCOPE OF WORK – MAI
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:	**MAI EARLY INTERVENTION SERVICES**
Service Goal:	Quickly link HIV infected individuals from communities of color (African American and Latinos) 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

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	100	55	20	0	0	0		**175**
Number of Visits = Regardless of number of transactions or number of units	125	65	35	0	0	0		**225**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	175	122	78	0	0	0		**375**
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	100	55	20	0	0	0		**175**
Number of Visits= Regardless of number of transactions or number of units	125	65	35	0	0	0		**225**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	175	122	78	0	0	0		**375**

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	200	110	40	0	0	0	**350**
Number of Visits = Regardless of number of transactions or number of units	250	130	70	0	0	0	**450**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	350	244	156	0	0	0	**750**

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: Connect/reconnect HIV infected individuals into care utilizing the "Bridge" program as the model. Activities: -MAI EIS staff will work with grass-roots community-based and faith-based agencies, local churches, and other non-traditional venues to reach targeted communities of color (African American and Latino 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. -MAI 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. -MAI 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.	1, 2, & 3	03/01/24-02/28/25	▪ MAI/EIS schedules and logs ▪ MAI/EIS Encounter Logs ▪ Linkage to Care Documentation Logs ▪ Assessment and Enrollment Forms ▪ Reporting Forms ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ▪ ARIES Reports

Element #2: Conduct in depth, one-on-one encounters that are planned and delivered in coordination with local HIV prevention outreach program to avoid duplicate efforts. Activities: -EIS MAI staff will coordinate with HIV Care and Treatment facilities who link patient to care within 30 days or less. -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.	1, 2, & 3	03/01/24-02/28/25	
Element #3: Re-linking HIV patients that have fallen out of care. Perform follow-up activities to ensure linkage to care. Activities: -Link patient 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-Cal, 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 MAI 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: MAI EIS staff will utilize evidence-based strategies and activities to reach African American and Hispanic/Latino HIV community. These include but are not limited to: Activities: -Developing and using outreach materials (i.e., flyers, brochures, website), focus groups, and surveys that are culturally and linguistically appropriate for African American and Hispanic/Latino communities. -Researching and utilizing the *Bridge* model asking HIV + individuals and high-risk HIV negative individuals to recruit their social contacts for HIV testing and linkage to care services.	1, 2, & 3	03/01/24-02/28/25	
Element #5: MAI 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.	1, 2, & 3	03/01/24-02/28/25	

Activities: MAI EIS staff will meet with DOPH Prevention on a weekly basis to exchange information on newly diagnosed ensuring that the person is referred to EIS MAI and in 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.			
Element #6: MAI 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: -MAI EIS staff will coordinate with prevention and outreach programs within the TGA to strategically plan service areas to serve. -MAI 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: MAI 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.). Activities: -MAI EIS staff will coordinate with non-medical case management services to assist with benefits counseling and rapid linkage to care and support services.	1, 2, & 3	03/01/24-02/28/25	