

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	
Contractor:	TruEvolution, Inc.
Grant Period:	March 1, 2023 – February 28, 2024
Service Category:	Housing Services
Service Goal:	To provide shelter and housing related referral services, 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:	<ul style="list-style-type: none"> • Improve retention in care (at least 1 medical visit in each 3-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
Proposed Number of Clients	6	2	N/A	1	1	N/A		10
Proposed Number of Visits = Regardless of number of transactions or number of units	12	4	N/A	2	2	N/A		20
Proposed Number of Units = One day of Housing (See Attachment P)	16	16	N/A	5	5	N/A		42
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								

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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
<p>Activities:</p> <ul style="list-style-type: none"> • 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. • Housing Services (financial assistance): Short-term or emergency housing defined as necessary to gain or maintain access to medical care • Current local limit = 90 days per client per grant program year • Services are provided based on established C&L Competency Standards. 	SA1, SA2, SA4 and SA5	03/01/23-02/28/24	<p>We will use the following outcome indicators to measure either aspect 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"> - Linkages to HIV Medical Care – 90% - HIV Viral Load Suppression – 90% - Housing Status – 90% <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>

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE
CATEGORY

Contract Number:	<i>Leave Blank</i>
Contractor:	TruEvolution, Inc.
Grant Period:	March 1, 2023 – February 28, 2024
Service Category:	Non-Medical Case Management
Service Goal:	Facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals.
Service Health Outcomes:	<ul style="list-style-type: none"> • Improve retention in care (at least 1 medical visit in each 6-month period) • Improve viral suppression rate

	SA1	SA2	SA3	SA4	SA5	SA6	FY	
	West Riv	Mid Riv	East Riv	San B	San B	San	23/24	
				West	East	B	TOTAL	
						Des		
						ert		
Proposed Number of Clients	15	9	N/A	3	3	N/A		30
Proposed Number of Visits = Regardless of number of transactions or number of units	15	9	N/A	3	3	N/A		30

Proposed Number of Units = Transactions or 15 min encounters (See Attachment P)	120	72	N/A	27	27	N/A		246
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Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted	Open/Group Length	Expected Population per Week	Session Closed Duration (hours)	Sessions Avg. Attend. per Session	Outcome Measures
N/A							
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Activities: <ul style="list-style-type: none"> Initial assessment of service needs Initial and ongoing assessment of acuity level Development of a comprehensive, individualized care plan Continuous client monitoring to assess the efficacy of the care plan Re-evaluation of the care plan at least every 6 months with adaptations as necessary Ongoing assessment of the client's and other key family members' needs and personal support systems Provide education, advice, and assistance in obtaining medical, social, community, legal, financial (e.g., benefits counseling), and other services Discuss budgeting with clients to maintain access to necessary services Case conferencing with Medical Case Management Staff on behalf of the client 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.). Services are provided based on established C&L Competency Standards 	SA1, SA2, SA4 and SA5	03/01/23 - 02/28/24	<p>We will use the following outcome indicators to measure either aspect 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"> HIV Viral Load Suppression – 90% <p>Benchmark rates will be recorded at the beginning of the cycle and there after every three months to determine areas in need of improvement.</p>

SCOPE OF WORK – MAI

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	<i>Leave Blank</i>
Contractor:	TruEvolution, Inc.
Grant Period:	March 1, 2023 – February 28, 2024
Service Category:	Early Intervention Services (MAI)
Service Goal:	Quickly link high risk individuals and “unaware” 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:	<ul style="list-style-type: none"> - Link new diagnosed HIV+ to HIV Medical Care - (Appointment scheduled w/24 hours for an appointment w/in 72 hours) - Retention in medical care (at least two medical visits in a 12-month period) and - Improved or maintained viral load suppression rates.

BLACK / AFRICAN AMERICAN

SA1
West

SA2
Mid

SA3
East

SA4
San
B

SA5
San
B

SA6
San
B

FY
23/24

	Riv	Riv	Riv	We st	Ea st	Des ert		TOTA L
Number of Clients	25	25	N/A	25	25	N/A		100
Number of Visits = Regardless of number of transactions or number of units	25	25	N/A	25	25	N/A		100
Proposed Number of Units = Transactions or 15 min encounters (See Attachment P)	25	25	N/A	25	25	N/A		100
HISPANIC / LATINO	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B We st	SA5 San B Ea st	SA6 San B Des ert		FY 23/24 TOTA L
Number of Clients	25	25	N/A	25	25	N/A		100
Number of Visits = Regardless of number of transactions or number of units	25	25	N/A	25	25	N/A		100
Proposed Number of Units = Transactions or 15 min encounters (See Attachment P)	25	25	N/A	25	25	N/A		100
TOTAL MAI (sum of two tables above)	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B We st	SA5 San B Ea st	SA6 San B Des ert		FY 23/24 TOTA L
Number of Clients	50	50	N/A	50	50	N/A		200
Number of Visits = Regardless of number of transactions or number of units	50	50	N/A	50	50	N/A		200
Proposed Number of Units = Transactions or 15 min encounters (See Attachment P)	50	50	N/A	50	50	N/A		200

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
Activities: <ul style="list-style-type: none"> Identify/locate HIV+ unaware and HIV+ that have fallen out of care Provide testing services and/or refer high-risk unaware to testing One-on-one encounters Coordination with local HIV prevention programs Identify and problem-solve barriers to care Provide education/information regarding availability of testing and HIV care services to HIV+, those at-risk, those affected by HIV, and caregivers No HIV prevention education. Referrals to testing, medical care, support services Follow-up activities to ensure linkage 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 Utilize standardized, required documentation to record encounters, progress Maintain up-to-date, quantifiable data to report and evaluate service. Maintain services based on C&L Competency Standards 	SA1, SA2, SA4 and SA5	03/01/23-02/28/24	<p>We will use the following outcome indicators to measure either aspect 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"> Linkages to HIV Medical Care – 90% HIV Viral Load Suppression – 90% <p>Benchmark rates will be recorded at the beginning of the cycle and there after every three months to determine areas in need of improvement.</p>

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CATEGORY

Contract Number:	<i>Leave Blank</i>
Contractor:	TruEvolution, Inc.
Grant Period:	March 1, 2023 – February 28, 2024
Service Category:	Early Intervention Services (EIS)
Service Goal:	Quickly link high risk individuals and “unaware” HIV infected individuals to testing services 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:	<ul style="list-style-type: none"> - Link new diagnosed HIV+ to HIV Medical Care - (appointment scheduled w/24 hours for an appointment w/in 72 hours) - Retention in medical care (at least two medical visits in a 12-month period) and - Improved or maintained viral load suppression rates.

	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Des ert	FY 23/24 TOTAL
Proposed Number of Clients	200	100	N/A	100	100	N/A	500
Proposed Number of Visits = Regardless of number of transactions or number of units	200	100	N/A	100	100	N/A	500
Proposed Number of Units = Transactions or 15 min encounters (See Attachment P)	200	100	N/A	100	100	N/A	500

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. Duration per Session	Session Length	Sessions per Week (hours)	Group	Outcome Measures
· N/A								
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*Goal numbers for clients, visits, and units may be impacted due to the current COVID-19 pandemic.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AR EA	TIMELINE	PROCESS OUTCOMES
Activities: <ul style="list-style-type: none"> • Identify/locate HIV+ unaware and HIV+ that have fallen out of care • Provide testing services and/or refer high-risk unaware to testing • One-on-one encounters • Coordination with local HIV prevention programs • Identify and problem-solve barriers to care • Provide education/information regarding availability of testing and HIV care services to HIV+, those at-risk, those affected by HIV, and caregivers • No HIV prevention education. • Referrals to testing, medical care, support services • Follow-up activities to ensure linkage • Reconnect those that have fallen out of care • 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 • Utilize standardized, required documentation to record encounters, progress • Maintain up-to-date, quantifiable data to report and evaluate service. • Maintain services based on C&L Competency Standards 	SA1, SA2, SA4 and SA5	03/01/23 - 02/28/24	<p>We will use the following outcome indicators to measure either aspect 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"> - Linkages to HIV Medical Care – 90% - HIV Viral Load Suppression – 90% <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>