SCOPE OF WORK – PART A / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
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.
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	4	4	392	4	4	13	**421**	**421**
Number of Visits = Regardless of number of transactions or number of units	17	17	1570	17	17	51	**1689**	**1689**
Number of Units = Transactions or 15 min encounters	38	38	3532	38	38	114	**3798**	**3798**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

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.	All	03/01/19-02/29/20	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.
Element #2: Development of a comprehensive Individualized Service Plan (ISP) with the client; **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 medical records (EMR) and electronic dental records (EDR); Reviewing health indicators to include medical visits and viral load; and Updating ISP and Care Plan as needed in collaboration with client.	All	03/01/19-02/29/20	ISP documented in ARIES. Treatment adherence counseling documented in ARIES. Benefits counseling documented in ARIES. 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 medical 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;	All	03/01/19-02/29/20	Referrals and outcomes documented in Progress Notes, ARIES and EMR. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.
and Maintaining ongoing communication with community partners and internal departments receiving referrals.			
Element #10: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	All	03/01/19-02/29/20	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 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.	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
Service Category:		Emergency Financial Assistance (EFA)
Service Goal:		To provide emergency financial assistance on a limited one-time and/or short-term, up to three months, utility payment assistance, to eligible clients throughout the TGA at risk for unstable and/or shut-off of utility(s) to ensure that clients 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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	0	0	20	0	0	15	**35**	**8**
Number of Visits = Regardless of number of transactions or number of units	0	0	20	0	0	15	**35**	**24**
Number of Units = Transactions or 15 min encounters	0	0	80	0	0	60	**140**	**360**

Recalculation of client-staff interaction/transactions time and effort. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Emergency Financial Assistance (EFA): EFA 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 EFA 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 EFA assistance and assist with applications or renewals for enrollment; Offering counseling, self-management strategies, training, and education that will support client's utility stability; Referring to needed services provided by community partners to include, shelters, transitional housing, sober living, and group quarters that have supportive environments; Case Conferencing; Ensuring shared access to electronic medical records (EMR) to monitor medical visits and viral load as well as living situation/housing and utility 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.	3,6l	03/01/19-02/29/20	Eligibility documentation complete at least every six months. Housing and EFA Needs Assessment results in client chart. Housing and EFA Plan available for review including causes of utility crises and a strategy to identify, and/or ensure progress towards long-term stability or a strategy to identify an alternate funding source for utility assistance Progress notes in ARIES. Referrals documented in Progress Notes and/or ARIES. Housing and Utility status recorded in ARIES. Case Conference logs. Employment records. MOUs/Contracts/Agreements/Letters of support from partners. Quality Improvement Plan.

Element #2: Emergency Financial Assistance (EFA): Short-term or emergency utility defined as necessary to gain or maintain access to medical care; and **Element #3:** Current local limit = Limited one-time and/or short-term, up to three months, per client per grant program year.	3,6l	03/01/19-02/29/20	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.

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.			
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.	3,6	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	5	15	463	1	2	23	**509**	**509**
Number of Visits = Regardless of number of transactions or number of units	20	57	1705	3	6	85	**1876**	**1876**
Number of Units = Transactions or 15 min encounters	80	227	6818	11	23	341	**7500**	**7500**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
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 medical 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-preventative visit rate; Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.	All	03/01/19-02/29/20	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.

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.	All	03/01/19-02/29/20	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 / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
Service Category:	Mental Health Services
Service Goal:	Minimize crisis situations and stabilize HIV+ clients' mental health status to maintain clients in the care system.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period); Improve viral suppression rate; Improved or maintained CD4 cell count; Decreased level of depression post 12 individual sessions; Decreased level of anxiety post 12 individual sessions; Clinically significant increase in their Global Assessment of Functioning (or equivalent) score post 12 individual sessions.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	1	1	11	1	1	1	**16**	**16**
Number of Visits = Regardless of number of transactions or number of units	1	6	81	1	1	6	**96**	**96**
Number of Units = Transactions or 15 min encounters	1	31	432	1	1	31	**497**	**497**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

Group Name and Description	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
Depression /Anxiety Support Solution	SA3	Including but not limited to PLWHA struggling with a range of Depressive & Anxiety Disorders	Open	10	1.5	1	Ongoing	Group Agenda; Treatment Plan Documented for Attendees; Access to Medical Care; stabilized or improved mental health.
Dialectical Behavior Therapy (DBT) Basics Group	SA3	PLWHA struggling with mental health disorders.	Closed	8	1.5	1	Ongoing	Group Agenda; Treatment Plan Documented for Attendees; Access to Medical Care; stabilized or improved mental health.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Initial individual mental health assessment (documented mental health diagnosis); **Element #2**: Development of care/treatment plan**;** **Element #3**: Tracking of individual progress; **Element #4**: Individual counseling session; **Element #7:** Psychiatric assessment/evaluation session; and **Element #8:** Psychiatric medications management session. **Activities:** Screening for Payer of Last Resort with support from on-site central registration team; Providing initial and follow-up appointments; Maintaining, and documenting in, paper charts and/or electronic medical record (EMR) customized to track all required data and generate reports; Maintaining pharmacy referral partner; Co-locating (to include shared electronic medical records) with medical clinic and social services including case management and early intervention teams; Case	All	03/01/19-02/29/20	Eligibility documentation complete at least every six months. Past and future appointment history in EMR, ARIES and/or paper charts. Progress notes, diagnoses, risk assessment results, prescriptions, medical history, referrals in EMR, ARIES and/or paper charts. Care plan includes treatment modality, start date, recommended number of sessions, date for reassessment, projected treatment end date, recommendations for follow up, and signature of the mental health professional. Health indicator trends/flowsheets/reports. Case Conference logs.

Conferencing; Tracking of medical visits, viral loads, and assessment tools/outcomes; Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.			Quality Improvement Plan. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.
Element #5: Group counseling session. **Activities:** Providing therapeutic groups on a regular schedule various days a week.	All	03/01/19-02/29/20	Published group schedules. Group Agenda. Attendance charted in client records.
Element #6: Case Conferencing session. **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.	All	03/01/19-02/29/20	Case Conference logs. ARIES Progress Notes.
Element #9: Referral to other mental health professionals. **Activities:** Maintaining, and documenting in, EMR customized to track all required data and generate reports; Employing referral specialist to navigate insurance; and Maintaining co-located specialty services (e.g. Transgender Specialist; Substance Abuse Specialist, etc.) and specialty services partners.	All	03/01/19-02/29/20	Progress notes in EMR, ARIES and/or paper charts. Referral queue in EMR, ARIES and/or paper charts. Results from outside referrals linked to chart and reviewed by provider in EMR, ARIES and/or paper charts. Results from internal referrals documented in EMR, ARIES and/or paper charts. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.
Element #10: 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.	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
Service Category:	Outpatient/Ambulatory Health Services
Service Goal:	To maintain or improve the health status of persons living with HIV/AIDS in the TGA.
Service Health Outcomes:	Linkage of 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); Increase rate of ART adherence; 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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	1	1	3	1	1	1	**8**	**8**
Number of Visits = Regardless of number of transactions or number of units	1	1	3	1	1	1	**8**	**8**
Number of Units = Transactions or 15 min encounters	1	1	27	1	1	1	**32**	**32**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Medical history taking; **Element #2:** Physical examination; **Element #3:** Diagnostic testing, including laboratory testing; **Element #4:** Treatment and management of physical and behavioral health conditions; **Element #5:** Behavioral risk assessment, subsequent counseling, and referral; **Element #6:** Preventive care and screening; **Element #7:** Pediatric development assessment; **Element #8:** Prescription, and management of medication therapy as well as financial assistance for prescription medications; and **Element #9:** Treatment adherence. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Providing initial, follow-up and urgent care appointments; Maintaining, and documenting in, electronic medical record (EMR) to track required data and generate reports; Maintaining laboratory referral partner; Co-locating (to include shared EMR) with behavioral healthcare; Maintaining pharmacy referral partner; Co-locating (to include shared EMR) with Medical Case Management and Early Intervention teams; Case Conferencing; Tracking of new patient linkage (newly diagnosed and returning to care), number of medical visits, prescription of/adherence to ART, viral loads; Employing staff qualified to serve low-income PLWHA.	All	03/01/19-02/29/20	Eligibility documentation complete at least every six months. Past and future appointment history in EMR. Progress notes, diagnoses and procedure codes, treatment plan, risk assessment results, prescriptions, medical history, lab orders/results, and referrals in EMR. Prescription Assistance Eligibility Forms Health indicator trends/flowsheets/reports. Case Conference logs. Quality Improvement Plan. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.
Element #10: Education and counseling on health and prevention issues. **Activities:** Documenting education and counseling provided to client; and Providing referrals to Psychosocial Support Services health education and support groups.		03/01/19-02/29/20	Progress notes in EMR. Attendance Logs for Psychosocial Support Services and other activities in Community Wellness Services department.
Element #11: Referral to and provision of specialty care related to HIV diagnosis. **Activities:** Maintaining, and documenting in, EMR customized to track all required data and generate reports; Employing referral specialist to navigate insurance; and Maintaining co-located specialty services (e.g. Hepatitis C treatment; Transgender Specialist; Psychiatry; Home Health, Dental, etc.) and specialty services partners.		03/01/19-02/29/20	Progress notes in EMR. Referral queue in EMR. Results from outside referrals linked to chart and reviewed by provider in EMR. Results from internal referrals documented in EMR. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.

Element #12: 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,		03/01/19-02/29/20	Staff development documentation and personnel files. Client Satisfaction Survey results. Staff race/ethnicity/gender/sexual orientation survey results.
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.			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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	37	94	1956	9	94	159	**2349**	**2349**
Number of Visits = Regardless of number of transactions or number of units	72	72	2540	7	33	134	**2858**	**2858**
Number of Units = Transactions or 15 min encounters	30	30	2816	30	30	91	**3027**	**3027**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

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 medical records (EMR) 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.	All	03/01/19-02/29/20	Resumes of staff and staff training records. Advertising/Promotion collateral. No-Show reports and other functions of the EMR. 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 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;	All	03/01/19-02/29/20	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 D.A.P. to provide testing and education services to the populations they serve. Lease with LabCorp and evidence of interface between EMR and LabCorp. Staff training logs. Volunteer files. Record of testing services provide through The Dock.

Recruiting and retaining volunteer test counselors; and Maintaining walk-in STD Clinic on-site at D.A.P.			
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.	All	03/01/19-02/29/20	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 EMR 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 Quickbase and EpicCare 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.	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	1	1	76	1	1	2	**82**	**82**
Number of Visits = Regardless of number of transactions or number of units	5	5	432	5	5	14	**466**	**466**
Number of Units = Transactions or 15 min encounters	27	27	2509	27	27	81	**2698**	**2698**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

Group Name and Description	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
Newly Diagnosed Support Group	SA3	PLWHA	Open	5	1.5	1	Ongoing	Attendance; Self report of group benefits.
HIV & Afternoon Tea: Psychosocial Support for individuals infected and affected by HIV	SA3	PLWHA and those affected by HIV/AIDS	Open	10	1.5	1	Ongoing	Attendance; Self report of group benefits.
Sexual Wellness Support Group	SA3	PLWHA and those affected by HIV/AIDS	Open	10	1.5	1	Ongoing	Attendance; Self report of group benefits.
HIV & Aging	SA3	Long-term survivors or individuals infected or affected by HIV over the age of 50	Open	10	1.5	1	Ongoing	Attendance; Self report of group benefits.
Talking Circle	SA3	PLWHA and those affected by HIV/AIDS	Open	10	1.5	1	Ongoing	Attendance; Self report of group benefits.

Group Latino (Bilingual Spanish)	SA3	Latino/Latina PLWHA and those affected by HIV/AIDS, particularly those whose preferred language is Spanish	Closed	10	2	1	Ongoing	Attendance; Self report of group benefits.
Isolation to Socialization	SA3	PLWHA and those affected by HIV/AIDS	Open	10	1.5	1	Ongoing	Attendance; Self report of group benefits.
Quilting & Stitch in time	SA3	PLWHA and those affected by HIV/AIDS	Open	10	4.5	1	Ongoing	Attendance; Self report of group benefits.
Pain Management Support Group	SA3	PLWHA and those affected by HIV/AIDS	Open	8	1.5	1	Ongoing	Group Agenda; Treatment Plan Documented for Attendees; Access to Medical Care; stabilized or improved mental health.

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

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Initial individual needs assessment; **Element #2**: Individual support/counseling session; and **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 medical records (EMR); 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.	All	03/01/19-02/29/20	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.	All	03/01/19-02/29/20	Case Conference logs. ARIES Progress Notes.

Activities: Holding weekly interdisciplinary Case Conference with all departments represented; and Documenting outcomes and planned course of action.			
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.	All	03/01/19-02/29/20	Progress notes in EMR, 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 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.	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
Service Category:	Substance Abuse Services (Outpatient)
Service Goal:	Minimize crisis situations and stabilize clients' substance use to maintain their participation in the medical care system.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period), Improve viral suppression rate, A clinically significant reduction in level of substance use/abuse post (12) individual or group sessions.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	1	1	56	1	1	2	**62**	**62**
Number of Visits = Regardless of number of transactions or number of units	4	4	391	4	4	13	**420**	**420**
Number of Units = Transactions or 15 min encounters	19	19	1758	19	19	57	**1891**	**1891**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

Group Name and Description	Service Area of	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
Substance Abuse Support Group	SA3	PLWHA struggling with chemical dependency and addiction	Open	10	1.5	2	Ongoing	Group Agenda; Treatment Plan Documented for Attendees; Access to Medical Care; stabilized or improved mental health.
Smoking Cessation	SA3	PLWHA with nicotine addiction	Closed	10	1	2		Group Agenda; Treatment Plan Documented for Attendees; Access to Medical Care; stabilized or improved mental health.
Let's Talk About Tina	SA3	PLWHA affected by or struggling with addiction to crystal metham-phetamine	Open	8	1	1	Ongoing	*Note: This is an affinity group that is anonymous. Therefore we will offer the service but will not document attendance as Ryan White-funded SAS to support the group objectives and keys to success.*
12-Step Meeting	SA3	PLWHA affected by or struggling with alcohol dependency	Open	8	1	1	Ongoing	*Note: This is an affinity group that is anonymous. Therefore we will offer the service but will not document attendance as Ryan White-funded SAS to support the group objectives and keys to success.*

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Initial individual substance abuse assessment; **Element #2:** Individual treatment plan for all clients receiving substance abuse services; **Element #3:** Update of plan every 120 days (Inland Empire HIV Planning Council requirement); **Element #4:** Individual counseling; **Element #8:** Pretreatment/recovery readiness programs; **Element #9:** Harm reduction; **Element #11:** Outpatient drug-free treatment and counseling; and **Element #14:** Relapse prevention. **Activities:** Screening for Payer of Last Resort with support from on-site central registration and case management teams; Providing initial and follow-up appointments; Maintaining, and documenting in, paper charts and/or electronic medical record (EMR) customized to track all required data and generate reports; Co-locating (to include shared electronic medical records) with medical clinic and social services including case management and early intervention teams; Case Conferencing; Tracking of medical visits, viral loads, and substance use/abuse self-report and/or results of screening tool; Employing staff qualified to serve low-income PLWHA; and Offering services five days a week.	All	03/01/19-02/29/20	Eligibility documentation complete at least every six months. Past and future appointment history in EMR, ARIES and/or paper charts. Progress notes, diagnoses, risk assessment results, prescriptions, medical history, referrals in EMR, ARIES and/or paper charts. Care plan includes quantity, frequency, and modality of treatment provided, date treatment begins and ends, regular monitoring and assessment of client progress and signature of the individual providing the service and/or supervisor as applicable. Health indicator trends/flowsheets/reports. Case Conference logs. Quality Improvement Plan. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.
Element #5: Group counseling. **Activities:** Providing therapeutic groups on regular schedule various days a wk.	All	03/01/19-02/29/20	Published group schedules. Group Agenda. Attendance charted in client records.
Element #6: Case Conferencing session **Activities:** Holding weekly interdisciplinary Case Conference with all departments represented; Documenting outcomes and planned course of action.	All	03/01/19-02/29/20	Case Conference logs. ARIES Progress Notes.

Element #7: Referral to other mental health professionals; **Element #10:** Behavioral health counseling assoc w substance use disorder; **Element #12:** Medication assisted therapy; and **Element #13:** Neuro-psychiatric pharmaceuticals. **Activities:** Maintaining, and documenting in, EMR customized to track all required data and generate reports; Employing referral specialist to navigate insurance; Maintaining co-located mental health services (e.g. Transgender Specialist; Psychiatry; Psychotherapy, etc.) and specialty services partners. Medication assisted therapy would be provided by referral only. We do not plan on SAS including the prescription of Neuro-psychiatric pharmaceuticals at this time. However, it is important to note that SAS is co-located with our psychiatric department and referrals can be made for further evaluation by qualified professionals.	All	03/01/19-02/29/20	Progress notes in EMR, ARIES and/or paper charts. Referral queue in EMR, ARIES and/or paper charts. Results from outside referrals linked to chart and reviewed by provider in EMR, ARIES and/or paper charts. Results from internal referrals doc. in EMR, ARIES and/or paper charts. Employment records. MOUs/Contracts/Agreements/Letters of support from partners.

Element #15: 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 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.	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.
	All	03/01/19-02/29/20	

SCOPE OF WORK – PART A / PART B

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

Contract Number:	
Contractor:	Desert AIDS Project
Grant & Period:	Part A Contract March 1, 2019 – February 29, 2020
	Part B Contract April 1, 2019 – March 31, 2020
Service Category:	Food Bank / Home Delivered Meals
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	5	5	465	5	5	15	**500**	**500**
Number of Visits = Regardless of number of transactions or number of units	15	15	1395	15	15	45	**1500**	**1500**
Number of Units = Transactions or 15 min encounters	218	218	20257	218	218	653	**21782**	**21782**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
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 = $60 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 medical records (EMR) and electronic dental records (EDR); Referring clients to co-located (to include shared electronic medical records) with 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.	All	03/01/19-02/29/20	Eligibility documentation complete at least every six months. Current Food Handler license from the County of Riverside Department of Environmental Health. Food voucher eligibility lists 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 EMR. Employment records. MOUs/Contracts/Agreements/Letters of support from 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.	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
Service Category:		Case Management (Non-Medical)
Service Goal:		Facilitate linkage and retention in car e 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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	14	14	1302	14	14	42	**1400**	**1400**
Number of Visits = Regardless of number of transactions or number of units	42	42	3906	42	42	126	**4200**	**4200**
Number of Units = Transactions or 15 min encounters	98	98	9114	98	98	294	**9800**	**9800**

Briefly explain any significant changes in service delivery between the two fiscal years:

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

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 medical 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.	All	03/01/19-02/29/20	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 medical records (EMR). Employment records. MOUs/Contracts/Agreements/Letters of support from partners
Element #3: Development of a comprehensive, individualized care plan; **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 EMR 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.	All	03/01/19-02/29/20	Care plan documented in ARIES. Treatment adherence counseling documented in ARIES. 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.	All	03/01/19-02/29/20	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,	All	03/01/19-02/29/20	Staff development documentation and personnel files. Client Satisfaction Survey results. Staff race/ethnicity/gender/sexual orientation survey results.

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.			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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	0	1	13	0	0	1	**15**	**15**
Number of Visits = Regardless of number of transactions or number of units	0	48	635	0	0	48	**731**	**731**
Number of Units = Transactions or 15 min encounters	0	768	10248	0	0	768	**11784**	**11784**

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Development of written care plan; **Element #2:** Documentation signed by professional that indicates services provided; **Element #3:** Address the medical, social, mental health, and environmental needs; **Element #4:** Ongoing activities to promote self-reliance; **Element #5:** Assist client in becoming actively engaged in their health care; and **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 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 medical 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.	2,3,6	03/01/19-02/29/20	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. MOUs/Contracts/Agreements/Letters of support from 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 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.	2,3,6	03/01/19-02/29/20	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 medical record (EMR) as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	3	3	265	3	3	3	**286**	**286**
Number of Visits = Regardless of number of transactions or number of units	9	9	795	9	9	9	**857**	**857**
Number of Units = Transactions or 15 min encounters	20	20	1855	20	20	60	**1995**	**1995**

Briefly explain any significant changes in service delivery between the two fiscal years:

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
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 include, shelters, transitional housing, sober living, and group quarters that have supportive environments; Case Conferencing; Ensuring shared access to electronic medical records (EMR) 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.	All	03/01/19-02/29/20	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. 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 program 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.	All	03/01/19-02/29/20	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	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors.

Staff and retaining additional language assistance as needed at no cost to the client; and Providing frequently used materials in Spanish.			Spanish versions of most common forms and signage.	

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
Service Category:		Medical Nutrition Therapy
Service Goal:		Facilitates 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 19/20 TOTAL	FY 18/19 TOTAL
Number of Clients	1	1	45	1	1	1	**50**	**50**
Number of Visits = Regardless of number of transactions or number of units	1	1	140	1	1	6	**150**	**150**
Number of Units = Transactions or 15 min encounters	6	6	558	6	6	18	**600**	**600**

Briefly explain any significant changes in service delivery between the two fiscal years:

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

Group Name and Description	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
Healthy Living: Nutrition Group	SA3	PLWHA	Open	5	1	1x per Month	Ongoing	Attendance; Group Chart Notes; Self report of group benefits.
Diabetes	SA3	PLWHA	Open	5	1	1x per Month	Ongoing	Attendance; Group Chart Notes; Self report of group benefits.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Nutrition assessment and screening; and **Element #2:** Dietary/nutritional evaluation. **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 service that will support maintenance of nutritional health to improve health outcomes or maintain positive health outcomes; Case Conferencing; Ensuring shared medical records review health indicators to include medical visits and viral load; Referring clients to co-located medical clinic, dental clinic, behavioral health, early intervention programs and other social services such as housing, food assistance and case management; and Referring clients to needed services provided by community referral partners.	All	03/01/19-02/29/20	Eligibility documentation complete at least every six months. Nutrition Assessment, Screening, and Evaluation of dietary/nutrition status developed by a Registered Dietician in electronic medical record (EMR). Case Conference logs. Employment records. MOUs/Contracts/Agreements/Letters of support from partners. Quality Improvement Plan.
Element #3: Food and/or nutritional supplements per medical provider's recommendation; and **Element #4:** Nutrition education and/or counseling. **Activities:** Developing a plan of care to include nutritional diagnosis, measurable goals, date services are to be initiated and completed or re-evaluated, and recommended services and their planned frequency; and Providing groups on a regular schedule.	All	03/01/19-02/29/20	Medical nutrition plan developed by a Registered Dietician. Progress notes in EMR and/or ARIES. Medical provider's order for food and/or nutritional supplements in EMR, paper charts and/or ARIES. Service deliveries in ARIES. Published group schedules. Attendance Logs. Documentation of topics/focus, group duration, group type (open/closed), general group goals.
Element #5: 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	All	03/01/19-02/29/20	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.

sexual diversity of those served; Recruiting, retaining and promoting staff representative of service area demographics; Reviewing C&L Competency Plan annually and updating as needed; Assessing C&L Competency; Tracking client demographics and language needs; Employing bilingual Spanish staff and retaining free language assistance as needed; Providing frequently used materials in Spanish.			C&L Competency Self-Assessment and plan to address deficiencies. Race, ethnicity and language proficiency in ARIES. Staff language proficiency survey results. "Interpreter Needed" alert in EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.

SCOPE OF WORK – PART A / PART B

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

Contract Number:		
Contractor:		Desert AIDS Project
Grant & Period:		Part A Contract March 1, 2019 – February 29, 2020
		Part B Contract April 1, 2019 – March 31, 2020
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 19/20 TOTAL**	**FY 18/19 TOTAL**
Number of Clients	7	7	616	7	21	42	**700**	**700**
Number of Visits = Regardless of number of transactions or number of units	18	18	1540	18	53	105	**1752**	**1752**
Number of Units = Transactions or 15 min encounters	28	28	2464	28	84	168	**2800**	**2800**

Briefly explain any significant changes in service delivery between the two fiscal years:

N/A. Desert AIDS Project (DAP) is committed to providing quality program and service delivery to community consumers.

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
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 with case managers to support review of health indicators to include medical visits and viral load; Ensuring shared access to electronic medical records (EMR); 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.	All	03/01/19-02/29/20	Eligibility documentation complete 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.
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	All	03/01/19-02/29/20	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 EMR as well as accounting of payment to interpretive service vendors. Spanish versions of most common forms and signage.