SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY	
Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2019 – February 29, 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. NOTE: Medical care for the treatment of HIV infection includes the provision of care that is consistent with the United States Public Health Service, National Institutes of Health, American Academy of HIV Medicine (AAHIVM).
Service Health Outcomes:	Improved or maintained CD4 cell count; Improved or maintained CD4 cell count, as a % of total lymphocyte cell count; and Improved or maintained viral load

	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**
Proposed Number of Clients	**59**	**17**	**9**	**0**	**0**	**0**		**85**
Proposed Number of Visits = Regardless of number of transactions or number of units	**238**	**68**	**34**	**0**	**0**	**0**		**340**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**2380**	**680**	**340**	**0**	**0**	**0**		**3400**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: DOPH-HIV/STD medical treatment team will provide the following service delivery elements to PLWHA receiving * HIV Outpatient/Ambulatory Health Services at Riverside Neighborhood Health Center, Perris Family Care Center and Indio Family Care Center. Provide HIV Care and Treatment- **Activities:** • Development of Treatment Plan • Diagnostic Testing • Early Intervention and Risk Assessment • Preventive Care and Screening • Practitioner Examination • Medical History Taking • Diagnosis and Treatment of Common Physical and Mental Conditions • Prescribing and Managing Medication Therapy • Education and Counseling on Health Issues • Continuing Care and Management of Chronic Conditions • Referral to and Provision of Specialty Care • Treatment Adherence Counseling/Education • Integrate and utilize ARIES to incorporate core data elements.	1, 2, & 3	03/01/19-02/29/20	• Patient Health Assessment • Lab Results • Treatment Plan • Psychosocial Assessments • Treatment Adherence Documentation • Case Conferencing Documentation • Progress Notes • Cultural Competency Plan • ARIES Reports
Element #2: The HIV/STD Branch Chief, Medical Director, and HIV Clinic Manager are responsible for ensuring Outpatient/Ambulatory Health Services are delivered according to the IEHPC Standards of Care and Scope of Work activities.	1, 2, & 3	03/01/19-02/29/20	

Activity: Management staff will attend Inland Empire HIV Planning Council Standard of Care Meetings. -Management/physician/Clinical staff will attend required CME training and maintain American Academy of HIV Medicine (AAHIVM) Certification.			
Element #3: Clinic staff will conduct assessments including evaluation health history and presenting problems. Those on HIV medications are evaluated for treatment adherence. Assessments will consists of: **Activities:** a) Completing a medical history b) Conducting a physical examination including an assessment for oral health care c) Reviewing lab test results d) Assessing the need for medication therapy e) Development of a Treatment Plan. f) Collection of blood samples for CD4 Viral load, Hepatitis and other testing g) Perform TB skin test and chest x-ray	1, 2, & 3	03/01/19-02/29/20	
Element #4: Clinicians will complete a medical history on patients which is not limited to: family medical history, psycho-social history, current medications, and environmental assessment. Diabetes, cardiovascular diseases, renal disease, GI abnormalities, pancreatitis, liver disease, or hepatitis. **Activities:** a) Conducting a physical examination b) Reviewing lab test results c) Assessing the need for medication therapy d) Development of a Treatment Plan.	1, 2, & 3	03/01/19-02/29/20	

Element #5: An assessment of the patients' current knowledge of HIV and treatment options is conducted by the designated staff providing patient education and risk assessment. **Activities:** Health education and counseling is provided to the patient in choosing an appropriate health education plan that will include education regarding the reduction of transmission of HIV and to reduce their transmission risk behaviors.	1, 2, & 3	03/01/19-02/29/20	
	1, 2, & 3	03/01/19-02/29/20	
Element #7: HIV Nurse Clinic Manager and Senior Communicable Disease (CDS) Staff will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activities:** -HIV Nurse Clinic Manager and Senior CDS will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards. -Training to be obtained through the AIDS Education and Training Center on a semi-annual basis. Training elements will be incorporated into policies/plans for the department.	1, 2, & 3	03/01/19-02/29/20	
Element #8: Outpatient/Ambulatory Medical Care staff will utilize standardized, required documentation to record encounters and progress.	1, 2, & 3	03/01/19-02/29/20	

Activities: -Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and review HIV Care Continum Data and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices."			

SCOPE OF WORK – PART A **USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY**	
Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2019 – February 29, 2020
Service Category:	MEDICAL CASE MANAGEMENT SERVICES (INCLUDING TREATMENT ADHERENCE)
Service Goal:	The goal of providing medical case management services is to ensure that those who are unable to self-manage their care, struggling with challenging barriers to care, marginally in care, and/or experiencing poor CD4/Viral load tests receive intense care coordination assistance to support participation in HIV medical care.
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved or maintained viral load Medical Visits *Reduction of Medical Case Management utilization due to client self-sufficiency.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 19/20 TOTAL**
Proposed Number of Clients	**287**	**82**	**41**	**0**	**0**	**0**		**410**

Proposed Number of Visits = Regardless of number of transactions or number of units	**861**	**246**	**123**	**0**	**0**	**0**		**1230**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**3444**	**984**	**492**	**0**	**0**	**0**		**4920**

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: The HIV Nurse Clinic Manager is responsible for ensuring MCM services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activities:** Management and MCM staff will attend Inland Empire HIV Planning Council Standards of Care meetings to ensure compliance. MCM staff will receive annual training on MCM practices and best practices for coordination of care, and motivational interviewing.	1, 2, & 3	03/01/19-02/29/20	▪ Medical Case Management Needs Assessments ▪ Patient Acuity Assessments ▪ Comprehensive Care Plan ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ▪ ARIES Reports
Element #2: Medical Case Managers will provide Medical Case Management Services to patients that meet the following criteria: **Activities:**	1, 2, & 3	03/01/19-02/29/20	

Need one or more of the following services: home health, home and community-based services, mental health, substance abuse, housing assistance, and/or are clients that exhibit needs based on acuity level.			
Element #3: Medical Case Managers will conduct an initial needs assessment to identify which HIV patients meet the criteria to receive medical case management. **Activities:** Services. Re-assessments will be conducted at a minimum of every four months by the MCM staff to determine service needs.	1, 2, & 3	03/01/19-02/29/20	
Element #4: Medical Case Managers will conduct initial and ongoing assessment of patient acuity level and service needs. **Activities:** If patient is determined to not need intensive case management services they will be referred and linked with case management (non-medical) services.	1, 2, & 3	03/01/19-02/29/20	
Element #5: The MCM staff will develop an individualized care plans in collaboration with patient, primary care physician/provider and other health care/support staff to maximize patient's care and facilitate cost-effective outcomes. **Activities:** The plan will include the following elements: problem/presenting issue(s), service need, goals, action plan, responsibility and timeframes.	1, 2, & 3	03/01/19-02/29/20	
Element #6: MCM staff will periodically re-evaluate and modify care plans as necessary (minimum of six months).	1, 2, & 3	03/01/19-02/29/20	

Activities: As patient presents with modified need, care plans will be updated. MCM staff will attend bi-weekly medical team case conferences to coordinate care for patient and update care plan as needed.			
Element #7: The MCM staff will discuss and document treatment adherence issues the HIV patient is experiencing and work with treatment team staff to provide additional education and counseling for patient. **Activities:** MCM staff will attend bi-weekly medical team case conferences to coordinate care for patient as needed. MCM staff will coordinate treatment adherence discussions with physician/nursing health education staff to support the patient with his HIV treatment.	1, 2, & 3	03/01/19-02/29/20	
Element #8: The MCM staff will work with the HIV patient to become effective self-managers of their own care**.** **Activities:** MCM staff will share the care plan with the treatment team during case conferencing and MCM staff will maintain ongoing coordination with internal programs and external agencies to which patients are referred for medical and support services. HIV Nurse Clinic Manager and Senior CDS will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served.	1, 2, & 3	03/01/19-02/29/20	

Element #9: MCM staff will utilize standardized, required documentation to record encounters and progress **Activities:** HIV Nurse Clinic Manager and Senior CDS will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established National Cultural and Linguistic Competency Standards. Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices."	1, 2, & 3	03/01/19-02/29/20	

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

Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2019 – February 29, 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 maintain in medical care. Decreasing the time between acquisition of HIV and entry into care will facilitate access to medications, decrease transition rates, and improve health outcomes.
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved retention in care (at least 1 medical visit in each 6 month period) Improved viral suppression rate Targeted HIV Testing-Maintain 1:1% positivity rate or higher

	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert		FY 19/20 TOTAL
Proposed Number of Clients	125	36	18	0	0	0		179
Proposed Number of Visits = Regardless of number of transactions or number of units	376	107	54	0	0	0		537
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1128	322	161	0	0	0		1611

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Identify/locate HIV+ unaware and HIV + that have fallen out of care **Activities:** EIS staff will work with grass-roots community-based and faith-based agencies, local churches and other non-traditional venues to reach targeted communities to perform targeted HIV testing, link unaware populations to HIV Testing and Counseling and	1, 2, & 3	03/01/19-02/29/20	▪ Outreach schedules and logs ▪ Outreach Encounter Logs ▪ LTC Documentation Logs ▪ Assessment and Enrollment Forms ▪ Reporting Forms ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan

Partner Services and newly diagnosed and unmet need to HIV care and treatment. EIS staff will work with prisons, jails, correctional facilities, homeless shelters and hospitals to perform targeted HIV testing, linking newly diagnosed to HIV care and treatment. EIS staff will work with treatment team staff to identify PLWHA that have fallen out-of-care and unmet need population to provide the necessary support to bring back into care and maintain into treatment and care. EIS staff will provide the following service delivery elements to PLWHA receiving EIS at Riverside Neighborhood Health Center, Perris Family Care Center and Indio Family Care Center. Services will also be provided in the community throughout Riverside County based on the Inland Empire HIV Planning Council Standards of Care.			ARIES Reports
Element #2 Linking newly diagnosed and unmet need individuals to HIV care and treatment within 30 days or less. Provide referrals to systems of care (RW & non-RW) **Activities:** EIS staff will coordinate with HIV Care and Treatment facilities wo link patient to care within 30 days or less. Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-cal, Insurance Marketplace, OA-Care HIPP, etc.) Interventions will also include community-based outreach, patient education, intensive case management and patient navigation strategies to promote access to care.	1, 2, & 3	03/01/19- 02/29/20	

Element #3 Re-linking HIV patients that have fallen out of care. Perform follow-up activities to ensure linkage to care. **Activities:** Link patient who has fallen out of care within 30 days or less. Coordinate with HIV care and treatment. Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-cal, Insurance Marketplace, OA-Care HIPP, etc.) Link patient to non-medical case management, medical case management to assist with benefits counseling, transportation, housing, etc. to help patient remain in care and treatment. Link high-risk HIV positive EIS populations to support services (i.e., mental health, medical case management, house, etc.) to maintain in HIV care and treatment. Participate in bi-weekly clinic care team case conferencing to ensure linkage and coordinate care for patient.	1, 2, & 3	03/01/19-02/29/20	
Element #4: EIS staff will utilize evidence-based strategies and activities to reach high risk MSM HIV community. These include but are not limited to: **Activities:** Developing and using outreach materials (i.e., flyers, brochures, website) that are culturally and linguistically appropriate for high risk communities-Utilizing the Social Networking model asking HIV + individuals and high risk HIV negative individuals to recruit their social contacts for HIV testing and linkage to care services.	1, 2, & 3	03/01/19-02/29/20	

Element #5: EIS staff will work with HIV Testing & Counseling Services to bring newly diagnosed individuals from communities of color to Partner Services and HIV treatment and care at DOPH-HIV/STD as well as other HIV care and treatment facilities throughout Riverside County. **Activities:** EIS staff will meet with DPOH Prevention on a weekly basis to exchange information on newly diagnosed ensuring that the person in referred to EIS and in linked to HIV care and treatment within 30 days or less Senior Communicable Disease Specialist (CDS) will review all data elements to ensure linkage and retention of patient.	1, 2, & 3	03/01/19-02/29/20	
Element #6: EIS staff will coordinate with local HIV prevention /outreach programs to identify target outreach locations and identify individuals' not in care and avoid duplication of outreach activities. **Activities:** EIS staff will coordinate with prevention and outreach programs within the TGA to strategically plan service areas to serve. EIS staff will work with the DOPH-Surveillance unit to target areas in need of services.		03/01/19-02/29/20	
Element #7: EIS staff will assist patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-Cal, Insurance Marketplace, OA Care HIPP, etc.). **Activities:** EIS staff will coordinate with non-medical case management services to assist with benefits counseling and rapid linkage to care and support services.		03/01/19-02/29/20	

Element #8: Senior CDS and Department Manager will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activities:** Senior CDS and Department Manager will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards. Training to be obtaining through the AIDS Education and Training Center on a semi-annual basis. Training elements will be incorporated into policies/plans for the department		03/01/19- 02/29/20	
Element #9: EIS Staff will utilize standardized, required documentation to record encounters and progress. **Activities:** EIS staff will maintain documentation on all EIS encounters/activities including demographics, patient contacts, referrals, and follow-up, Linkage to Care Documentation Logs, Assessment and Enrollment Forms and Reporting Forms in each patient's chart Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators, continuum of care data and		03/01/19- 02/29/20	

provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices.			

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2019 – February 29, 2020
Service Category:	**CASE MANAGEMENT SERVICES (NON-MEDICAL)**
Service Goal:	The goal of Case Management (non-medical) is to facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals
Service Health Outcomes:	"Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved or maintained viral load Accessing Medical Care (at least two medical visits in a 12 month period)"

	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**
Proposed Number of Clients	**129**	**37**	**18**	**0**	**0**	**0**		**184**
Proposed Number of Visits = Regardless of number of transactions or number of units	**386**	**110**	**56**	**0**	**0**	**0**		**551**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**1546**	**442**	**220**	**0**	**0**	**0**		**2208**

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
• Open Enrollment/Covered California Education Forum	1,2,&3	Patients who qualify for Covered California	Open	15	2hrs	2x's per year between Oct. 15-Dec. 7	2x's per year	-Enrollment in Covered California
• How to apply for Medi-cal Inland Empire Health Plan Education Forum	1,2,&3	Newly diagnosed	Open	15	2hrs	2x's per year	2x's per year	-Enrollment in Medi-cal IEHP
• What is Office AIDS Health Insurance Premium Payment Education Forum	1,2,&3	Newly diagnosed and pts. With SOC, Health Care premiums	Open	15	2 hrs	2x's per year	2x's per year	-Enrollment in OA-HIPP

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: The HIV Nurse Clinic Manager is responsible for ensuring Case Management (Non-Medical) Services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activities:** Case Manager will work with patient to conduct an initial intake assessment within 3 days from referral.	1, 2, & 3	03/01/19-02/29/20	▪ Patient Assessments ▪ Case Management Tracking Log ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ▪ ARIES Reports
Element #2: Initial and on-going of acuity level **Activities:** Case Manager will provide initial and ongoing assessment of patient's acuity level during intake and as needed to determine Case Management or Medical	1, 2, & 3	03/01/19-02/29/20	

Case Management needs. Initial assessment will also be used to develop patient's Care Plan. Case Manager will discuss budgeting with patients in order to maintain access to necessary services and Case Manager will screen for domestic violence, mental health, substance abuse, and advocacy needs.			
Element #3: Develop of a comprehensive, individual care plan **Activities:** Case Manager will refer and link patients to medical, mental health, substance abuse, psychosocial services, and other services as needed and Case Manager will provide referrals to address gaps in their support network. Case Manager will be responsible for eligibility screening of HIV patients to ensure patients obtain health insurance coverage for medical care and that Ryan White funding is used as payer of last resort. Case Manager will refer to eligibility technician in order for patient to apply for medical, Covered California, ADAP and/or OA CARE HIPP etc. Case Manager and Eligibility tech will coordinate and facilitate benefit trainings in order for patients to become educated on covered California open enrollment, Medi-cal IEHP, OA- CARE HIPP etc.	1, 2, & 3	03/01/19- 02/29/20	
Element #4: Case Manager will provide education and counseling to assist the HIV patients with transitioning due to changes in the ACA. **Activities:** Case Manager will assist patients with obtaining needed financial resources for daily living such as bus pass vouchers, gas cards, and other emergency financial assistance.	1, 2, & 3	03/01/19- 02/29/20	
Element #5: Case Manager will educate patients regarding allowable services for family members, significant others, and friends in the patient's support system. Services include education on HIV disease, partner testing, care and treatment issues, and prevention education. The goal is to develop and strengthen the patient's support system and maintain their connection to medical care. **Activities:**	1, 2, & 3	03/01/19- 02/29/20	

Case Manager will provide education to patient about health education, risk reduction, self-management, and their rights, roles, and responsibilities in the services system.			
Element # 6: HIV Nurse Clinic Manager and Senior CDS will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activity:** HIV Nurse Clinic Manager and Senior CDS will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards.	1, 2, & 3	03/01/19-02/29/20	
Element #7: Non-MCM staff will utilize standardized, required documentation to record encounters and progress. **Activities:** Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices."	1, 2, & 3	03/01/19-02/29/20	

SCOPE OF WORK – PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2019 – February 29, 2020

Service Category:	Medical Nutrition Therapy
Service Goal:	Facilitate maintenance of nutritional health to improve health outcomes or maintain positive health outcomes.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6 month period) Improve viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 19/20 TOTAL**
Proposed Number of Clients	**98**	**28**	**14**	**0**	**0**	**0**		**140**
Proposed Number of Visits = Regardless of number of transactions or number of units	**196**	**56**	**28**	**0**	**0**	**0**		**280**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**980**	**280**	**140**	**0**	**0**	**0**		**1400**

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**
HIV Nutrition 101	1,2,3		Closed	10	2	Every 6 months	Every 6 months	Improved retention in care (at least 1 medical visit every 6-month period) Improved viral suppression
How to Eat Healthy on a Budget	1,2,3		Closed	10	2	Every 6 months	Every 6 months	Improved retention in care (at least 1 medical visit every 6-month period) Improved viral suppression
HIV Medication Interactions and Nutrition	1,2,3		Closed	10	2	Every 6 months	Every 6 months	Improved retention in care (at least 1 medical visit every 6-month period) Improved viral suppression

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Medical Nutrition Therapist will develop a Nutrition Screening Tool to identify patients who need Medical Nutrition Therapy Assessments. Risk factors could include but are not limited to: Weight loss, wasting, obesity, drug use/abuse, hypertension, cardiovascular disease, liver dysfunction etc. **Activities:** HIV patients to be screened at every medical appointment by the physician or nursing staff in order to identify nutrition related problems. Patients will be referred to MNT based on the following criteria: -HIV/AIDS diagnosis -Unintended weight loss or weight gain -Body mass index below 20 -Barriers to adequate intake such as poor appetite, fatigue, substance abuse, food –insecurity, and depression	1, 2, & 3	03/01/19-02/29/20	MNT schedules/logs MNT encounter logs Nutrition Screening and MNT assessment MNT Referrals Progress/treatment notes ARIES Reports Cultural Competency Plan Academy of Nutrition and Dietetics Standards
Element #2: HIV patients will be assessed by MNT based on the following criteria: -High risk, to be seen by an RDN within 1 week -Moderate risk, to be seen by an RDN within 1 month -Low risk, to be seen by an RDN at least annually **Activities:** Initial MNT assessment and treatment will include the following: -Gathering of baseline information. Routine quarterly or semi-annually follow-up can be scheduled to continue education and counseling. - Nutrition-focused physical examination; anthropometric data; client history; food /nutrition-related history; and biochemical data, medical tests, and procedures. -Identification as early as possible new risk factors or indicators of nutritional compromise. -Discuss plan of treatment with treating physician. Treating physician will RX food and/or nutritional supplements. -Participate in bi-weekly case conferences to discuss treatment planning and coordination with the medical team	1, 2, & 3	03/01/19-02/29/20	
Element #3:	1, 2, & 3	03/01/19-02/29/20	

HIV Patients who are identified for group education based on MNT assessment and treatment will be referred to MNT group/educational class **Activities:** MNT will develop educational curriculum. HIV patient will attend MNT group/educational class as recommended by MNT and treating physician.			
Element #4: HIV Nurse Clinic Manager will ensure that MNT staff receive ongoing education and training in culturally competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender identity, sexual orientation, and religious preference of community served. **Activity:** HIV Nurse Clinic Manager will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards.	1, 2, & 3	03/01/19-02/29/20	
Element #5: MNT staff will utilize standardized, required documentation to record encounters and progress. **Activities:** Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and provide opportunities for improvement in care and services, improve desired patient outcomes, and results can be used to develop and recommend "best practices".	1, 2, & 3	03/01/19-02/29/20	