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OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	HRSA-22-011
Opportunity Title:	Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas
Opportunity Package ID:	PKG00266211
CFDA Number:	93.918
CFDA Description:	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease
Competition ID:	HRSA-22-011
Competition Title:	Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas
Opening Date:	03/29/2021
Closing Date:	06/21/2021
Agency:	Health Resources and Services Administration
Contact Information:	Contact Hanna Endale at (301)443-1326 or email HEndale@hrsa.gov

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Application for Federal Assistance (SF-424)
Form Version:	2.1
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 04:39:49 PM EDT
Form State:	No Errors

FORM ACTIONS:

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OMB Number: 4040-0004
Expiration Date: 12/31/2022

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [ ] New
- [x] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier: H76HA00154

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: San Bernardino County Public Health Department

* b. Employer/Taxpayer Identification Number (EIN/TIN): 95-6002748

* c. Organizational DUNS: 1063768610000

d. Address:

* Street1: 351 N. Mountain View Avenue, 3rd Floor
Street2:
* City: San Bernardino
County/Parish:
* State: CA: California
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 92415-0010

e. Organizational Unit:

Department Name: Public Health

Division Name: Clinical Health and Prevention

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Ms.
* First Name: Morena
Middle Name:
* Last Name: Garcia
Suffix:

Title: Public Health Program Manager

Organizational Affiliation:

* Telephone Number: 760-956-4457
Fax Number:

* Email: Morena.Garcia@dph.sbcounty.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.918

CFDA Title:

Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease

*** 12. Funding Opportunity Number:**

HRSA-22-011

* Title:

Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas

13. Competition Identification Number:

HRSA-22-011

Title:

Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White Part C HIV/AIDS Program provides Outpatient Early Intervention Services (EIS) to all San Bernardino County residents.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CA-031 * b. Program/Project: CA-031

Attach an additional list of Program/Project Congressional Districts if needed.

Congressional_Districts.docx | Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 01/01/2022 * b. End Date: 12/31/2024

18. Estimated Funding ($):

* a. Federal	388,443.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	388,443.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☒ a. This application was made available to the State under the Executive Order 12372 Process for review on 06/16/2021 .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	Mr.	* First Name:	Curt
Middle Name:			
* Last Name:	Hagman		
Suffix:			

* Title: Chairman, County Board of Supervisors

* Telephone Number: 909-387-4866 Fax Number:

* Email: curt.hagman@bos.sbcounty.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

Project Abstract

Project Title: CY 2021 Part C Early Intervention Services (EIS) Program
Applicant Name: San Bernardino County Department of Public Health (SBCDPH)
Address: 351 N Mountain View Avenue, San Bernardino, CA 92415-0010
Project Director Name: Morena Garcia, MPA
Contact Phone Numbers: Voice: (760) 956-4457 Fax: (760) 956-1620
E-mail Address: Morena.Garcia@dph.sbcounty.gov
Web Site Address: http://www.sbcounty.gov/dph

Grant Program Funding Requested: Part C EIS funding amount $388,443; of which 60% is designated under the Minority AIDS Initiative (MAI)

The San Bernardino County Department of Public Health (SBCDPH) Clinic Operations Section seeks competitive continuation funding in the amount of $388,443 to provide outpatient HIV primary medical care to low-income persons living with HIV (PLWH) who reside in San Bernardino County. SBCDPH delivers HIV primary care services through three clinic sites located in the cities of San Bernardino, Ontario, and Hesperia. Specific services to be supported through Part C Early Intervention Services (EIS) funds include: comprehensive HIV primary care services with referrals to specialty medical services, medical case management, nutrition services, mental health and substance abuse screening and referral, and referral for oral health care services.

San Bernardino County, California spans 20,164 square miles and is geographically the largest county in California and in the contiguous United States (U.S.). The San Bernardino and Ontario clinic sites target urban areas of the county, while the Hesperia clinic targets a more rural population. All three clinic sites are designated as a Federally Qualified Health Center (FQHC). As of December 31, 2019, San Bernardino County reported a total of 4,907 persons living with HIV and AIDS (PLWH). This represents an 11.24% overall growth in HIV/AIDS prevalence in the three-year period from 2017 to 2019[1].

Sixty percent (60%) of current Part C funds received by the SBCDPH are designated under the Minority AIDS Initiative (MAI). PLWH in San Bernardino County are extremely diverse. During the three year period (2017-2019), 70.1% of San Bernardino County's HIV/AIDS prevalence was among communities of color; 23.1% were African American and 47.0% were Latino. HIV incidence data (i.e., newly diagnosed) provides an indication of the emerging populations in which the epidemic is growing. According to the Ryan White Part A Riverside/San Bernardino, Transitional Grant Area (TGA) data, from 2017-2019, 50.1% of the new HIV cases were Latino and 16.1% were African American. One in five new HIV cases was identified as African American and one in two new HIV cases was identified as Latino.

Of the 4,907 PLWH reported in San Bernardino County in 2019, an estimated 1,227 (25%) are aware of their HIV positive status, but are not in care. Further estimates reveals that the Unmet Need is highest among communities of color with 23.5% of Latino PLWH and 11.6% of African American PLWH, compared to 12.6% of White PLWH.

[1] California Department of Public Health, Office of AIDS, California HIV Surveillance Report - 2019

Congressional Districts Served by Project/Performance Sites

CA – 08
CA – 027
CA – 031
CA – 035
CA – 039

ii. *Project Narrative*: Table of Contents

ii. Project Narrative

- ***INTRODUCTION***

The San Bernardino County Department of Public Health (DPH), founded in 1931, has along history of providing medical services to the residents of San Bernardino County. The proposed project sites (San Bernardino, Hesperia and Ontario) described in this Part C EIS application currently provide in scope health center program services and other traditional public health funded services, such as Every Woman Counts, Reproductive Health Services and Immunizations. The DPH has extensive experience managing grants, including federal funds. The San Bernardino County DPH has provided outpatient HIV medical services since 1990. The DPH received its first Ryan White Part C (formerly Title III) Early Intervention Services (EIS) funding award one year later in 1991 as thePart C Grantee. The target population for this application are HIV positive persons who are lowincome, uninsured, underinsured or underserved living in San Bernardino County. For the purpose of this application, People Living with HIV and AIDS (PLWHA) will be referred to as PLWH. The service area for the proposed project is the entire County of San Bernardino.

San Bernardino County is one of two counties that form the Ryan White Part A Riverside/San Bernardino, California Transitional Grant Area (TGA). Historically, Riverside County has surpassed San Bernardino County in terms of total number of PLWH in the TGA. In the three full years (2017-2019) of reporting HIV and AIDS cases, the TGA now has 14,614 PLWH; 31.4% (4,907) of total PLWH live in San Bernardino County. There is a three-year increase (9.70%) in total of PLWH from 4,473 in 2017 to 4,907 in 2019. This outpaces San Bernardino County's population growth (1.29%) during the same period from January 1, 2017 to January 1, 2019 and provides evidence of the increasing burden of the epidemic on the county.[1,2]

However, the real burden of the HIV/AIDS epidemic in San Bernardino County is more hidden than the numbers of PLWH reported officially in the electronic HIV/AIDS reporting system (eHARS) database to the State of California Office of AIDS (OA). Two critical populations include: (1) the number of individuals who are infected and remain unaware of their HIV status, and (2) the real number of PLWH living in the county and receiving HIV services in the county who have moved here from other jurisdictions, and therefore were likely reported in those jurisdictions. For example, neighboring Los Angeles (LA) County, California, which has the second-largest HIV/AIDS epidemic in the United States (U.S.), often have individuals who migrate into San Bernardino County are usually not included in the eHARS database as they were reported in other counties and states.

Data from the Centers for Disease Control and Prevention (CDC) HIV estimates that 6.5% of Californians are HIV positive. In San Bernardino County, the 2019 HIV/AIDS prevalence was

[1] Note: All HIV and AIDS prevalence data are reported through the HIV/AIDS Reporting System (HARS) database, which was maintained locally in 2006 and is now maintained by the State of California, Office of AIDS (OA). In 2009, the State OA transitioned to an electronic HARS system, referred to as eHARS.

[2] State of California, Department of Finance, *E-4 Population Estimates for Cities, Counties, and the State, 2011-2020, with 2010 Census Benchmark*. Sacramento, California, May 2020.

4,589 and it is estimated that 280 people are HIV positive, but have not been tested/diagnosed thus "*unware*" of their HIV status.[3] Data from the TGA's *2014 Comprehensive Needs Assessment* (CNA), the latest data available, provides compelling evidence of the migration pattern of PLWH into San Bernardino County. In an analysis of the 115 San Bernardino County CNA survey respondents, 25.2% overall (N=29 unduplicated respondents) received their HIV or AIDS diagnosis outside of California. Local data suggests that there may be as many as 1,358 additional PLWH living and receiving HIV primary medical care and other services in San Bernardino County who are not included in the county's official eHARS surveillance reports.[4] These additional PLWH in the county represent an increase in the number PLWH who are unaware of their status and remain undiagnosed, the approximate number is 374 additional individuals using the CDC's unaware estimate for California.

San Bernardino County's HIV/AIDS epidemic has been exacerbated by the most current estimate of "unmet need" (i.e., aware of HIV status but not in care). Per the California HIV Surveillance Report – 2019 [4], San Bernardino currently has a total of 4,907 PLWH, of which only 3,538 (72.1%) are in care and 2,911 (59.3%) of those in care are virally suppressed. 1,369 PLWH (i.e., 28% of 4,907 PLWH) are not in care.

The crisis in San Bernardino County is not only about numbers of people reported and unreported prevalence, aware and unaware, in care or out of care, *it is also a crisis in funding*. With changes in the health care environment and insurance marketplace, and reduction in funding for the SBCDPH Ryan White Part C EIS program; CY 2016 ($478,221), CY 2017 ($466,745 a 2.4% reduction), and CY 2018 (458,188 a 4.2% reduction) there has been a burden to meet the needs of PLWH in the San Bernardino County.[5]

The San Bernardino County Department of Public Health is requesting the Funding Preference, qualifying under the *Increased Burden* criteria, as well as the *Rural* and *Underserved* criteria. With Ryan White Part C Early Intervention Services (EIS) funding, DPH will continue to provide HIV services to our existing patients and retain them in care, perform community outreach to encourage community member's to take advantage of testing opportunities, and make every effort to ensure those newly diagnosed with HIV are able to obtain the services that they need.

- ***NEEDS ASSESSMENT***

1) Target Populations Currently Being Served by SBCDPH

As of December 31, 2019, San Bernardino County reported 4,907 persons living with HIV and AIDS (PLWH). This represents a 9.70% overall growth in HIV/AIDS prevalence in the three-year period from 2017 to 2019. In 2014, San Bernardino County ranked 8th in total reported

[3] Centers for Disease Control and Prevention. *Prevalence of Undiagnosed HIV Infection Among Persons Aged > 13 Years – National HIV Surveillance System, United States, 2005-2008.* June 15, 2012. MMWR 2012:61(02); 57-64.
[4] California Department of Public Health, Office of AIDS, California HIV Surveillance Report — 2019.
[5] Limitation: Notice of Awards for Ryan White Part C EIS Program for San Bernardino County Public Health Department.

living HIV cases among California's 61 Local Health Departments (LHD).[6] Table 1 presents the County's reported HIV and AIDS incidence and prevalence data, and overall HIV Seroprevalence for Calendar Years (CY) 2017 to 2019.[7]

Table 1. HIV (non-AIDS) and AIDS Incidence and Prevalence; and HIV Testing Data, 2017-2019

Category	2017	2018	2019	3-year Increase/(Decrease)
Newly reported with HIV (incidence)	**253**	**224**	**226**	**(1.8%)**
Number living with HIV(prevalence)	2041	2223	2197	13.7%
Newly reported with AIDS (incidence)	95	93	51	(4.4%)
Number living with AIDS (prevalence)	2432	2490	2392	6.0%
Number testing positive in Public Health Setting	39	26	12	(69.2%)
Seroprevalence for HIV in Public Health Setting	0.7%	0.7%	0.5%	(0.3%)
Seroprevalence for HIV tests done through Alternative Test Sites (ATS)	0.5%	0.4%	0.7%	40.0%

Source: CA Office of AIDS eHARS Download 4/8/17 as reported through December 31st of each year.

San Bernardino County experienced level numbers of newly reported HIV cases from 2017 to 2019 and the County added 703 new HIV cases during this three-year period, resulting in a 10.6% decrease in overall HIV prevalence. As of December 31, 2019, Riverside County reported 818 new HIV cases during this same period, resulting in 1521 new HIV cases in the TGA.[8] San Bernardino County accounts for 46.1% of the TGA's total HIV incidence and 32% of the TGA's HIV prevalence.

A similar trend is occurring with new AIDS cases. San Bernardino County added 239 new AIDS cases to its total AIDS prevalence between 2017 and 2019, resulting in level reporting for this three-year period. This represents 43.5% of all newly diagnosed AIDS cases in the TGA (n=550) in 2017-2019. Thus, San Bernardino County comprised 32% of the TGA's AIDS prevalence (n=5,383) as of December 31, 2019. Historically in the TGA, the HIV/AIDS epidemic in San Bernardino County has been overshadowed by Riverside County's epidemic.

However, the epidemic in San Bernardino County has become stable. This is evidenced in the County's overall proportion of the TGA's epidemic, from 33.1% of the TGA's total HIV/AIDS prevalence as of December 31, 2017 to 31.4% (n=4,589) of the TGA's total HIV/AIDS prevalence (n=14,614) as of December 31, 2019.

[6] CA Office of AIDS eHARS Download

When compared to the TGA or even the State of California, San Bernardino County has a very different epidemic pattern. Both the TGA, which includes data from both Riverside and San Bernardino Counties, and California's epidemic are similar and represent a common pattern in which there are more Whites, males, and risk related to men who have sex with men (MSM). In San Bernardino County, the epidemic profile reflects more persons of color, a higher proportion of women, heterosexual and injection drug use (IDU) fueling transmission. Table 2 depicts the demographic and risk exposure profile of these three geographic regions to illustrate these differences.

Table 2. Comparison of Selected Characteristics for Persons Living with HIV and AIDS (Prevalence) as of December 31, 2019, Between San Bernardino County, the Riverside-SanBernardino, California Transitional Grant Area, and the State of California

Category	San Bernardino County (1)	TGA (1)	California (2)
Persons Living With HIV/AIDS	***4,907***	***14,614***	***137,785***
White	28.1%	*50.0%*	37.2%
Black or African American	23.9%	*13.0%*	17.0%
Latino or Hispanic	43.0%	*32.0%*	37.7%
Other races (non-White)	5.0%	*4.0%*	8.0%
Male	89.0%	89.0%	86.7%
Female	11.0%	11.0%	11.7%
Transgender	Unknown	Unknown	1.6%
MSM	51.5%	70.0%	76.8%
Injection Drug Use	10.5%	5.0%	4.2%
MSM & IDU	6.8%	6.0%	7.4%
Heterosexual	15.7%	12.0%	4.0%
Perinatal	1.0%	0.0%	0.0%
Other / Risk not reported/identified	14.5%	6.0%	4.6%

(1) Source: CA Office of AIDS eHARS Download; data as of December 31, 2019. May not add due to rounding.
(2) California Department of Public Health, Office of AIDS, HIV/AIDS Surveillance Section, data as of December 31, 2019.

As seen, three-quarters (71.9%) of San Bernardino County's HIV/AIDS prevalence is among communities of color; this compares to 45.0% of the TGA overall and 54.7% in California. One-fifth (11.0%) of PLWH in San Bernardino County are female, compared to 11.0% of PLWH in the TGA and only 11.7% in California. Thus, it is not surprising that heterosexual risk accounts for 15.7% of San Bernardino County's epidemic compared to 12.0% in the TGA and 4.0% in California. Injection drug use (IDU) also contributes to a larger proportion (10.5%) of the epidemic in San Bernardino County compared to 5.0% in the TGA and 4.2% in California. Thereis also a slightly higher proportion of MSM/IDU risk (6.8%) in San Bernardino County than in the TGA (6.0%).

HIV and AIDS incidence data (i.e., newly diagnosed) provides an indication of the emerging populations in which the epidemic is growing. Table 3 depicts the racial/ethnic profile of newly diagnosed HIV cases for 2018 and 2019. When compared to the racial/ethnic profile of San Bernardino County's general population from the State of California's Department of Finance

2019 population estimates, an alarming pattern emerges. During this two-year period, HIV and AIDS incidence data (i.e., newly diagnosed) provides an indication of the emerging populations in which the epidemic is growing. This is disproportionate to their representation in the general population. Although Latinos are proportional to their population among newly diagnosed HIV cases during these two years (57.5%) of new cases compared to 59.5% of the total population, this trend marks a dramatic shifting in the County's epidemic, as Latinos now comprise 51.2% of all people living with HIV (prevalence). African Americans continue to be the most disproportionately impacted racial/ethnic population and are over-represented among new HIV cases and total HIV prevalence. One in five new HIV case is an African American and one in two new cases is Latino.

Table 3. Newly Reported People Living with HIV (Any Stage) (Incidence) by Race/Ethnicity for Two Years (2018 and 2019 total) Compared to Proportion of Racial/Ethnic Group in the General Population in SBC and Total HIV/AIDS Prevalence as of December 31, 2019

Racial/Ethnic Group	General Population (1)	HIV/AIDS Prevalence (2)		Total New HIV Cases (2018 & 2019) (2)	
		Number	Percent	Number	Percent
White	31.2%	1,223	26.7.1%	109	19.6%
Black or African American	8.4%	1,096	23.9%	108	19.4%
Latino or Hispanic	51.1%	2,348	51.2%	320	57.5%
Other race	9.1%	124	2.7%	19	3.4%
Unknown race	n/a	0	0.0%	0	0.0%
Total	100%	4,791	100%	403	100%

(1) State of California, Department of Finance, Report P-2: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060.
(2) CA Office of AIDS eHARS .

A similar pattern is occurring among newly diagnosed AIDS cases (incidence). Table 4 presents the racial/ethnic profile of new AIDS cases for the two-year period that includes 2018 and 2019 data as compared with the current racial/ethnic profile of the general population, as well as total persons living with AIDS (prevalence) in San Bernardino County.

Table 4. Newly Reported People Living with AIDS (Incidence) by Race/Ethnicity for Two Years(2018 and 2019 total) Compared to Proportion of Racial/Ethnic Group in the General Population and Total AIDS Prevalence as of December 31, 2019

Racial/Ethnic Group	General Population (1)	AIDS Prevalence (2)		Total New AIDS Cases (2018 & 2019) (2)	
		Number	Percent	Number	Percent
White	31.2%	620	25.2%	27	19.0%
Black or African American	8.4%	570	23.1%	31	21.8%
Latino or Hispanic	51.1%	1154	46.8%	76	53.5%
Other race	9.1%	121	4.9%	8	5.6%
Total	100%	2,465	100%	142	100.0%

(1) State of California, Department of Finance, Report P-2: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060.
(2) CA Office of AIDS eHARS

As with new HIV cases, 75.3% of all new AIDS cases are among communities of color compared to their representing about two-thirds of the general population and total AIDS cases. The number of new AIDS cases among African Americans is severely disproportionate to their representation in the population (23.1% compared to 8.4%). They also represent a slightly lower proportion of new AIDS cases (21.8%) than total AIDS prevalence (23.1%). Although the proportion of Latinos being diagnosed as a new AIDS case (53.5%) is greater than their representation in total AIDS prevalence (46.8%), this proportion isconsiderably less than their representation in the general population (51.1%).

Table 5 depicts the 3-year change in total HIV/AIDS prevalence by race/ethnicity. Latino HIV/ AIDS cases grew by 20.2% (n=394), followed by African Americans (9.5%; n=95). Whites living with HIV/AIDS grew by 0.24%. A new PLWH is twice as likely to be Latino as White.

Table 5. People Living with HIV/AIDS by Race/Ethnicity for 2017-2019 and 3 Yrs. Percent Change

Racial/Ethnic Group	2017(1)	2018 (1)	2019 (1)	3-year Increase Percent/(Number)
Total Living With HIV/AIDS (prevalence) **	***4,473***	***4,713***	***4,589***	***2.60% (116)***
White	1,220	1,230	1,223	0.24% (3)
Black or African American	1,001	1,034	1,096	9.5% (95)
Latino or Hispanic	1,954	2,145	2,348	20.2% (394)
Other races (non-White)	100	123	124	24.0% (24)

(1) Source: CA Office of AIDS eHARS.

** The total by racial/ethnic group does not add to total prevalence number because they did not include cases with unreported race.

Other populations with significant increases during the three-year period from 2017-2019 include: (1) MSM, increased by 9.0%; (2) Males increased by13.2%; (3) Females increased by 25%; (4) Youth, aged 13-24 years, increased by 1.6%; PLWH aged 25-44 years increased by 22.0%; and (5) geographically, the East Valley Service Area increased by 2.8% or 25 PLWH. San Bernardino County's Desert Service Area grew by 63.8% (372 individuals) which issignificant for this predominantly rural area. [10]

Unmet Need: HRSA's criteria for Unmet Need quantifies the number of PLWH who are *aware of*

[9] Centers for Disease Control and Prevention. HIV Surveillance – United States, 1981-2008. MMWR 2011:60:689-693.

[10] CA Office of AIDS eHARS Download

their HIV positive status but *not in care*. In the TGA's Fiscal Year 2017-2018 Part A funding application (submitted October 2016), the Part A Grantee developed its most recent estimate of Unmet Need according to HRSA guidelines. The Part A Grantee estimates that 28% of PLWH in the TGA are *aware but out of care;* it estimates 36% of these PLWH are in San Bernardino County. Thus, of the currently reported 4,031 PLWH, an estimated 1,451 (36%) of PLWH are not in care. The TGA's estimate further reveals that Unmet Need is highest among communities of color relative to their proportion in prevalence: 30% of Latino or Hispanic PLWH (33.5% of cases) and 37% of African American or Black PLWH (16% of cases) compared to 25% of WhitePLWH (47% of cases). As this is aggregated TGA-level data (county-level estimates with demographic characteristics have not been developed), the actual level of Unmet Need among PLWH of color in San Bernardino County may actually be higher.

Surrogate Markers: There are several key indicators, which demonstrate the level of risk in the population for HIV. Key among these is a community's general fertility rate and teen birth rate (15-19 years). These provide evidence of unprotected sexual activity in the population. Given the high proportion of heterosexual risk (15.7%) reported as the mode of exposure among current PLWH in San Bernardino County as of December 31, 2016, this indicator is critical.

Table 6. General Fertility Rate and Teen Birth Rate per 1,000 Females for San Bernardino County, Riverside County, and the State of California, 2014

Category	San Bernardino County	Riverside County	California
General Fertility Rate	69.5	64.1	55.4
Teen Birth Rate (15-19 years)	27.7	20.9	20.8

State of California, Department of Finance, Demographic Research Unit. *Historical and Projected Fertility Rates and Births, 1990-2040*. Sacramento: California Department of Finance. February 2017.
State of California, Maternal, Child and Adolescent Health Division, County Profiles 2014. Sacramento, California.
Centers for Disease Control and Prevention; National Center for Health Statistics

As seen in Table 6, San Bernardino County's general fertility rate is slightly higher (69.5 per 1000 population) than in Riverside County (64.1 per 1000), which together with San Bernardino County comprises the TGA, and in California (63.4 per 1000). However, alarming among femaleteens (15 to 19 years) is the very high teen birth rate in the county of 27.7 per 1000 compared to 20.9 per 1000 in Riverside County, and 20.8 per 1000 in California. This unprotected sex among young women may contribute to the dramatic increase of HIV/AIDS among youth (100%, n=72) from 2014 to 2016 noted earlier, as well as having a greater proportion of PLWH who are female (18.9%, n=763) than in California or the TGA.

The incidence and prevalence of sexually transmitted infections (STI) is another surrogate marker of unprotected sexual activity. The rates of STIs in San Bernardino County have dramatically increased from 2010 to 2018, and the County is within the top ten of California's 61jurisdictions for number of reported cases of chlamydia. The county has one of the highest number of cases of congenital syphilis.[11] A growing body of evidence demonstrates that HIV-negative persons with STIs are more vulnerable to HIV acquisition if exposed.[12]

[11] CA Department of Public Health. STD Control Branch, Sexually Transmitted Diseases Data tables, 2018 Executive Summary.

[12] Barnabas RV et al., More Evidence That HSV-2 Infection Increases Risk for HIV Acquisition. *Journal of Acquired Immune Deficiency Syndrome,* 2011 Apr 5.

The co-morbidity of STIs in PLWH also facilitates transmission of HIV during unprotected sexual contact. In 2014, the TGA completed a*Comprehensive Prevention and Care Needs Assessment* targeting both HIV positive and HIV negative individuals. Among the 115 San Bernardino County HIV positive respondents to the *2014 Needs Assessment*, 15.7% (n=18) reported having an STI currently or during the past 12 months. Table 7 presents the estimated rate of infection among PLWH for selected STIs and hepatitis C with the rate reported in the County's general population.

Table 7. Comparison of Rates of Selected Diseases per 100,000 between the General Population (2016) and People Living with HIV and AIDS (PLWH) in San Bernardino County (2016)

Category	General Population 2,147,933 (1)		PLWH 4,031 (2)	
	Number	Rate (per 100,000)	Number (4)	Rate (per 100,000)
Syphilis (Total)	759 (3)	35.3	278	6896.6
Gonorrhea	3,384 (3)	157.5	173	4291.7
Chlamydia	11,507 (3)	535.7	104	2580.0
Hepatitis C Chronic	4,600 (3)	214.1	173	4291.7

(1) State of California, Department of Finance, E-2. *CA County Population Estimates and Components of Change by Year- July 1, 2010-2016.* December 2016.
(2) CA Department of Public Health, Office of AIDS, eHARS download April, 2017.
(3) CalREDIE download, 4/2017.
(4) Estimates for PLWHA based on Inland Empire HIV Planning Council Comprehensive Needs Assessment Data 2014.

The rates of chlamydia, syphilis, gonorrhea, and hepatitis C (chronic) are dramatically higher among PLWH. A PLWH in San Bernardino County is 20 times more likely to be infected with hepatitis C than a person in the general population. Hepatitis C is strongly associated with injection drug use, which is itself a direct risk for HIV infection as individuals share needles and/or other drug paraphernalia. As seen earlier (Table 2), 10.5% of HIV transmission in San Bernardino County is associated with injection drug use; this proportion is significantly higher than the proportion of IDU-related HIV/AIDS prevalence in the TGA (7.3%) and higher than theproportion in California (6.6%). In addition (Table 2), another 6.8% of PLWH report a dual risk of MSM and IDU combined; this is also higher than in the TGA (6.1%) but comparable to California (7.3%).[13] [14]

Alcohol use impairs judgment and contributes to unsafe sexual behaviors that put people at risk for HIV. According to the 2*015 California Health Interview Survey*, 33.6% of the population in San Bernardino County had a history of binge drinking (5 or more drinks on at least one occasion during the past year). This compares to 34.2% of the population in the TGA, and 34.7%of California's population overall.[15]

The Social Context of HIV/AIDS

The County of San Bernardino is located in the inland portion of Southern California. With an area of 20,164 square miles, San Bernardino County is geographically the largest county in the contiguous United States. The county's 2,147,933 residents live in rural mountain and desert

[13] Source: California Office of AIDS eHARS Download 4/18/2017. Data as of December 31, 2016.
[14] Source: California DPH, Office of AIDS, HIV/AIDS Surveillance Section, data as of December 31, 2014.
[15] Source: University of California, Los Angeles, California Health Interview Survey, 2015. (Available at: www.askCHIS.com).

communities as well as large urban centers. Between 2014 and 2019, San Bernardino County's population grew by 3.39% (n=70,925); making it the 5th most populous county in the State.[16]

The residents in San Bernardino County as a whole is characterized by diverse racial/ethnic distributions, high levels of poverty, unemployment, and the uninsured. According to the most recent population estimates from the CA Department of Finance, 68.5% of San Bernardino County's general population is comprised of racial/ ethnic communities of color (Table 3). Latinos or Hispanics are the majority population and comprise 51.1% of all residents; African Americans or Blacks comprise 8.4% of the population and all other races combined comprise 9.0% of the population. San Bernardino County's PLWH are similarly diverse and non-white individuals comprise 66.9% of all PLWH (Table 2). With this tremendous diversity, there are numerous issues that may present barriers to accessing health care services in San Bernardino County, including among them language and citizenship status. According to the University of California, Los Angeles' *2015 California Health Interview Survey* (CHIS), 13.0% of San Bernardino County residents are not U.S. citizens. This compares to 12.4% of residents in the TGA overall. However, results from the TGA's *2014 Needs Assessment* reveal that among the 115 San Bernardino County PLWH respondents, 7.8% stated that they are not a U.S. citizen; all undocumented Latinos. About 11.2% of San Bernardino County's population speaks Spanish as their primary language according to the *2015 CHIS*. This is much more than the 10.6% of TGA residents that primarily speak Spanish. In the *2014 Needs Assessment*, 15.6% of PLWH respondents identify Spanish as their primary language.

Table 8 presents the most recent data available regarding several socio-economic characteristics within the population. Unless otherwise noted, all San Bernardino County and TGA (for comparison) data are from UCLA's *2015 CHIS* and comparable data for PLWH in San Bernardino County is from the TGA's *2014 Needs Assessment.*

Table 8. Selected Socio-Economic Characteristics of the General Population and PLWH

Category	TGA (1)	San Bernardino County (1)	PLWHA (2)
Poverty (<100% FPL)	20.3%	15.7%	50.4%
Education (less than high school)	20.8%	18.1%	27.8%
Unemployed	39.0%	32.4%	70.4%
Uninsured (18-64 years)	15.6%	19.2%	12.2%
Homeless	0.09% (3)	0.09% (4)	14.8%
Illicit Drug Use (past month)	N/A	8.0% (5)	25.2%
No Vehicle Available	N/A	5.7% (6)	46.2%

(1) UCLA, California Health Interview Survey, 2015.
(2) Riverside-San Bernardino, California TGA *2014 Comprehensive Prevention and Care Needs Assessment,* June 2014.
(3) Riverside County 2017 Homeless Count and Subpopulation Survey, 2017.
(4) County of San Bernardino Office of Homeless Services, Point-In-Time Homeless Count & Survey Report, 2017.
(5) SAMHSA, Substate estimates from the 2006-2008 National Surveys on Drug Use and Health.
(6) U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates.

[16] State of California, Department of Finance, *E-2. California County Population Estimates and Components of Change by Year- April 1, 2010-2021, May 2021.*

Poverty: According to the *2015 CHIS,* 15.7% (about 1 in 6) of all San Bernardino County residents had an income less than the 100% of the Federal Poverty Level (FPL). This is somewhat lower than the level of poverty in the TGA overall (20.3%). However, a staggering 50.4% of PLWH in San Bernardino County (1 out of every 2 people) are living below 100% of the FPL. Poverty impacts the cost and complexity of service delivery in several ways. First, the poor frequently defer primary medical care until they are seriously ill due to fear of denial of service and financial uncertainty. One study revealed that more than one-third of PLWH who had competing subsistence needs (e.g., not enough money for food, clothing, or housing) postponed or went without care altogether.[17] It is difficult to estimate the additional cost of delayed treatment. Low-income PLWH are more likely to seek care in the emergency room when he or she does get sick; this group disproportionately impact African Americans, Latinos, and women.[18] Poor health outcomes and lost quality of life may be the experience of PLWH who delay treatment.

Education: According to the United States Census Bureau 2018 American Community Survey, 20.2% of San Bernardino County adult residents have not completed high school or an equivalent education; this includes 7.1% of the population who have an 8th grade education or less. Among San Bernardino County PLWH, significantly more (27.8%) have not completed high school or an equivalent. About 7.8% of PLWH have less than an 8th grade education. Among PLWH who speak Spanish as their primary language, 27.8% havenot completed high school. When examined by race/ethnicity, Latino PLWH have the lowest education level overall, 40.9% do not have a high school education. This compares to 29.6% of African American or Black PLWH and 9.1% of White PLWH. In an increasingly complex healthcare environment, lower educational attainment may impede a person's ability to navigate this system, including but not limited to filling out required paperwork, and being able to read and understand written materials, including prescription information.

Unemployment: Among those aged 16 years or older in the San Bernardino County and TGA general population, 10.5% percent are unemployed as of 2012 according to the UCLA Center for Health Statistics. Among San Bernardino County's PLWH, 70.4% reported that they were unemployed or disabled. Only 20.1% of PLWH report that they are working part-time or full-time; 10.4% of PLWH who are unemployed are looking for work. Unemployment in San Bernardino County will likely continue. For the few PLWH who are working, losing a job can have a devastating impact on income but also cause the loss of job-based insurance, which contributes to increasing numbers of persons needing public support to provide for their HIV primary medical care.

Uninsured: The *2015 CHIS* reveals that 19.2% of San Bernardino County residents 18-64 years old are uninsured; 15.6% of all TGA residents. The *2014 Needs Assessment* shows that 12.2% of PLWH aged 18-64 years in San Bernardino County are uninsured. Being uninsured and underinsured are significant issues for PLWH. PLWH who lack insurance may defer care.

[17] Cunningham WE, Mosen DM, et al. The impact of competing subsistence needs and barriers on access to medical care for persons with HIV receiving care in the United States. *Medical Care.* Vol. 37, No. 12, 1999, pp. 1270-1281.
[18] Gifford AL, Collins R., et al. Propensity of HIV Patients to Seek Urgent and Emergent Care. *Journal of General Internal Medicine,* Vol. 15, No. 12, 2000, pp. 833-840.

When any care is deferred, the cost and complexity of treatment increases because PLWH are often further along the HIV disease continuum. One study found that "Medicaid insurance and a usual source of care" were protective factors against the delay in seeking medical care after diagnosis."[19] Delaying care may result in poorer health outcomes as well as necessitate the need for more frequent and intensive services.

Homelessness: The San Bernardino County Office of Homeless Services 2019 Point-In-Time Homeless Count and Survey Report resulted in the identification of 2,607 homeless individuals countywide. The count also found that 71.6% of homeless were male; 9.3% of homeless were veterans. In terms of health conditions, 19.7% of homeless were severely mentally ill and 20.4% were chronic substance users. The count further revealed that 2.2% of all homeless were living with HIV or AIDS.

In the TGA's *2014 Needs Assessment,* seventeen (17) San Bernardino County PLWH respondents stated that they were currently homeless (14.8%). Homelessness contributes to deteriorating health status. This population is hard-to-reach and difficult to engage in primary medical care, particularly those with co-morbid substance abuse and/or mental health conditions.Homeless PLWH require significant outreach and case management services to address their needs, including advocacy and follow-up.

Drug Use: The Substance Abuse and Mental Health Services Administration (SAMHSA) conducts the annual *National Surveys on Drug Use and Health (NSDUH)*, which estimates the prevalence of alcohol and substance use in a population.[20] The 2006-2008 NSDUH found that 8% of San Bernardino County's population (Sub state Region 12) had used an illicit drug in the past month, including marijuana.[21] Further, 3.8% of the population had used an illicit drug *excluding* marijuana. Illicit drug use is significantly higher among the County's PLWH than in the general population. Among PLWH, 25.2% used an illicit substance in the past month (including marijuana), and 3.5% had used an illicit drug in the past month (excluding marijuana).In their responses to the *2014 Needs Assessment,* 21.7% of San Bernardino County PLWH self- reported a need for outpatient substance abuse services; 17.4% stated a need for either outpatient or inpatient substance abuse services during the previous 12 months. The San Bernardino County Department of Behavioral Health, Alcohol and Drug Services (DBH) is the largest provider of substance abuse treatment for low-income individuals. Foothill AIDS Project provides outpatient substance abuse treatment for low-income PLWH.

Lack of Transportation: According to the 2011-2015 American Community Survey, 5.7% of San Bernardino County households do not have a vehicle available. In the *2014 Needs Assessment,* 37.4% of PLWH respondents stated that they use public transportation (i.e., bus) to get to their medical appointments. With the County spanning 20,164 square miles, lack of transportation imposes a significant barrier to accessing care for a large number of persons. Nearly half (45.4%) of San Bernardino County respondents to the *2014 Needs Assessment* identified a need for

[19] Turner BJ, Cunningham WE, et. al. Delayed Medical Care after Diagnosis in a US National Probability Sample of Persons Infected with HIV. *Archives of Internal Medicine,* Vol. 160, No. 17, 2000, pp. 2614-2622.
[20] Source: SAMHSA, Sub state estimates from the 2006-2008 National Surveys on Drug Use and Health.
[21] Sub state Region 12 includes San Bernardino, Inyo, and Mono Counties. These two small counties have a population of 32,748 residents as of the U.S. Census 2010, about 1.6% of San Bernardino County's total population. Thus, the overall impact of these small counties in this region is negligible. The data provided is the closest estimate of prevalence available for San Bernardino.

assistance with transportation in order to get to their medical appointments. Transportation is consistently cited as a major barrier to care among PLWHA, particularly those living in the Desert Service Area, which has limited access to service other than primary medical care (see Attachment 9: Service Area Map). PLWHA in this region are able to receive HIV primary care locally at the County's Hesperia Health Center location in Hesperia, CA. While the Hesperia Health Center location does offer some specialty care services i.e., dental and support services, it is still up to an hour away from some outlying rural areas, such as Lucerne Valley.

Community Infrastructure: The San Bernardino County DPH is one of the few providers of HIV primary care services in the County. It delivers services through three geographically divergent sites located in each of the County's Health Planning Regions: (1) East Valley, (2) West Valley, and (3) Desert (see Attachment 9). The DPH is the Grantee for both Part B and Part C funding to provide HIV primary medical care services to low-income PLWH who have no other resources to pay for care. There is currently two Part A-funded medical providers that offer services to PLWH in San Bernardino County: (1) AIDS Healthcare Foundation located in the West Valley region (2) Borrego located throughout San Bernardino and Riverside Counties. The Loma Linda University Children's Hospital provides both inpatient and outpatient HIV primary care to children through the age of 21 years, funded through the California Children's Services. The Veterans Administration Medical Center is also located in San Bernardino County, providing HIV primary medical care to veterans living throughout southern California. Loma Linda University also provides HIV primary care services to adults through their Division of Infectious Diseases.

Apart from these, there is a dearth of HIV medical care in the County for low-income PLWH. Currently, there are nine HRSA-designated Federally Qualified Health Centers in the County. Four FQHCs (Hesperia, Ontario Adelanto and San Bernardino) are operated by the DPH, HIV related primary care services are offered in three of the locations. With the exception of SAC Health Systems (SACHS), most local providers and entities refer their HIV positive patients to one of the three county-operated health centers. Besides the DPH, there is only one major provider of dental services and three community-based organizations (CBOs) provide other primary care and supportive services(e.g., home health care, mental health treatment, substance abuse treatment, food and transportation assistance, outreach, etc.). These are mostly available in the East Valley Health Planning Region. Based on the surveillance data of new HIV/AIDS cases as well as prevalence data, there is a growing need to strengthen the infrastructure to better serve PLWH in the West Valley and Desert regions of the county.

Target Populations served by the Ryan White Part C Program

The San Bernardino County DPH's Part C HIV Program uses the Ryan White eligibility criteria established by the TGA's Part A Planning Council to target low-income (i.e., <300% of the FPL) PLWH in San Bernardino County as potential clients for HIV primary care services. Based upon the results of the *2014 Needs Assessment,* 94.8% of all PLWH in the County (n=4,031 persons) fall within this income threshold. As payer of last resort, Part C funds will be used to especially target PLWH who are uninsured (12.2% of all PLWH, n=492). The demographic characteristics the HIV Program's target population will mirror the epidemiological pattern of the epidemic.
Table 9 below depicts the demographic characteristics of the general population in San Bernardino County and compares this to the 2016 reported HIV/AIDS prevalence data and the HIV Program 2016 HIV client population.

Table 9. Demographic Characteristics of 2019 San Bernardino County General Population; 2019 HIV/AIDS Prevalence; and 2019 San Bernardino County Clinic Operations HIV Clients

Characteristic	General Population[a]		HIV/AIDS Prevalence[b]		HIV Program Clients[b,c]	
	Number	Percent	Number	Percent	Number	Percent
TOTAL Population	2,176,150	100%	4,589	100%	3701	100%
White	679,432	31.2%	1,230	26.8%	1783	48.1%
African American/Black	183,037	8.4%	1,096	23.9%	526	14.2%
Latino/Hispanic	1,113,534	51.1%	2,348	51.2%	1312	35.4%
Other Race (non-White)	200,147	9.1%	124	2.7%	78	2.1%
Unknown Race	0	0.0%	0	0.0%	2	0.05%
Male	1,083,923	49.8%	4,099	89.3%	3250	87.8%
Female	1,092,227	50.1%	819	17.8%	451	12.2%
Transgender	Unknown	N/A	Unknown	N/A	38	1.0%
0-12 years	(d)		3[e]	0.06%	0	0.0%
13-24 years	(d)		172[e]	3.7%	68	1.8%
25-44 years	603,078	27.7%	1,942[e]	42.3%	994	26.9%
45-64 years	504,286	23.1%	2,379[e]	51.8%	2156	58.3%
65 years and older	265,225	12.2%	422[e]	9.1%	483	13.1%
Unknown	0	0.0%	0	0.0%	0	0.0%
MSM	Unknown		2,690	58.6%	254	32.1%
IDU	Unknown		467	10.1%	64	8.1%
MSM/IDU	Unknown		291	6.3%	32	4.1%
Heterosexual	Unknown		500	10.9%	91	11.5%
Other/Perinatal	Unknown		37	0.8%	3	0.3%
No Identified Risk	Unknown		280	6.1%	346	43.9%

[a] Source: State of California, Department of Finance, Report P-2: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060.
[b] California Office of AIDS eHARS Download 4/2017.
[c] Source: ARIES export 7/12/2017
[d] Note: Age categories in the U.S. Census data are not comparable to HIV/AIDS prevalence data and HIV Program client data.
[e] Note: Age data reported to the State Office of AIDS represents current age.

The DPH Clinic Operations currently serves a higher proportion of clients who are from communities of color (51.7%) compared to 75.0% of total PLWH in the County. In 2019, 35.4% of Clinic Operations HIV clients are Latino compared to 51.1% of total PLWH. This is consistent with the 20.2% growth in new HIV and AIDS cases (Table 5) combined. Due to undocumented residency status, this population is also more likely to be among the uninsured and therefore in need of Part C-funded services.

The San Bernardino County DPH continues to deliver targeted HIV testing services to African American residents and utilizes social media campaign strategies to promote testing, increase access and linkage to care. The number of African American clients has increased to 14.2% and better matches their representation in total HIV/AIDS prevalence (23.9%, these efforts will continue in order to better address this disproportionately impacted population.

The DPH Clinic Operations Section refers pediatric HIV/AIDS cases to the Loma Linda

University Children's Hospital for HIV primary and specialty care. They are able to follow pediatric patients until the age of 21. Vertical transmission of HIV from mother to child have been reduced in the County due to screening of pregnant women in public and private settings. HIV and AIDS prevalence data only captures point-in-time age at the time of reporting. Thus, it does not reflect actual age of the HIV Program's target population. An analysis of the *2014 Needs Assessment* data show that on average San Bernardino County respondents have aged 15 years since their initial diagnosis. Table 9 depicts the ages of 2016 HIV Program clients. Over 90% of all clients are in the two age groups of 25-44 years (38.7%) and 45-64 years (52.4%).

In San Bernardino County, MSM comprise 54.6% of all PLWH and 32.1% (n=254) of HIV Program clients. In 2019 alone, 51.1% (n=116) of newly diagnosed HIV cases (n=227) were among MSM. Thus, it is likely that MSM will continue to be a key target population for services. In 2019, the HIV Program had 12 clients (5.2%) who were exposed to HIV through injection drug use (IDU) and another 9 (3.9%) who had the dual risk of MSM and IDU. This is slightly less than is reported in the County's total HIV/AIDS prevalence. This trend may continue, as IDU and MSM/IDU are fewer among newly diagnosed HIV and AIDS cases.
Heterosexual risk is also declining among newly diagnosed HIV cases. In 2019, they comprised only 21.5% of new cases compared to 22.1 % of total HIV/AIDS prevalence. With this decline, San Bernardino County is also having fewer women among newly diagnosed HIV cases (15.9%) compared to their representation in total HIV/AIDS prevalence (16.7%). About 12.2% of HIV Program clients were female at the end of 2019. This higher proportion of female clients may be due to the fact that women are more likely than men to seek HIV medical care. The TGA estimates that 27% of all male PLWH who are aware of their HIV status are not in care (i.e., Unmet Need). This compares to 32% of female PLWH who know their HIV status that are not in care.

As noted earlier in Table 8, approximately 12.2% (n=492) of all San Bernardino County PLWHA are uninsured. Currently, about 17.89% of the HIV Program's 2019 clients receiving HIV primary medical care had no insurance. Another 64.17% of clients had Medi-Cal (Medicaid in California), and 30.24% had Medicare or MediCal/Medicare as the primary payer. As the population of Latinos continues to rise among newly diagnosed HIV and AIDS cases, the HIV Program anticipates that the number and percentage of uninsured clients will rise as Latinos, who are not U.S. citizens become infected. They may also delay care as they are unable to pay for the high cost of HIV/AIDS care.

2) The Local HIV Service Delivery System and any recent changes, including changes as a result of the COVID-19 pandemic

- **HIV Service Providers (see Attachment 9: Service Area Map)**

There are seven principal providers of primary medical care for PLWH in San Bernardino County. They are: (1) the San Bernardino County Department of Public Health (DPH), (2) JerryL Pettis Memorial Veterans' Medical Center, (3) Kaiser Permanente, (4) Loma Linda UniversityMedical Center, (5) AIDS Healthcare Foundation, (6) the County's Arrowhead Regional Medical Center, and (7) the Social Action Community Health System (SACHS) affiliated with the Loma Linda University Medical Center. SACHS is the principal provider of dental care for PLWH in San Bernardino County and in 2010, opened a small outpatient clinic for persons living with HIV.

San Bernardino County Department of Public Health Clinic Operations Section provides HIV medical care through clinics at three locations countywide, including the City of San Bernardino (East Valley Health Planning Region), Ontario (West Valley), and Hesperia (Desert). All three clinics are designated Federally Qualified Health Centers (FQHC). AIDS Healthcare Foundation servesthe West Valley region and is located near the Los Angeles County border. With these few exceptions, all other primary care resources are located within ten miles of the urban center of the City of San Bernardino. Table 10 illustrates the services provided by each entity, number of clients served and the regions of San Bernardino County primarily served by each provider. A map of the service area, including providers of HIV primary health care and a HIV support services, with an accompanying legend, is included as Attachment 9.

Table 10. San Bernardino County HIV Services by Provider, Services, # of Clients, Regions Served

Service Provider	Services Provided	Clients Served CY 2016	Regions Served
San Bernardino County DPH Clinic Operations/ HIV Program Services	1, 3, 4, 6, 7, 8, 10, 14, 15, 16, 18	3701	East Valley; West Valley; Desert
Jerry L Pettis Memorial Veterans' Medical Center	1, 2, 19	429	East Valley
AIDS Healthcare Foundation	1, 3, 12, 15	107	West Valley
Arrowhead Regional Medical Center	1, 2, 4, 11, 14, 19	Est 290	East Valley
Social Action Community Health System	1, 5	263 (dental care)	East Valley
Loma Linda University Medical Center	1, 2, 19	Est 50 pediatric HIV 150 adult HIV	East Valley
Kaiser Permanente (private)	1, 2, 6, 8, 9, 11, 18, 19	591	East Valley
Foothill AIDS Project	4, 7, 9, 12, 13, 14, 15, 17	507	East Valley; West Valley; Desert

The DPH's Clinic Operations HIV clinical services program is the local HIV medical clinic in San Bernardino County and provides the majority of outpatient HIV primary medical care for PLWH in this area. The staff is representative of the populations served and the populations served are representative of those groups disproportionately affected by HIV. Clinic Operations Section maintains one HIV medical care clinic in each of its three health planning regions noted above. Clinic Operations Section offers comprehensive, patient-centered care from all three sites. In 2019, the HIV Program provided services for 3,701 unduplicated clients.

Current services include, but are not limited to:

- Adult medical examination, evaluation and treatment;
- Pap smears (anal and cervical); referral to colposcopy and high resolution anoscopy for those with dysplasia;
- Tuberculosis screening and treatment; radiology; laboratory services; screening for hepatitis A, B and C;
- Pharmacy and access to the California AIDS Drug Assistance Program (ADAP);

- Psychosocial evaluation and counseling;
- Mental health services;
- Immunizations;
- Health education, risk reduction and behavior change support, treatment adherence education;
- Medical and non-medical case management including development of individualized care plan;
- Benefits counseling;
- Nutritional assessment and counseling;
- Referral for substance abuse counseling, and treatment;
- Referral for biomedical research; and
- Referral for treatment or procedures, which exceed the clinic's scope of service.

At the beginning of the COVID-19 outbreak caused by the novel coronavirus, SARS-CoV-2, there was a decrease in the number of immunocompromised patients attending their scheduled appointments. With the lack of a preventive vaccine, avoiding exposure was the safest alternative for HIV-positive patients. Beginning in April 2020, providers at the DPH Clinic Operations FQHCs sites began telephonic appointments. Telephonic appointments offered patients an opportunity to speak to their providers over the phone regarding any medical concerns they may be experiencing and refill prescriptions.

In order to minimize the exposure to COVID-19 for DPH Clinic Operations FQHC patients, the program implemented a reduced schedule in March 2020, when the first COVID-19 case was reported in San Bernardino County. This schedule allowed well-patients to be scheduled to access health care services from 8am to 12pm. Patients who were exhibiting COVID-19 symptoms and/or had been exposed to someone who had tested positive, were scheduled from 1pm to 5pm for COVID testing only. Telephonic appointments were offered throughout the day for all immunocompromised patients who did not feel comfortable coming into the health center. Telehealth services were implemented in August 2020.

COVID-19 testing were offered during regular scheduled visits. This has allowed patients to minimize exposure by eliminating a separate visit for testing only. As of February 2021, the DPH has been administering the COVID-19 vaccine at all three FQHCs as a stand-alone appointment and as part of their regular scheduled visits. The clinical team has continuously provided COVID-19 educational materials to all patients via handouts during their visit, emailing information as it becomes available via the patient portal, and during telehealth consultations. Clinical staffing has been shifted internally to ensure continuity of care and greatest achievement of goals and objectives while ensuring COVID-19 testing and vaccines are made available to all patients.

- **Public Funding in Support of HIV Services:**

RW Part A: The San Bernardino County DPH administers RW Part A dollars for the Riverside/San Bernardino, CA TGA, but the DPH Clinic Operations Section does not receive Part A funds. DPH received $7,457,128 for FY 20/21 and all service dollars are contracted out to community-based organizations. The Desert AIDS Project (DAP) receives funding from RW Part A ($ 2,725,090) to provide a myriad of HIV core and support services in the TGA (through its maincampus in Palm Springs (Riverside County)). The vast majority of DAP clients reside in Riverside County, though the agency does provide care for some patients who reside in the eastern most section of the San Bernardino County Desert Planning Region. The Social Action Community Health

Systems (SACHS) receives RW Part A funding ($557,783) to provide dental services to PLWH. The Foothill AIDS Project receives funding from Part A ($ 2,402,871) to provide HIV support services, mental health, substance abuse and early intervention services in the TGA. The AIDS Healthcare Foundation (AHF) receives funding from Part A ($392,555) of the Ryan White Program to provide HIV primary care and medical case management in the WestValley Health Planning Region. The County of Riverside receives funding in the amount of ($ 743,486, for the provision of medical and support services.

Part B (State Single Allocation): The San Bernardino County DPH receives Part B funding ($879, 797) through a *master grant agreement* with the California DPH, Office of AIDS (CA OA) to support administrative and Early Intervention Services. A percentage is contracted out to Foothill AIDS Project (FAP), TruEvolution, and Borrego Community Health Foundation for support and outreach services. There is also an allocation for the Data to Care function, which required outreach to get clients linked, or back into care.

HIV Prevention (State Single Allocation): Through a master grant agreement with the California DPH, Office of AIDS (CA OA), DPH also receives Centers for Disease Control (CDC) and Prevention funding as follows:

- HIV Prevention Program (these are core HIV prevention dollars that originate from CDC and flow through the State Office of AIDS) -- $697,132
- Ending the HIV Epidemic (also originate from CDC and flow through the State Office of AIDS) -- $1,003,464
- Data 2 Care Project (This is the portion from her Part B monies that we are able to utilize for work on the Data 2 Care project) -- $200,173
- HIV Surveillance – awaiting on confirmation from the Accountant that supports CDS but it looks like the new current amount is $256,250 – I'll verify that dollar figure

ADAP: The San Bernardino County DPH receives CA AIDS Drug Assistance Program funds ($75,000, approx.) to administer the ADAP program within the three FQHC's. ADAP pays enrollment sites a floor amount of $5,000 and fee for service for activities pertaining to the provision of ADAP enrollment services.

Part C (Early Intervention Services-EIS): The San Bernardino County DPH receives funding from Part C ($449,158 in FY 19/20) of the Ryan White (RW) Program to support HIV clinical services (support for HIV provider salaries), mental health services, clinical quality management and laboratory support.

Part F (Community Based Dental Partnership): The Social Action Community Health Systems (SACHS) receives RW Part F Community Based Dental Partnership ($ 84,428). The Clinical Health and Prevention Services Division Chief participates in the local collaborative along with the PH Health Officer.

Minority AIDS Initiative (MAI): Part B MAI funding ($63,883) received through the master grant agreement from the CDPH OA support outreach services to link HIV positive minorities to care.

Minority AIDS Initiative (MAI): Part A MAI funding ($568,501) received through the master grant

agreement from the HRSA to support minorities into care.

Medi-Cal (CA Medicaid) and Medicare: The Arrowhead Regional Medical Center (ARMC) is the primary provider of County hospital services within the County. It relies on private insurance, Medi-Cal (CA Medicaid), Medicare, County Medically Indigent Adult (MIA) funds and research grants. ARMC receives no RW Part A funds.

- **Gaps in Local Services / Barriers to Care:**

Unmet Health Needs and Gaps in Primary Care Services: Understanding that people of color, living with HIV (Latino and African American), delay care and enter the HIV system of care through the portal of Community Based Organizations (CBOs) or Emergency Care Departments due to the documented distrust of government, and stigma associated with the disease. The DPH Clinic Operations Section sees a clear need for *trust-based* ***Medical and non-Medical Case Management.*** It has become evident, *from the HIV staff experience* that PLWH of color remain in care through their rapport developed with staff. Clients often ask for *"their nurse"* or *"their clerk".* There is a vital need for establishing rapport to identify and maintain PLWH in care.

The Clinic Operation Section provides ***Dental Care*** for adults 21 and older. Adults receive exams, x-rays, cleanings, fluoride treatments, fillings, full dentures and other medically necessary dental services.
Maintaining oral health for PLWH is paramount to ensuring positive health outcomes. The health centers also continue to collaborate with the PH Oral Health Team, which provides increased opportunity for service delivery to this population.

Nutrition Counseling is a clear need for the PLWH the HIV Program serves. The HIV Program has been able to access Nutrition Counseling services through partnership with the assigned Registered Dietician to the Health Centers. The services are limited as the Dietician is assigned to be at each Health Center, on a part time basis. .

Impact of Service Gaps
Local State OA and ARIES data show that there are an estimated 3,399 PLWH who need HIV Primary Care, but are not receiving it. While the HIV Program has made inroads to identifying those that are HIV+ but are not in care, using strategies such as targeted outreach, it is clear that more has to be done to bring those in need of care into care. For those that are already in care who responded to the 2014 Needs Assessment, the service needs that were identified which indicate service gaps included Dental Care, Nutrition Counseling, and Benefits Counseling/Health Insurance Premium Counseling among others. There is a heightened need for Dental Care for PLWH in the County, currently there is only one agency receiving RW Part A funds to provide dental services to PLWH. The restoration of dental services as one of the benefits under the Medi-Cal program will assist with paying for needed dental services for adults 21 years and older.

As the Healthcare Marketplace continues to change, the benefits systems become even more complex, the need for Benefits Counseling/Health Insurance Premium Counseling continues to increase. As stated earlier, among San Bernardino County PLWH, nearly 20% have not completed high school and 41% of residents speak a language other than English at home. This lack of educational attainment, in

addition to not being able to read or understand English materials for those whose primary language is Spanish, can compromise an individual's ability to negotiate complex systems of care impacting their ability to remain in care. Thus, Benefits Counseling/Health Insurance Premium Counseling can bridge the gap between understanding the system of care and making well-informed health decisions.

Barriers to Care: Substance abuse is a significant barrier to care for PLWHA in the County. More than 25% of all PLWHA responding to the 2014 Needs Assessment reported using an illicit substance in the past month (including marijuana), and 3.5% had used an illicit drug in thepast month (excluding marijuana). While the Department of Behavioral Health provides treatment to for at least one illicit drug-related diagnosis in the County, these services target the most severe cases of substance use, are typically court ordered, and are not tailored to PLWH who may have chronic substance abuse issues impacting their ability to adhere to treatment.

Mental health issues are also a barrier to care particularly when coupled with substance abuse. ARIES data show that over 37% (N=63) of the HIV Program's clients who received HIV Primary Care in 2016, had a documented need for Mental Health Services meaning that they hada diagnosable Mental Health disorder ranging from chronic depression to psychiatric disorders requiring inpatient treatment. Untreated or unmanaged mental health disorders clearly compromise the ability of PLWHA to enter and remain in care. Further, there is a need for appropriate psychiatric monitoring of medication for those taking psychoactive medication.

Populations not being served: Along with CA OA Incidence data, the 2014 Needs Assessment results present compelling new data on populations impacted by HIV. While there are five Part A-funded providers of HIV medical and support services within the County, the HIV Program, which is the largest and most comprehensive provider of HIV Primary Care, is facing a *new challenge*; the emergence of a new spike in HIV infection in the West Valley Health Planning Region. Seventy-three percent (73%) of all new HIV/AIDS infections in 2016 were among persons of color; African American and Latino. While the HIV Program serves 171 PLWH in the West Valley, this number is far below the known prevalence in the area (N=1,697). In addition, nearly 22% of all new HIV diagnoses are simultaneously diagnosed with AIDS indicating a delay in access to care. Of these 75% are persons of color. It is clear that there is a real need to identify PLWH of color who do not know their status and bring them into care. While troubling,this data is evidence that the need for Part C funding is more critical than ever.

PLWH With Unmet Need: In 2016, the RW Part A Program Office worked with epidemiology staff from the two-county TGA and a consultant to develop an *Unmet Need* estimate using HRSA's approved methodology. In August 2016, the TGA estimated that 36% of PLWH livingin San Bernardino County (N=1,451) are aware of their HIV status but not in primary medical care. Currently a demographic profile of PLWH is available only for the TGA as a whole and isnot county-specific. According to this TGA-wide demographic profile, the majority of PLWH with Unmet Need are female (32%) and African American (37%), followed by Latinos (30%). This profile is unfortunately more representative of the HIV/AIDS epidemic in Riverside County. As this estimate is updated annually as part of the planning process for RW Part A funding, the Part C HIV Program will work with the Part A Program staff to ensure that the upcoming (August 2018) estimate of Unmet Need include a demographic profile for San Bernardino County.

- **Current Health Care Landscape and Changes in the Health Care Delivery System that Affect the Delivery of Services**

The most significant recent change impacting the accessibility of services for PLWH in San Bernardino County is reduction in funding to provide services. SBCDPH Ryan White Part C EIS program has seen continual decrease in funding from 2016; CY 2016 ($478,221), CY 2017 ($466,745 a 2.4% reduction), and CY 2018 (458,188 a 4.2% reduction). In addition, the change in reimbursement for ADAP services by the CA Office of AIDS, ADAP program from an allocation amount of $43,875 to a floor amount of $15,000 and fee for service for activities pertaining to the provision of ADAP enrollment services, does not fully cover the cost to provide ADAP enrollment services.

As of May 1, 2014, the State of California restored ***Dental Care*** benefits for adults 21 and older. Adults can now receive exams, x-rays, cleanings, fluoride treatments, fillings, full dentures and other medically necessary dental services. PLWH can now access dental services if they have Medi-Cal. For those patients who do not qualify, RW Part A provides services through the SACHS clinic; unfortunately, this is the only RW Part A dental provider.

President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010. The main goal of the Affordable Care Act (ACA) was to extend health coverage

to many of the 42 million nonelderly uninsured individuals across the country, including many of the 5.8 million who lived in California. California was one of a handful of states to undertake an early expansion of its Medicaid program in anticipation of full expansion in 2014. The state did so under its five-year "Bridge to Reform§1115 Medicaid Demonstration Waiver, which was approved by the federal government in 2010. In addition to other provisions,the waiver allowed for federal matching funds for the creation of a county-based coverage expansion program, known as the Low-Income Health Program (LIHP), which covered low- income adults who were not otherwise eligible for Medi-Cal. San Bernardino County, was one ofthe counties that participated in the LIHP program. The county LIHP plan was referred to as ArrowCare and was a collaboration of five county entities: Arrowhead Regional Medical Center, Behavioral Health, Public Health, Human Services, and the Transitional Assistance Department (TAD). The benefits provided under the waiver were more limited than Medi-Cal. These individuals were either auto-enrolled in Medi-Cal or transferred to Covered California when ACA coverage expansions became available in January 2014. Table 11, illustrates the change ininsurance status from 2014 to present for patients accessing primary HIV medical care.

Table 11: Insurance Status of all HIV Clients for Primary HIV Medical Care

Insurance Source	# of Clients CY 2014	% of Total	# of Clients CY 2015	% of Total	# of Clients CY 2016	% of Total	# of Clients CY 2017 (6/30)	% of Total
Private Insurance/Private Pay	2	0.2	0	0	0	0	0	0
MediCare	166	16.8	153	16.3	139	15.4	112	18.1
Medi-Cal	532	54.0	593	63.2	541	60.0	360	58.1
Medi-Cal/Medicare	9	0.9	8	0.8	8	0.9	8	1.3
Other Public	1	0.1	0	0	0	0	0	0
No Insurance/Ryan White	276	28.0	185	19.7	214	23.7	139	22.5
Unknown	0	0	0	0	0	0	0	0
Total Clients*	**986**	**100.0**	**939**	**100.0**	**902**	**100.00**	**619**	**100.00**

*Clients may have more than one insurance payer during a year, so the total will exceed the actual number of clients

Under federal law, undocumented immigrants remain ineligible to enroll in federally funded full Medi-Cal coverage. However, California has taken several actions to expand eligibility for immigrants. Recent state legislation would further expand coverage for undocumented immigrants. Senate Bill 75 "Medi-Cal Expansion for Undocumented Children" was enacted in May 2016. This bill expanded full-scope Medi-Cal benefits to children under 19 years of age regardless of immigration status. RW Part C program provides services to PLWH who are unable to participate in the ACA due to their immigration status.

- ***METHODOLOGY***

The San Bernardino County DPH has centralized all medical services, including HIV outpatient/ ambulatory/primary medical care under the *Clinic Operations Section*. The Clinic Operations Section provides a broad range of HIV related services in three locations throughout the County. The DPH has established agreements with community based organizations and providers for services clients have difficulty accessing, e.g., dental care and substance abuse treatment.

1) HIV Care Continuum Services

A. HIV-Diagnosed

- ***Describe how counseling, testing and referral services are delivered in the service area***

Ryan White (RW) Part C funds <u>are not used</u> for this service as there is sufficient California Department of Health Services, Office of AIDS (CA OA) prevention funding to meet the demand for this service. To cast the widest "*Testing Net*" in targeting high-risk individuals, theDPH *HIV Prevention Team* offers both standard and rapid anonymous and confidential HIV antibody testing and counseling to high-risk individuals.

The HIV Prevention Team targets high risk individuals by offering counseling and testing at targeted venues where high-risk populations can be reached (e.g., adult detention facilities; day reporting centers; substance abuse recovery centers; gay clubs and bath houses, etc.). Additionally, the HIV Prevention Team offers counseling and testing in the community via streetlevel outreach from a mobile van used to provide services to hard-to-reach populations who might not otherwise access testing and care through the DPH. Most of the mobile testing efforts were affected during the 2020 calendar year due to the COVID-19 Pandemic, but confidential In-Home HIV test kits were made available through the HIV Prevention Program or the TakeMeHome.co website in order to meet the community needs. Mobile testing efforts have been reinstated as of April 2021 as the population is being vaccinated throughout San Bernardino County.

<u>Ensuring the Confidentiality/Anonymity of Clients and Test Results:</u> The confidentiality of clients testing for HIV is preserved in two ways:

I. Laboratory slips contain only numbers for anonymous testing, while client name is required for confidential testing. Informed consent documents contain only the minimal information needed, including the client's name and uniquelaboratory identifier. This minimizes the likelihood that anyone who did not have access to both the consent form and the laboratory report could ever identify a client's test result. During transport between field testing sites and the Public Health Laboratory, all records are kept in locked cases. Furthermore, all records (consent forms and test results) are stored in a locked file with access limited to designated staff.

II. Clients who opt for anonymous counseling and testing do not sign written consents, but rather give verbal consent. Clients testing anonymously are given a slip of paper that contains their unique laboratory number. The results are given only when they present the unique laboratory number. Great care is taken to match the demographic characteristics on the counseling form with the client who presents for the test results to ensure that clients do not receive or are given access to someone else's results.

All confidential and anonymous test site personnel have also completed mandatory Health Insurance Portability and Accountability Act (HIPAA) and Ethics training.

B. Linkage to Care

- **How are newly identified individuals with HIV linked into and provided with outpatient primary health care and support services and how are these newly identified individuals successfully transitioned into care.**

During CY 2020, SBCDPH FQHCs implemented rapid HIV testing,which are available to all patients during regular scheduled and walk-in primary care visits. During the same year, DPH also implemented same day access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) for anyone who may not already have tested for HIV but comes in the FQHCs with high risk of having exposure to HIV. Anyone receiving positive results from the rapid testing receives counseling and is linked to care on the same day as appointments are scheduled on the spot and all HIV services are explained by the primary care provider.

When a client receives a positive HIV antibody test result, during the services provided by HIV Prevention Team, the person performing as the HIV test counselor makes an immediate referral to one of the three SB County Health Centers, HIV Program. Initial clinic appointments are available to new clients and made within thirty days. For those clients in need of medical insurance, on-site eligibility workers facilitate timely income and insurance requirement verification. If the clients prefer to see their own physician, a consent to release medical information is secured. The test result is then forwarded to the client's primary care provider. For patients who choose to receive specialty services from the DPH FQHCs, but choose to keep their own primary care provider, we get authorization from their insurance in order to continue specialty care. Clients are provided with every opportunity to enroll in care. The San Bernardino County HIV team makes every effort to collaborate to improve services and access on behalf of the program. The Department has long-standing relationships with community providers and services to increase the ability to assist the clients in obtaining necessary services. Referrals for non-medical services, e.g., housing, food or clothing are made to community based AIDS service organizations such as Foothill AIDS Project.

- ***Efforts to increase enrollment in services by persons most affected by the epidemic.***

SBCDPH's HIV Prevention Team provides outreach programs specific to persons/communities of color, women, adolescents, MSM and IDU. These efforts are enhanced by the use of a *mobile testing van*. Providing prevention education, outreach and testing through a mobile van mitigates barriers for traditionally hard-to-reach populations who might be challenged by presenting to a formal governmental facility. Targeted venues include, but are not limited to: adult detention facilities; day reporting centers; substance use/abuse recovery centers; gay clubs, bars, coffee houses and bath houses; adult book stores; homeless shelters and the Rainbow Pride Youth Alliance. Interventions include street level, one-to-one outreach and small and large group prevention education. Partnerships with CBOs are essential in promoting community-testing events to yield the greatest outreach to targeted behavioral risk groups. The HIV Prevention

Team partners with local organizations to provide rapid testing, outreach and education at various community sites on National Black HIV/AIDS Awareness Day, National Women and Girls HIV/AIDS Awareness Day, National STD Awareness Month, National HIV Testing Awareness day, National Latino HIV/AIDS awareness day and World AIDS Day.

Other strategies used to reach and link target populations include developing staff skills in providing culturally/linguistically sensitive services; enhanced field visits by the MAI and Retention in Care outreach teams to re-engage persons (particularly persons of color) in care; maintaining strong relationships with other staff at entry points along the continuum, and promoting rapid HIV testing. During the current project period, special efforts have been taken by the HIV Prevention Team to increase enrollment in services by persons most affected by the epidemic by establishing new Alternative Test Sites (ATS) targeting sex industry workers (SIW) (especially women of color) and MSM. The ATS for SIW has been very well received by the target population; staff report strong peer to peer outreach as an unexpected positive outcome. The prevention team integrates prevention messages into annual STD Awareness month *Media Campaigns* designed to increase testing and linkage to care.

- ***How clients who test HIV-positive receive facilitated/timely referrals to primary care.***

When a client receives a positive HIV antibody test result, the HIV test counselor makes an immediate referral to one of the three San Bernardino County HIV clinics. Initial clinic appointments are available to new clients and made *within two weeks of first contact*. On-site eligibility workers facilitate timely income and insurance requirement verification. Licensed medical providers assess individual client needs to facilitate an earlier appointment if needed. If the client prefers to see their own physician, a *consent to release of medical information* is secured from the client and the test result is forwarded to the client's primary care provider.

If the client does not want to enroll in care with the San Bernardino County HIV clinics and also does not have a primary care physician, a referral is made to other local clinics, e.g., AIDS Healthcare Foundation Clinic, Borrego Community Health Foundation or the Social Action Community Health Services HIV Clinic. Clinic Operations staff working in HIV services have long standing relationships with these care providers and have the ability to assist the client in obtaining an appointment. Referrals for non-medical services; e.g., housing or food, are made to community based AIDS service organizations such as Foothill AIDS Project (FAP).

- ***How individuals who know they are positive but are not receiving primary medical care will be identified and enrolled in care.***

Early engagement and retention in HIV care is widely noted for resulting in optimal health outcomes. Clinic Operations staff work with the TGA's Ryan White (RW) Part A Program, through the use of the ARIES HIV management information system, in reconnecting into care PLWH who know their status, but have fallen out of HIV care. Using ARIES, Clinic Operations staff are able to identify PLWH who have missed their medical appointments. Once identified, HIV Prevention Team staff working in MAI or retention in care projects are able to follow-up with clients who have fallen out of care, including making field visits when needed.

In addition to these efforts of reconnecting PLWH who have fallen out of care, HIV Prevention Team staff, including MAI-funded Outreach workers, target areas of high HIV incidence to identify HIV positive persons who know their status and work to build linkages to care.
Furthermore, the HIV Prevention Team staff work collaboratively with other CBOs, and recipients of Ryan White Part A EIS dollars to provide outreach into affected communities.

- ***Describe policies and procedures for partner counseling services.***

The HIV Prevention Team has established a protocol for *Partner Counseling and Referral Services (PCRS)* using the *CA Office of AIDS PCRS Protocol Development Guidelines*. The goal of PCRS is to reduce the transmission of HIV by informing sexual and needle-sharing partners of possible exposure and providing risk reduction, and HIV counseling and testing and referral services to both positive and negative partners. The State's PCRS protocol includes:
(1) An HIV Prevention Team counselor informs clients of PCRS during the risk assessment (*pre-test counseling*) portion of the HIV antibody counseling and testing process. (2) Should the client test positive, they are reminded of the availability of PCRS. (3) Information regarding the availability of PCRSis also provided to HIV-positive clients during the initial intake appointment with Clinic Operations and then twice a year thereafter as part of regular health education/risk reduction services; and (4) clients are assisted with partner notification. The three methods of partner notification include: (1) the client informs their partner(s), (2) the client and an HIV test counselor or other Public Health employee present the positive test results together, and (3) the client requests that a Public Health Communicable Disease Investigator (CDI) notify the partner(s) anonymously. In this third method, the CDI will contact the named partner(s) and provide linkages for testing at a DPH facility or arrange for HIV testing in the field as needed. The DPH makes PCRS available at multiple points of entry into the system of care (e.g., HIV testing sites, EIS, community clinics, CBOs, STD/Reproductive Health clinics). Through a collaborative partnership with the DPH Communicable Disease Section, the DPH is also increasing outreach to public and private providers to inform them, as well as their clients, of available PCRS through the DPH.

C. Retention in Care

- **Strategies used to retain people with HIV in medical care, including any related to telehealth**

SBCDPH focus in retaining PLWH in medical care is essential to ensure the effectiveness of drug-associated viral suppression, continuing in care management including periodical lab work, health screenings and reduction in transmission. SBCDPH has assigned staff who work with PLWH as building a rapport with patients has proven to improve patient participation and continuation of services. SBCDPH provides a comprehensive variety of services at each FQHC, which facilitates the care of PLWH. These services include case management, expanded appointment options (telehealth and telephonic), one-stop care for HIV related services, primary care, reproductive health, dental care, behavioral health services, ADAP services, on-site Medi-Cal application services, and COVID-19 related services. SBCDPH also partners with the Foothill AIDS Project to have an on-site staff member to assist and arrange support services for patients as they attend their health care appointments.

During the COVID-19 pandemic, SBCDPH, as most health care providers, faced operational challenges in ensuring patients' continued care and safety by minimizing unnecessary exposure. SBCDPH implemented the following operational strategies to ensure retention in care for all

patients, during CY 2020:

- Provided patients up-to-date health care information, advances in services, and educational materials via Patient Portal.
- Retained all staff working on-site.
- Established changes in appointment scheduling to reduce the number of patients at a time in order to allow social distancing.
- Implemented telephonic and telehealth appointment availability. This technique allowed patients to attend appointments remotely and in the safety of their homes and minimize the exposure to COVID-19. Patients were offered the choice of services depending on current availability of phones, mobile devices or home computers in order to minimize a financial burden on patients.
- Utilized existing staff to provide distance care management and referral process for all necessary services, including lab orders and referrals to supportive services.
- Allocated resources to offer COVID-19 testing and administration of vaccines as stand-alone services and as addition to services provided during scheduled appointments.

D. Antitroviral Use and Viral Suppression

- **Success and challenges of current strategies including any related to telehealth**

SBCDPH provides care management services for PLWH to ensure adherence to viral suppression treatment through antiretroviral therapy (ART), which improves clinical outcomes, minimizes mortality, improves quality of life, and minimizes HIV transmission. The HIV clinical team continues to educate PLWH on the benefits of ART in order to improve adherence and continuation of medication. ADAP services are offered in-house in order to assist patients with the associated cost with ART and to assist them navigate the application, approval and renewal process.

SBCDPH has ensured that PLWH have continuous access to the HIV specialist by either telephonic or telehealth services. Telehealth appointments have provided SBCDPH the opportunity to provide remote medical services to PLWH in order to avoid break in care during the COVID-19 pandemic but it has also presented some challenges. Some patients, who may have already been inclined to not follow directions on lab work, adherence to prescription or attendance for appointments, may feel encouraged to not attend in-person due to fear of exposure to COVID-19. These same patients may not have access to mobile devices, connectivity services, or computer at home, limiting their willingness to participate in a telehealth appointment. Patient education on privacy and security is also important to ensure the patients' privacy is maintained at all times and not compromised by the possibility of someone in the patient's household overhearing information being shared and discussed with the patient.

Continuous ART adherence education is enforced at every appointment and CD4 cell counts are monitored regularly during refill appointments. Telehealth appointments follow the same established guidelines as in-person appointments with the difference that patients may hesitate going to the assigned labs causing a delay in services. In order to make telehealth appointments successful, SBCDPH applies the same in-person care team, which includes outreach and referral services being offered, and ensuring continuous patient retention in care.

2) Description of Core Medical Services

- ***The proposed diagnostic and therapeutic services that will be provided.***

The HIV Program uses the Geenius HIV1/2 Supplemental Assay technique to confirm HIV infection. Immunodeficiency is measured through CD4 cell counts and based on the physical examination; e.g. if a client has a CD4 cell count above 500 cells per mm^3, but an examination of the oral cavity identifies thrush, a yeast infection that develops in the mouth, then immunodeficiency is suspected. The DPH uses tests called flow cytometry for CD4 cell counts and polymerase chain reaction to measure extracellular viral RNA to determine a client's immune status and viral load. Highly active anti-retroviral therapy (HAART) is available to reduce the clients' viral load. Genotyping and phenotyping tests are employed to guide treatmentplanning for cases that are more complicated.

Prophylactic medications and vaccinations for opportunistic infections are prescribed per United States Public Health Service (USPHS) guidelines; e.g. *Pneumocystis jiroveci* pneumonia, *Toxoplasma gondii, Mycobacterium avium intracellulare, Mycobacterium tuberculosis,* pneumococcal vaccine, and hepatitis A and B vaccines. Treatment interventions for opportunistic malignancies and other AIDS defining conditions are also provided, including screening for cervical and anal cancers. Abnormal results are further referred for colposcopy or high-resolution anoscopy. In response to growing incidence of syphilis in San Bernardino County, the HIV Medical Director has proposed a revised syphilis protocol for men who have sex with men that includes screening every 6 months and enhanced health education and risk reduction sessions focusing on the syphilis disease process. The periodicity of medical evaluations can vary from weekly or bi-weekly to monthly, quarterly or semi-annually and is medically determined by several factors; i.e. USPHS guidelines, locally developed protocols, an individual client's CD4 count/viral load, level of adherence to treatment regimens and pregnancy.

The most recent protocol editions are used for the *USPHS Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescent; Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health andInterventions to Reduce Perinatal HIV Transmission in the United States; Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents; and Guidelines for Incorporating HIV Prevention into the Medical Care of Persons Living with HIV* and the *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*. Staff work with pregnant women and women of childbearing age to educate them on the importance of HAART and the need to adhere to the prescribed regimen to preserve the woman's health and to reduce the likelihood of perinatal transmission.

- ***Strategies used to engage women and minority population in HIV- related clinical trials***

In San Bernardino County, the two largest minority groups impacted are the Latino and African American communities. Additionally, other minority groups served in San Bernardino County include Asian/Pacific Islanders and American Indians/Alaska Natives. Maintaining a strong presence in the local community, especially working with organizations that target African American and Latino communities is essential for minimizing barriers to care. The Department of Public Health maintains strong partnerships with local community based organizations and conducts outreach efforts, resulting in more minorities accessing comprehensive HIV services, including specialized HIV medical care. These coordinated efforts have involved the following agencies: San Bernardino

County Probation Department Day Reporting Center (DRC) we provide community classes to target the post-incarcerated in order offer HIV education with on-site rapid HIV testing; and Foothill AIDS Project targeting African American/Latino people living with HIV/AIDS (PLWH). The program also provides outpatient/ambulatory health services within the County Detention Centers by conducting new-patient visits, medication adjustments, lab orders, patient education and linkage to care upon release.

Clients can be referred internally for certain clinical trials or externally to the University of California Los Angeles Medical Center or the University of California Irvine Medical Center. Both medical centers are within acceptable driving distances or are accessible through public transportation. The DPH has participated in a number of expanded access protocols, which enable clients' access to necessary medications without having to travel long distances.
SBCDPH has also created informational flyers regarding clinical trials available to our patients within a fifty mile (50) radius. These flyers are posted in the lobby area and in examination rooms at all three FQHCs providing HIV services. On a quarterly basis, the Health Educator Specialist (HES) researches current trials in the Southern California area on clinicaltrials.gov and clinical connection.com. Once the local trials are identified, the EHS contacts the local institutions and verifies the trials are current and our patients would be able to participate, if desired. Once the information is verified, the information on the flyer is updated.

- ***Availability of AIDS Drug Assistance Program or other local pharmacy program.*** ADAP is funded by the Ryan White Program Part B and is administered by the CA Office of AIDS. ADAP is available to qualified clients. The DPH Clerical staff screen all clients for ADAP eligibility, along with screening for other benefits including Medi-Cal (CA Medicaid). Eligibility screening is done annually and clients are contacted prior to their ADAP expiring to make an appointment for re-enrollment. The local RW Part A funded Pharmacy Assistance Program is intended to fill gaps when a client is waiting for eligibility determination from ADAP, Medi-Cal, or other pharmacy insurance. In some cases, if a client needs HIV related medication, but does not have all the necessary paperwork and all local Part A Drug Assistancefunds are depleted, a 30-day eligibility period is granted to allow the client access to needed medications and to complete the process.

- ***The laboratory that you plan to use to support CD4, viral load, and other tests.***

Clinic Operations uses the San Bernardino County DPH Laboratory to provide flow cytometry for CD4 cell counts, quantitative polymerase chain reaction to measure extracellular viral RNA and HIV-1 genotyping. The laboratory also provides tests for syphilis; gonorrhea; chlamydia; herpes; hepatitis A, B, C; cytomegalovirus; toxoplasma antibody; occult blood; hemoglobin and pregnancy. *Lab Corp and Quest Medical Laboratories* provides complete blood counts with differential, Pap smear interpretation, chemistry panels, lipid profiles, liver function tests, hepatitis B and C subtyping, quantitative viral load testing, sedimentation rates, testosterone levels, lipase, thyroid stimulating hormone, progesterone, amylase and other specialty tests.
Phenotyping tests are performed by Monogram Biosciences. The DPH also uses Part B funds to support HIV primary care and laboratory support, including CD4 cell counts, genotyping and phenotyping in San Bernardino County.

- ***Staff training related to HIV primary care, including AETC available training.***

Annually, the HIV physician and physician assistant attend the University of California San Francisco's School of Medicine *Medical Management of AIDS: A Comprehensive Review of HIV Management Conference*. Other training opportunities are identified throughout the year. All Clinic Operations staff working in HIV services must complete HIV-related continuing education on an annual basis. Staff are required to complete annual cultural competency training. The DPH utilizes training opportunities provided by the Pacific AIDS Education Training Centers (AETC) when possible. Three AETCs are available in neighboring Los Angeles and Orange counties. Other staff training opportunities are available through the California STD/HIV Prevention Training Center and the State of California Office of AIDS.

- ***How consumers are involved in decisions regarding their personal health care regimen.***

Patient self-management is a key element of the *Chronic Care Model,* which has shaped service delivery over the past nine years in the TGA. The DPH provides support for clients to be actively involved in decisions regarding their personal care regimen, utilizing these methods:

HIV Treatment and Individual Care Plan: The HIV Treatment Plan (focusing primarily on medical care) is completed at intake and updated annually thereafter. The client reviews, signs, and receives a copy of their plan. Physicians, together with clients, review treatment options prior to the initiation or adjustment of specific therapies. Clients meet with a nurse at the end ofeach clinic visit to ensure that the client understands the treatment regimen or any changes to their therapy. Health Education Specialists and nursing staff provide information and strategies to assist the client in making healthy lifestyle decisions as well as offer behavior change supportand treatment adherence education. The Medical Case Manager works with clients to help them navigate the care system, such as securing referrals to specialty and subspecialty services and to access community-based support services. The treatment team holds periodic case conferences toevaluate clients and their treatment plans. Clients can participate in the case conference during the discussion of their plan.

A separate *Individualized Care Plan* (ICP) (focusing on behavioral and support service needs) is developed with each client by the Medical Case Manager, in collaboration with Health EducationSpecialist as needed, addressing behavioral (risk reduction) goals, and support service needs. TheICP is completed at intake and updated annually thereafter. The ICP is discussed with the client and the client reviews, signs, and receives a copy of their plan. As an example, the ICP may include objectives addressing Housing or Food needs.

- ***After-hours and weekend coverage for urgent or emergency medical and dental care.***

Clients requiring after-hours or weekend emergency medical care are advised to access emergency departments of local hospitals. Clients who must access emergency care or are hospitalized during after-hours or on weekends are encouraged to inform the provider of their HIV care at the DPH to facilitate the sharing of critical medical information. All patients can access an after-hours advice line by calling the Clinic Operation patient line. HIV patients with Inland Empire Health Plan (IEHP) managed care plan, can also access the 24-Hour Nurse Advice Line, and the line is open after hours, holidays and weekends. Medical Case Management staff are responsible for follow through with the hospital or after-hours care provider to obtain pertinent information to update the client's medical record and to ensure continuity of care following hospital discharge. DPH provides direct dental services onsite to clients at three Federally Qualified Health Centers.

- ***Enrolling patients into primary care services.***

After the onset of the Affordable Care Act, most patients who have insurance (public or private) were required to have a medical home. The primary care provider was the gatekeeper for all health care services for the patient and referred to services as needed. This is to assist with coordination and continuity of care by one provider. Patients who receive specialty care at the three clinic sites (Ontario, Hesperia and San Bernardino) are linked to a primary care provider with the help of HIV Part B funds. HIV Part C staff work with HIV Part B staff to identify patients in need ofprimary care services, and link them to a medical home. That could be internally or externally depending on the patient preference.

- ***Transfer of HIV-positive youth and their medical information into adult care.***

Children and youth receive ongoing HIV care and treatment from diagnosis to age 21 through the Loma Linda University (LLU) Medical Center. At age 21, the LLU Medical Center refers HIV positive youth to the DPH's Clinic Operations or to other HIV care providers in San Bernardino County depending on the client's residence. To maintain confidentiality, the LLU Medical Center provides the HIV positive youth with information about the available adult care HIV resources in the county. The client then calls Clinic Operations to make an initial appointment. The LLU Medical Center follows up on referrals to ensure linkage to care. For those youth that choose to receive care at one of the County's DPH HIV clinics, the client signs a*release of information* and the Clinic Operations clerical support staff processes the request for the transfer of medical records from the LLU Medical Center. Once an HIV positive youth entersthe Clinic Operations HIV system of care at age 21, he or she is assigned to a Medical Home andMedical Case Manager. The Medical Case Manager will have an initial meeting with the HIV positive youth to assess needs for support services, as well as to provide the youth client with information about available community resources. The Medical Case Manager provides specific referrals for services based on the individual's needs and will follow-up with the youth client within 2 weeks of the initial referral to determine the outcome, identify any barriers, and mutually develop a plan to overcome identified barriers. During the first year after transitioning care from the LLU Medical Center, the Medical Case Manager will follow up with youth clients quarterly to ensure engagement and retention in care.

3) Description of Supportive Services

Part C refers patients to Part B for supportive services, the services are complimentary and consistent with Part B, and are not duplicative.

4) Description of Referral System and Care Coordination

- ***Referrals to specialty and subspecialty medical care and other health and social services.***

Referrals for specialty and subspecialty medical care are predicated on medical screening, testing, evaluation and physical assessments conducted by the physician. When the needs of the client exceed the scope of service provided by the DPH, a referral is generated to the appropriateservice provider(s). Registered nurses (RN) process all medical referrals (with the exception of outpatient mental health and substance abuse treatment) and LVNs or Health Services Assistantsmake those for social support services. Referrals to outside providers are made based on individual consumer eligibility and insurance status. Every effort is made to ensure the entity to which the client is referred has available appointments to ensure timely access to care and treatment. For clients

without insurance, referrals for specialty care are made to the Arrowhead Regional Medical Center (County hospital) system of care. Maternal and infant health services are provided on site at the San Bernardino, Ontario and Hesperia Health Center by contracted OB, which makes coordination of services for pregnant HIV positive women through the perinatal and post-partum periods relatively seamless. HIV specialty care for exposed/infected children is coordinated with LLU Medical Center. Referrals can be monitored in ARIES to verify timeliness of the referral, if the appointment was kept, and if information regarding the referral was returned to the referring physician.

- ***How referrals are tracked and followed up, including the result.***

The process to facilitate and track referrals is accomplished through the utilization of ARIES, the TGA's HIV information management system. Each referral for specialty and subspecialty medical care is entered into ARIES by data entry staff. *Referral Reports* are generated periodically and are reviewed by the Medical Case Manager to identify all pending and incomplete referrals. RNII/Medical Case Managers are responsible for determining and overseeing needed follow up on all referrals to ensure linkages to care.

- ***Coordination with admission/emergency room staff and discharge planners.*** Coordination between the Clinic Operations RNII/Medical Case Managers and providers of acute inpatient or emergency services occurs on a case-by-case basis. Emergency room and specialty service physicians (e.g. infectious disease, internal medicine) communicate by telephone on clients in emergency care or those who have been hospitalized and those who areready to be discharged. When a request for medical records is received along with a signed released of information, the RNII/Medical Case Manager works with clerical support staff to process the request per protocol and contact the requestor to ensure delivery.

Clients are also a part of their admission/discharge processes. They are requested to telephone their assigned Medical Case Manager when they present to an emergency department, when they are hospitalized, or when they are about to be discharged from inpatient care. In the case of the latter, RNII/Medical Case Managers coordinate with discharge planners to ensure that clients will get the care, assistance and durable medical equipment that they might need subsequent to release from the hospital. Copies of relevant medical records, discharge summaries and medical orders are requested from the facility to guide follow-up care. Follow-up appointments through Clinic Operations are scheduled as soon as possible after discharge.

5) Health Care Coverage, Benefit Coordination and Third Party Reimbursements

- ***Plans for outreach and enrollment of RWHAP clients into new health coverage options.***

The County of San Bernardino has established multidisciplinary groups consisting of county and non- county Stakeholders who were involved in the development of the LIHP. This same group proactively moved their agenda forward to address the anticipated outreach and enrollment activities after ACA. DPH has established partnerships with local agencies to increase enrollment eligibility through Covered California, the state marketplace and Medi-Cal. Partnerships with the Transitional Assistance Department (TAD), which allowed Eligibility Workers to be placed on-site at the Hesperia, Ontario and San Bernardino Health Centers, assures Medi-Cal eligibility is determined accurately and timely. The Eligibility Workers enroll patients; provide guidance and technical assistance to ensure compliance with state and federal laws.

The three clinic sites are also FQHCs, which have supplemental Outreach and Enrollment Assistance funds to assist patients with health insurance options available through the State Marketplace and the enrollment process. Activities under this Outreach and Enrollment Assistance project are two-pronged: 1) "in reach" with existing FQHC patients and 2) outreach to non-patients in the target service area to make these individuals aware of options they are eligible for, determine eligibility for individuals, and provide assistance to individuals in navigating the enrollment processes.

- **How are your clients educated about out of pocket cost**

As patients seek services with DPH, they are informed of the various no-cost programs available to them, including applying for Medi-Cal benefits and ADAP. Patients are also informed any related fees are based on household income. The Sliding Fee Scale and Schedule of Discount Table are posted in all lobbies and provided to patients, prior to services being rendered. If a patient requires any special services or referrals, they are advised of potential out of pocket cost, as the referral is done.

- **Health Care Coverage, Benefit Coordination and Third Party Reimbursement:**

In each of the three *health planning regions* where Clinic Operation's HIV clinics are located, an on-site *Eligibility Worker* (non-Part C funded) functions as a *Benefits Counselor*. Newly enrolled clients meet with the Eligibility Worker to determine which, if any, Federal, State or local support programs are available to the client. This is intended to ensure that Ryan White is the payer of last resort. These Eligibility Workers screen each client for Medi-Cal (CA Medicaid), Private Insurance, Veterans Administration, ADAP, etc. As needed, Eligibility Workers are able to provide clients with assistance in the preparation of applications, referral information and telephone numbers to facilitate enrollment. If the client is found to be eligible for any third party payer source, then that source is identified as the payer of services and is billed for services rendered. If a client has a pending application with a third party payer, but needs HIV care (e.g., client is waiting on Medi-Cal determination), the client is provided care and if the client is determined to be eligible for Medi-Cal, then the DPH Fiscal Services Section

back-bills Medi-Cal for services rendered.

- ***How program income is collected, tracked, and used to support your HIV program.*** Program Income is collected *daily* by the Receptionist/Office Assistant II. Any income collected is processed for submission to the DPH's central Fiscal and Administrative Services (FAS) where Fiscal Specialists (FS) prepare funds for deposit including allocating HIV program income to those cost centers used by Clinic Operations in the cost accounting system; e.g. *$200 to 0843-RW Part C.* The FAS Program Manager is authorized to manage these accounts. On a *monthly* basis, the FS generates *Program Revenue* reports by Program indicating the amounts of Program Income and associated *object codes* to identify the source of income; e.g. *$200 to 0843-RW Part C (8860-Medicaid).* Revenue allocated to Clinic Operations from Program Income sources are used by Clinic Operations to pay for additional HIV primary medical care services for eligible clients.

- ***Your organization's participation or intent to participate in the 340B Drug Pricing Program.***

The San Bernardino County DPH currently participates in the 340(B) Drug Discounting Program to purchase medications at a discount price. The specific Ryan White Part C 340 B ID number is HV00154.

6) Coordination and linkages with Other HIV Programs

Part A: The County of San Bernardino is the Part A Grantee for the Riverside/San Bernardino, California Transitional Grant Area (TGA). For FY 20/21 Part A was awarded $7,457,128, of which 85% of that goes to services and is contracted to 5 agencies: Desert AIDS Project (DAP), AIDS Healthcare Foundation (AHF), Foothill AIDS Project (FAP), Riverside County and SACHS. The San Bernardino County Clinic Operations Section is not a recipient of Part A funding. The services provided by Clinic Operations are consistent with those supported by Part A, but not duplicative of other providers.

Other RWHAP Providers: AIDS Healthcare Foundation (AHF) is the only primary medical care provider funded by Part A in San Bernardino County. AHF is located in the far west end of San Bernardino County near the populous Los Angeles County border (Attachment 9). There is no overlap between the clients of Clinic Operations and AHF. Further, the DPH Clinic Operations Section is the only provider of HIV primary medical care to operate clinics in each of the three health planning regions of San Bernardino County. *A Letter of Support from the Part A Grantee of Record is attached to this application (Attachment 10)*

Part B: The SBC Department of Public Health, Clinic Operations Section is not a recipient of Part B funding. The DPH Ryan White Program receives $879,797 by means of a *master grant agreement* with the CA State Office of AIDS for administration and Early Intervention Services. The funds are contracted out to: Foothill AIDS Project (FAP) for case management, food, transportation, and Outreach) services; TruEvolution for Outreach services; and Borrego Community Health Foundation for Outreach. Part C refers patients to Part B for supportive services, the services are complimentary and consistent with Part B, and are not duplicative. *A Letter of Support from the Part B Grantee of Record is attached to this application (Attachment 10).*

Part C EIS: There are no other Part C-funded programs in San Bernardino County.

Part F: SACHS is a recipient of both Ryan White Part F and Part A funding. For CY 2020, SACHS received $103,002 for Part F funding, and for GY 20/21 they received $557,783 for part A funding. The Part A funding is used to deliver direct Oral Health Care services to PLWH.

CDC HIV Prevention Grant: CDC HIV Prevention Grant: SBC Department of Public Health, Health Education Section receives CDC Prevention funding in the form of a master grant agreement from the CA Office of AIDS. The HIV Prevention Program focuses on identifying persons identifying persons living with HIV/AIDS and linking them to care. Targeted populations include MSM, IDU and their sex partners, high risk African American and Latina women, unhoused persons and transgendered/at risk youth for primary prevention. Interventions include: HIV prevention education, linkage to care,

retention and re-engagement in care, PrEP/PEP navigation, targeted HIV antibody

counseling/testing at Alternative Test Sites, enhanced via a mobile van, In-Home HIV test kits and expansion of Syringe Services Programs. Hepatitis C screening is also offered to eligible target populations.

The HIV Prevention Team has designed and implemented outreach/HIV antibody counseling and testing programs specific to persons/communities of color, women, adolescents, MSM and IDU. Effective and efficient prevention interventions require positive collaboration with CBOs. The HIV Prevention Team maintains strong partnerships with the Foothill AIDS Project to offer coordinated outreach into San Bernardino County neighborhoods to offer HIV antibody counseling and testing to target populations that might not otherwise access the DPH.

For newly identified persons with HIV infection, referrals for HIV primary care are provided, including linkage to the DPH's Part C EIS clinics, the Desert AIDS Project/H Street Clinic, AIDS Healthcare Foundation and/or their personal physician. The immediate linkage of the newly identified HIV positive client to primary medical care is important to developing a trusting relationship and removing barriers for those clients that may otherwise delay in seeking treatment and support services.

The DPH also provides Sexually Transmitted Infection (STI) screening and treatment services. HIV Prevention Team outreach staff are well-versed in providing at risk individuals with information about sexually transmitted infections (STI), risk reduction strategies and referrals for STI screening and treatment through Clinic Operations. Staff also provide outreach contacts with referrals to DPH Clinic Operations for other needed services such as tuberculosis screening and treatment; to the Department of Behavioral Health for substance abuse counseling and treatment or mental health counseling; and to CBOs for housing and food assistance.

Prevention Education include Pre-Exposure Prophylaxis (PrEP) information and resources, the basics of HIV transmission, risk reduction counseling, treatment adherence support, partner elicitation services (assistance in disclosing HIV status to partners), and referrals to other available resources.

- ***Describe targeted outreach efforts for specific communities and/or emerging target populations you serve.***

Maintaining a strong presence in the local community, especially working with organizations that target African American and Latino communities is essential for minimizing barriers to care.The DPH's *HIV Prevention Team Outreach and Education Staff* (non-Part C funded) collaboratewith several providers targeting communities of color in San Bernardino County. These coordinated efforts have involved the following agencies: California Department of Corrections Day Reporting Center and County Probation Department – targeting the post-incarcerated; and Foothill AIDS Project- targeting African American and Latino PLWH, including MSM among others.

- ***How clients will have access to support services to achieve their HIV medical outcomes.***

Clinic Operations employs a RN/LVN/Care Assistants team structure at each HIV service site to

provide -Medical Case Management (and non-medical case management) services for clients.

Additionally, non-MCM Services are funded by Part A and provided by Desert AIDS Project, and Foothill AIDS Project; Clinic Operations coordinates with outside social service providers as needed so as not to duplicate services.

Translation: Translation is available through current bilingual staff. Literature is translated into Spanish, and cultural competency training is provided to all staff members to sensitize them to cultural concerns, particularly those associate with Hispanic/Latino/a culture.

Transportation: Transportation is coordinated by the case manager or clinic staff using cab vouchers. *Medical Transportation Services* are provided by the Foothill AIDS Project, a Part A provider.

- ***Other federally funded services in San Bernardino County:*** The County of San Bernardino Department of Public Health receives $$1,970,097 (20/21).from the United States Department of Health and Human Services, Health Resources and Services Administration to operate four Federally Qualified Health Centers (FQHCs) that provide enhanced health care services in the High Desertand Valley communities of the Count.

- ***WORK PLAN*** (See Attachment 12)

- ***RESOLUTION OF CHALLENGES***

    - ***Factors that facilitated and hindered implementation of your project.***

Challenges	Resolutions	Outcomes/Current Status
Change in the health care environment	~Before 2011: Ryan White was the only medical option for PLWH	~PLWH who did not have private insurance received services

		through Ryan White.
	~2011-2013: Low Income Health Plans (LIHP) • Bridged patients into government funded medical programs that they previously did not qualify	~SBCDPH assists PLWH to enroll into ACA through the Medi-Cal Expansion Program.
	~2014-Present: Affordable Care Act • Expanded medical services to adults (<138% FPL) through the Medi-Cal Expansion program; • Provided Essential Health Benefits; • Removed pre-existing conditions; and • Assisted patients with paying for premiums under market exchanges such as Covered CA • If eligible for ADAP, the State Office of AIDS will assist with premiums, co-pays and out of pocket expenses	~As a result, there has been a decrease in the number of Ryan White patients as RW is payor of last result. • CY 2014: 54% of HIV patients had MediCal while 28% had RW Part C • CY 2016: 60% had MediCal compared to 24% RW Part C ~Under the ACA, PLWH have more options available to them, comprehensive care, and a wider network of collaborative partners. ~ACA released funds to provide other support services.
	~May 1, 2014-Present: Dental Services • The State of California restored ***Dental Care*** benefits for adults 21 and older.	~This provided access to PLWH to receive exams, x-rays, cleanings, and other medically necessary dental services
	~2017-Present: Repeal of the ACA • May 4, 2017: The House of Representatives passed a measure to repeal and replace the Affordable Care Act.	~ Repeal would eliminate or reduce benefits awarded by the ACA, eliminate

	• July 26, 2017: The Republican Senate voted 51-50 to begin debating the repeal of the Affordable Care Act • July 11, 2019: Young Undocumented Californians Cheer Promise Of Health Benefits.	premium assistance and loss of other HIV/STD related funding ~Starting January 2020, income-eligible undocumented adults from age 19 until they turn 26, will be able to apply for Medi-Cal, making California the first state in the United States to cover this group. California estimates 138,000 young adults will become insured under the new policy
Reduction/Increase HIV Funding	~From 2014-Present • Decrease in RW Part C funding o FY 16/17: $478,221 o FY 17/18: $466, 745 o FY 18/19: 458, 188 o FY 19/20: $449,158 • Increase in RW Part A funding • ADAP: o FY 16/17: change in reimbursement from allocation funding (FY 15/16: $43, 875) to base funding ($15,000) and fee for service for enrollment services	~This change is expected as access to ACA has shifted the need from medical type services to support services such as case management, oral health, mental health, and food assistance

Ethnic or Minority Groups served	~ In 2016, the prevalence of PLWH in San Bernardino County who are minorities was 72%. Specifically, 43% were Latino; 24% were black; 4.8% were other race (non-white); and 0.2% were of unknown race. African Americans make up 8% of the population but account for 24% of PLWH. Delays in seeking testing whether due to stigma or access to culturally sensitive testing settings contribute to many African American and Latino clinic clients developing AIDS within three months of HIV diagnosis; 15.0% and 24.5% respectively	~Outreach: RW Part C works with the HIV prevention team to outreach, educate and test minority groups through a mobile testing van, street one to one outreach, and community testing events. ~ 2014-2015, there were 129 outreach efforts to connect patients of color back into care ~Linked to Care: When a client receives a positive HIV antibody test result, the HIV test counselor makes an immediate referral to one of the three clinic sites. Initial clinic appointments are available to new clients and made *within two weeks of first contact*

		~Retained in Care: Early engagement and retention in HIV care contributes greatly to positive health outcomes. Those "lost to follow-up" are re-engaged back to care by staff making phone calls and field visits. From 2014-2016 (year-to-date) a total of 228 clients.

- ***EVALUATION AND TECHNICAL SUPPORT CAPACITY***

Quality Management (QM)

- ***Infrastructure:***

a. Describe the program's quality goals.

The purpose of the HIV Program's Clinical Quality Management (CQM) Program is to coordinate a systematic approach for evaluating and improving the quality of services. As outlined in its written CQM plan, the goals of the CQM Program are to promote access to and maintenance patients in medical care, and to improve health outcomes for PLWH. CQM goals are met by:

- Establishing, implementing, and continuously improving a *Clinical Quality Management plan*;
- Ensuring HIV Primary Care services adhere to the *Department of Health and Human Services (DHHS)* treatment guidelines and standards of care;
- Ensuring productive quality improvement activities and improved compliance with HIV/AIDS Bureau and local quality management expectations; and
- Measuring and evaluating client level health outcomes, ensuring the provision of high quality, and culturally and linguistically competent medical care and support services to Ryan White (RW) eligible PLWH who are not able to obtain needed services through other sources.

b. Describe the QM infrastructure, including the key leaders and quality committee.

Under the direction of the HIV Program Clinical Director; one Registered Nurse (RN) II/CQM 0.20 FTE is responsible for ensuring compliance with the HIV Program's CQM Plan objectives and all HRSA CQM requirements, including ensuring that all data is captured and reported. To ensure this is accomplished the HIV Program has established the CQM team to provides general oversight to and monitoring of the CQM Plan progress and clinical quality improvement (CQI) initiatives across the three clinical sites. The QMC is comprised of the HIV Medical Director, RNII/CQM Lead, LVN II, Clinical Therapists, and the HIV Prevention team. The CQM team also identifies areas of improvement, coordination of services, training and strategies to improve service delivery. The CQM team lead is the PH Program Manager (0.05 FTE) and includes the

HIV Medical Director, RNII/CQM Lead, Clinical Therapist II, Public Health Epidemiologist, HIV Prevention Team Lead, Ryan White Part A and B Program Representative, Public Health Nurse Manager and Public Health Program Manager. The SC and QMC meets monthly and attendance is recorded on a sign-in sheet. Minutes are recorded, circulated and provided to grantors for the purpose of audit.

c. Describe the resources dedicated to QM activities.

A successful CQM program relies on the commitment and support of key staff at every level of the organization. While not funded by Part C funds, the PH Chief of Community Health Services/Director of Nursing has championed all continuous quality improvement for health services provided by the Department of Public Health including HIV services. To support the specific needs of the Part C Program, 2.12 % FTE of Part C funds have been allocated to ensure the facilitation of clear CQM program initiatives. This represents 0.20 FTE of one RNII/CQM Lead who is responsible for monitoring all HIV CQM activities including facilitating the activities of the CQM. Other members of the QMC, while not funded by Part C CQM funds, bring additional resources to bear. These members includes the HIV Medical Director, who is a member of the American Association of HIV Medicine (AAHIVM), with 30plus years of HIV Primary Care experience; licensed Vocational Nurses with expertise in not only HIV, but other aspects of care including sexually transmitted diseases, tuberculosis, reproductive health, and maternal health.

d. Describe the role of consumers in the QM program.

The HIV Program has created several mechanisms for consumers to become actively involved in improving services. These include: (1) San Bernardino County Public Health Department (SBCPHD) Community Health Center Governing Board (CHCGB), which is a co-applicant board, that includes seventeen (17) members seated. Six of the of the seventeen members are health center patients and the non-patient CHCGB members comprise of a reasonable representation of the service area and are selected for their expertise in social services (Mental Health and Medical Field (2) Client Satisfaction Survey which are conducted annually. The last Client Satisfaction Survey was conducted in 2020 (3) and a formalized Grievance process to hear, address, and resolve client-specific concerns.

e. How the program monitors the effectiveness of the QM infrastructure and QI activities.

The HIV Program has three internal quality processes to assess the CQM Program progress. *First,* the CQM Plan and work plan goals are evaluated *annually* at the end of the calendaryear to identify emerging or continuing clinical issues and to develop needed measures for thefollowing year.

Second, the Quality Improvement and Quality Assurance (QI/QA) Committee meets *monthly* and maintains an active agenda of items/initiatives that are derived from the CQM Plan. The agenda items/initiatives are reviewed on a monthly basis to assess progress and address any emerging issues.

Third, the CQM meets *monthly* to evaluate implementation of HIV services in the County, coordination of DPH HIV programs (HIV prevention, Surveillance and Ryan White A, B, and C), training needs across the DPH, change in health care landscape, and new treatments options and technology.

Fourth, The CQM creates quality improvement charter as part of the Clinic Operations QI/QA committee. The members are responsible for providing updates, issues and outcomes to the leadership committee. The QI/QA committee in turn presents to the Health Center Governing Board on a quarterly and annual basis.

- ***CQM Performance Measurement:***
  - ***a. Identify the clinical indicators used to measure performance.***

The HIV Program has selected twelve clinical indicators from the HRSA/HAB CQM Groups 1 and 2 indicators. Table 13 outlines the Programs quality indicators that are monitored annually for HIV Primary Medical Care.

Table 13. Clinical Quality Service Indicators Monitored for Select Services

Service Category	Indicator	How Indicator is Measured[1]
HIV Primary Medical Care	TB Results	# and % of clients with TB test and results in the
	CD4 Count	# and % with improved/maintained CD4 count
	Viral Load	# and % with improved/maintained viral load
	Medical Visits	# and % with 2 or more medical visits within year
	HAART	# and % of AIDS patients prescribed HAART
	Hepatitis B	# and % with screening for Hepatitis B
	Hepatitis B	# and % with care and treatment for Hepatitis B
	Pap	# and % with Pap screening
	Oral Exam	# and % receiving oral exam during review period
	Syphilis Screen	# and % with screening for Syphilis

[1]Data for measurements in this Table are gathered electronically & in client charts.

b. Describe the data collection plan and process.

The plan for data collection includes the following steps. First, the *HIV Clinic Receptionist/Office Assistant II completes the client contact sheet* (0.10 FTE) to record each visit and provide the clinic staff with relevant client information, e.g., reason for visit, etc. Other clinic staff add data to the tool as services are rendered as listed below:

- Clinical Therapist I (0.25 FTE) adds Mental Health screening information,
- Care Assistant (0.30 FTE) adds HIV testing/counseling and patient support,
- Licensed Vocational Nurse II (LVN II) (0.20 FTE) adds HIV nursing care, treatment adherence, care coordination, and health education, and
- Registered Nurse II (RNII) (0.20 FTE) adds HIV nursing care, medical case management, and prescription refills; and Physician (0.25 FTE) and Physician Assistants (0.20 FTE) provide HIV Primary Care Services.

Once all data has been collected, it is then entered into the EMR. As of January 1, 2020, ARIES is no longer being used and all data is collected via the EMR. Data is also collected

after patient visits (daily - entered by the RNs and LVNs), case conferences (monthly - entered by the RNs/LVNs).

c. Describe the process for reporting and disseminating the results and findings.

The RNII/CQM Lead (0.20 FTE) is responsible for coordinating the reporting and disseminating the CQM findings. Other reports such as the Ryan White Services Report (RSR) are prepared and shared with HIV Program staff by the PH Program Manager (0.05 FTE). The reports are also shared with the Nurse Manager and Clinic Supervisors to inform the administration and management of clinic activities including complying with reporting requirements. Other key staff review the CQM data and reports at various intervals. For example, all staff participating in monthly case conferences review CQM data to determine client follow up activities. The reports are shared with the Clinic Operations QI/QA Committee and an annual report is presented to the Community Health Center Governing Board.

d. Describe how data are used for quality improvement activities.

The Program Manager coordinates the distribution of reports from the EMR for evaluating progress in achieving performance indicators. The EMR system can generate reports in aggregate for all three sites or by service site on over 1,200 data elements. The EMR can also generate tailored reports as unanticipated needs arise. This range of flexibility allows the CQM to develop reports that effectivelyinform the development of QI/QA initiatives.

For example: (1) for females that have received a Pap smear during the review period, the related quality performance report will identify those females that had a visit during the review period but did not receive a Pap smear. The Program Manager and Clinical Director then review and discuss this information with the Medical Case Management team to ensure intensive follow up on those clients to ensure they receive the required services. (2) For all clients receiving CD4 labs during a review period, the relevant quality performance report can identify those clients that did not return for a second visit within that review period for the follow up CD4 lab. This information prompts non-Medical Case Management staff to make efforts to reach the client by sending letters, making phone calls, and making referrals to outreach services if necessary to ensure that the client remains in care.

- ***Continuous Quality Improvement (CQI)***
  - ***a. Describe the quality management approach to systematizing QI activities.***

The HIV Program's CQM plan aims to promote access to and maintenance in HIV Primary care and to improve health outcomes for PLWH. The seamless integration of CQM and QI/QA activities into HIV primary care is the thrust of the CQM plan with the ultimate aim of creating a *Patient-Centered Medical Home*.

To achieve this goal, quality management is embedded into all aspects of HIV Program services. This begins with the delivery of HIV primary care services in accordance with (1) an established standard of quality care founded on the most current United States Public Health Services (USPHS) guidelines, and (2) HIV Primary care standards developed by the local Part A Ryan

White Planning Council (i.e., Inland Empire HIV Planning Council). Additional mechanisms to systematize QM into HIV Program services include:

1) Use of the *Plan, Measure, Assess and Improve* (PMAI) performance improvement model, developed by the Joint Commission on Accreditation of Healthcare Organizations in 1999, as the framework for performance improvement activities, e.g., in 2010, the HIV Program used PMAI to improve the availability of AIDS Drug Assistance appointments;
2) Ongoing implementation of QI/QA activities through routine activities, i.e., regular reviewof performance reports, monthly CQM meetings, regular feedback of findings from QI/QA activities and QM indicators to QMC at monthly meetings, etc.;
3) Established measures for quality control including daily point of service determination of client eligibility, weekly chart reviews against a standardized review tool developed by the RNII/CQM Lead, bi-weekly interdisciplinary case conferences, that include Nurses, Medical Providers, and Case Managers, and quarterly peer review for physicians, etc.;
4) Active consumer involvement through mechanisms such as the Consumer Advisory Committee, Needs Assessment, Satisfaction Survey, etc.;
5) Ongoing continuing education/training for staff as dictated by licensing and credentialing requirements depending on the classification;
6) Use of effective management information systems with established protocols for data collection and data entry, including initial and ongoing staff training on these systems (e.g., training on EMR enhancements);
7) Regular evaluation of administrative functions, i.e., review of cost efficiency (cost per unit of service), and program effectiveness (ability to achieve stated objectives);
8) Regular review of program performance against outcome measures based on HRSA's HIV/AIDS Bureau (HAB) Performance Measures and national benchmarks for selected indicators.

b. Identify the areas for improvement your program identified over the last year.

Three areas of improvement in HIV Risk Counseling, Medical Visits and PCP Prophylaxis for clients with CD4 <200 $^{cells/mm3}$ were identified.

Table 14. Clinical Indicators Identified for Improvement

Service Category	OPR[1] Measure	Indicator	2015	2016	% Difference
HIV Primary Medical Care	14	HIV Risk Counseling[2]	68.1%	68.3%	+0.2%
	1	Medical Visits (2 or more)[2]	69.6%	64.1%	-5.5%
	3	PCP Prophylaxis for clients with CD4 <200 cells/mm3[2,5]	61.5%	81.8%	+20.3%

[1]Office of Performance Review Measures/HAB Group 1 Indicators
[2] ARIES RSR
[3] ARIES STAR report
[4] ARIES HAB QM Indicators- Summary Report
[5] Denominator includes only those clients for which measure is medically indicated.

There was a decrease in the Medical Visits (2 or more) which presents an opportunity to re-engage patients back into care (-5.5%). PCP Prophylaxis for clients with CD4 <200 $^{cells/mm3}$ (+20.3%), there was a minimal gain in this area, which represents an opportunity for continued improvement as this is a key indicators of improved health outcomes.

The DPH is currently discussing strategies to increase the percent of medical visits by working in collaboration with Part A and Part B providers such as Foothill AIDS Project and Borrego. Each of these agencies provide testing, referrals, linkage and retention with a focus on African American and Latino PLWH or at risk.

Strategies that have been implemented to increase the percent of PCP Prophylaxis for clients needing it include: (1) case conferences focusing specifically on an interdisciplinary team (IDT) review of records to ensure PCP Prophylaxis is provided when warranted, and (2) review of the relevant performance report at the monthly QMC meetings to evaluate progress.

c. An example of an HIV primary care quality improvement project.

The CQM strategies are proving effective as evidenced by improvement in a sample of selected indicators in Table 15.

Table 15. Improvement in Clinical Indicators for HIV Primary Medical Care

Indicator	2019	2020	% Difference
Immunizations – Hepatitis B	47.4	67.8%	20.4%
Cervical Cancer Screening: Pap test done in the review period	23%	66.7	47.3%
Medical Visits at least twice a year	47.0%	90.4%	43.4%
Annual STI screenings	48.3%	91.3%	43.0%

[1]Office of Performance Review Measures/HAB Group 1 Indicators
[2] 2020 Ryan White Part C Charter Report – EMR RSR report

The Program saw a significant decrease in OPR Measure 4: *Cervical Cancer Screening*. To address this, a systematic, coordinated, and well documented effort led by the RNII/CQM Lead and the Clinical Director included; (1) creating a QI/QA charter and adding it to the quarterly QI/QA Committee agenda for discussion and strategizing; the creation of a *tracking system* to capture the number of clients declining a Pap, number receiving Paps, number choosing to go to an outside provider for screening, and timeframes related to all activity; (3) the development of a *screening tool* to gather the data for the trackingsystem; (4) a place for the client to initial on the tool that they were offered the procedure *annually* by HIV Program Staff and whether the procedure would be done in house; and (5) monthly revisiting of the item at QMC to assess progress.

- ***Information Systems***

The Clinic Operations Section currently uses *Electronic Medical Record* as its primary registration management system. DPH In 2017, DPH selected GE Centricity™ Practice Solution as its new Electronic Medical Record (EMR) and Practice Management (PM) system. Centricity™ Practice Solution has a fully integrated EMR and PM system designed to help DPH enhance clinical and financial productivity of its ambulatory practice. DPH has completely integrated all HIV tracking through the EMR. As of January 1, 2020, the EMR has been used to capture all the data elements required by the various HRSA/HAB reporting requirements, including the Ryan White Services Report (RSR). The 2020 Patient and Provider RSR reports were completed utilizing the EMR, thus eliminating the use of ARIES.

The EMR is able to measure the following: (1) number of unduplicated clients and all the specific HIV services they receive *at client level* including early intervention services/primary care, outreach, and case management services (Note: the DPH Clinic Operations HIV Prevention Team tracks HIV counseling and testing and prevention data through the State of California Office of AIDS' Local Evaluations Online database); (2) multipledemographic data on all clients served which can be analyzed by funding stream and geographicarea; (3) epidemiologic data on all clients receiving services (including new cases of TB, active cases of TB and MDR-TB); (4) exposure and diagnostic categories of clients receiving services; the number of clients receiving services by CDC classification of HIV disease; and (6) multiple fiscal data including service contract amounts and cost of RW-funded care. To enhanceClinic Operations capacity to analyze cost data, the DPH uses the County of San Bernardino's cost accounting system to track the extent to which the costs of HIV-related health care is paid for by third party payers, how those funds are used, and the average cost of providing each category of early intervention services.

The EMR generates the required Ryan White Services Report (RSR) in suitable format for uploading to the Electronic Handbooks per HRSA requirements

Describe if you use or plan to implement an electronic health record (EHR).

In January 2017, the Department of Public Health selected GE Centricity™ Practice Solution as its new Electronic Medical Record (EMR) and Practice Management (PM) system. Centricity™ Practice Solution has a fully integrated EMR and PM system designed to help SBCPHD enhance clinical and financial productivity of its ambulatory practice. The DPH has completely integrated all record keeping into the EMR; this has assisted staff with entering data to only one system, therefore reducing the error rate in data entry.

- ***ORGANIZATIONAL INFORMATION***

- ***The mission of your organization. How does a Part C EIS project fit within this mission?*** Established in 1931, the San Bernardino County Department of Public Health (DPH) has as its vision: *Healthy People in Vibrant Communities*. Its mission. Working in partnership to promote and improve health, wellness, safety and quality of life in San Bernardino County. Within the DPH, the essential functions of Clinic Operations Section are to provide a wide range of low-cost, confidential health services. Our mission is to protect health, prevent disease, and promote health and well-being, patient-centered clinical health care services including reproductive health, maternal health, tuberculosis screening, immunizations, and HIV services. The current Part C EIS project allows the DPH to provide patient-centered comprehensive HIV services to PLWH who do not

have other resources to pay for their care; thereby fulfilling the DPH's mission and vision.

- ***The structure of your organization (see Attachment 5)***

The DPH is organized into the following divisions: Community and Family Health Services; Disease Control, Clinic Health and Prevention; Environmental Health; Animal Control; and Finance and Administration. Each division is divided into several sections and within those are numerous categorical programs. The HIV care services are delivered by the Clinic Operations Section which is housed within the Division of Clinical Health and Prevention Services. An organizational chart is provided as Attachment 11 that depicts these relationships, including reporting.

- ***Your organization's experience in providing HIV primary care services.***

The DPH offered its first, four-hour block of outpatient HIV medical care in the city of San Bernardino on Thursday, March 29, 1990. Since then services have expanded to provide HIV Primary Medical Care in the cities of Hesperia, Ontario, and the West Valley Detention Center (county jail) in the city of Etiwanda (Note: the Sheriff's Department funds a physician and a Health Educator Specialist to provide examination and treatment once a month at the County jail).

Collectively, the HIV Program's staff have over *250 combined years* of experience in the medical field and *153 years* of experience providing HIV primary medical care to PLWH. Over 50% of the staff providing HIV services have more than 10 years of experience each. The multi-disciplinary team- comprised of physician, physician assistant, nurses, medical case managers, clinical therapists, care assistants, health education specialists, and office assistants-- delivers outpatient HIV primary medical care, mental health and psychosocial support services, medical case management, health education/risk reduction (including treatment education and partner services) and non-medical case management. Clinic Operations staff also screen for substance abuse issues. Dental referrals are handled internally to the in-house dentist. Referrals are also made for specialty medical care (provided by the County Hospital), and substance abuse treatment (funded by the San BernardinoCounty Department of Behavioral Health).

Over 60% of staff are bilingual (Spanish/English) and bicultural. The medical staff includes a physician who is board certified in general preventive medicine and certified as a HIV Specialists by the American Association of HIV Medicine who performs as the HIV Medical Director. A physician assistant who has undergone months of training under the supervision of the HIV Medical Director, to enhance skills and competency in HIV care. All professional staff are encouraged to participate in training opportunities on the care of the HIV patient. Medical case management is provided through a team approach, directed by Registered Nurses; this is augmented with Licensed Vocational Nurses for care coordination. Care Assistants, Health Education Specialist and Clinical Therapist also provide support for non-medical case management. Cultural and Linguistic Competency and diversity trainings enhance staff knowledge and skills with an increasingly diverse client population. Outreach efforts further increase understanding of the local community.

Over the years, the DPH has successfully responded to emerging populations. This begins with the analysis of surveillance data and trends in the epidemic. Epidemiology staff assists with these efforts. The results of periodic Needs Assessments conducted with consumers provide feedback

regarding emerging needs and populations. As emerging populations are identified, the DPH Clinic Operations Section infrastructure (i.e., policies, Cultural Competency Standards, required training, outreach services, etc.) is designed to ensure that emerging needs are identified and addressed, particularly among communities of color.

- ***Systems ensuring that HHS Guidelines, clinical standards and protocols are followed.***

The Clinic Operations Section implements the standards of care developed by the Inland Empire HIV Planning Council for outpatient medical care. These standards, revised in March 2009, define outpatient medical care as: "primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines." The following are sample protocols used in Clinic Operations Section: (1) the most recent editions of the United States Public Health Service (USPHS) Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents; (2) Task Force Recommendations for the Use of Antiretroviral Drugs inPregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIVTransmission in the United States; (3) Guidelines for Prevention and Treatment of OpportunisticInfections in HIV-Infected Adults and Adolescents; (4) Guidelines for Incorporating HIV Prevention into the Medical Care of PLWHA; and (5) the Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings.

To ensure compliance with standards and protocols, the following methods are used: (1) Periodic Provider Peer Review using a standardized review tool; (2) ongoing oversight of peer review process by the Clinic Operations Medical Director; (3) Chart Review by the RNII/QM Lead using a standardized tool; (4) ongoing oversight of Chart Review process by the HIV Medical Director; (5) Work Performance Evaluations of all clinical staff by licensed/credentialed supervisors on at least an annual basis and more frequently if needed; (6) scheduled training of Clinic Operations staff to ensure staff is knowledgeable of current standards and protocols; (7) signed acknowledgement of staff having received trainings to ensure accountability; and (8) theuse of Human Resources-approved *progressive disciplinary measures* leading up to and including termination for clinical staff that are continually out of compliance.

To stay apprised of the latest changes in clinical standards and treatment protocols, the medical providers subscribe to a number of electronic health information services, which provide updated information as it becomes available. Further, physician staff attend the National Ryan White HIV Care and Treatment Conference in DC for Medical Management of HIV/AIDS. In addition, select staff attend the annual Medical Management of HIV Conference at the University of California, San Francisco School of Medicine.

- ***Experience with the fiscal management of grants and contracts.***

The San Bernardino County Department of Public Health (DPH) has extensive experience with the fiscal management of grants.

The San Bernardino County Department of Public Health Clinic Operations Section, within which HIV services are embedded, is responsible for the administration of Part C in San Bernardino County. Along with managing Part C, this Section also manages other funding streams including funds from the California Department of Health Services, Office of AIDS, RWHIV Program Parts B, Minority AIDS Initiative, ADAP and HIV Prevention; Family Planning, Access, Care, and Treatment (Family PACT); and the California Family Health Council (Title X).

San Bernardino County maintains a sophisticated *Electronic Cost Accounting System*. All expenses are assigned to *cost centers* for accounting purposes and assigned 4-digit *numerical codes*. These codes are assigned to specific programs and funding streams. Clinic Operations Section uses several cost center codes; e.g., HIV Prevention (1049); RW Part B (3785), and RW Part C(0843). Along with cost center codes there are specific *labor activity* codes. Examples of activity codes include: clinical activity (500); managerial (600); and clerical (850). To manage payroll, the County utilizes an *Electronic Payroll System.* Using the *cost center codes* and *labor activitycodes*, employees enter their time into this payroll system; e.g., a physician would submit the time spent on Part C-funded medical activities using the Part C Program code (0843) and the labor activity code (500-Clinical).

These biweekly electronic time entries are reviewed for accuracy and approved by first line supervisors; e.g., Clinic Supervisors, etc. This system enables Clinic Operations Section to monitor grant expenditures by tracking labor costs by funding stream and bytype of work activity. To ensure secondary review of labor expenditures, on a biweekly basis, the County Auditor's Office uses an Electronic Payroll System and the Accounting System to prepare aggregate reports entitled *Labor Cost Distribution Reports* by program. These reports are routed to the Clinic Operations Section. Select Section staff review these reports for accuracy and resolve discrepancies when they occur.

Services and supplies are reported using the same cost accounting centers, as previously described, with an *object code*; e.g., office supplies (2305), medical supplies (2840), and mileage(2940). Aggregate reports entitled *Detailed Expenditures by Program and Object Code,* are prepared by the Auditor's Office on a monthly basis. The Program Coordinator and Accountant III review these reports for accuracy and resolve discrepancies when they occur. On a quarterly basis, the Program Coordinator and Accountant III prepare *Expenditure Projection Reports* to anticipate shortfalls in funding in enough time to request budget adjustments. The Program Coordinator and Accountant III present these reports to the Department of Public Health Chief Finance Officer for review and approval.

Before any invoices are prepared, all expenditures are reconciled against the labor distribution and cost center reports, compared against grant allowances, and reviewed/approved by the manager/designee, an Accounting supervisor assigned to Clinic Operations Section long with a Division Chief/designee,. Source documents for all these reports are retained on file to validate the accuracy of expenditure reports and to be made available for audit purposes.

As described there are various fiscal controls to ensure effective monitoring of grant expenditures; i.e., *systems* (Electronic Cost Accounting and Payroll systems), *established processes* (time entry requirements for Program staff and regular fiscal and labor reporting with sufficient specificity to discern discrepancies), *oversight* (various levels of monitoring of grant expenditures from line level supervisors to mid-level management (Program Coordinator and Deputy Chief) to DPH Executive Management (Chief Finance Officer).

- ***Level of experience in federal grants management.***

As previously stated, the San Bernardino County Department of Public Health (DPH) has extensive experience with the fiscal management of grants, including federal grants.

The DPH serves as a direct recipient ofthe Part C EIS grant; for other grants with federal source dollars, the DPH acts as recipient, sub recipient and/or pass through agency. The DPH is subject to and meets Single Audit requirements on an annual basis.

- ***The discounted fee schedule that is being used and how it is implemented.***

The HIV Program uses a sliding fee schedule based on income level for its clients. The schedule was developed and is updated annually using the *Federal Poverty Guidelines (FPL).* This fee schedule is used to determine what percent of the cost of the visit will be paid by the client.

- ***The annual cap on individual patient charges related to HIV services and monitoring.***

The HIV assigned clerical representative (verifies the client's income level and enters the data into the EMR. A sliding *fee level*, the percent of the cost of the visit that will be paid by the client, is determined using the *Federal Poverty Guidelines* and the client's income. This is then entered into the EMR e.g. a client whose family size is *three* individuals and the *household monthly income* is between $1,850 - $2,306, places the client within the 101%-125% range of *Federal Poverty Level (FPL)* and would therefore pay 10% of the cost of the visit. When fees are paid, these amounts are entered into the EMR. The system then tracks fees collected overtime to ensure that the total amount ofpayments does not exceed the annual caps as set by the RW Program. The HIV Receptionist/Office Assistant II enters any income changes into the EMR if this changes before the next screening.

- ***How you verify client income for purposes of the fee schedule and caps on charges.***

Client individual income level is verified prior to enrollment in HIV services with Clinic Operations Section by the assigned clerical representative and annually thereafter. Documented proof of income is collected to verify earnings. Acceptable forms of documentation include: three current,consecutive paycheck stubs; three current, consecutive bank statements; SSI or SSDI letter; Medically Indigent Service Plan (MISP)/County Medical Service Plan (CMSP) letter; or letter from some other form of government assistance (i.e., Medi-Cal (Medicaid in California)); or support affidavit. This documentation is placed in the client's chart and data is entered into ARIES. Reports are generated on a monthly basis to determine which clients, if any, are missing documentation.

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OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	HRSA-22-011
Opportunity Title:	Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas
Opportunity Package ID:	PKG00266211
CFDA Number:	93.918
CFDA Description:	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease
Competition ID:	HRSA-22-011
Competition Title:	Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas
Opening Date:	03/29/2021
Closing Date:	06/21/2021
Agency:	Health Resources and Services Administration
Contact Information:	Contact Hanna Endale at (301)443-1326 or email HEndale@hrsa.gov

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Budget Information for Non-Construction Programs (SF-424A)
Form Version:	1.0
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 06:46:12 PM EDT
Form State:	No Errors

FORM ACTIONS:

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BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 02/28/2022

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Ryan White HIV/AIDS Program Part C EIS	93.918	$	$	$ 388,443.00	$	$ 388,443.00
2.						
3.						
4.						
5. Totals		$	$	$ 388,443.00	$	$ 388,443.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1)	(2)	(3)	(4)	(5)
	Ryan White HIV/AIDS Program Part C EIS				
a. Personnel	$ 181,089.00	$	$	$	$ 181,089.00
b. Fringe Benefits	93,551.00				93,551.00
c. Travel	9,653.00				9,653.00
d. Equipment					
e. Supplies	4,000.00				4,000.00
f. Contractual					
g. Construction					
h. Other	50,000.00				50,000.00
i. Total Direct Charges (sum of 6a-6h)	338,293.00				$ 338,293.00
j. Indirect Charges	50,150.00				$ 50,150.00
k. TOTALS (sum of 6i and 6j)	$ 388,443.00	$	$	$	$ 388,443.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

	(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	Ryan White HIV/AIDS Program Part C EIS	$	$	$	$
9.					
10.					
11.					
12. TOTAL (sum of lines 8-11)		$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 388,443.00	$ 97,110.75	$ 97,110.75	$ 97,110.75	$ 97,110.75
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 388,443.00	$ 97,110.75	$ 97,110.75	$ 97,110.75	$ 97,110.75

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

	(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16.	Ryan White HIV/AIDS Program Part C EIS	$ 388,443.00	$ 388,443.00	$ 388,443.00	$
17.					
18.					
19.					
20. TOTAL (sum of lines 16 - 19)		$ 388,443.00	$ 388,443.00	$ 388,443.00	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: $338,293

22. Indirect Charges: $50,150

23. Remarks:

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Contact Information:	Contact Hanna Endale at (301)443-1326 or email HEndale@hrsa.gov

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Budget Narrative Attachment Form
Form Version:	1.2
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 04:48:17 PM EDT
Form State:	No Errors

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Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Attachment 1b - Budget Justification Narrative.docx

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To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

Budget Justification for RW Part C - NCC

Budget	How these costs support the achievement of project objectives.
Early Intervention Services (EIS) **Core Medical Services (CMS)**	Please note that the CY 2022 budget was constructed based on the award amount of $388,443. EIS and Core Medical Service Funds (EIS & CMS Funds) will support the costs of service delivery within our comprehensive continuum of HIV care including primary medical care, medical evaluations, HIV infection treatment, and prophylactic and treatment interventions for HIV infection complications **supporting the Work Plan's Medical Care objective #1**. EIS & CMS Funds will support the cost of outpatient mental health (MH) and outpatient substance abuse (SA) care; i.e. screening, assessment, diagnosis, and treatment using an multidisciplinary approach involving primary care or specialty physicians and, as needed, MH and or substance abuse professionals **supporting the Work Plan's Medical Care objectives #2, 3, 4 and 5.** EIS & CMS Funds will support the cost of diagnosis, prophylaxis, and treatment of Tuberculosis, Hepatitis B and C, and sexually transmitted infections **supporting the Work Plan's Medical Care objectives #6, 7 and 8.** EIS & CMS Funds will cover the costs of a Dentist to provide Oral Health Services and the local HRSA-supported HIV/AIDS Community-Based Dental Partnership Program **supporting the Work Plan's Medical Care objective #9.** EIS & CMS Funds will support the costs of Nutritional Services including screening education/counseling, dietary/nutritional evaluation, and nutritional supplements, **supporting the Work Plan's C Medical Care objectives #10.** Treatment Adherence including patient education, counseling, and IDT monitoring (primary supported through HIV Prevention funds) is part of the comprehensive model of care in Clinic Operations, **supporting the Work Plan's Medical Care objective #11.** Medical Case Management (MCM) services (paid for by RW Part C funds) are also part of the comprehensive care model, to include Specialty and Subspecialty referrals, e.g. oncology or pulmonary, and further **support the Work Plan's Medical Care objectives #12 and 13.**
Support Services	Not paid for with Part C grants.
Clinical Quality Management (CQM)	CQM Funds will support CQM staff to ensure the proper implementation and enhancement of the Program's CQM activities including the review, revision, and implementation of the CQM Plan and guiding the improvement of service quality to improve patients' health outcomes ensuring at least two visits per patient per year, two viral load counts per patient per year, ART therapy and, if female, Pap screening, **supporting the CQM Program's objectives #4, 5, 6, and 7.** These activities will increase service access to and retention of PLWH, particularly Minority PLWH, by ensuring the delivery of high quality, culturally competent/linguistically appropriate HIV primary care.
Administration	Administration Funds budgeted under Personnel cover costs related to programmatic, reporting and compliance requirements; and to negotiate and prepare contracts, monitor expenses, and prepare invoices.

Indirect	Total Indirect requested does not exceed the 10% administrative cap established for this Part C EIS grant. Indirect is being charged at 18.26% of personnel costs. In kind funds will support Program management to ensure that Consumer Involvement is included in the planning, implementation, and evaluation of program activities. Administration Funds will also cover the costs to ensure compliance with all Part C Program requirements and Conditions of Award including timely completion of progress reports, oversight of program expenditures, compliance with expenditure requirements, and oversight of non-CQM data entry and analysis.

a. Personnel Costs: Early Intervention Services/Core Medical Services	**Total: $153,293**
Clinical Therapist I (J. Stiansen, I. Obregon,) (0.25 FTE @ $73,882): Responsible for completing psychosocial assessments, providing individual and group clinical therapy, and referrals for psychiatry referrals, linkage and follow up.	$18,471
Contract PH Physician Specialty Svcs (R. Zane, MD) (0.25 FTE @ $186,231) Employed to engage in examination, diagnose and treatment of clients. This also includes involvement with CQM activities. Position requirements are medical licensure in California and training in HIV care and management.	$46,558
Public Health Dentist (C. Hoang, DDS) (0.05 FTE @ $156,795) Dr. Hoang will be providing Oral Health Care services to patients. This includes providing referrals and follow-up with client needs.	$7,840
Care Assistant (T. Ortega, G. Delgadillo, J. Flores) (0.30 FTE @ $39,751): Provide paraprofessional patient support, this includes rooming patients, taking vitals, performing blood draws and assisting with ARIES data entry.	$11,925
Licensed Vocational Nurse II (E. Jover, E. Sanchez) (0.20 FTE @ $48,147): Provide HIV nursing care, treatment adherence, care coordination, health education, and data entry.	$9,627
Clinical Director (M. Bird-Livingston) (0.05 FTE @ $139,804): Provides oversight of the RNII. This includes leading and overseeing case conferences.	$6,990
Nutritionist (D. Panganiban) (0.05 FTE @ $62,853) Provide nutritional screening and assessment; the measurement of body mass index (BMI); assistance with dietary planning, food preparation and storage; calculation of caloric requirements; and recommendations for and provision of nutritional supplements that assist the client to maintain a stable weight.	$3,143
HIV Clinic Receptionist/Office Assistant II (C. Lynn, V. Cardiel) (0.20 FTE @ $38,330): Provide the clinic staff with relevant client information, e.g., reason for visit. This include preforming as first point of contact with clients.	$7,666
Physician Assistant (C. Sims) (0.20 FTE @ $111,360): Provide HIV Primary Care Services under the direction of the Physician Specialist.	$22,272
Radiologic Technician (A. Snow) (0.05 FTE @ $76,736): Provide X-ray services to patients based on referred need. This includes chest X-rays for patients	$3,837

Health Education Assistant (R. De La Cruz) (0.10 FTE @ $59,888): Provide health education services to HIV/AIDS patients.	$5,989
RNII/Clinical Quality Management Lead (D. Norman) (0.10 FTE @ $89,759): Under the direction of the Clinical Operations Clinical Director, is responsible for ensuring compliance with all HRSA CQM requirements including ensuring that all data is captured and reported, running reports and interpreting data to identify areas for CQM improvement, reviewing HIV Charts, recommending CQI Initiatives; and coordinating multi-site CQM training.	$8,976
Personnel Costs: Clinical Quality Management **Total:**	**$8,976**
RNII/Clinical Quality Management Lead (D. Norman) (0.10 FTE @ $89,759): Under the direction of the Clinical Operations Clinical Director, is responsible for ensuring compliance with all HRSA CQM requirements including ensuring that all data is captured and reported, running reports and interpreting data to identify areas for CQM improvement, reviewing HIV Chart, recommending CQI Initiatives; and coordinating multi-site CQM training.	$8,976
Personnel Costs: Administration **Total:**	**$18,820**
Accountant III (J. Pinedo) (0.10 FTE @ $72,103): Required to negotiate and prepare contracts, monitor expenses and prepare invoices.	$7,210
PH Epidemiologist (Vacant) (0.03 FTE @ $76,099): Required to prepare the RSR report and gather any additional data that is required for grant purposes.	$1,522
Public Health Program Coordinator (S. Garcia) (0.05 FTE @ $91,972): Provide guidance for grant activities, develop scopes of work, budgets, monitor compliance and prepare progress reports.	$4,598
Public Health Program Manager (M. Garcia) (0.05 FTE @ $109,793): Oversee administrative functions of the program. Provide guidance for grant activities, develop scopes of work, budgets, monitor compliance and prepare progress reports.	$5,490
b. Fringe Benefits (51.66% of salaries)	**$ 93,551**
Benefits package averages 51.66%. Fringe benefits percentages by component estimated to remain fairly consistent for 2021-2022. Benefits include: Health Insurance, SDI/Short Term Disability, Life Insurance, FICA, Worker's Compensation, Cafeteria Plan, Survivor's Benefits and Retirement.	
Subtotal: Personnel and Benefits	**$274,640**
c. Travel	**$9,653**

Clinical Quality Management: ***Local Travel – Mileage:*** This represents the mileage cost for staff to travel to outlying HIV clinics and for Program Coordinator to attend Planning Council meetings. ($0.56 per mile x 2,951 miles = $1,653) ***Medical Management of HIV/AIDS –*** Costs associated to send 1 provider to the conference in S.F.- $4,000 (possibility of being a virtual conference) ***RW Annual Conference –*** Costs associated to send Program Manager and Accountant to the conference $4,000 (possibility of being a virtual conference)	**$9,653**
d. Equipment	**$0**
e. Supplies	**$4,000**
Early Intervention Services/Core Medical Services: $2,000 is budgeted for the cost of medical supplies such as gloves, syringes, needles, gauze, specimen tubes, examination table covers, etc. and $2,000 is budgeted for dental related expenses such as fillings, numbing medications, gauze, syringes, tips, etc.	**$4,000**
f. Contractual Services	**$0**
g. Construction	**$0**
h. Other	**$50,000**
Early Intervention Services/Core Medical Services: This represents $50,000 for outside laboratory services including hepatitis panels, HSV 1 and 2, HCV RNA, and HCV and HPV genotyping, cholesterol and triglycerides, comprehensive metabolic panels, anal cytology, and testing for opportunistic infections related to HIV. Outside laboratory services at approximately $4,167 per month x 12 months = $50,000.	**$50,000**
i. Indirect -- For all Categories: ($50,150) Indirect is being charged at 18.26% of personnel costs (includes IT, Fiscal & Administrative Services, Facilities Administration, Department Management, Department Operations, Warehouse, Countywide Cost Allocation)	**$50,150**
GRAND TOTAL	**$388,443**
Budget Adjustments from one Year to the Next	

WORKSPACE FORM

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OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	HRSA-22-011
Opportunity Title:	Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas
Opportunity Package ID:	PKG00266211
CFDA Number:	93.918
CFDA Description:	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease
Competition ID:	HRSA-22-011
Competition Title:	Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas
Opening Date:	03/29/2021
Closing Date:	06/21/2021
Agency:	Health Resources and Services Administration
Contact Information:	Contact Hanna Endale at (301)443-1326 or email HEndale@hrsa.gov

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Project/Performance Site Location(s)
Form Version:	2.0
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 04:45:13 PM EDT
Form State:	No Errors

FORM ACTIONS:

CHECK FOR ERRORS | SAVE | PRINT

View Burden Statement

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: San Bernardino County Public Health Department

DUNS Number: 1063768610000

* Street1: 606 E. Mill Street

Street2:

* City: San Bernardino County: San Bernardino

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 92415-0010 * Project/ Performance Site Congressional District: CA-031

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: San Bernardino County Public Health Department

DUNS Number: 1063768610000

* Street1: 150 E. Holt Blvd

Street2:

* City: Ontario County: San Bernardino

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 91761-2107 * Project/ Performance Site Congressional District: CA-035

Delete Entry Next Site

Project/Performance Site Location 2

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: San Bernardino County Public Health Department

DUNS Number: 1063768610000

* Street1: 16453 Bear Valley Road

Street2:

* City: Hesperia County: San Benardino

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 92345-1752 * Project/ Performance Site Congressional District: CA-008

Delete Entry Next Site

Additional Location(s) Add Attachment Delete Attachment View Attachment

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APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Grants.gov Lobbying Form
Form Version:	1.1
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 04:47:22 PM EDT
Form State:	No Errors

FORM ACTIONS:

CHECK FOR ERRORS | SAVE | PRINT

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	San Bernardino, County of
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	
* First Name:	Curt
Middle Name:	
* Last Name:	Hagman
Suffix:	
* Title:	Board of Supervisor, Chairman
* SIGNATURE:	Completed on submission to Grants.gov
* DATE:	Completed on submission to Grants.gov

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WORKSPACE FORM

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Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Key Contacts
Form Version:	1.0
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 04:54:24 PM EDT
Form State:	No Errors

FORM ACTIONS:

CHECK FOR ERRORS | SAVE | PRINT

OMB Number: 4040-0010
Expiration Date: 12/31/2022

Key Contacts Form

*** Applicant Organization Name:**

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Director

Prefix: Ms.

* First Name: Morena

Middle Name:

* Last Name: Garcia

Suffix:

Title: Public Health Program Manager

Organizational Affiliation:

San Bernardino County Public Health Department

* Street1: 16453 Bear Valley Road

Street2:

* City: Hesperia

County:

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 92345

* Telephone Number: 760-956-4457

Fax:

* Email: morena.garcia@dph.sbcounty.gov

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CFDA Description:	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease
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Agency:	Health Resources and Services Administration
Contact Information:	Contact Hanna Endale at (301)443-1326 or email HEndale@hrsa.gov

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS00689497
Application Filing Name:	Winfred Kimani
DUNS:	1063768610000
Organization:	SAN BERNARDINO, COUNTY OF
Form Name:	Attachments
Form Version:	1.2
Requirement:	Mandatory
Download Date/Time:	May 06, 2021 04:42:38 PM EDT
Form State:	No Errors

FORM ACTIONS:

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ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	Attachment 1 - Line Item Budg	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	Attachment 2 - Indirect Cost	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	Attachment 3 - Staffing Plan	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	Attachment 5 - Part C Org Cha	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	Attachment 6 - RWHAP Part C E	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	Attachment 7 - Maintenance of	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9	Attachment 9 - Service Area M	Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	Attachment 12 - Work Plan Rep	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13	Attachment 13 - National Prov	Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14	Attachment 14-Proof of Non-Pr	Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Attachment 1 - CY 2022 Specific Line Item Budget

Line Item	Salary	FTEs	Early Intervention Services	Core Medical Services	Support Services	Clinical Quality Management	Admin	Total
a. Personnel								
Accountant III (J. Pinedo)	72,103	0.1000	-	-	-	-	7,210	7,210
Care Assistant (T. Ortega, G. Delgadillo, J. Flores)	39,751	0.3000	11,925	11,925	-	-	-	11,925
Clinical Director (M. Bird-Livingston)	139,804	0.0500	6,990	6,990	-	-	-	6,990
Clinical Therapist (J. Stiansen, I. Obregon)	73,882	0.2500	18,471	18,471	-	-	-	18,471
Contract PH Physician Specialty Svcs (R. Zane, MD)	186,231	0.2500	46,558	46,558	-	-	-	46,558
Public Health Dentist (C. Hoang, DDS)	156,795	0.0500	7,840	7,840	-	-	-	7,840
Health Education Assistant (R. De La Cruz)	59,888	0.1000	5,989	5,989	-	-	-	5,989
Licensed Vocational Nurse II (E. Jover, E. Sanchez)	48,137	0.2000	9,627	9,627	-	-	-	9,627
Nutritionist (D. Panganiban)	62,853	0.0500	3,143	3,143	-	-	-	3,143
Office Assistant II /HIV Clinic Receptionist (C.Lynn, V. Cardiel)	38,330	0.2000	7,666	7,666	-	-	-	7,666
Physician Assistant (C. Sims)	111,360	0.2000	22,272	22,272	-	-	-	22,272
Public Health Epidemiologist (Vacant)	76,099	0.0200	-	-	-	-	1,522	1,522
Public Health Program Coordinator (S. Garcia)	91,972	0.0500	-	-	-	-	4,599	4,599
Public Health Program Manager (M. Garcia)	109,793	0.0500	-	-	-	-	5,490	5,490
Radiologic Technician (A. Snow)	76,736	0.0500	3,837	3,837	-	-	-	3,837
Registered Nurse II/Clinical Quality Management Lead (D. Norman)	89,759	0.2000	8,976	8,976	-	8,976	-	17,952
Sub-Total Personnel		2.12	153,293	153,293	-	8,976	18,820	181,089
b. Fringe Benefits (51.66%)			79,191	79,191	-	4,637	9,723	93,551
Sub-Total Personnel & Fringe Benefits			**232,484**	**232,484**	**-**	**13,613**	**28,543**	**274,640**
c. Travel								
Local Mileage /Motorpool			-	-	-	1,653	-	1,653
Medical Management of HIV/AIDS (SF)			-	-	-	4,000		4,000
RW Part C Annual Conference			-	-	-		4,000	4,000
Sub-Total Travel			**-**	**-**	**-**	**5,653**	**4,000**	**9,653**
d. Supplies								
Medical Supplies			4,000	4,000	-	-	-	4,000
Sub-Total Supplies			**4,000**	**4,000**	**-**	**-**	**-**	**4,000**
e. Other								
Laboratory Costs			50,000	50,000	-	-	-	50,000
Sub-Total Other			50,000	50,000	-	-	-	50,000
f. Total Direct Charges (a-e)			286,484	286,484	-	19,266	32,543	338,293
g. Indirect Charges (18.26% of S&B)			42,452	42,452	-	2,486	5,212	50,150
h. TOTALS (f-g)			**328,936**	**328,936**	**-**	**21,752**	**37,755**	**388,443**
% of Request by Category			84.68%	84.68%	0.00%	5.60%	9.72%	100.00%

Indirect Cost Rate Proposal
San Bernardino County
Department of Public Health
For Use in Fiscal Year 2021/22
(Using Audited Financials for FY 2018/2019)

		Description of Costs	Total Costs (Based on Actual Costs Incurred)	Total Unallowable Excludable Costs	Total Allowable Indirect Costs	Total Allowable Direct Costs	Direct Program Costs	All Other Direct Costs
				Total Cost Components			Allowable Direct Cost	
			a	b	c	d = (a-b-c)	e	f = (d-e)
Salaries & Benefits:								
		Salaries/Wages	45,969,447.13	625,085.39	3,832,164.53	41,512,197.21	41,512,197.21	-
		Overtime/Comp. Time	236,391.33	-		236,391.33	236,391.33	-
		Benefits	23,593,607.93	320,822.21	1,966,840.87	21,305,944.85	21,305,944.85	-
Total Salaries & Benefits			**69,799,446.39**	**945,907.60**	**5,799,005.40**	**63,054,533.39**	**63,054,533.39**	**-**
Services & Supplies:								
	A	Clothing & Personal Supplies	25,315.20		11.86	25,303.34	25,303.34	-
	B	Telecommunication Costs	861,772.26		57,708.02	804,064.24	804,064.24	-
	C	Insurance	1,420,260.97		1,202,378.00	217,882.97	217,882.97	-
	D	Medical, Dental & Lab Supplies	942,733.36		1,800.96	940,932.40	940,932.40	-
	E	Equipment Maintenance, Operations & Re	261,484.05		23,773.33	237,710.72	237,710.72	-
	F	Office Expense	2,162,221.55		641,690.67	1,520,530.88	1,520,530.88	-
	G	Postage	272,596.16		1,972.73	270,623.43	270,623.43	-
	H	Printing & Courier	192,175.57		12,558.79	179,616.78	179,616.78	-
	I	Memberships	118,016.69		24,306.56	93,710.13	93,710.13	-
	J	Training	16,208.84		6,372.94	9,835.90	9,835.90	-
	K	Subscriptions, and Publications	4,351.27		412.78	3,938.49	3,938.49	-
	L	Public Relations/ Advertising	71,811.26		775.00	71,036.26	71,036.26	-
	M	Utilities	210,242.78		996.99	209,245.79	209,245.79	-
	N	Professional Services	19,736,250.65	146,237.26	704,473.22	18,885,540.17	18,885,540.17	-
	O	County Svcs (COWCAP)			-	-	-	-
	P	Information Technology	1,425,048.83		324,820.44	1,100,228.39	1,100,228.39	-
	Q	Rental Costs of Buildings and Equipment	4,413,698.54	49,224.00	23,741.51	4,340,733.03	4,340,733.03	-
	R	Facilities Maintenance, Operations & Rep	733,385.88		364,342.50	369,043.38	369,043.38	-
	S	Motor Pool	1,156,681.67		1,394.65	1,155,287.02	1,155,287.02	-
	T	Travel	533,201.06		58,239.68	474,961.38	474,961.38	-
	U	Audit	22,115.76		-	22,115.76	22,115.76	-
	V	County Counsel	145,973.40		15,386.25	130,587.15	130,587.15	-
	W	Other	9,702.25		1,705.34	7,996.91	7,996.91	-
	X	Human Resources	328,905.42		328,905.42	-	-	
	Z	Reimbursements			-	-	-	-
		Revenue		3,724.04	(3,724.04)	-	-	-
		Total Services & Supplies	**35,064,153.42**	**199,185.30**	**3,794,043.60**	**31,070,924.52**	**31,070,924.52**	**-**
Capital Expenditures (Improvement)				-	-	-	0	
Capital Expenditures (Fixed Assets)			340,100.53	340,100.53	-	-	-	-
Total Budgetary Expenditures			105,203,700.34	1,485,193.43	9,593,049.00	94,125,457.91	94,125,457.91	-
Cost Plan Costs								
	AA	Space Use	314,615.00	-	314,615.00	-	-	-
	AA	Computer Software &Equip Use	380,546.00	33,679.00	346,867.00	-	-	-
	M	Utilities	436,237.00	-	436,237.00	-	-	-
	EE	Auditor-Controller	421,014.00	62,054.00	358,960.00	-	-	-
	BB	County Admin. Office	240,868.00	44,498.00	196,370.00	-	-	-
	U	County Counsel	21,628.00	(1,794.00)	23,422.00	-	-	-
	R	Facility Management Custodial	(2,197.00)	-	(2,197.00)	-	-	-
	R	Facility Management Grounds	(2,912.00)	-	(2,912.00)	-	-	-
	R	Facility Management Maintenance	9,899.00	43.00	9,856.00	-	-	-
	W	Human Resources	64,211.00	96,144.00	(31,933.00)	-	-	-
	CC	Purchasing	97,046.00	2,960.00	94,086.00	-	-	-
	Q	Real Estate Services	14,079.00	-	14,079.00	-	-	-
	P	IS Geographical Info System	57,905.00	10,023.00	47,882.00	-	-	-
	DD	Cost Estimation	-	-	-	-	-	-
	DD	Roll Forward	133,544.00	17,244.00	116,300.00	-	-	-
		Total Cost Plan	2,186,483.00	264,851.00	1,921,632.00	-	-	-
Total Allowable Indirect Costs (AIC)					11,514,681.00			
Dist. Of AIC Based on Salary/Wages					(11,514,681.00)			
Totals			107,390,183.34	1,750,044.43	-	94,125,457.91	94,125,457.91	-

INDIRECT COST RATE (AIC / Total Direct Salaries & Benefits):				
Admin/Department Overhead	9,593,049.00	**15.214%**		
County Overhead	1,921,632.00	**3.048%**		23,593,607.93	
Allowable Indirect Cost (AIC)	11,514,681.00	**18.261%**		45,969,447.13	**51.32%**
Total Direct Salaries & Benefits	63,054,533.39			69,563,055.06	
INDIRECT COST RATE (AIC / Total Allowable Direct Costs)					
Admin/Department Overhead	9,593,049.00	**10.192%**			
County Overhead	1,921,632.00	**2.042%**			
Allowable Indirect Cost (AIC)	11,514,681.00	**12.233%**			
Total Allowable Direct Costs	94,125,457.91				

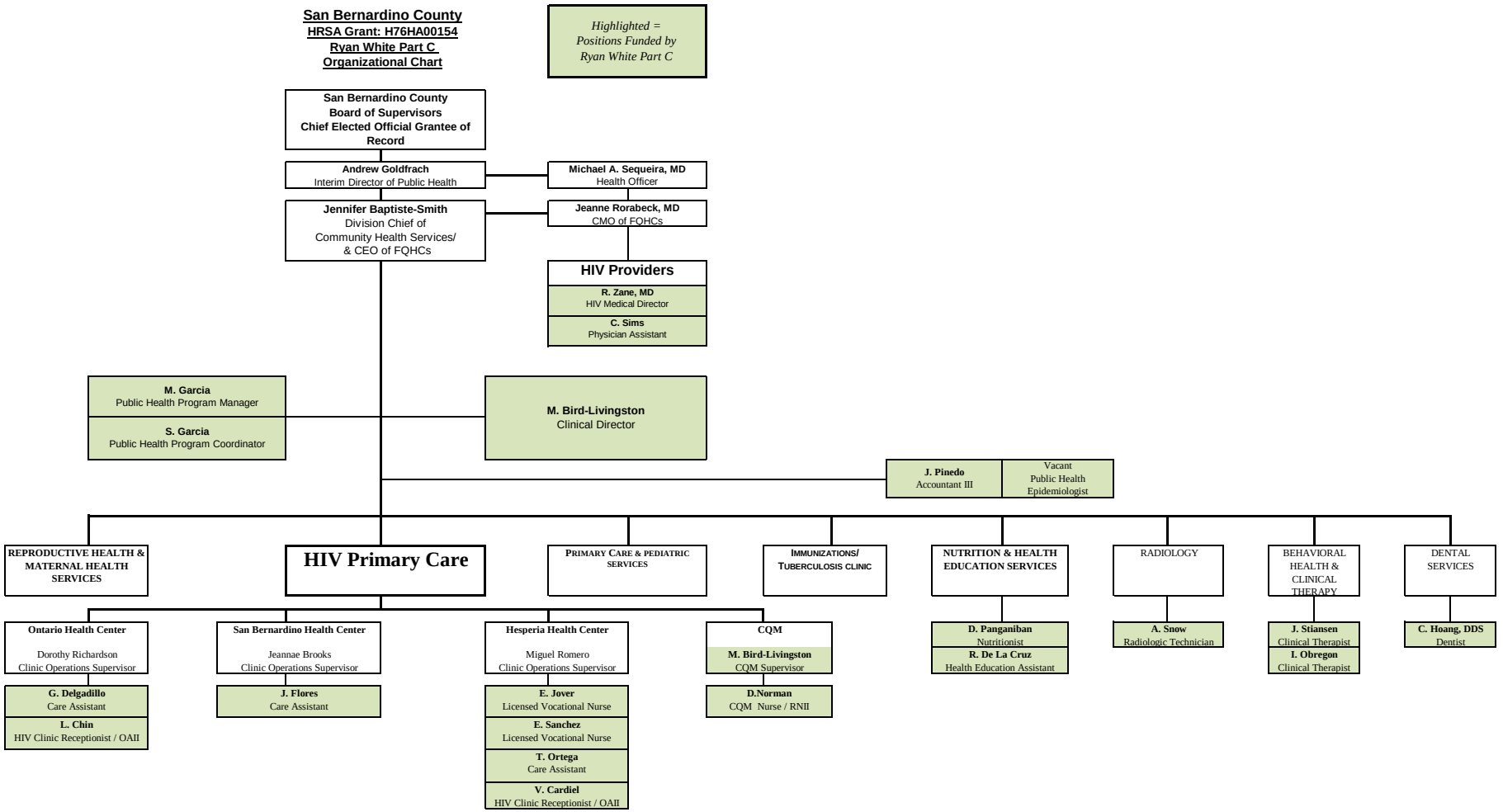
Attachment 3 -- Staffing Plan

Title	Name (*=bilingual)	Education	Funding Source	Experience	Medi-Cal/Medicare Provider #
Contract PH Physician Specialty Svcs	Zane, Ryan	MD	0.25 FTE Part C, 0.75 Medi-Cal	Certified HIV Specialist by AAHIVM; 30+ years providing HIV/AIDS medical care	Medi-Cal: ZZT11488F Medicare: 1669534293
Public Health Dentist	Hoang, Christine	DDS	0.05 FTE Part C, 0.95 FTE Medi-Cal	13 years experience providing dental services at a Private Practice, 1 year advanced education in general Dentistry	Medi-Cal: ZZT11488F Medicare: 1245493105
Physician Assistant	Sims, Charles	PA	0.20 FTE Part C, 0.80 FTE Medi-Cal	25 years experience providing medical care, with 7 years experience in HIV/AIDS	Medi-Cal: ZZT11488F Medicare: 1679503189
Registered Nurse II	Norman, Debbie	RN	0.20 FTE Part C, 0.80 FTE Medi-Cal	25+ years of experience as a Registered Nurse	
Clinical Therapist	Stiansen, Jonathan	M.S., LMFT	0.15 FTE Part C, , 0.85 FTE Medi-Cal	25 years mental health counseling/12 years HIV/AIDS	
	Obregon, Irma	PsyD, LMFT	0.10 FTE Part C, , 0.90 FTE Medi-Cal		
Licensed Vocational Nurse II	Jover, Elenita	LVN	0.10 FTE Part C, 0.90 FTE Medi-Cal	15+ years combined in nursing (12 years combined in HIV/AIDS)	
	E. Sanchez	LVN	0.10 FTE Part C, 0.90 FTE Medi-Cal		

Care Assistant	Delgadillo, Gabriela	MA	0.10 FTE Part C, 0.90 Local cost	10+ combined years in HIV/AIDS care; 3 staff members are trained as HIV test counselors	
	Ortega, Theresa	MA	0.10 FTE Part C, 0.90 Local cost		
	Flores, Joana	MA	0.10 FTE Part C, 0.90 Local cost		
Office Assistants	Chin, Lynn		0.10 Part C, 0.90 FTE Local Cost	20+ years of service to county residents	
	Cardiel, Veronica	ADAP Certified	0.10 Part C, 0.90 FTE Local cost		
Clinical Director	Bird-Livingston, Melanie	RN, PHN, BSN	0.05 Part C, 0.05 Title X, 0.90 Local Cost	20+ combined years in nursing (10+ years in management	
Nutritionist	Panganiban, Donna	Registered Dietician	0.05 Part C, 0.95 FTE Local cost	7 years of experience	
Public Health Epidemiologist	Vacant		0.03 Part C, 0.97 FTE Local cost		
Radiologic Technician	Snow, Allison	CRT R, Fluoroscopy, and ARRT	0.05 Part C, 0.95 FTE Local cost	30+ years	
Health Education Assistant	De La Cruz, Roxana	Health Education Assistant	0.10 FTE Part C, 0.05 WVDC, 0.85 Local cost	10+ years working in the HIV field	
Public Health Program Manager	Garcia, Morena	MPA	0.05 FTE Part C, 0.95 FTE Local cost	10+ years in program management	

Public Health Program Coordinator	Garcia, Starlet	MPA	0.05 FTE Part C, 0.95 FTE Local cost	Over 3 years of operation management in a clinical setting	
Accountant III	Pinedo, Jonathan	MBA	0.10 FTE Part C, 0.10 Title X, 0.80 FTE Local cost	7 years experience providing administrative support to programs in Public Health	
Total FTE	2.12 FTE Part C				

Project Organizational Chart



Appendix A: RWHAP Part C EIS Additional Agreements and Assurances

Ryan White HIV/AIDS Treatment Extension Act of 2009, RWHAP Part C EIS

The authorized representative of the applicant must include a signed and scanned original copy of the attached form with the grant application. This form lists the program assurances that must be satisfied to qualify for a RWHAP Part C grant.

NOTE: The text of the assurances has been abbreviated on this form for ease of understanding; however, recipients are required to comply with all aspects of the assurances as they are stated in the Act.

I, the authorized representative of_____in applying for a grant under RWHAP Part C of Title XXVI, sections 2651–2667 of the Public Health Service Act, hereby certify that:

I. As required in section 2651:

A. Grant funds will be expended only for providing core medical services as described in subsection (c), support services as described in subsection (d), administrative expenses as described in section 2664(g)(3), and a clinical quality management program under 2664(g)(5).

B. Grant funds will be expended for the purposes of providing, on an outpatient basis, each of the following early intervention required services:

1) Counseling individuals with respect to HIV in accordance with section 2662;
2) Testing to confirm the presence of HIV; to diagnose the extent of immune deficiency; to provide clinical information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;
3) Other clinical preventive and diagnostic services regarding HIV, and periodic medical evaluations of individuals with HIV;
4) Providing the therapeutic measures described in 2 above; and
5) Referrals described in section 2651(e)(2);

C. Recipient will expend at least 50 percent of grant funds awarded for activities described in 2) – 4) above.

D. After reserving funds for administration and clinical quality management, recipient will use at least 75 percent of the remaining grant funds to provide core medical services that are needed in the area involved for individuals with HIV who are identified and eligible under this title (including services regarding the co-occurring conditions of the individuals).

E. RWHAP Part C services will be available through the applicant entity, either directly or, if the recipient is not a Medicaid provider, through public or nonprofit private entities, or through for-profit entities if such entities are the only available provider of quality HIV care in the area.

F. Grant funds may also be expended to provide the support services that are needed for individuals with HIV to achieve their medical outcomes.

II. As required under section 2652(b), all providers of services available in the Medicaid State plan must have entered into a participation agreement under the State plan and be qualified to receive payments under such plan, or, for entities providing services under the award on behalf of the recipient, receive a waiver from this requirement.

III. As required under section 2654(a): Provisions of services to persons with hemophilia will be made and/or coordinated with the network of comprehensive hemophilia diagnostic and treatment centers.

IV. As required under section 2661(a): The confidentiality of all information relating to the person(s) receiving services will be maintained in accordance with applicable law.

V. As required under section 2661(b): Informed consent for HIV testing will be obtained.

VI. As required under section 2662: The applicant agrees to provide appropriate counseling services, under conditions appropriate to the needs of individuals.

VII. As required under section 2663: All testing that is conducted with RWHAP funds will be carried out in accordance with sections 2661 and 2662.

VIII. As required under section 2664(a)(1)(C): Information regarding how the expected expenditures under the grant are related to the planning process for localities funded under Part A (including the planning process described in section 2602) and for States funded under Part B (including the planning process described in section 2617(b)) will be submitted.

IX. As required under section 2664(a)(1)(D): A specification of the expected expenditures and how those expenditures will improve overall client outcomes, as described in the State plan under section 2517(b) will be submitted.

X. As required under section 2664(a)(2): A report to the Secretary in the form and on the schedule specified by the Secretary will be submitted.

XI. As required under section 2664(a)(3): Additional documentation to the Secretary regarding the process used to obtain community input into the design and implementation of activities related to the grant will be submitted.

XII. As required under section 2664(a)(4): Audits regarding funds expended under RWHAP Part C will be submitted every 2 years to the lead State agency under section 2617(b)(4) and will include necessary client level data to complete unmet need calculations and the Statewide Coordinated Statements of Need process.

XIII. As required under section 2664(b): To the extent permitted under State law, regulation or rule, opportunities for anonymous counseling and testing will be provided.

XIV. As required under section 2664(c): Individuals seeking services will not have to undergo testing as a condition of receiving other health services.

XV. As required under section 2664(d): The level of pre-grant expenditures for early intervention services will be maintained at the level of the year prior to the grant year.

XVI. As required under section 2664(e): A schedule of charges specified in section 2664 (e) will be utilized.

XVII. As required under section 2664(f): Funds will not be expended for services covered, or which could reasonably be expected to be covered, under any State compensation program, insurance policy, or any Federal or State health benefits program (except for a program administered by or providing services of the Indian Health Service); or by an entity that provides health services on a prepaid basis.

XVIII. As required under section 2664(g): Funds will be expended only for the purposes awarded, such procedures for fiscal control and fund accounting as may be necessary will be established, and not more than 10 percent of the grant will be expended for administrative expenses, including planning and evaluation, except that the costs of a clinical quality management program may not be considered administrative expenses for the purposes of such limitation.

XIX. As required under section 2667: Agreement that counseling programs shall not be designed to promote, or encourage directly, intravenous drug abuse or sexual activity, homosexual or heterosexual; shall be designed to reduce exposure to and transmission of HIV/AIDS by providing accurate information; shall provide information on the health risks of promiscuous sexual activity and intravenous drug abuse; and shall provide information on the transmission and prevention of hepatitis A, B, and C, including education about the availability of hepatitis A and B vaccines and assisting patients in identifying vaccination sites.

XX. As required under section 2681: Assure that services funded will be integrated with other such services, coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

XXI. As required under section 2684: No funds will be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature: _____ Date: _____

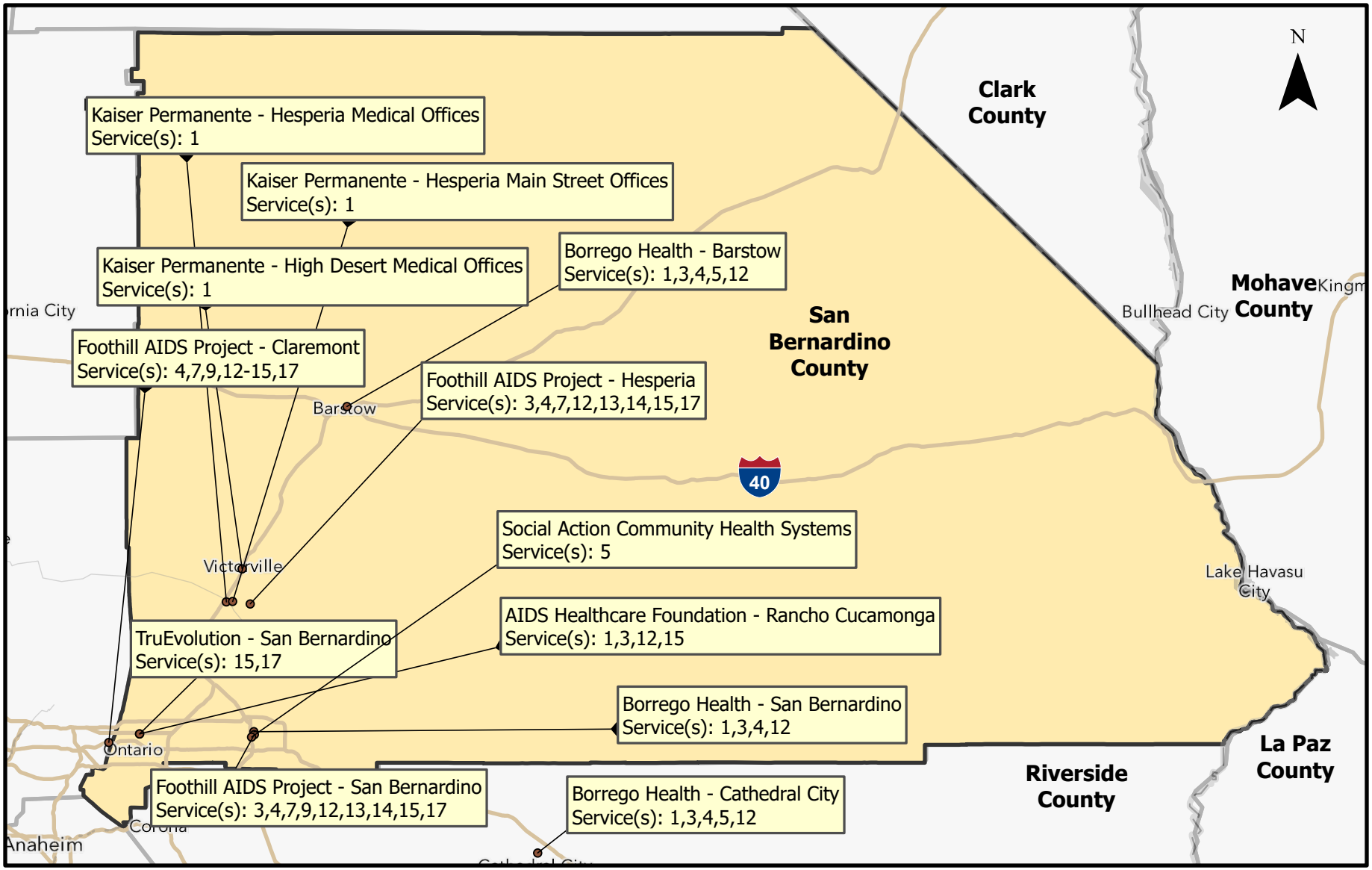
Title: _____

Maintenance of Effort (Attachment 7)

NON-FEDERAL EXPENDITURES

Baseline:	
FY Prior to Application (Actual)	Current FY of Application (Estimated)
Actual prior FY non-federal funds, including in-kind, expended for activities proposed in this application.	Estimated current FY non-federal funds, including in-kind, designated for activities proposed in this application.
Amount: $5,803.94	Amount: $22,824.48

Providers Offering HIV/AIDS Services to San Bernardino County Residents



Services Provided:

1 - Outpatient medical care
2 - Inpatient medical care
3 - Medical case management
4 - Mental health services
5 - Dental care
6 - HIV counseling and testing
7 - Early Intervention services
8 - Local pharmacy assistance
9 - Substance abuse services
10 - ADAP enrollment
11 - Home and community-based care
12 - Medical transportation
13 - Food bank
14 - Psychosocial services
15 - Case management (non-medical)
16 - Health education/risk education
17 - Housing
18 - Laboratory support
19 - Specialty care

WORK PLAN REPORT	CY 2021	
HIV Testing and Counseling (HIV Diagnosed) **(***Only if you are requested to use RWHAP Part C funds for HIV counseling/testing services***)**	**Recipient**	**Subrecipient A**
	Objective/ Actual (#)	**Objective/ Actual (#)**
1. Projected # of persons receiving high risk targeted testing and counseling services.	0	0
2. Projected # of persons with a confirmatory positive HIV test result	18	0
ACCESS TO CARE (LINKAGE)	**Recipient**	**Subrecipient A**
	Objective/ Actual (#)	**Objective/ Actual (#)**
1. Projected # of newly diagnosed persons enrolled in care within 3 months of HIV diagnosis	8	50
RETENTION IN CARE: Core Medical Services ***(List only the Core Medical Services defined in PCN 16-02 that were supported by RWHAP Part C funds)***	**Recipient**	**Subrecipient A**
Number of Persons receiving:	**Objective/ Actual (#)**	**Objective/ Actual (#)**
ex. 1. Medical Case Management	111	160
ex. 2. Medical Nutrition Therapy	50	45
ex. 3. Mental Health Services	111	110
ex. 4. Outpatient Ambulatory Health Services	111	160
RETENTION IN CARE: Support Services ***(List only the Support Services defined in PCN 16-02 that were supported by RWHAP Part C funds to support)***	**Recipient**	**Subrecipient A**
Number of Persons receiving:	**Objective/ Actual (#)**	**Objective/ Actual (#)**
ex. 1. Linguistic Services	0	0
ex. 2. Medical Transportation	0	0
ex. 3. Non-Medical Case Management Services	0	0
Antiretroviral Use and Viral Suppression	**Recipient**	**Subrecipient A**
	Objective/ Actual (#)	**Objective/ Actual (#)**
Projected # of people with HIV Receiving ART	529	600
Projected # of people with HIV with HIV Viral Load Suppression (Less than 200 copies)	171	600

Table of Provider Medicaid and Medicare Numbers (National Provider Identifier)

Provider	NPI #
Charles Sims	**1679503189**
Ryan Zane	**1669534293**

Attachment 14- Proof of Non-Profit Status

INTEROFFICE MEMO

DATE: January 24, 2002 **PHONE:** 387-6654

FROM: STEWART HUNTER, Staff Analyst
Public Health - Fiscal and Administrative Services

TO: BETSY CLINE, Public Health Manager
Nutrition Section

SUBJECT: Department of Public Health Tax Status

The taxpayer identification number for the County of San Bernardino and the Department of Public Health, an organizational unit of the County, is 95-6002748. The County is a political subdivision of the State of California, created for the purposes of government and to exercise governmental functions on behalf of the State. The County is not a corporation of any kind, and therefore, does not possess a tax-exempt certificate, in accordance with the United States Internal Revenue Code [e.g., a 501(c)(3) corporation].

The County was established in 1853 by State statute (Section 2, Statutes of California, Chapter LXXVIII, approved April 26, 1853). Please see the attached copy of the statute.

AUDITOR/CONTROLLER
RECORDER
04 NOV 16 AM 8:36

Internal Revenue Service

Attachment 7 - Proof of Non-Profit Status

Department of the Treasury
P. O. Box 2508
Cincinnati, OH 45201

Date: November 9, 2004

San Bernardino County
LVA San Bernardino County
% San Bernardino County
222 W. Hospitality Ln. Fl. 3
San Bernardino, CA 92415-0001

Person to Contact:
Paul Perry 31-07423
Customer Service Representative
Toll Free Telephone Number:
8:00 a.m. to 6:30 p.m. EST
877-829-5500
Fax Number:
513-263-3756
Federal Identification Number:
95-6002748

Dear Sir/Madam:

This is in response to your request of November 9, 2004, regarding your organization's exemption from Federal income tax.

As a governmental unit or a political subdivision thereof, your organization is not subject to Federal income tax under the provisions of Section 115(1) of the Internal Revenue Code, which states in part:

> "Gross income does not include income derived from ... the exercise of any essential governmental function and accruing to a State or any political subdivision thereof ..."

Because your organization is a governmental unit or a political subdivision thereof, its income is not taxable as explained above. Contributions used exclusively for public purposes are deductible under Section 170(c)(1) of the Code.

Your organization is not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Your organization may obtain a letter ruling on its status under section 115 by following the procedures specified in Rev. Proc. 2004-1 or its successor.

If you have any questions, please call us at the teiephone number shown in the heading of this letter.

Sincerely,

Gordon Le

for Janna K. Skufca, Director, TE/GE
Customer Account Services

eight hundred and fifty-two, or so much as may be necessary to liquidate the interest due on said bonds up to the first day of July, one thousand eight hundred and fifty-three: And no existing law shall be so construed as to conflict with the provisions of this Act.

SEC. 2. After the liquidation of the interest aforesaid, the surplus of the moneys above provided to be appropriated as aforesaid, if there be any, shall be paid into the General Fund of the State, and shall constitute a part of the same. Appropriation of surplus.

Approved, April 26, 1853.

CHAPTER LXXVIII.

AN ACT

For dividing the County of Los Angeles, and making a new County therefrom, to be called "San Bernardino County."

The People of the State of California, represented in Senate and Assembly, do enact as follows:

SECTION 1. The County of Los Angeles is hereby divided as follows: Beginning at a point where a due south line drawn from the highest peak of the Sierra de Santiago intersects the northern boundary of San Diego County; thence running along the summit of said Sierra to the Santa Ana river, between the ranch of Sierra and the residence of Bernardo Yorba; thence across the Santa Ana river along the summit of the range of hills, that lie between the Coyotes and Chino, (leaving the ranchos of Ontiveras and Ybana to the west of this line,) to the southeast corner of the ranch of San Jose; thence along the eastern boundaries of said ranch and of San Antonio, and the western and northern boundaries of Cucamonga ranch to the ravine of Cucamonga; thence up said ravine to its source in the coast range; thence due north to the northern boundary of Los Angeles County; thence northeast to the State line; thence along the State line to the northern boundary line of San Diego County; thence westerly along the northern boundary of San Diego to the place of beginning. Division and boundaries.

SEC. 2. The eastern portion of Los Angeles County, so cut off, shall be called San Bernardino County, and the seat of justice thereof, shall be at such place as the majority of the voters shall determine at the first county election, hereinafter provided to be County of San Bernardino, and seat of justice thereof.

held in said county, and shall remain at the place so designated until changed by the people, as provided by law.

Election of county officers.

SEC. 3. During the fourth week of June next, there shall be held an election in said Bernardino County, for the election of the following officers, to wit: one County Judge, one County Attorney, one County Clerk, who shall also be Recorder; one County Surveyor, one Sheriff, one Coroner, one Treasurer and one Assessor.

Term of office of County Judge.

SEC. 4. The County Judge, chosen under this Act, shall hold office until the first Monday of April, A. D., one thousand eight hundred and fifty-four, and until his successor shall be elected and qualified. The other officers shall hold their office until the first Monday of October, one thousand eight hundred and fifty-three, and until their successors are elected and qualified. The successors of the officers elected under this Act, shall be chosen at the general elections established by law, which shall take place next preceding the expiration of their respective terms.

Of other county officers.

Election of their successors.

Board of Commissioners.

SEC. 5. Isaac Williams, David Seely, H. G. Sherwood, and John Brown, are hereby appointed and constituted a Board of Commissioners, to designate the election precincts in the County of San Bernardino, for the election of officers at the first election, and to appoint the Inspectors of Election at the several precincts designated to receive the returns of the election, and to issue certificates of election.

Powers and duties.

County election, and regulations thereof.

SEC. 6. The provisions of "An Act to regulate Elections," passed March twenty-third, one thousand eight hundred and fifty, shall apply to the county election ordered by this Act, except that the Board of Commissioners shall designate the election precincts, appoint the Inspectors of Election at such precincts, receive the returns of election, and issue the several certificates to the persons elected.

Inspectors of Elections.

Organization of Board and duties.

SEC. 7. For the purpose of designating the several precincts in the county, the said Board shall meet two weeks previous to the day of election, and at said meeting shall designate the precincts of the county, and appoint the Inspectors of Election at such precincts. The said Board shall appoint one of their number as President, and one as Clerk, and shall keep a record of their proceedings; two-thirds of the number of said Board shall constitute a quorum to transact business.

Notices of election precincts, &c.

SEC. 8. The said Board shall immediately after designating the precincts in the county, and appointing the Inspectors thereof, give notice of such precincts and Inspectors, by advertisement in Spanish and English, in the Los Angeles Star, and by notice posted at each of said precincts in Spanish and English.

Precincts may be opened if not established.

SEC. 9. If precincts be not established according to the provisions of this Act, an election may be held at any place or places where there are not less than thirty resident electors present.

Returns of election. To be canvassed by Board of Commissioners and statement of the result.

SEC. 10. Sealed returns from the officers of elections may be delivered to any member of the Board. The Board shall meet in the county within five days subsequent to the election, and the returns shall then be opened and read, and under their direction,

and in their presence a tabular statement shall be made out, showing the vote given in each precinct in the county, or if precincts be not established at each place where polls were opened as provided for in the preceding section of this Act, for each person, and for each of the offices to be filled at the election, and for the Seat of Justice of the county, and also the entire vote given in the county for each person. The statement thus made out by such Board, shall be signed by the President and Clerk.

President of the Board shall declare the result and issue Certificates of Election.

SEC. 11. So soon as the statement and certificates are made out by the Board, the President shall declare the result, and immediately make out, send or deliver to each person chosen, a certificate of election, signed by him as President of the Board of Commissioners and attested by the Clerk.

Persons elected shall qualify within twenty days.

SEC. 12. Each person chosen shall qualify and enter upon the discharge of his duties within twenty days after the receipt of his certificate of election. The person elected as County Judge shall qualify before the President of the Board of Commissioners of the county. Persons elected to the other offices may qualify before said President or before the County Judge.

Statement of result of election to be forwarded to Secretary of State.

SEC. 13. The President of said Board shall transmit, without delay, a copy of the tabular statement prepared as provided in section ten, to the Secretary of State. The election returns of said county, the tabular statement and the record of proceedings of the Board, shall be retained by the President of the said Board, until the person elected as Clerk of said county shall have qualified and entered upon his duties, after which they shall be filed in the office of said clerk.

Returns and Record of Board to be filed with County Clerk.

San Bernardino county, excepted from Supervisor's Act.

SEC. 14. The County of San Bernardino is hereby excepted from the operation of the Supervisor Act, passed May third, A.D., one thousand eight hundred and fifty-two, shall be attached to the first Judicial District, and shall be entitled to one member of Assembly, and Los Angeles County to one member of Assembly, and the two counties jointly shall elect one Senator, until otherwise provided by law.

Legislative apportionment.

Appointment of Commissioners to regulate the debt of Los Angeles county.

SEC. 15. At the first term of the Court of Sessions held in San Bernardino County, there shall be appointed two Commissioners, to meet a like number of Commissioners, to be appointed by the Board of Supervisors of Los Angeles County, for the purpose of ascertaining the proportion of the debt of Los Angeles County, that is justly chargeable to San Bernardino County. The said Commissioners shall proceed to ascertain the total indebtedness of Los Angeles County, that shall have accrued up to the time of the organization of San Bernardino County. They shall apportion to the respective counties a portion of said indebtedness, proportioned to the amount of taxable property returned by the Assessor of Los Angeles County, for the year one thousand eight hundred and fifty-three, which is hereby made the basis for apportioning the debt aforesaid. Said Commissioners shall report their apportionment to the Court of Sessions and Board of Supervisors of their respective counties, and if they shall ratify said appor-

Duties of Commissioners.

Debt of Los Angeles county due from San Bernardino county.

tionment, it shall be final and binding on the two counties. For the proportion of the unfundable debt of Los Angeles County that shall be apportioned to San Bernardino County, the Court of Sessions of said county shall draw a warrant in favor of the Treasurer of Los Angeles County, payable out of the Treasury of San Bernardino County. Of the funded debt of Los Angeles County, the amount found justly chargeable to San Bernardino County shall be assumed by said county, and the principal and interest thereof paid at its County Treasury; *Provided*, that the holders of said proportion of the debt consent to such assumption and payment.

Former Act to apply to the county of San Bernardino.

SEC. 16. All the provisions of the Act to "Fund the Debt of Los Angeles county, and provide for the payment thereof," passed March the eighteenth, one thousand eight hundred and fifty-three, shall have the same force and be obligatory on the same officers in San Bernardino county as in Los Angeles county, and shall continue in full force and obligation until the extinguishment of the said funded debt, and until its proportion of the funded debt shall be set off to said county, as provided for in the preceding section.

San Bernardino county to pay its proportion of interest yearly.

The Court of Sessions in San Bernardino county shall each year draw a warrant on the Treasurer of said county in favor of the Treasurer of Los Angeles county, for the total amount of the interest tax of that year, payable out of the first moneys paid into the Treasury on the annual assessment of each year, as provided in the Act aforesaid, and shall each and every year draw a warrant for said tax, until the total extinguishment of the debt aforesaid.

Actions for violating this section.

It shall be the duty of the Treasurer of Los Angeles county to bring suit against any and every officer of San Bernardino county who may hinder the prompt payment of the interest tax aforesaid, into the Treasury of Los Angeles [county]; and the District Court having jurisdiction in said county, shall have power to issue all necessary writs to enforce the provisions of this Act and the Funding Act aforesaid; and the proportion of the funded debt set off to San Bernardino county shall be paid and liquidated to the holders thereof in the manner provided in the said Funding Act.

Jurisdiction of District Court.

Assessments and duty of County Assessor of Los Angeles county.

SEC. 17. In case the Assessor of Los Angeles county shall have completed his assessment of the portion of said county that is hereby set off to San Bernardino county, or any part thereof, before the organization of said county, he shall certify to the Court of Sessions of said county, when organized, his assessment of all property and polls in said county, for their action, and such assessment shall be deemed the legal assessment of said county for the present year, subject to the action of the Board of Equalization of said county; and the delinquent list of all property and polls in said county of San Bernardino, for the year one thousand eight hundred and fifty-two, that shall not have been collected on the organization of said county, shall be assigned to said county for its use and benefit.

Delinquent list of 1852.

Compensation of Associate Justices of Court of Sessions.

SEC. 18. The Associate Justices of the Court of Sessions of said county, shall receive as compensation two dollars per diem for each day's actual attendance on the terms of court. The

172 W. 3rd Street, San Bernardino, CA 92415 | Phone: 909.387.6492 Fax: 909.387.6493

www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health
Administration

Andrew Goldfrach, FACHE
Interim Director

Joshua Dugas
Assistant Director

Michael A. Sequeira, M.D.
Health Officer

May 14, 2021

Morena Garcia, MPA
Public Health Program Manager
Department of Public Health
351 North Mountain View
San Bernardino, CA 92415-0010

Dear Ms. Garcia:

The Riverside/San Bernardino TGA Ryan White Part A and the San Bernardino County Ryan White Part B recipient is writing in support of the San Bernardino County Public Health Department's (SBCPHD) efforts in submitting an application for Ryan White HIV/AIDS Program Part C Early Intervention Services Program: Existing Geographic Service Areas Funding to provide comprehensive primary health care and support services in an outpatient setting for low income, uninsured, and underserved people with HIV.

I understand that Ryan White Part C funds are needed to continue support and delivery of HIV primary care in SBC to provide: (1) counseling for individuals with respect to HIV; (2) targeted HIV testing; (3) periodic medical evaluations of individuals with HIV and other clinical and diagnostic services regarding HIV; (4) therapeutic measures for preventing and treating the deterioration of the immune system, and for preventing and treating conditions arising from HIV; and (5) referrals for people with HIV to appropriate providers of health and support services. These services are to be provided directly or through referrals, contracts or memoranda of understanding (MOUs) in three SBCPHD Federally Qualified Health Centers (FQHCs): Hesperia, Ontario and San Bernardino.

The DPH receives $8,131,931 in Ryan White Part A funding that is contracted out to community based organizations, and receives $943,680 in Part B funding for targeted HIV testing, referral services, access and linkage to care, and outreach services. Part C dollars complement Part B dollars by supporting mental health services, clinical quality management activities, laboratory, and to augment outpatient ambulatory medical care. Routine analysis of service reports and communication with Part A and B providers ensures that Part C services while complimentary, are not duplicative.

BOARD OF SUPERVISORS

Col. Paul Cook (Ret.) First District | Janice Rutherford Second District | Dawn Rowe Vice Chair, Third District | Curt Hagman Chairman, Fourth District | Joe Baca, Jr. Fifth District

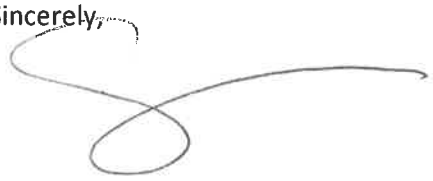
Leonard X. Hernandez
Chief Executive Officer

The FQHCs act as a safety net by providing preventive primary care, dental and integrated behavioral health services in a primary care setting reducing stigma and discrimination to a vulnerable hard to reach populations. The collaboration between Ryan White Part A, B and Part C Programs with Public Health continues to example of on-going efforts to identify efficient ways for better service the community.

The Riverside/San Bernardino TGA Part A and San Bernardino County Part B recipient support this application for continued funding

Please do not hesitate to contact my office at 909-387-6492, if I can be of any assistance in the Department's efforts.

Sincerely,



Shannon Swims
Program Coordinator
Ryan White Program
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