THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number

20-1180 A-1

SAP Number

4400015714

Department of Public Health

Department Contract Representative	Lisa Ordaz, HS Contracts
Telephone Number	(909) 388-0222
Contractor	County of Riverside, Department of Public Health
Contractor Representative	Lea Morgan, HIV/STD Branch Chief
Telephone Number	(951) 358-5307
Contract Term	March 1, 2021 through February 29, 2024
Original Contract Amount	$2,245,365
Amendment Amount	-($78,633)
Total Contract Amount	$2,166,732
Cost Center	9300371000

IT IS HEREBY AGREED AS FOLLOWS:

AMENDMENT NO. 1

It is hereby agreed to amend Contract No. 20-1180, effective July 27, 2021, as follows:

SECTION V. FISCAL PROVISIONS

Paragraph A is amended to read as follows:

A. The maximum amount of payment under this Contract shall not exceed $2,166,732, of which $2,166,732 may be federally funded, and shall be subject to availability of funds to the County. If the funding source notifies the County that such funding is terminated or reduced, the County shall determine whether this Contract will be terminated or the County's maximum obligation reduced. The County will notify the Contractor in writing of its determination and of any change in funding amounts. The consideration to be paid to Contractor, as provided herein, shall be in full payment for all Contractor's services and expenses incurred in the performance hereof, including travel and per diem.

Original Contract	$2,245,365	March 1, 2021 through February 29, 2024
Amendment No. 1	($78,633) decrease	March 1, 2021 through February 29, 2024

It is further broken down by Program Year as follows:

Program Year	Dollar Amount
March 1, 2021 through February 28, 2022	$722,244*
March 1, 2022 through February 28, 2023	$722,244*
March 1, 2023 through February 29, 2024	$722,244*
Total	$2,166,732

*This amount includes a decrease of $26,211 per year.

ATTACHMENTS

ATTACHMENT A – Remove and Replace SCOPE OF WORK for Program Year 2021-22
ATTACHMENT J – Remove and Replace PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2021-22

All other terms and conditions of Contract No. 20-1180 remains in full force and effect.

SAN BERNARDINO COUNTY

►

Curt Hagman, Chairman, Board of Supervisors

Dated:

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

Lynna Monell
Clerk of the Board of Supervisors
San Bernardino County

By
Deputy

County of Riverside, Department of Public Health
(Print or type name of corporation, company, contractor, etc.)

By ►
(Authorized signature - sign in blue ink)

Name Karen Spiegel
(*Print or type name of person signing contract)*

Title Chair, Board of Supervisors
(Print or Type)

Dated:

Address P.O. Box 7600

Riverside, CA 92503

FOR COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
►	►	►
Adam Ebright, County Counsel	Becky Giroux, HS Contracts	Andrew Goldfrach, Interim Director
Date	Date	Date

SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY	
Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2021 – February 28, 2022
Service Category:	OUTPATIENT/AMBULATORY HEALTH SERVICES
Service Goal:	To maintain or improve the health status of persons living with HIV/AIDS in the TGA. NOTE: Medical care for the treatment of HIV infection includes the provision of care that is consistent with the United States Public Health Service, National Institutes of Health, American Academy of HIV Medicine (AAHIVM).
Service Health Outcomes:	Improved or maintained CD4 cell count; Improved or maintained CD4 cell count, as a % of total lymphocyte cell count; and improved or maintained viral load

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 21/22 TOTAL**
Proposed Number of Clients	**74**	**21**	**10**	**0**	**0**	**0**	**105**
Proposed Number of Visits = Regardless of number of transactions or number of units	**296**	**84**	**40**	**0**	**0**	**0**	**420**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**2960**	**840**	**400**	**0**	**0**	**0**	**4200**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: DOPH-HIV/STD medical treatment team will provide the following service delivery elements to PLWHA receiving * HIV Outpatient/Ambulatory Health Services at Riverside Neighborhood Health Center, Perris Family Care Center and Indio Family Care Center. Provide HIV Care and Treatment- **Activities:** • Development of Treatment Plan • Diagnostic Testing • Early Intervention and Risk Assessment • Preventive Care and Screening • Practitioner Examination • Medical History Taking • Diagnosis and Treatment of Common Physical and Mental Conditions • Prescribing and Managing Medication Therapy • Education and Counseling on Health Issues • Continuing Care and Management of Chronic Conditions • Referral to and Provision of Specialty Care • Treatment Adherence Counseling/Education • Integrate and utilize ARIES to incorporate core data elements.	1, 2, & 3	03/01/21-02/28/22	• Patient Health Assessment • Lab Results • Treatment Plan • Psychosocial Assessments • Treatment Adherence Documentation • Case Conferencing Documentation • Progress Notes • Cultural Competency Plan • ARIES Reports
Element #2: The HIV/STD Branch Chief, Medical Director, and HIV Clinic Manager are responsible for ensuring Outpatient/Ambulatory Health Services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activity:** Management staff will attend Inland Empire HIV Planning Council Standard of Care Meetings. -Management/physician/Clinical staff will attend required CME training and maintain American Academy of HIV Medicine (AAHIVM) Certification.	1, 2, & 3	03/01/21-02/28/22	

Element #3: Clinic staff will conduct assessments including evaluation health history and presenting problems. Those on HIV medications are evaluated for treatment adherence. Assessments will consists of: **Activities:** a) Completing a medical history b) Conducting a physical examination including an assessment for oral health care c) Reviewing lab test results d) Assessing the need for medication therapy e) Development of a Treatment Plan. f) Collection of blood samples for CD4 viral load, Hepatitis and other testing g) Perform TB skin test and chest x-ray	1, 2, & 3	03/01/21-02/28/22
Element #4: Clinicians will complete a medical history on patients including but not limited to: family medical history, psycho-social history, current medications, and environmental assessment, diabetes, cardiovascular diseases, renal disease, GI abnormalities, pancreatitis, liver disease, or hepatitis. **Activities:** a) Conducting a physical examination b) Reviewing lab test results c) Assessing the need for medication therapy d) Development of a Treatment Plan.	1, 2, & 3	03/01/21-02/28/22

Element #5: An assessment of the patients' current knowledge of HIV and treatment options is conducted by the designated staff providing patient education and risk assessment. **Activities:** Health education and counseling is provided to the patient in choosing an appropriate health education plan that will include education regarding the reduction of transmission of HIV and toreduce their transmission risk behaviors.	1, 2, & 3	03/01/21-02/28/22	
Element #6: Based on medical history, physical examination and lab-test results, clinician will develop a treatment plan. Activities: Treatment plan will include diagnosis and treatment for common physical conditions such as opportunistic infections related to HIV, which may include but are not limited to: candidacies, cervical cancer, herpes simplex, Karposis Sarcoma, tuberculosis.	1, 2, & 3	03/01/21-02/28/22	

Element #7: HIV Nurse Clinic Manager and Senior Communicable Disease (CDS) Staff will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activities:** -HIV Nurse Clinic Manager and Senior CDS will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards. -Training to be obtained through the AIDS Education and Training Center on a semi-annual basis. Training elements will be incorporated into policies/plans for the department.	1, 2, & 3	03/01/21-02/28/22	
Element #8: Outpatient/Ambulatory Medical Care staff will utilize standardized, required documentation to record encounters and progress. **Activities:** -Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and review HIV Care Continuum Data and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices."	1, 2, & 3	03/01/21-02/28/22	

SCOPE OF WORK – PART A **USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY**	
Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2021 – February 28, 2022
Service Category:	MEDICAL CASE MANAGEMENT SERVICES (INCLUDING TREATMENT ADHERENCE)
Service Goal:	The goal of providing medical case management services is to ensure that those who are unable to self-manage their care, struggling with challenging barriers to care, marginally in care, and/or experiencing poor CD4/Viral load tests receive intense care coordination assistance to support participation in HIV medical care.
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved or maintained viral load Medical Visits *Reduction of Medical Case Management utilization due to client self-sufficiency.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 21/22 TOTAL**
03/01/21Proposed Number of Clients	366	**105**	**53**	**0**	**0**	**0**	**524**
Proposed Number of Visits = Regardless of number of transactions or number of units	**1098**	**315**	**159**	**0**	**0**	**0**	1572
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**4403**	**1258**	**629**	**0**	**0**	**0**	**6290**

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: The HIV Nurse Clinic Manager is responsible for ensuring MCM services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activities:** Management and MCM staff will attend Inland Empire HIV Planning Council Standards of Care meetings to ensure compliance. MCM staff will receive annual training on MCM practices and best practices for coordination of care, and motivational interviewing.	1, 2, & 3	03/01/21-02/28/22	▪ Medical Case Management Needs Assessments ▪ Patient Acuity Assessments ▪ Comprehensive Care Plan ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ▪ ARIES Reports
Element #2: Medical Case Managers will provide Medical Case Management Services to patients that meet the following criteria. **Activities:** Need one or more of the following services: home health, home and community-based services, mental health, substance abuse, housing assistance, and/or are clients that exhibit needs based on acuity level.	1, 2, & 3	03/01/21-02/28/22	

Element #3: Medical Case Managers will conduct an initial needs assessment to identify which HIV patients meet the criteria to receive medical case management. **Activities:** Services re-assessments will be conducted at a minimum of every four months by the MCM staff to determine service needs.	1, 2, & 3	03/01/21-02/28/22
Element #4: Medical Case Managers will conduct initial and ongoing assessment of patient acuity level and service needs. **Activities:** If patient is determined to not need intensive case management services they will be referred and linked with case management (non-medical) services.	1, 2, & 3	03/01/21-02/28/22
Element #5: The MCM staff will develop an individualized care plan in collaboration with patient, primary care physician/provider and other health care/support staff to maximize patient's care and facilitate cost-effective outcomes. **Activities:** The plan will include the following elements: problem/presenting issue(s), service need, goals, action plan, responsibility and timeframes.	1, 2, & 3	03/01/21-02/28/22

Element #6: MCM staff will periodically re-evaluate and modify care plans as necessary (minimum of six months). **Activities:** As patient presents with modified need, care plans will be updated. MCM staff will attend bi-weekly medical team case conferences to coordinate care for patient and update care plan as needed.	1, 2, & 3	03/01/21-02/28/22	
Element #7: The MCM staff will discuss and document treatment adherence issues the HIV patient is experiencing and work with treatment team staff to provide additional education and counseling for patient. **Activities:** MCM staff will attend bi-weekly medical team case conferences to coordinate care for patient as needed. MCM staff will coordinate treatment adherence discussions with physician/nursing health education staff to support the patient with his HIV treatment.	1, 2, & 3	03/01/21-02/28/22	

Element #8: The MCM staff will work with the HIV patient to become effective self-managers of their own care**.** **Activities:** MCM staff will share the care plan with the treatment team during case conferencing and MCM staff will maintain ongoing coordination with internal programs and external agencies to which patients are referred for medical and support services. HIV Nurse Clinic Manager and Senior CDS will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served.	1, 2, & 3	03/01/21-02/28/22	
Element #9: MCM staff will utilize standardized, required documentation to record encounters and progress **Activities:** HIV Nurse Clinic Manager and Senior CDS will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established National Cultural and Linguistic Competency Standards. Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices."	1, 2, & 3	03/01/21-02/28/22	

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

Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2021 – February 28, 2022
Service Category:	EARLY INTERVENTION SERVICES (PART A)
Service Goal:	Quickly link HIV infected individuals to testing services, core medical services, and support services necessary to support treatment adherence and maintain in medical care. Decreasing the time between acquisition of HIV and entry into care will facilitate access to medications, decrease transition rates, and improve health outcomes.
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved retention in care (at least 1 medical visit in each 6 month period) Improved viral suppression rate Targeted HIV Testing-Maintain 1:1% positivity rate or higher

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 21/22 TOTAL**
Proposed Number of Clients	**162**	**46**	**23**	**0**	**0**	**0**		**231**
Proposed Number of Visits = Regardless of number of transactions or number of units	**487**	**139**	**69**	**0**	**0**	**0**		**695**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**499**	**143**	**71**	**0**	**0**	**0**		**713**

ATTACHMENT A

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
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PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Identify/locate HIV+ unaware and HIV + that have fallen out of care **Activities:** EIS staff will work with grass-roots community-based and faith-based agencies, local churches and other non-traditional venues to reach targeted communities to perform targeted HIV testing, link unaware populations to HIV Testing and Counseling and Partner Services and newly diagnosed and unmet need to HIV care and treatment. EIS staff will work with prisons, jails, correctional facilities, homeless shelters and hospitals to perform targeted HIV testing, linking newly diagnosed to HIV care and treatment. EIS staff will work with treatment team staff to identify PLWHA that have fallen out-of-care and unmet need population to provide the necessary support to bring back into care and maintain into treatment and care. EIS staff will provide the following service delivery elements to PLWHA receiving EIS at Riverside Neighborhood Health Center, Perris Family Care Center and Indio Family Care Center. Services will also be provided in the community throughout Riverside County based on the Inland Empire HIV Planning Council Standards of Care.	1, 2, & 3	03/01/21-02/28/22	▪ Outreach schedules and logs ▪ Outreach Encounter Logs ▪ LTC Documentation Logs ▪ Assessment and Enrollment Forms ▪ Reporting Forms ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ARIES Reports
Element #2 Linking newly diagnosed and unmet need individuals to HIV care and treatment within 30 days or less. Provide referrals to systems of care (RW & non-RW) **Activities:** EIS staff will coordinate with HIV Care and Treatment facilities who link patient to care within 30 days or less.	1, 2, & 3	03/01/21-02/28/22	

Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi- Cal, Insurance Marketplace, OA-Care HIPP, etc.) Interventions will also include community-based outreach, patient education, intensive case management and patient navigation strategies to promote access to care.			
Element #3 Re-linking HIV patients that have fallen out of care. Perform follow-up activities to ensure linkage to care. **Activities:** Link patients who have fallen out of care within 30 days or less. Coordinate with HIV care and treatment. Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi- call, Insurance Marketplace, OA-Care HIPP, etc.) Link patient to non-medical case management, medical case management to assist with benefits counseling, transportation, housing, etc. to help patient remain in care and treatment. Link high-risk HIV positive EIS populations to support services (i.e., mental health, medical case management, house, etc.) to maintain in HIV care and treatment. Participate in bi-weekly clinic care team case conferencing to ensure linkage and coordinate care for patient.	1, 2, & 3	03/01/21- 02/28/22	

Element #4: EIS staff will utilize evidence-based strategies and activities to reach high risk MSM HIV community. These include but are not limited to: **Activities:** Developing and using outreach materials (i.e., flyers, brochures, website) that are culturally and linguistically appropriate for high risk communities-Utilizing the Social Networking model asking HIV + individuals and high risk HIV negativeindividuals to recruit their social contacts for HIV testing and linkage to care services.	1, 2, & 3	03/01/21- 02/28/22
Element #5: EIS staff will work with HIV Testing & Counseling Services to bring newly diagnosed individuals from communities of color to Partner Services and HIV treatment and care at DOPH- HIV/STD as well as other HIV care and treatment facilities throughout Riverside County. **Activities:** EIS staff will meet with DOPH Prevention on a weekly basis to exchange information on newly diagnosed patients ensuring that the person is referred to EIS and linked to HIV care and treatment within 30 days or less Senior Communicable Disease Specialist (CDS) will review all data elements to ensure linkage and retention of patient.	1, 2, & 3	03/01/21- 02/28/22

Element #6: EIS staff will coordinate with local HIV prevention /outreach programs to identify target outreach locations and identify individuals not in care and avoid duplication of outreach activities. **Activities:** EIS staff will coordinate with prevention and outreach programs within the TGA to strategically plan service areas to serve. EIS staff will work with the DOPH-Surveillance unit to target areas in need of services.		03/01/21- 02/28/22	
Element #7: EIS staff will assist patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-Cal, Insurance Marketplace, OA Care HIPP, etc.).		03/01/21- 02/28/22	
EIS staff will coordinate with non-medical case management services to assist with benefits counseling and rapid linkage to care and support services.			

Element #8: Senior CDS and Clinic Supervisor will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activities:** Senior CDS and Clinic Supervisor will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards. Training to be obtaining through the AIDS Education and Training Center on a semi-annual basis. Training elements will be incorporated into policies/plans for the department.		03/01/21- 02/28/22	
Element #9: EIS Staff will utilize standardized, required documentation to record encounters and progress. **Activities:** EIS staff will maintain documentation on all EIS encounters/activities including demographics, patient contacts, referrals, and follow-up, Linkage to Care Documentation Logs, Assessment and Enrollment Forms and Reporting Forms in each patient's chart. Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators, continuum of care data and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices".		03/01/21- 02/28/22	

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

Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2021 – February 28, 2022
Service Category:	CASE MANAGEMENT SERVICES (NON-MEDICAL)
Service Goal:	The goal of Case Management (non-medical) is to facilitate linkage and retention in care through the provision of guidance and assistance with service information and referrals
Service Health Outcomes:	"Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved or maintained viral load Accessing Medical Care (at least two medical visits in a 12 month period)"

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 21/22 TOTAL**
Proposed Number of Clients	**172**	**49**	**24**	**0**	**0**	**0**	**245**
Proposed Number of Visits = Regardless of number of transactions or number of units	**515**	**147**	**73**	**0**	**0**	**0**	**735**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**2059**	**589**	**294**	**0**	**0**	**0**	**2942**

Group Name and Description (must be HIV+ related)	**Service Area of**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
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	Service Delivery							
• Open Enrollment/Covered California Education Forum	1,2,&3	Patients who qualify for Covered California	Open	15	2hrs	2x's per year between Oct. 15-Dec. 7	2x's per year	-Enrollment in Covered California
• How to apply for Medi-Cal Inland Empire Health Plan Education Forum	1,2,&3	Newly diagnosed	Open	15	2hrs	2x's per year	2x's per year	-Enrollment in Medi-Cal IEHP
• What is Office AIDS Health Insurance Premium Payment Education Forum	1,2,&3	Newly diagnosed and pts. With SOC, Health Care premiums	Open	15	2 hrs.	2x's per year	2x's per year	-Enrollment in OA-HIPP

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: The HIV Nurse Clinic Manager is responsible for ensuring Case Management (Non-Medical) Services are delivered according to the IEHPC Standards of Care and Scope of Work activities. **Activities:** Case Manager will work with patient to conduct an initial intake assessment within 3 days from referral.	1, 2, & 3	03/01/21-02/28/22	▪ Patient Assessments ▪ Case Management Tracking Log ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ▪ ARIES Reports

Element #2: Initial and on-going of acuity level **Activities:** Case Manager will provide initial and ongoing assessment of patient's acuity level during intake and as needed to determine Case Management or Medical Case Management needs. Initial assessment will also be used to develop patient's Care Plan Case Manager will discuss budgeting with patients in order to maintain access to necessary services and Case Manager will screen for domestic violence, mental health, substance abuse, and advocacy needs..	1, 2, & 3	03/01/21- 02/28/22	
Element #3: Development of a comprehensive, individual care plan **Activities:** Case Manager will refer and link patients to medical, mental health, substance abuse, psychosocial services, and other services as needed and Case Manager will provide referrals to address gaps in their support network. Case Manager will be responsible for eligibility screening of HIV patients to ensure patients obtain health insurance coverage for medical care and that Ryan White funding is used as payer of last resort. Case Manager will refer to eligibility technician in order for patient to apply for Medi-Cal, Covered California, ADAP and/or OA CARE HIPP etc. Case Manager and Eligibility tech will coordinate and facilitate benefit trainings in order for patients to become educated on covered California open enrollment, Medi-Cal IEHP, OA- CARE HIPP etc.	1, 2, & 3	03/01/21- 02/28/22	
Element #4: Case Manager will provide education and counseling to assist the HIV patients with transitioning due to changes in the ACA. **Activities:** Case Manager will assist patients with obtaining needed financial resources for daily living such as bus pass vouchers, gas cards, and other emergency financial assistance.	1, 2, & 3	03/01/21- 02/28/22	

Element #5: Case Manager will educate patients regarding allowable services for family members, significant others, and friends in the patient's support system. Services include education on HIV disease, partner testing, care and treatment issues, and prevention education. The goal is to develop and strengthen the patient's support system and maintain their connection to medical care. **Activities:** Case Manager will provide education to patient about health education, risk reduction, self-management, and their rights, roles, and responsibilities in the services system.	1, 2, & 3	03/01/21- 02/28/22	
Element # 6: HIV Nurse Clinic Manager and Senior CDS will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is	1, 2, & 3	03/01/21- 02/28/22	
respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. **Activity:** HIV Nurse Clinic Manager and Senior CDS will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards.			
Element #7: Non-MCM staff will utilize standardized, required documentation to record encounters and progress. **Activities:** Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices."	1, 2, & 3	03/01/21- 02/28/22	

SCOPE OF WORK – PART A USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY	
Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2021 – February 28, 2022
Service Category:	MEDICAL NUTRITION THERAPY
Service Goal:	Facilitate maintenance of nutritional health to improve health outcomes or maintain positive health outcomes.
Service Health Outcomes:	Improve retention in care (at least 1 medical visit in each 6-month period) Improve viral suppression rate.

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 21/22 TOTAL**
Proposed Number of Clients	**257**	**73**	**36**	**0**	**0**	**0**	**366**
Proposed Number of Visits = Regardless of number of transactions or number of units	**513**	**147**	**73**	**0**	**0**	**0**	**733**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	**2567**	**733**	**367**	**0**	**0**	**0**	**3667**

Group Name and Description (must be HIV+ related)	**Service Area of Service Delivery**	**Targeted Population**	**Open/ Closed**	**Expected Avg. Attend. per Session**	**Session Length (hours)**	**Sessions per Week**	**Group Duration**	**Outcome Measures**
HIV Nutrition 101	1,2,3		Closed	10	2	Every 6 months	Every 6 months	Improved retention in care (at least 1 medical visit every 6-month period) Improved viral suppression

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

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Medical Nutrition Therapist will develop a Nutrition Screening Tool to identify patients who need Medical Nutrition Therapy Assessments. Risk factors could include but are not limited to: Weight loss, wasting, obesity, drug use/abuse, hypertension, cardiovascular disease, liver dysfunction etc. **Activities:** HIV patients to be screened at every medical appointment by the physician or nursing staff in order to identify nutrition related problems. Patients will be referred to MNT based on the following criteria: -HIV/AIDS diagnosis -Unintended weight loss or weight gain -Body mass index below 20 -Barriers to adequate intake such as poor appetite, fatigue, substance abuse, food insecurity, and depression	1, 2, & 3	03/01/21-02/28/22	MNT schedules/logs MNT encounter logs Nutrition Screening and MNT assessment MNT Referrals Progress/treatment notes ARIES Reports Cultural Competency Plan Academy of Nutrition and Dietetics Standards

Element #2: HIV patients will be assessed by MNT based on the following criteria: -High risk, to be seen by an RDN within 1 week -Moderate risk, to be seen by an RDN within 1 month -Low risk, to be seen by an RDN at least annually **Activities:** Initial MNT assessment and treatment will include the following: -Gathering of baseline information. Routine quarterly or semi-annually follow-up can be scheduled to continue education and counseling. - Nutrition-focused physical examination; anthropometric data; client history; food /nutrition-related history; and biochemical data, medical tests, and procedures. -Identification as early as possible new risk factors or indicators of nutritional compromise. -Discuss plan of treatment with treating physician. Treating physician will RX food and/or nutritional supplements. -Participate in bi-weekly case conferences to discuss treatment planning and coordination with the medical team	1, 2, & 3	03/01/21-02/28/22	
Element #3: HIV Patients who are identified for group education based on MNT assessment and treatment will be referred to MNT group/educational class **Activities:** MNT will develop educational curriculum. HIV patient will attend MNT group/educational class as recommended by MNT and treating physician.	1, 2, & 3	03/01/21-02/28/22	
Element #4: HIV Nurse Clinic Manager will ensure that MNT staff receive ongoing education and training in culturally competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender identity, sexual orientation, and religious preference of community served. **Activity:** HIV Nurse Clinic Manager will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards.	1, 2, & 3	03/01/21-02/28/22	

Element #5: MNT staff will utilize standardized, required documentation to record encounters and progress. **Activities:** Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators and provide opportunities for improvement in care and services, improve desired patient outcomes, and results can be used to develop and recommend "best practices".	1, 2, & 3	03/01/21- 02/28/22	

SCOPE OF WORK – MAI USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY	
Contract Number:	*Leave Blank*
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2021 – February 28, 2022
Service Category:	**MAI EARLY INTERVENTION SERVICES**
Service Goal:	Quickly link HIV infected individuals from communities of color (African American and Latinos) to testing services, core medical services, and support services necessary to support treatment adherence and maintain in medical care. Decreasing the time between acquisition of HIV and entry into care will facilitate access to medications, decrease transition rates, and improve health outcomes.
Service Health Outcomes:	Improved or maintained CD4 cell count Improved or maintained CD4 cell count, as a % of total lymphocyte cell count Improved retention in care (at least 1 medical visit in each 6 month period) Improved viral suppression rate Targeted HIV Testing-Maintain 1.1% positivity rate or higher

BLACK / AFRICAN AMERICAN	**SA1** West Riv	**SA2** **Mid Riv**	**SA3** **East Riv**	**SA4** San B West	**SA5** San B East	**SA6** San B Desert		**FY 21/22** **TOTAL**
Number of Clients	23	8	5	0	0	0		**36**
Number of Visits = Regardless of number of transactions or number of units	121	37	22	0	0	0		**180**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	631	181	90	0	0	0		**902**

HISPANIC / LATINO	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert		FY 21/22 TOTAL
Number of Clients	23	8	5	0	0	0		**36**
Number of Visits= Regardless of number of transactions or number of units	121	37	22	0	0	0		**180**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	631	181	91	0	0	0		**903**

TOTAL MAI (sum of two tables above)	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert		FY 21/22 TOTAL
Number of Clients	47	15	10	0	0	0		**72**
Number of Visits = Regardless of number of transactions or number of units	244	73	44	0	0	0		**361**
Proposed Number of Units = Transactions or 15 min encounters	1263	361	181	0	0	0		**1805**

(See Attachment P)								

Group Name and Description (must be HIV+ related)	Service Area of Service Delivery	Targeted Population	Open/ Closed	Expected Avg. Attend. per Session	Session Length (hours)	Sessions per Week	Group Duration	Outcome Measures
•								
•								
•								

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Identify/locate HIV+ unaware and HIV + that have fallen out of care Activities: -MAI EIS staff will work with grass-roots community-based and faith-based agencies, local churches and other non-traditional venues to reach targeted communities of color (African American and Latino communities) to perform targeted HIV testing, link unaware populations to HIV Testing and Counseling and Partner Services and newly diagnosed and unmet need to HIV care and treatment. -MAI EIS staff will work with prisons, jails, correctional facilities, homeless shelters and hospitals to perform targeted HIV testing, linking newly diagnosed to HIV care and treatment.	1, 2, & 3	03/01/21-02/28/22	▪ MAI/EIS schedules and logs ▪ MAI/EIS Encounter Logs ▪ Linkage to Care Documentation Logs ▪ Assessment and Enrollment Forms ▪ Reporting Forms ▪ Case Conferencing Documentation ▪ Referral Logs ▪ Progress Notes ▪ Cultural Competency Plan ▪ ARIES Reports

-MAI EIS staff will work with treatment team staff to identify PLWHA that have fallen out-of-care and unmet need population to provide the necessary support to bring back into care and maintain into treatment and care. -MAI EIS staff will provide the following service delivery elements to PLWHA receiving MAI EIS at Riverside Neighborhood Center, Perris Family Care Center and Indio Family Care Center. Services will also be provided in the community throughout Riverside County based on the Inland Empire HIV Planning Council Standards of Care.			
Element #2 -Linking newly diagnosed and unmet need individuals to HIV care and treatment within 30 days or less. Provide referrals to systems of care (RW & non-RW) Activities: -EIS MAI staff will coordinate with HIV Care and Treatment facilities who link patient to care within 30 days or less. -Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-Cal, Insurance Marketplace, OA-Care HIPP, etc.) -Interventions will also include community-based outreach, patient education, intensive case management and patient navigation strategies to promote access to care.	1,2,&3	03/01/21-02/28/22	

Element #3 Re-linking HIV patients that have fallen out of care. Perform follow-up activities to ensure linkage to care. Activities: -Link patient who have fallen out of care within 30 days or less. Coordinate with HIV care and treatment. --Assist HIV patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-Cal, Insurance Marketplace, OA-Care HIPP, etc.) -Link patient to non-medical case management, medical case management to assist with benefits counseling, transportation, housing, etc. to help patient remain in care and treatment. -Link high-risk HIV positive MAI populations to support services (i.e., mental health, medical case management, house, etc.) to maintain in HIV care and treatment. -Participate in bi-weekly clinic care team case conferencing to ensure linkage and coordinate care for patient.	1,2,&3	03/01/21-02/28/22	
Element #4: MAI EIS staff will utilize evidence-based strategies and activities to reach African American and Hispanic/Latino HIV community. These include but are not limited to: Activities: -Developing and using outreach materials (i.e., flyers, brochures, website) that are culturally and linguistically appropriate for African American and Hispanic/Latino communities.	1, 2, & 3	03/01/21-02/28/22	

-Utilizing the Social Networking model asking HIV + individuals and high risk HIV negative individuals to recruit their social contacts for HIV testing and linkage to care services.			
Element #5: MAI EIS staff will work with HIV Testing & Counseling Services to bring newly diagnosed individuals from communities of color to Partner Services and HIV treatment and care at DOPH-HIV/STD as well as other HIV care and treatment facilities throughout Riverside County. Activities: MAI EIS staff will meet with DOPH Prevention on a weekly basis to exchange information on newly diagnosed ensuring that the person is referred to EIS MAI and in linked to HIV care and treatment within 30 days or less -Senior Communicable Disease Specialist (CDS) will review all data elements to ensure linkage and retention of patient.	1, 2, & 3	03/01/21-02/28/22	
Element #6: MAI EIS staff will coordinate with local HIV prevention /outreach programs to identify target outreach locations and identify individuals' not in care and avoid duplication of outreach activities Activities: -MAI EIS staff will coordinate with prevention and outreach programs within the TGA to strategically plan service areas to serve. -MAI EIS staff will work with the DOPH-Surveillance unit to target areas in need of services.	1, 2, & 3	03/01/21-02/28/22	
Element #7: MAI EIS staff will assist patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-	1, 2, & 3	03/01/21-02/28/22	

Cal, Insurance Marketplace, OA Care HIPP, etc.). Activities: -MAI EIS staff will coordinate with non-medical case management services to assist with benefits counseling and rapid linkage to care and support services.			
Element #8: Senior CDS and Department Manager will ensure that clinic staff at all levels and across all disciplines receive ongoing education and training in cultural competent service delivery to ensure that patients receive quality care that is respectful, compatible with patient's cultural, health beliefs, practices, preferred language and in a manner that reflects and respects the race/ethnicity, gender, sexual orientation, and religious preference of community served. Activities: -Senior CDS and Department Manager will review and update on an ongoing basis the written plan that outlines goals, policies, operational plans, and mechanisms for management oversight to provide services based on established national Cultural and Linguistic Competency Standards. -Training to be obtaining through the AIDS Education and Training Center on a semi-annual basis. Training elements will be incorporated into policies/plans for the department.	1, 2, & 3	03/01/21-02/28/22	
Element #9: EIS MAI Staff will utilize standardized, required documentation to record encounters and progress. Activities: -MAI EIS staff will maintain documentation on all MAI EIS encounters/activities including demographics, patient contacts, referrals,	1, 2, & 3	03/01/21-02/28/22	

and follow-up, Linkage to Care Documentation Logs, Assessment and Enrollment Forms and Reporting Forms in each patient's chart -Information will be entered into ARIES. The ARIES reports will be used by the Clinical Quality Management Committee to identify quality service indicators, continuum of care data and provide opportunities for improvement in care and services, improve desired patient outcomes and results can be used to develop and recommend "best practices".			

RYAN WHITE PART A/MAI PROGRAM BUDGET AND ALLOCATION PLAN
Fiscal Year March 1, 2021 – February 28, 2022

AGENCY NAME: County of Riverside Public Health SERVICE: Outpatient/Ambulatory Health Services

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
Physician IV Per Diem : (Zane, R.) ($167,368 x RW 0.121887 FTE) Provides medical diagnosis, treatment, and management including the prescription of antiretroviral therapy to patients with HIV disease at three health care centers in Riverside County. Perform diagnostic testing, documentation and tracking of viral loads and CD4 counts. Early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental health needs.	**$146,968**	**$20,400**	**$167,368**
Physician IV: (Wu, P.) ($167,368 x RW 0.061165 FTE) Provides medical diagnosis, treatment, and management including the prescription of antiretroviral therapy to patients with HIV disease at three health care centers in Riverside County. Perform diagnostic testing, documentation and tracking of viral loads and CD4 counts. Early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental health needs.	**$157,131**	**$10,237**	**$167,368**
Nurse Practitioner: (Ajala-Staats, C.)($120,000 x RW 0.04583 FTE) Provides medical diagnosis, treatment, and management including the prescription of antiretroviral therapy to patients with HIV disease at three health care centers in Riverside County. Perform diagnostic testing, documentation and tracking of viral loads and CD4 counts. Early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental health needs.	**$114,500**	**$5,500**	**$120,000**
Physician IV: (Nguyen, A./Vo, T.)($60,000 x RW 0.47 FTE) Provides medical diagnosis, treatment, and management including the prescription of antiretroviral therapy to patients with HIV disease at three health care centers in Riverside County. Perform diagnostic testing, documentation and tracking of viral loads and CD4 counts. Early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental health needs.	**$31,800**	**$28,200**	**$60,000**
Health Services Assistant: (Ramirez, G.) ($50,500 x .RW 0.20 FTE) Provides direct patient care and provides support duties to physicians, registered nurses and LVN's at three health care centers.	**$40,400**	**$10,100**	**$50,500**
Health Services Assistant: (Rosado, P.) ($46,500 x RW 0.20 FTE) Provides direct patient care and provides support duties to physicians, registered nurses and LVN's at three health care centers.	**$37,200**	**$9,300**	**$46,500**
Health Services Assistant: (Theard, C.) ($46,500 x RW 0.10752 FTE) Provides direct patient care and provides support duties to physicians, registered nurses and LVN's at three health care centers.	**$41,500**	**$5,000**	**$46,500**
Asst Nurse Manager: (Wright, M. ($125,000 x RW 0.080 FTE) This position will be responsible to provide direct patient care and plans, organizes, directs and evaluates nursing/medical services at three health care centers.	**$115,000**	**$10,000**	**$125,000**
LVN III: (Rojas-Merry, S.) ($57,200 x RW 0.2 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	**$45,760**	**$11,440**	**$57,200**
Fringe Benefits 42**%** of Total Personnel Costs	**$306,709**	**$46,274**	**$352,983**
TOTAL PERSONNEL	**$1,036,968**	**$156,451**	**$1,193,419**
Other *(Other items related to service provision such as supplies, rent, utilities, depreciation, maintenance, telephone, travel, computer, equipment, etc. can be added below)*			
Laboratory Services: Medical testing and assessment for HIV/AIDS clinical care	**$5,000**	**$6,114**	**$11,114**
Medical Supplies: Medical supplies/equipment to support daily activities at three health care centers. This includes syringes, blood tubes, plastic gloves, etc.	**$5,000**	**$1,500**	**$6,500**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$3,000**	**$5,000**	**$8,000**

Pharmacy Supplies: Provide pharmaceutical assistance to HIV patients receiving Outpatient/Ambulatory Health Services at three health care centers.	**$0**	**$5,500**	**$5,500**
Travel: Mileage and Carpool for clinic and support staff to provide Outpatient/Ambulatory Health Services to HIV patients at the Riverside, Perris and Indio health care centers (Mileage calculated at Fed IRS Rate).	**$6,000**	**$600**	**$6,600**
TOTAL OTHER	**$19,000**	**$18,714**	**$37,714**
SUBTOTAL (Total Personnel and Total Other)	**$1,055,968**	**$175,165**	**$1,231,133**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc. See next page.)	$104,424	$19,462	$123,886
TOTAL BUDGET (Subtotal & Administration)	**$1,160,392**	**$194,627**	**$1,355,019**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) $194,627

- **Total Number of Ryan White Units to be Provided for this Service Category:** 4200
- **Total Ryan White Budget (Column B) Divided by Total RW Units to be Provided:** $ 46

(*This is your agency's RW cost for care per unit*)

[2]**List Other Payers Associated with funding in Column A:**	Medi-Cal and Ryan White Part B

RYAN WHITE PART A/MAI PROGRAM BUDGET AND ALLOCATION PLAN
Fiscal Year March 1, 2021 – February 28, 2022

AGENCY NAME: County of Riverside Public Health SERVICE: Medical Case Mgmt.

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
Social Services Practitioner III: (Inzunza, K.)($70,000 x RW 0.22143 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$54,500**	**$15,500**	**$70,000**
Social Services Practitioner III: (Brown, A)($70,000 x RW 0.22143 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$54,500**	**$15,500**	**$70,000**
Social Services Practitioner III: (Jimenez, B.)($70,000 x RW .0616 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$65,688**	**$4,312**	**$70,000**
Communicable Disease Specialist: (Arrona, I.) ($68,900 x RW 0.25 FTE) Provides Medical Case Management Services to HIV patients; conduct initial and ongoing assessment of patient service needs, assess patient acuity level, develop a care plan in collaboration with patient; work in collaboration with multidisciplinary HIV care team at three health care centers.	**$51,675**	**$17,225**	**$68,900**
Asst Nurse Manager (Wright, M.) ($125,000 x RW 0.10 FTE) This position will be responsible to provide direct patient care and plans, organizes, directs and evaluates nursing/medical case management services at three health care centers.	**$112,500**	**$12,500**	**$125,000**
LVN II: (Barajas, V.) ($52,300 x RW 0.25 FTE) Provides Medical Case Management Services to HIV patients; provide coordination and follow - up of medical treatment. Provide treatment adherence counseling at three health care centers.	**$39,225**	**$13,075**	**$52,300**
LVN II: (Malixi, E.) ($52,300 x RW 0.25 FTE) Provides Medical Case Management Services to HIV patients; provide coordination and follow - up of medical treatment. Provide treatment adherence counseling at three health care centers.	**$39,225**	**$13,075**	**$52,300**
LVN III: (Merry-Rojas, S.) ($57,200 x RW 0 FTE) Provides Medical Case Management Services to HIV patients; provide coordination and follow - up of medical treatment. Provide treatment adherence counseling at three health care centers.	**$57,200**	**$0**	**$57,200**
LVN II: (Del Villar, D.) ($54,000 x RW 0.15481 FTE) Provides Medical Case Management Services to HIV patients; provide coordination and follow - up of medical treatment. Provide treatment adherence counseling at three health care centers.	**$45,640**	**$8,360**	**$54,000**
Fringe Benefits 42**%** of Total Personnel Costs	**$218,464**	**$41,810**	**$260,274**
TOTAL PERSONNEL	**$738,617**	**$141,357**	**$879,974**
Other *(Other items related to service provision such as supplies, rent, utilities, depreciation, maintenance, telephone, travel, computer, equipment, etc. can be added below)*			
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$0**	**$2,461**	**$2,461**
Travel: Mileage and Carpool for clinic and support staff to provide MCM Services to HIV patients at the Riverside, Perris and Indio health care centers (Mileage calculated at Fed IRS Rate).	**$1,500**	**$958**	**$2,458**
Total Other	**$1,500**	**$3,419**	**$4,919**
SUBTOTAL (Total Personnel and Total Other)	**$740,117**	**$144,776**	**$884,893**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$74,012	$16,086	$90,098
TOTAL BUDGET (Subtotal & Administration)	**$814,129**	**$160,862**	**$974,991**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) 160862

- **Total Number of Ryan White Units to be Provided for this Service Category:** $0 6290
- **Total Ryan White Budget (Column B) Divided by Total RW Units to be Provided:** $ 26

(*This is your agency's RW cost for care per unit*)

[2]**List Other Payers Associated with funding in Column A:**	Ryan White Part B

04.14.21 RL

RYAN WHITE PART A/MAI PROGRAM BUDGET AND ALLOCATION PLAN
Fiscal Year March 1, 2021 – February 28, 2022

AGENCY NAME: County of Riverside Public Health SERVICE: EIS

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
Communicable Disease Specialist: (Murillo, R) ($67,000 x RW 0.25 FTE) Provide EIS Services to unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Provide targeted HIV testing.	**$50,250**	**$16,750**	**$67,000**
SR. Communicable Diseases Specialist: (Ortiz, M.) ($70,500 x RW 0.26596 FTE) Supervises EIS services to unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Oversees QA activities.	**$51,750**	**$18,750**	**$70,500**
Communicable Disease Specialist: (Arrona, I.) ($68,900 x RW 0.25 FTE) Provide EIS Services to unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Provide targeted HIV testing.	**$51,675**	**$17,225**	**$68,900**
Communicable Disease Specialist: (Vacant) ($67,000 x RW 0.25 FTE)Provide EIS Services to unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Provide targeted HIV testing.	**$50,250**	**$16,750**	**$67,000**
Fringe Benefits 42**%** of Total Personnel Costs	**$85,649**	**$29,180**	**$114,829**
TOTAL PERSONNEL	**$289,574**	**$98,655**	**$388,229**
Other *(Other items related to service provision such as supplies, rent, utilities, depreciation, maintenance, telephone, travel, computer, equipment, etc. can be added below)*			
Travel: Mileage and Carpool for clinic and support staff to provide EIS Services to HIV patients at the Riverside, Perris and Indio health care centers (Mileage calculated at Fed IRS Rate).	**$1,500**	**$213**	**$1,713**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$0**	**$879**	**$879**
HIV testing kits to perform targeted HIV testing. To help the unaware learn of their HIV statues and receive referral to HIV care and treatment services.	**$0**	**$0**	**$0**
TOTAL OTHER	**$1,500**	**$1,092**	**$2,592**
SUBTOTAL (Total Personnel and Total Other)	**$291,074**	**$99,747**	**$390,821**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$34,720	$11,083	$45,803
TOTAL BUDGET (Subtotal & Administration)	**$325,794**	**$110,830**	**$436,623**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) 110830

- **Total Number of Ryan White Units to be Provided for this Service Category:** 713
- **Total Ryan White Budget (Column B) Divided by Total RW Units to be Provided:** $ 155

(*This is your agency's RW cost for care per unit*)

[2]List Other Payers Associated with funding in Column A:	Ryan White Part B

04.14.21 RL

RYAN WHITE PART A/MAI PROGRAM BUDGET AND ALLOCATION PLAN
Fiscal Year March 1, 2021 – February 28, 2022

AGENCY NAME: County of Riverside Public Health SERVICE: Non Medical Case Mgmt.

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
Communicable Disease Specialist: (Arrona, I.) ($67,000 x RW 0.31716 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$45,750**	**$21,250**	**$67,000**
Social Services Practitioner III: (Inzunza, K.)($70,000 x RW 0.22571 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$54,200**	**$15,800**	**$70,000**
Social Services Practitioner III: (Brown, A.)($70,000 x RW 0.10714 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$62,500**	**$7,500**	**$70,000**
Social Services Practitioner III: (Jimenez, B.)($70,000 x RW 0.08 FTE) Help patients identify all available health and disability benefits. Educate patients on public and private benefits at three health care centers. Assist patients with accessing community, social, financial, and legal resources.	**$64,400**	**$5,600**	**$70,000**
Licensed Voc Nurse: (Barajas V) ($52,000 x RW 0.25 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	**$39,000**	**$13,000**	**$52,000**
Licensed Voc Nurse: (Malixi, E.) ($52,000 x RW 0.125 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	**$45,500**	**$6,500**	**$52,000**
Licensed Voc Nurse: (Del Villar, D) ($52,000 x RW 0.04808 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	**$49,500**	**$2,500**	**$52,000**
Fringe Benefits 42**%** of Total Personnel Costs	**$151,557**	**$30,303**	**$181,860**
TOTAL PERSONNEL	**$512,407**	**$102,453**	**$614,860**
Other *(Other items related to service provision such as supplies, rent, utilities, depreciation, maintenance, telephone, travel, computer, equipment, etc. can be added below)*			
Travel: Mileage and Carpool for clinic and support staff to provide Non MCM Services to HIV patients at the Riverside, Perris and Indio health care centers (Mileage calculated at Fed IRS Rate).	**$500**	**$200**	**$700**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$0**	**$960**	**$960**
TOTAL OTHER	**$500**	**$1,160**	**$1,660**
SUBTOTAL (Total Personnel and Total Other)	**$512,907**	**$103,613**	**$616,520**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$51,291	$11,512	$62,803
TOTAL BUDGET (Subtotal & Administration)	**$564,198**	**$115,125**	**$679,323**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) $115,125

- **Total Number of Ryan White Units to be Provided for this Service Category:** $0 2942
- **Total Ryan White Budget (Column B) Divided by Total RW Units to be Provided:** $ 39

(*This is your agency's RW cost for care per unit*)

[2]**List Other Payers Associated with funding in Column A:**	Ryan White Part B

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RYAN WHITE PART A/MAI PROGRAM BUDGET AND ALLOCATION PLAN
Fiscal Year March 1, 2021 – February 28, 2022

AGENCY NAME: County of Riverside Public Health SERVICE: Medical Nutrition Therapy

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
Nutritionist (Rodriguez, I.) ($45,000 x 0.20 FTE) Performs nutritional assessments on HIV patients ; Teaches and counsels HIV patients on healthy food choices and food preparation. Determines, through application of various published standards, whether individuals are at nutritional risk. Gives direct nutritional and dietetic consultation to individuals with special nutritional needs in an individual and group session.	**$36,000**	**$9,000**	**$45,000**
Program Director (Francisco, F.) ($50,000 x 0.13 FTE) Performs nutritional assessments on HIV patients ; Teaches and counsels HIV patients on healthy food choices and food preparation. Determines, through application of various published standards, whether individuals are at nutritional risk. Gives direct nutritional and dietetic consultation to individuals with special nutritional needs in an individual and group session.	**$43,500**	**$6,500**	**$50,000**
Nutritionist (Mansell, S.) ($45,000 x 0.18888 FTE) Performs nutritional assessments on HIV patients ; Teaches and counsels HIV patients on healthy food choices and food preparation. Determines, through application of various published standards, whether individuals are at nutritional risk. Gives direct nutritional and dietetic consultation to individuals with special nutritional needs in an individual and group session.	**$36,500**	**$8,500**	**$45,000**
Nutritionist (McCarthy, M.) ($45,000 x 0.17333 FTE) Performs nutritional assessments on HIV patients ; Teaches and counsels HIV patients on healthy food choices and food preparation. Determines, through application of various published standards, whether individuals are at nutritional risk. Gives direct nutritional and dietetic consultation to individuals with special nutritional needs in an individual and group session.	**$37,200**	**$7,800**	**$45,000**
Nutritionist (Varela, M.) ($45,000 x 0.16111 FTE) Performs nutritional assessments on HIV patients ; Teaches and counsels HIV patients on healthy food choices and food preparation. Determines, through application of various published standards, whether individuals are at nutritional risk. Gives direct nutritional and dietetic consultation to individuals with special nutritional needs in an individual and group session.	**$37,750**	**$7,250**	**$45,000**
Fringe Benefits 42**%** of Total Personnel Costs	**$80,199**	**$16,401**	**$96,600**
TOTAL PERSONNEL	**$271,149**	**$55,451**	**$326,600**
Other *(Other items related to service provision such as supplies, rent, utilities, depreciation, maintenance, telephone, travel, computer, equipment, etc. can be added below)*			
Travel: Mileage for Medical Nutrition Therapy staff to provide direct patient care, follow-up on patient assessments improving health outcomes. (Mileage calculated at Fed IRS Rate).	**$0**	**$1,048**	**$1,048**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$0**	**$0**	**$0**
TOTAL OTHER	**$0**	**$1,048**	**$1,048**
SUBTOTAL (Total Personnel and Total Other)	**$271,149**	**$56,499**	**$327,648**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$27,115	$6,277	$33,392
TOTAL BUDGET (Subtotal & Administration)	**$298,264**	**$62,776**	**$361,040**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) 62776

- **Total Number of Ryan White Units to be Provided for this Service Category:** $0 3667
- **Total Ryan White Budget (Column B) Divided by Total RW Units to be Provided:** $ 17

(*This is your agency's RW cost for care per unit*)

[2]**List Other Payers Associated with funding in Column A:**	Ryan White Part B
04.14.21 RL	

RYAN WHITE PART A/MAI PROGRAM BUDGET AND ALLOCATION PLAN
Fiscal Year March 1, 2021 – February 28, 2022

AGENCY NAME: County of Riverside Public Health SERVICE: MAI/EIS

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
Communicable Disease Specialist: (Murillo, R..) ($67,000 x RW 0.15 FTE) Provide MAI EIS Services to African American and Latino unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Perform targeted HIV testing.	**$56,950**	**$10,050**	**$67,000**
SR. Communicable Diseases Specialist: (Ortiz, M.) ($70,500 x RW 0.10 FTE) Supervises MAI EIS services to African American and Latino unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Oversees QA activities.	**$63,450**	**$7,050**	**$70,500**
Communicable Disease Specialist: (Vacant) ($67,000 x RW 0.16418 FTE) Provide MAI EIS Services to African American and Latino unaware and unmet need populations in service areas 1, 2, and 3 in Riverside County. Identify barriers to care. Assist patient with linkage to medical care and wraparound services. Link newly diagnosed HIV+ to medical care in 30 days or less. Assist patients that have fallen out of care facilitating access to care. Perform targeted HIV testing.	**$56,000**	**$11,000**	**$67,000**
Asst Nurse Manager: (Wright, M.. ($129,000 x RW 0.10659 FTE) This position will be responsible to provide direct patient care and plans, organizes, directs and evaluates nursing/medical services at three health care centers.	**$115,250**	**$13,750**	**$129,000**
Fringe Benefits 42**%** of Total Personnel Costs	**$122,493**	**$17,577**	**$140,070**
TOTAL PERSONNEL	**$414,143**	**$59,427**	**$473,570**
Other *(Other items related to service provision such as supplies, rent, utilities, depreciation, maintenance, telephone, travel, computer, equipment, etc. can be added below)*			
Travel: Mileage and Carpool for clinic and support staff to provide Services to HIV patients at the Riverside, Perris and Indio health care centers (Mileage calculated at Fed IRS Rate).	**$1,000**	**$3,710**	**$4,710**
HIV testing kits to perform targeted HIV testing. To help the unaware learn of their HIV statues and receive referral to HIV care and treatment services.		**$0**	**$0**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$500**	**$7,085**	**$7,585**
TOTAL OTHER	**$1,500**	**$10,795**	**$12,295**
SUBTOTAL (Total Personnel and Total Other)	**$415,643**	**$70,222**	**$485,865**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$39,991	$7,802	$47,793
TOTAL BUDGET (Subtotal & Administration)	**$455,634**	**$78,024**	**$533,658**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) $78,024.00

- **Total Number of Ryan White Units to be Provided for this Service Category:** $0.00 1805
- **Total Ryan White Budget (Column B) Divided by Total RW Units to be Provided:** $43

(*This is your agency's RW cost for care per unit*)

[2] **List Other Payers Associated with funding in Column A:** Ryan White Part B

04.14.21 RL