SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM: 3.23
(ID # 23874)
MEETING DATE:
Tuesday, January 30, 2024

FROM : RUHS-PUBLIC HEALTH:

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-PUBLIC HEALTH: Ratify and Approve Amendment No. 3 to Contract No. 20-1180 with San Bernardino County, Department of Public Health to Provide Medical Care and Support Services for Individuals Living with Human Immunodeficiency Virus (HIV) Acquired Immunodeficiency Syndrome (AIDS) Under the Ryan White HIV/AIDS Treatment Extension Act of 2009 to Extend the Period of Performance Through February 28, 2026. All Districts. [Total Amended Amount: $1,508,717; up to $585,831 in additional compensation - 100% Local]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve Amendment No. 3 to Contract No. 20-1180 with San Bernardino County, Department of Public Health, to provide medical care and support services for individuals living with Human Immunodeficiency Virus (HIV) Acquired Immunodeficiency Deficiency Syndrome (AIDS) under the Ryan White HIV/AIDS Treatment Extension Act of 2009 to extend the period of performance for two (2) years through February 28, 2026 and increase the compensation amount by $1,508,717 for an aggregate compensation amount of $3,905,542;
2. Authorize the Chair of the Board to sign the Amendment on behalf of the County; and
3. Authorize the Director of Public Health, or designee, based on the availability of fiscal funding and as approved to form by County Counsel, to: (a) sign all amendments, certifications, assurances, reports, or other related documents required by San Bernardino County that exercise the options of the Agreement, including modifications of the statement of work, that stay within the intent of the Agreement; and (b) sign amendments to the compensation provisions that do not exceed the sum total of fifteen percent (15%) of the total aggregate amount.

ACTION:Policy

Kim Saruwatari, Director of Public Health 1/24/2024

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Perez, seconded by Supervisor Jeffries and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Gutierrez
Nays:	None
Absent:	None
Date:	January 30, 2024
xc:	RUHS-PH

Kimberly A. Rector
Clerk of the Board
By: Naomy Li
Deputy

SUBMITTAL TO THE BOARD OF SUPERVISORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$769,914	$769,914	$1,539,828	$0
NET COUNTY COST	$0	$0	$0	$0
SOURCE OF FUNDS: 100% Local			**Budget Adjustment:** No	
			For Fiscal Year: 23/24 – 25/26	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Ryan White Care Act (RWCA) Human Immunodeficiency Virus/Acquired Immunodeficiency Deficiency Syndrome (HIV/AIDS) Treatment Modernization Act of 2009 provides financial relief to geographic areas significantly impacted by AIDS and HIV. The counties of Riverside and San Bernardino became eligible in 1994 to receive RWCA Funds. The act was named after Ryan White, a teenager from Indiana who brought awareness of the epidemic through his struggle with HIV/AIDS and AIDS-related discrimination. In 1994, San Bernardino County, Department of Public Health, began receiving RWCA Part A funding to support programs in the Transitional Grant Area (TGA) of San Bernardino County and Riverside County.

A new report found that 6,895 people were estimated to be living with HIV/AIDS in 2020 within the Coachella Valley and other parts of eastern Riverside County. In 2020, about 10,458 people were living with HIV/AIDS countywide.

According to a Centers for Disease Control (CDC) report in 2018, out of everyone living with HIV (diagnosed and undiagnosed) 65% received some care, 50% were retained in care, and 56% were virally suppressed or undetectable. Having a suppressed or undetectable viral load protects the health of a person living with HIV by preventing disease progression. A person living with HIV who takes HIV medicine as prescribed can virally suppress their HIV and stay healthy with no risk of sexually transmitting HIV to negative HIV partners.

Impact on Residents and Businesses

Acceptance of this contract amendment will allow Riverside University Health System - Public Health (RUHS-PH) to continue providing crucial HIV/AIDS services for HIV Medical, Support Care, and wrap-around services. It will also provide culturally relevant HIV prevention messaging and support to reduce the number of new HIV cases within Riverside County by 90% by 2030.

Additional Fiscal Information

This contract award does not require any county matching funds and there is no impact to County General Funds. The total increased amount awarded to RUHS-PH is $1,508,717, which brings the aggregate total to $3,905,542. The estimated allocation for each county fiscal year throughout the duration of the period of performance is as follows:

Year	County Fiscal Year
FY 21/22	$722,244
FY 22/23	$873,556
FY 23/24	$769,914
FY 24/25	$769,914
FY 25/26	$769,914
Total	**$3,905,542**

Contract History and Price Reasonableness

RUHS-PH has received funding from San Bernardino County for over 20 years to provide services for the Ryan White Program Part A. The Board of Supervisors approved Contract No. 20-1180 on December 7, 2021, on Agenda Item 3.42 in the amount of $2,245,365 for the period of performance of March 1, 2021, through February 29, 2024. Amendment No. 1 was executed on April 14, 2022, to decrease the amount of funding by $78,633 for a revised amount of $2,166,732. Amendment No. 2 was executed on May 17, 2023, to increase the amount of funding by $230,093 for a revised amount of $2,396,825. Amendment No. 3 aims to extend the period of performance by two (2) years through February 28, 2026, and increase the amount of funding by $1,508,717 for a new aggregate amount of $3,905,542.

ATTACHMENTS:

ATTACHMENT A. Amendment No. 3 to Contract No. 20-1180 with San Bernardino County, Department of Public Health

Douglas Cardonez Jr. 1/24/2024

Gregg Gu, Chief Deputy County Counsel 1/24/2024

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

SAN BERNARDINO COUNTY

Contract Number

20-1180 A-3

SAP Number

4400015714

Department of Public Health

Department Contract Representative	Derrick Younger
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 28, 2026
Original Contract Amount	$2,396,825
Amendment Amount	$1,508,717
Total Contract Amount	$3,905,542
Cost Center	9300371000

IT IS HEREBY AGREED AS FOLLOWS:

AMENDMENT NO. 3

It is hereby agreed to amend Contract No. 20-1180, effective September 26, 2023, 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 $3,905,542, of which $3,905,542 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
Amendment No. 2	$ 230,093	March 1, 2022 through February 29, 2024
Amendment No. 3	$ 1,508,717	March 1, 2023 through February 28, 2026

JAN 30 2024 3.23

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	$873,556
March 1, 2023 through February 29, 2024	$769,914*
March 1, 2024 through February 28, 2025	$769,914
March 1, 2025 through February 28, 2026	$769,914
Total	$3,905,542

*This amount includes a decrease of $31,111 from the previous year.

SECTION VIII. TERM

Amend Section VIII to read as follows:

This Contract is effective as of March 1, 2021, and is extended from its original expiration date of February 28, 2024, to expire on February 28, 2026, but may be terminated earlier in accordance with provisions of Section IX of the Contract.

ATTACHMENTS

ATTACHMENT A3 – Add SCOPE OF WORK for Program Year 2022-23
ATTACHMENT B3 – Add SCOPE OF WORK MAI for Program Year 2022-23
ATTACHMENT J3 – Add PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

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

This Amendment may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute the same Amendment. The parties shall be entitled to sign and transmit an electronic signature of this Amendment (whether by facsimile, PDF or other email transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Amendment upon request.

ATTEST:
KIMBERLY A. RECTOR, Clerk
By Naomy Li
DEPUTY

Approved as to Form:
Minh C. Tran
County Counsel

By: Gregg Gu
Gregg M. Gu
Chief Deputy County Counsel

SAN BERNARDINO COUNTY

► Dawn Rowe
Dawn Rowe, Chair, Board of Supervisors

Dated: SEP 26 2023

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 CHUCK WASHINGTON
(Print or type name of person signing contract)

Title Chair, Board of Supervisors
(Print or Type)

Dated: JAN 30 2024

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	► Patty Steven	► Joshua Dugas
Adam Ebright, County Counsel	Pa[illegible] ntracts	Jo[illegible] ctor
Date September 20, 2023	Date September 20, 2023	Date September 20, 2023

JAN 30 2024 3.23

SCOPE OF WORK for Program Year 2022-23

SCOPE OF WORK – RYAN WHITE PART A

USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2023 - February 29, 2024
Service Category:	**NON-MEDICAL CASE MANAGEMENT SERVICES**
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 suppression rate Improve retention in Care (at least one medical visit each 6-month period)

	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert	FY 23/24 TOTAL
Proposed Number of Clients	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)*	2,000	400	200	0	0	0	**2,600**

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:	1, 2, & 3	03/01/23-02/29/24	• Patient Assessments • Care Plans

SCOPE OF WORK for Program Year 2022-23

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.			• 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 to maintain access to necessary services and Case Manager will screen for domestic violence, mental health, substance abuse, and advocacy needs.	1, 2, & 3	03/01/23- 02/29/24	
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 assist patient to apply for medical, Covered California, ADAP and/or OA CARE HIPP etc. • Case Manager will coordinate and facilitate benefit trainings for patients to become educated on covered California open enrollment, Medi-Cal IEHP, OA- CARE HIPP etc.	1, 2, & 3	03/01/23- 02/29/24	
Element #4: Case Manager will provide education and counseling to assist the HIV patients with transitioning if insurance or eligibility changes. **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		

SCOPE OF WORK for Program Year 2022-23

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD
Grant Period:	March 1, 2023 – February 29, 2024
Service Category:	**Medical Case Management (MCM)**
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 Improved retention in care (at least 1 medical visit in each 6-month period) 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 23/24 TOTAL
Proposed Number of Clients	455	130	65	0	0	0	**650**
Proposed Number of Visits = Regardless of number of transactions or number of units	1,365	390	195	0	0	0	**1,950**
Proposed Number of Units = Transactions or 15 min encounters	2,000	600	200	0	0	0	**2,800**

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

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

SCOPE OF WORK for Program Year 2022-23

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 Committee 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	03/01/23-02/28/24	• Medical Case Management Needs Assessments • Patient Acuity Assessments • Benefit and resource referrals • 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 TGA MCM service category criteria: **Activities:** • Benefits counseling, support services assessment and assistance with access to public and private programs the patient may qualify for. Make referrals for: home health, home and community-based services, mental health, substance abuse, housing assistance as needed	1, 2, & 3	03/01/23-02/28/24	
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:** Initial patient, family member and personal support system assessment. Re-assessments will be conducted at a minimum of every four months by MCM staff to determine ongoing or new service needs.	1, 2, & 3	03/01/23-02/28/24	
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	03/01/23-02/28/24	

SCOPE OF WORK for Program Year 2022-23

Element #5: The MCM staff will develop comprehensive, individualized care plans in collaboration with patient, primary care physician/provider and other health care/support staff to maximize patient's care and facilitate cost-effective outcomes. **Activities:** • The plan will include the following elements: problem/presenting issue(s), service need(s), goals, action plan, responsibility, and timeframes.	1, 2, & 3	03/01/23- 02/28/24	

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2023 – February 29, 2024
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; as a % of total lymphocyte cell count. Improved or maintained viral load. Improve retention in care (at least 1 medical visit in each 6-month period). Link newly diagnosed HIV+ to care within 30 days: and Increase rate of ART adherence

	SA1 West Riv	**SA2** Mid Riv	**SA3** East Riv	**SA4** San B West	**SA5** San B East	**SA6** San B Desert	**FY 23/24** **TOTAL**
Proposed Number of Clients	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	2800	800	500	0	0	0	**4,100**

SCOPE OF WORK for Program Year 2022-23

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

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
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 through the following: **Activities:** • Development of Treatment Plan • Diagnostic testing • Early Intervention and Risk Assessment • Preventive care and screening • Practitioner examination • Documentation and review of medical history • 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	03/01/23-02/28/24	• Patient health assessment • Lab results • Treatment plan • Psychosocial assessments • Treatment adherence documentation • Case conferencing documentation • Progress notes • Cultural Competency Plan • ARIES reports • Viral loads • Reduction in unmet need • Prescription of/adherence to ART
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	03/01/23-02/28/24	

SCOPE OF WORK for Program Year 2022-23

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
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 consist of: **Activities:** • Completing a medical history • Conducting a physical examination including an assessment for oral health care • Reviewing lab test results • Assessing the need for medication therapy • Development of a Treatment Plan. • Collection of blood samples for CD4 Viral load, Hepatitis, and other testing • Perform TB skin test and chest x-ray	1, 2, & 3	03/01/23-02/28/24	
Element #4: Clinicians will complete a medical history on patients, including family medical history, psycho-social history, current medications, environmental assessment, diabetes, cardiovascular diseases, renal disease, GI abnormalities, pancreatitis, liver disease, and hepatitis. **Activities:** • Conducting a physical examination • Reviewing lab test results • Assessing the need for medication therapy • Development of a Treatment Plan.	1, 2, & 3	03/01/23-02/28/24	

SCOPE OF WORK for Program Year 2022-23

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2023 – February 29, 2024
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 23/24 TOTAL
Proposed Number of Clients	143	46	22	0	0	0	**211**
Proposed Number of Visits = Regardless of number of transactions or number of units	392	112	56	0	0	0	**560**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	500	300	200	0	0	0	**1,000**

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

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 to identify nutrition related problems. Patients will be referred to MNT based on the following criteria: o HIV/AIDS diagnosis o Unintended weight loss or weight gain o Body mass index below 20	1, 2, & 3	03/01/23-02/28/24	• 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 • Viral loads

SCOPE OF WORK for Program Year 2022-23

○ Barriers to adequate intake such as poor appetite, fatigue, substance abuse, food insecurity, and depression			
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 follows- up can be scheduled to continue education and counseling. • Nutrition-focused physical examination; anthropometric data; client history; food /nutrition-related history; biochemical data, medical tests, and procedures. • Identify 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	03/01/23- 02/28/24	
Element #3: HIV patients who are identified for group education based on MNT assessment and treatment will be referred to MNT group/educational classes **Activities:** • MNT will develop educational curriculum. • HIV patient will attend MNT group/educational class as recommended by MNT and treating physician.	1, 2, & 3	03/01/23- 02/28/24	

SCOPE OF WORK for Program Year 2022-23

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

Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2023 – February 29, 2024
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 23/24 TOTAL**
Proposed Number of Clients	**125**	**70**	**30**	**0**	**0**	**0**		**225**

SCOPE OF WORK for Program Year 2022-23

Proposed Number of Visits = Regardless of number of transactions or number of units	317	160	90	0	0	0		567
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	1,200	675	425	0	0	0		2,300

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
•								
•								
•								

SCOPE OF WORK for Program Year 2022-23

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE	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	03/01/23-02/29/24	▪ 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	03/01/23-02/29/24	

SCOPE OF WORK for Program Year 2022-23

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	03/01/23- 02/29/24	

SCOPE OF WORK for Program Year 2022-23

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	1, 2, & 3	03/01/23- 02/29/24	

SCOPE OF WORK for Program Year 2022-23

asking HIV + individuals and high risk HIV negative individuals to recruit their social contacts for HIV testing and linkage to care services.			
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	03/01/23- 02/29/24	
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.	1, 2, & 3	03/01/23- 02/29/24	
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.).	1, 2, & 3	03/01/23- 02/29/24	

SCOPE OF WORK for Program Year 2022-23

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.	1, 2, & 3	03/01/23- 02/29/24	
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,	1, 2, & 3	03/01/23- 02/29/24	

improve desired patient outcomes and results can be used to develop and recommend "best practices.			

Add SCOPE OF WORK MAI for Program Year 2022-23

SCOPE OF WORK – MAI USE A SEPARATE SCOPE OF WORK FOR EACH PROPOSED SERVICE CATEGORY	
Contract Number:	
Contractor:	County of Riverside Department of Public Health, HIV/STD Branch
Grant Period:	March 1, 2023 – February 29, 2024
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 23/24 TOTAL**
Number of Clients	27	9	6	0	0	0	**42**
Number of Visits = Regardless of number of transactions or number of units	144	42	26	0	0	0	**212**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	350	234	156	0	0	0	**740**

Add SCOPE OF WORK MAI for Program Year 2022-23

HISPANIC / LATINO	SA1 West Riv	SA2 Mid Riv	SA3 East Riv	SA4 San B West	SA5 San B East	SA6 San B Desert		FY 23/24 TOTAL
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)*	350	150	131	0	0	0		**631**

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 23/24 TOTAL
Number of Clients	50	17	11	0	0	0		**78**
Number of Visits = Regardless of number of transactions or number of units	265	79	48	0	0	0		**392**
Proposed Number of Units = Transactions or 15 min encounters *(See Attachment P)*	700	384	287	0	0	0		**1,371**

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
•								
•								
•								

Add SCOPE OF WORK MAI for Program Year 2022-23

PLANNED SERVICE DELIVERY AND IMPLEMENTATION ACTIVITIES:	SERVICE AREA	TIMELINE	PROCESS OUTCOMES
Element #1: Connect/reconnect HIV infected individuals into care utilizing the "Bridge" program as the model. 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. -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.	1, 2, & 3	03/01/23-02/29/24	▪ 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
Element #2: Conduct in depth, one-on-one encounters that are planned and delivered in coordination with local HIV prevention outreach program to avoid duplicate efforts. 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	03/01/23-02/29/24	
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.)	1, 2, & 3	03/01/23-02/29/24	

Add SCOPE OF WORK MAI for Program Year 2022-23

-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.			
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), focus groups, and surveys that are culturally and linguistically appropriate for African American and Hispanic/Latino communities. -Researching and utilizing the *Bridge* model asking HIV + individuals and high-risk HIV negative individuals to recruit their social contacts for HIV testing and linkage to care services.	1, 2, & 3	03/01/23-02/29/24	
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	03/01/23-02/29/24	
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.	1, 2, & 3	03/01/23-02/29/24	

Add SCOPE OF WORK MAI for Program Year 2022-23

-MAI EIS staff will work with the DOPH-Surveillance unit to target areas in need of services.			
Element #7: MAI EIS staff will assist patients with enrollment or transition activities to other health insurance payer sources (i.e., ADAP, MISP, Medi-Cal, Insurance Marketplace, OA Care HIPP, etc.). Activities: -MAI EIS staff will coordinate with non-medical case management services to assist with benefits counseling and rapid linkage to care and support services.	1, 2, & 3	03/01/23-02/29/24	

PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

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

Budget Category	A Non-RW Cost (Other Payers)[2]	B RW Cost	C Total Cost[1]
Personnel			
Physician IV Per Diem : (Zane, R.) ($174,062 x 0.020108 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.	$170,562	$3,500	$174,062
Physician IV: (Vacant) ($174,062 x .057451 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.	$164,062	$10,000	$174,062
Nurse Practitioner Per Diem: (Latif/Cole/Gilbert) ($191,000 x 0.104712 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.	$171,000	$20,000	$191,000
Office Assistant III: (Pineda, V.) ($37,104 x 0.1617075 FTE) Provides support to providers and nurses at three health care centers	$31,104	$6,000	$37,104
Health Services Assistant: (Hunt, A.) ($47,542 x .141328 FTE) Provides direct patient care and provides support duties to physicians, registered nurses and LVN's at three health care centers	$40,823	$6,719	$47,542
Health Services Assistant: (Rosado, P.) ($50,433 x 0.297424 FTE) Provides direct patient care and provides support duties to physicians, registered nurses and LVN's at three health care centers	$35,433	$15,000	$50,433
Health Services Assistant: (Ramirez, G.) ($50,433 x 0.128884 FTE) Provides direct patient care and provides support duties to physicians, registered nurses and LVN's at three health care centers	$43,933	$6,500	$50,433
Asst Nurse Manager: (Vacant) ($108,000 x 0.018509 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.	$106,001	$1,999	$108,000
LVN III: (Rojas-Merry, S.) ($81,650 x 0.122474 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	$71,650	$10,000	$81,650
Fringe Benefits 42% of Total Personnel Costs	$350,519	$33,482	$384,001
TOTAL PERSONNEL	**$1,185,087**	**$113,200**	**$1,298,287**
***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	$20,000	$25,000
Medical Supplies: Medical supplies/equipment to support daily activities at three health care centers. This includes syringes, blood tubes, plastic gloves, etc.	$5,000	$10,000	$15,000
Office/Computer Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	$3,000	$272	$3,272
Communication: Cell phone and desk phone expenses for staff. Will support daily activities at the health care centers and call clients and other staff.	$3,360	$960	$4,320
Pharmacy Supplies: Provide pharmaceutical assistance to HIV patients receiving Outpatient/Ambulatory Health Services at three health care centers.	$35,000	$9,040	$44,040
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	$500	$6,500
TOTAL OTHER	**$57,360**	**$40,772**	**$98,132**
SUBTOTAL (Total Personnel and Total Other)	**$1,242,447**	**$153,972**	**$1,396,419**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc. See next page.)	$124,244	$15,397.00	$139,641
TOTAL BUDGET (Subtotal & Administration)	**$1,366,691**	**$169,369**	**$1,536,060**

[1] Total Cost = Non-RW Cost (Other Payers) + RW Cost (A+B) $ 169,369.00

- **Total Number of Ryan White Units to be Provided for this Service Category:** $0.00 4100
- **Total Ryan White Budget (Column C) Divided by Total RW Units to be Provided:** $ 41

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

PROGRAM BUDGET . ..ND ALLOCATION PLAN for Program . ear 2022-23

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			
SR. Communicable Disease Specialist: (Wilson P) ($69 777 x 0 086991 FTE; Supervises EIS services to unaware and unmet need populations in service areas 1 2 and 3 in Riverside County Identify carriers 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	$63,707	$6,070	$69,777
Communicable Disease Specialist: (Leal R) ($56 871 x 0 3860842 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	$34,914	$21,957	$56,871
Communicable Disease Specialist: (Arrona I ; ($72 971 x 0 088364 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	$66,523	$6,448	$72,971
Communicable Disease Specialist: (Ramos G) ($60 192 x 0 215976 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	$47,192	$13,000	$60,192
Asst Nurse Manager: (Vacant) ($108 000 x 0 046296 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	$103,000	$5,000	$108,000
Fringe Benefits 42% of Total Personnel Costs	$132,441	$22,040	$154,481
TOTAL PERSONNEL	**$447,777**	**$74,515**	**$522,292**
***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**	**$249**	**$1,249**
Rent/Utilities/Maintenance: Office/cubicle Space for clinic and support staff to provide MAI services. Includes utility and maitnenance costs.	**$3,418**	**$1,482**	**$4,900**
Communication: Cell phone and desk phone expenses for staff. Will support daily activities at the health care centers and call clients and other staff	**$2,456**	**$784**	**$3,240**
HIV testing kits to perform targeted HIV testing To help the unaware learn of their HIV status and receive referral to HIV care and treatment services.	**$0**	**$0**	**$0**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	**$800**	**$377**	**$1,177**
TOTAL OTHER	**$7,674**	**$2,892**	**$10,566**
SUBTOTAL (Total Personnel and Total Other)	**$455,451**	**$77,407**	**$532,858**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$45,545	$7,740	$53,285
TOTAL BUDGET (Subtotal & Administration)	**$500,996**	**$85,147**	**$586,143**

PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

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: (Rosales, S.)($67,701 x 0.15509372 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.	$57,201	$10,500	$67,701
Social Services Practitioner III: (Alatore, R.)($75,874 x 0.155521 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.	$64,074	$11,800	$75,874
Social Services Practitioner III: (Jimenez, B.)($84,834 x 0.1477945 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.	$72,296	$12,538	$84,834
Communicable Disease Specialist: (Arrona, I.) ($72,971 x 0.08222445 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.	$66,971	$6,000	$72,971
Asst Nurse Manager (Vacant) ($108,000 x 0.0462963 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.	$103,000	$5,000	$108,000
LVN II (Malixi, E.) ($77,159 x 0.23328452 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.	$59,159	$18,000	$77,159
LVN II (Del Villar, D.) ($78,702 x 0.31765394 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.	$53,702	$25,000	$78,702
Fringe Benefits 42% of Total Personnel Costs	$200,089	$37,312	$237,401
TOTAL PERSONNEL	$676,492	$126,150	$802,642
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.	$1,252	$500	$1,752
Communication: Cell phone and desk phone expenses for staff. Will support daily activities at the health care centers and call clients and other staff.	$2,887	$893	$3,780
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).	$1,499	$799	$2,298
Total Other	$5,638	$2,192	$7,830
SUBTOTAL (Total Personnel and Total Other)	$682,130	$128,342	$810,472
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$68,213	$12,834	$81,047
TOTAL BUDGET (Subtotal & Administration)	$750,343	$141,176	$891,519

PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

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			
SR. Communicable Disease Specialist: (Wilson P) ($69 777 x 0 286627399 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	$49,777	$20,000	$69,777
Communicable Disease Specialist: (Leal R) ($56 871 x 0 2989221 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	$39,871	$17,000	$56,871
Communicable Disease Specialist (Ramos G.) ($60 192 x 0 4672547 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	$32,067	$28,125	$60,192
Communicable Disease Specialist (Arrona I.) ($72 971 x 0 301489633 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	$50,971	$22,000	$72,971
Fringe Benefits 54% of Total Personnel Costs	$72,528	$47,048	$119,576
TOTAL PERSONNEL	**$245,214**	**$134,173**	**$379,387**
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**	**$999**	**$2,499**
Communication: Cell phone and desk phone expenses for staff. Will support daily activities at the health care centers and call EIS Clients.	**$1,368**	**$745**	**$2,113**
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink etc.	**$0**	**$3,000**	**$3,000**
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**	**$500**	**$500**
Rent/Utilities/Maintenance: Office/cubicle Space for clinic and support staff to provide EIS services. Includes utility and maintenance costs.	**$3,491**	**$1,409**	**$4,900**
TOTAL OTHER	**$6,359**	**$6,653**	**$13,012**
SUBTOTAL (Total Personnel and Total Other)	**$251,573**	**$140,826**	**$392,399**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$25 157	$14 082	**$39,239**
TOTAL BUDGET (Subtotal & Administration)	**$276,730**	**$154,908**	**$431,638**

PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

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.) ($72,971 x 0.1068918 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.	$65,171	$7,800	$72,971
Social Services Practitioner III: (Rosales, S.)($72078 x 0.1290269 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.	$62,778	$9,300	$72,078
Social Services Practitioner III: (Alatore, R.)($72078 x 0.1290269 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.	$62,778	$9,300	$72,078
Social Services Practitioner III: (Jimenez, B.)($84,834 x 0.1296650 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.	$73,834	$11,000	$84,834
Licensed Voc Nurse: (Barajas V) ($76,462 x 0.1294761 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	$66,562	$9,900	$76,462
Licensed Voc Nurse: (Malixi, E.) ($77,161 x 0.1051697 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	$69,046	$8,115	$77,161
Licensed Voc Nurse: (Del Villar, D) ($78,702 x 0.0724251 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	$73,002	$5,700	$78,702
Licensed Voc Nurse: (Medina, O) ($77,159 x 0.1425628 FTE) Provides direct patient care and provides support duties to physicians, and registered nurses at three health care centers.	$66,159	$11,000	$77,159
Fringe Benefits 42% of Total Personnel Costs	$226,519	$30,288	$256,807
TOTAL PERSONNEL	$765,849	$102,403	$868,252
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	$320	$820
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	$0	$43	$43
Communication: Cell phone and desk phone expenses for staff. Will support daily activities at the health care centers and call clients	$3,510	$810	$4,320
Enter item name and description			$0
TOTAL OTHER	$4,010	$1,173	$5,183
SUBTOTAL (Total Personnel and Total Other)	$769,859	$103,576	$873,435
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$76,985	$10,357	$87,342
TOTAL BUDGET (Subtotal & Administration)	$846,844	$113,933	$960,777

PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

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 (Rodrigues S ; ($60 570 x 0 1568433218 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	$51,070	$9,500	$60,570
Program Director (Stewart J) ($108 166 x 0 05066287 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	$102,686	$5,480	$108,166
Nutritionist (Mansell S ; ($77 536 x 0 064421688 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	$72,541	$4,995	$77,536
Nutritionist (McCarthy M) ($77 536 x 0 12897234 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	$67,536	$10,000	$77,536
Nutritionist (Varela M) ($77 536 x 0 1676640528 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	$64,536	$13,000	$77,536
Fringe Benefits 42% of Total Personnel Costs	$150,515	$18,049	$168,564
TOTAL PERSONNEL	**$508,884**	**$61,024**	**$569,908**
***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	$2,000	$2,000
Office Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	$0	$401	$401
Medical Supplies: Medical supplies/equipment Bio-Electrical Impedance Analysis (BIA) machine includes plastic gloves, etc.		$0	$0
TOTAL OTHER	**$0**	**$2,401**	**$2,401**
SUBTOTAL (Total Personnel and Total Other)	**$508,884**	**$63,425**	**$572,309**
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$50 888	$6 342	$57 230
TOTAL BUDGET (Subtotal & Administration)	**$559,772**	**$69,767**	**$629,539**

PROGRAM BUDGET AND ALLOCATION PLAN for Program Year 2022-23

AGENCY NAME: County of Riverside Public Health SERVICE: CQM

	A	B	C
Budget Category	**Non-RW Cost (Other Payers)[2]**	**RW Cost**	**Total Cost[1]**
Personnel			
LVN III: (Rojas-Merry, S.) ($81,650.00 x 0.28781384 FTE) Establish and maintain Clinic Quality Control of office paperwork, clinic audits, and clinic logs at the health care centers. Reviews and maintains proper clinic workflow processes for quality control and identify gaps.	$58,150	$23,500	$ 81,650
Fringe Benefits 42% of Total Personnel Costs	$24,423	$9,870	$ 34,293
TOTAL PERSONNEL	$82,573	$33,370	$115,943
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).	$500	$300	$800
Clinic Licenses: Clinic License renewals for Clinics to maintain high clinical quality management (ex. CLIA)	$290	$160	$450
Communication: Cell phone and desk phone expenses for staff. Will support daily activities at the health care centers and call EIS Clients.	$473	$175	$648
Office/Computer Supplies: Office supplies/equipment to support daily activities at three health care centers. This includes paper, pens, ink, etc.	$1,000	$1,278	$2,278
Rent/Utilities/Maintenance: Office/cubicle Space for clinic and support staff to provide MAI services. Includes utility and maintenance costs.	$894	$331	$1,225
Medical Supplies: Medical supplies/equipment Bio-Electrical Impedance Analysis (BIA) machine includes plastic gloves, etc.		$0	$0
TOTAL OTHER	$3,157	$2,244	$5,401
SUBTOTAL (Total Personnel and Total Other)	$85,730	$35,614	$121,344
Administration (limited to 10% of total service budget) (Include a detailed description of items within such as managerial staff etc.)	$11,594		$ 11,594
TOTAL BUDGET (Subtotal & Administration)	$97,324	$35,614	$132,938