

**ENDING THE HIV EPIDEMIC (EHE)
Policies & Procedures Manual
Grant Year - 2026**



**Cuyahoga County Board of Health
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CUYAHOGA COUNTY
BOARD OF HEALTH
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ENDING THE HIV EPIDEMIC (EHE)

Policies & Procedures Manual

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Introduction

STATEMENT OF PURPOSE

The Cuyahoga County Board of Health has developed this manual as a guide for the effective implementation of the Ending the HIV Epidemic (EHE) Program grant management and service delivery business processes. This manual should be used as a point of reference for EHE Program grantee staff and EHE funded contractors/service providers.

This manual contains a broad range of information to assist grantee staff and contractor/service providers in day to day management of program and reporting requirements. This manual is meant to be a “living document” and will continue to be updated as legislative and program changes occur.

APPLICATION AND USE OF THIS MANUAL

This policies and procedures manual has been designed as a resource tool for the administration and implementation of the EHE Programs. The manual has been organized by types of business transactions and requirements. Each policy and/or procedure contains the following:

- **Policy Statement:** Provides a background, description and intent of the policy
- **Procedures:** Action items required for the contractor/service provider to be compliant with established policy
- **Authority/Oversight:** Origin of the policy and the entity that provides oversight for implementation of the policy/procedure
- **Published Date:** The effective date of the policy/procedure, including any revision date(s)

The development of EHE policies and procedures is an open and ongoing process requiring updates and/or changes that may result from legislative, administrative, fiscal, programmatic and/or continuous quality improvement changes. Updates and/or revisions to these policies and procedures will be provided by the EHE grantee’s office in the form of a “Policy and Procedure Revision Form” that will identify the policy/procedure being updated or changed, the effective date, and the updates or changes to the policy/procedure. It is expected that updated/revised policies and procedures will be shared with appropriate staff responsible for implementing the policy/procedure.

Questions regarding the implementation of the policies and procedures in this manual should be directed to the EHE Program Supervisor. Any exemption sought to these policies/procedures must be approved by the Program Supervisor or Population Health Services Deputy Director.

Definitions

Policies: The rules or guidelines by which an agency operates. They may be general or specific but always reflect the philosophy, mission and goals of the agency. Policies are generally approved by the agency’s leadership and implemented by management. They define operations such as staff

organization, services, business hours, and conditions for business transactions.

Policies may, among other functions, set criteria for eligibility to receive services, establish the agency's commitment to confidentiality of protected or sensitive information, and/or processes for managing and monitoring of contracts.

Procedures: The methods or sets of instructions by which policies are carried out. Procedures provide specific steps for accomplishing required tasks, handling information, and making service delivery decisions.

Constructive feedback related to this manual is welcomed and will be thoughtfully considered by EHE staff as updates and revisions are being made. All comments, suggestions or feedback should be forwarded to the EHE Program Supervisor at elark@ccbh.net.

Overview - Ryan White Program

HISTORY

The Ryan White Program was established in 1990 to improve the quality and availability of care for limited-income, uninsured, and underinsured individuals and families affected by HIV/AIDS. The program is named after an Indiana teenaged boy whose courageous struggle with HIV and against AIDS-related discrimination helped educate the nation.

The AIDS epidemic began in the early 1980s and has had the greatest impact on populations at high risk for poverty and with limited or no access to the health care system. Persons with HIV/AIDS (PWHAs) tend to be poorer than the general population, and clients accessing Ryan White Program services tend to represent the poorest of the poor since they are more likely to have limited or no source of public or private payment for services.

RYAN WHITE CARE ACT LEGISLATION

In August 2009, the U.S. Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to improve the quality and availability of health care services for low-income, uninsured, and underinsured PWHAs. The legislation has been reauthorized four times since its enactment, with the most recent reauthorization occurring in 2009. The Ryan White Treatment Extension Act expired on September 30, 2013, but funding has been extended in subsequent years through appropriations bills. This critical federal funding allows over 500,000 PWHAs receive necessary health care each year.

RYAN WHITE PROGRAM EXTENSIONS ACT

Language:

The Ryan White HIV/AIDS Treatment Extension Act of 2009 provides the federal HIV/AIDS programs in the Public Health Services (PHS) Act under Title XXVI flexibility to respond effectively to the changing epidemic. In 2009 the Act extended the manner in which Ryan White funds can be used, with a continued emphasis on providing life-saving and life-extending services for persons living with HIV/AIDS across the country.

Key Points of the 2009 Reauthorization:

- Minority AIDS Initiative (MAI) funds under Parts A and B will be distributed according to a formula based on the distribution of populations disproportionately impacted by HIV/AIDS.
- Continued issuance of Part A funds to Emerging Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). For TGAs that lose their eligibility status, the state in which the TGA is located will receive incremental transfers of funding for three years.
- A new requirement to determine not only the size and demographics of the diagnosed HIV/AIDS population, but also those who are infected but unaware of their HIV status. One-third of Part A supplemental grant funds are to be based on the EMA's/TGA's ability to demonstrate its success in identifying infected individuals unaware of their status and

linking them to care.

- Part A and Part B grantees must develop comprehensive plans that include a strategy for identifying infected individuals who are not aware of their status and linking them to appropriate health care services. The strategy must focus on reducing barriers to routine testing and disparities in access to services for minorities and underserved communities.
- The allowance for unobligated balances to be carried over into the next grant year increased from 2% to 5% of formula funds.

GUIDING PRINCIPLES OF THE 2009 REAUTHORIZATION OF THE RYAN WHITE PROGRAM

The Ryan White Part A Program addresses the health needs of PWHAs by funding primary health care services and supportive services that enhance access to and retention in care. The following principles were crafted by the HIV/AIDS Bureau (HAB) to guide all funded Ryan White programs in implementing CARE Act provisions and addressing emerging challenges in HIV/AIDS care:

Revise Care Systems to Meet Emerging Needs

The Ryan White Program stresses the role of local planning and decision making with broad community involvement to determine how to best meet HIV/AIDS care needs. This requires assessing the shifting demographics of new HIV/AIDS cases and revising care systems to meet the needs of emerging communities and populations. A priority focus is on meeting the needs of traditionally underserved populations hardest hit by the epidemic, particularly PWHAs who know their HIV status but are not in care. This entails outreach, early intervention services (EIS), and other needed services to ensure that clients receive primary health care and supportive services.

Ensure Access to Quality HIV/AIDS Care

The quality of HIV/AIDS medical care, including combination antiretroviral therapies and prophylaxis for opportunistic infections, can make a critical difference in the lives of PWHAs. Programs should employ quality management strategies to ensure that available treatments are accessible and delivered according to established and current HIV-related treatment guidelines.

Coordinate Services with Other Health Care Delivery Systems

Ryan White funded services are meant to fill gaps in care, which requires coordination across Ryan White Parts A – F and other federal, state and local programs. Such coordination can help maximize efficient use of resources, enhance systems of care, and ensure coverage of HIV/AIDS related services within managed care plans, particularly Medicaid Managed Care.

Evaluate the Impact of Funds and Make Needed Improvements

Federal policy and funding decisions are increasingly determined by outcomes. Programs need to demonstrate the impact of Ryan White funds on improving access to quality care and treatment along with areas of continued need. Programs also need to have quality assurance and evaluation mechanisms in place that assess the effects of Ryan White resources on the health outcomes PWHAs served.

Ending the HIV Epidemic Program

In the 2019 State of the Union address, a new public health priority for the United States was announced: Ending the HIV Epidemic (EHE). Ending new HIV infections is now possible. Our longstanding HIV prevention mechanisms, such as condom use and syringe service programs, continue to be effective in reducing new transmissions. Furthermore, new prevention methods are increasingly present in communities including the U=U movement and PrEP.

In addition to successful prevention and treatment, new ways to intervene during an HIV outbreak are being utilized to reduce the impact when an outbreak does occur. Fifty-seven jurisdictions with the highest occurrence of HIV transmissions were targeted for the first round of funding to plan and implement new services aimed at greatly reducing new HIV transmission. Included in these fifty-seven jurisdictions were three in Ohio: Cuyahoga, Franklin, and Hamilton counties.

Cuyahoga County has a long history of investment in HIV services, through both private and public funds preceding the Ryan White Act in 1990. The county, located in the Cleveland transitional grant area (TGA), is well positioned to leverage existing Ryan White and other public and private resources as well as existing infrastructure to achieve the primary goal set out in the national plan: a 90 percent reduction of new infections by 2030. The Cuyahoga County Board of Health and other committed community partners have been actively engaged in activities to reduce new transmissions through prevention efforts, diagnose those with HIV, link PWH (persons with HIV) to care, provide support for PWH to remain in care, and plan for potential outbreaks. This work will continue under the structure of the Cuyahoga EHE plan.

Ending the HIV Epidemic cannot be achieved by one agency, rather it is a collaborative effort that will require active engagement from community-based agencies and community members. This plan welcomes involvement from the entire community during the ten-year implementation. The participation of multiple health and social service agencies, as well as individual advocates during the development of this plan, indicates the community is fully engaged in this process and are likely to remain committed to the goal of reducing new HIV transmissions by 90 percent over the next five years. In order to make progress on the current goals, CCBH & EHE partners have identified eight overarching strategies that touch all areas of work related to HIV. Additionally, strategies have been developed in each of the five strategies; Prevent, Diagnose, Treat, Respond, and Community Engagement.

Currently, EHE Cuyahoga County funds the following services at local agencies:

- (OAHS) Rapid Start ART
- Medical Transportation
- Intensive Medical Case Management
- Emergency Financial Assistance
- (EIS) Peer Navigation/Community Health Worker
- Psychosocial Support
- Nonmedical Case Management
- (Other Professional Services) Legal Services
- (OAHS) Mobile Health Clinics

EHE Strategies

OVERARCHING STRATEGIES

The eight strategies identified as vital to reaching the goals of ending the HIV epidemic in Cuyahoga County address both systems and individuals. The values of community stakeholders who are engaged in ending the epidemic are reflected in these overarching strategies.

- Reduce Systemic Racism
- Populations of Focus
- Social Impact Media
- Health Education
- HIV Professionals Workforce Development
- Modernization of HIV Laws
- Data & Research Infrastructure

PREVENT STRATEGY

Preventing new HIV transmissions will be essential to ending the HIV epidemic in Cuyahoga County. Five strategies have been proposed to prioritize the continuation of successful existing prevention activities expanding them as necessary, and to create new programs and opportunities for innovative and evidence-based practices to be implemented within the community.

- Condom Distribution
- Equitable PrEP/PEP Access
- Protective Factors & Risk Reduction
- Empowering Youth & Young Adults
- U=U Messaging

DIAGNOSE STRATEGY

Diagnosing those with HIV as early as possible prevents individuals from unknowingly transmitting the virus to others. Proposed strategies in the diagnosis pillar focus on increasing access to testing for all community members by working across social service and health sectors to offer testing in a convenient and accessible way that meets people where they are. The importance of community health workers and peer navigation is reflected within the strategies and draws upon existing models that have found success in this and other communities.

- Equitable Access to HIV Testing
- Increased EHE Initiatives
- Partnerships
- (CHW) Peer Navigation

TREAT STRATEGY

Receiving treatment rapidly and effectively allows PWH to reach sustained viral suppression. As a person's viral load becomes undetectable, it also becomes untransmittable. Strategies in the treat pillar focus on guiding PWH into care and providing the support necessary to remain in care through medical care, support networks, peer support, and meeting the basic need of housing.

- Viral Suppression
- Linkages to Care
- Support Networks for PWH
- Peer Support
- Stigma Reduction
- Integrated Care
- Housing

RESPOND STRATEGY

Responding to HIV outbreaks requires connecting prevention and treatment services to people quickly and effectively. Effective outbreak response must be built on a plan that can be enacted rapidly with clear roles for each entity involved developed prior to an outbreak occurring. Ohio Department of Health and local public health departments, including Cuyahoga County Board of Health, collaborate on outbreak response plans. The nature of the outbreak will determine the community partners which need to be engaged. In addition, outbreak response relies heavily on partner identification and notification to move people to testing and resources as needed.

- Outbreak Response Plan
- Partner Identification

Eligibility Criteria

Unlike Ryan White Part A, the EHE Program does not have a limiting eligibility policy. Ryan White Part A eligibility assessments are encouraged by providers receiving both funding streams to prevent duplicating services and resources. EHE Program funds and services are intended to be utilized within the Cuyahoga County jurisdiction. However, these funds can be used outside the jurisdiction to serve those in need within the Cleveland TGA with prior approval from the Board. The EHE Program operates as a payor of last resort. This means that federal funds can only pay for care and medications if no other source (such as Medicaid, Medicare, private insurance, or state programs) is able to pay. Providers must check and exhaust all other options first. Clients receiving EHE-funded services must only meet the following:

HIV/AIDS diagnosis- The patient or client must have a confirmed HIV diagnosis.

Intake Requirements

To establish a care relationship, the client intake must include the collection of the following demographic information:

1. Date of intake
2. Name and signature of the person completing the intake
3. Client name, address, phone number, date of birth, and CAREWare ID
4. Language(s) spoken and/or preferred language of communication
5. Best communication method(s) to be used for follow-up
6. Demographics (sex at birth, current gender, race/ethnic origin)
7. HIV status, year of diagnosis, and relevant risk factor(s) for HIV infection
8. Client Income documentation (Self-attestation signature for zero-income households)
9. Housing status, and residency documentation
10. Insurance status
11. Emergency Contact(s)
12. Any other service-specific data or data required for the CAREWare system
13. Documentation of financial need.

All agencies are required to have a client intake policy on file. It is the responsibility of the agency to determine and document. Clients should live or receive medical services in Cuyahoga County and have an HIV/AIDS diagnosis. Services will be provided to clients without discrimination on the basis of: HIV infection, race, creed, age, sex, identity, expression, marital or parental status, sexual orientation, religion, physical or mental handicap, nationality, or any other basis prohibited by law.

Standards of Care

Service standards of care (SOC) outline the elements and expectations an Ending the HIV Epidemic (EHE) service provider follows when implementing a specific service category.

The purpose of service SOC are to ensure that all EHE service providers offer the same fundamental components of the given service category across a service area. Service SOC establish the minimal level of service or care that an EHE funded agency or provider may offer within a jurisdiction. They set a benchmark by which services are monitored, and subrecipient contracts are developed. Each funded service category must have a unique set of service standards. There may be some overlap of service SOC among two or more service categories (e.g., medical case management and non-medical case management may both assist with enrolling clients in insurance assistance programs).

Please reference the Standards of Care manual for more information.

Data to Care

Data to Care (D2C) is a public health strategy that uses HIV surveillance data and other data sources to identify persons with HIV who are not in care, link those who are not in care to appropriate medical and social services, and ultimately support the HIV Care Continuum. The CCBH EHE program is the lead for D2C activities in the Cuyahoga County jurisdiction. It is strongly advised that individuals last seen by a Part A or EHE-funded medical provider be contacted by that provider to get them back into care to monitor labs, prescriptions, and achieve/maintain viral suppression.

Please reference the Data to Care manual for more information.

CAREWare

CAREWare is free, HRSA sponsored software used to manage and monitor HIV clinical and supportive care as well as produce federally required service reports. CAREWare is updated regularly to be compliant with HAB reporting requirements. The software is scalable and can be customized to meet local needs.

CAREWare was originally released at a Grantee (Recipient) Meeting in 2000. Usage has increased steadily each year and today over 800 Ryan White-funded agencies in 48 States, Puerto Rico, and the U.S. Virgin Islands use the software to manage their HIV/AIDS information.

The Cleveland TGA began using the CAREWare data collection system in 2011. The Cuyahoga County EHE jurisdiction began using the CAREWare data collection system in 2021. All Cleveland TGA and EHE sub-recipients are required to enter data using the CAREWare system. Due to changes in HRSA/HAB reporting requirements and availability of new features or modules, the Cleveland TGA CAREWare software is typically updated every 6-8 months. Only clients that meet our TGA's eligibility requirements or are receiving EHE-funded medical services should be entered into the Cleveland TGA's CAREWare system.

Please reference the Ryan White Part A Program Cleveland TGA CAREWare 6.0 Manual for more information on how CAREWare is utilized for data reporting and collection.

Core Guidelines

PROGRAM STANDARDS

The Subrecipient responsibilities include the following:

1. Deliver professional services in a manner consistent with the corresponding public health standards, generally accepted best practices and professional protocols, and the definition for service as established by the U.S. Department of Health and Human Services, Health Resources Services Administration HIV/AIDS Bureau.
2. The Subrecipient must adhere to the EHE Care Standards of Care which will be provided at the beginning of the grant year and agency webpage. Any changes or updates to the Standards of Care within the grant year will be provided to the Sub-Recipient via a Policy Change Notification

through email and be posted to agency website.

3. Provide each client with information and referral regarding all providers and other community services for persons living with HIV/AIDS.
4. Promote client-driven access to primary care and other services as appropriate.
5. Advertise, promote, and market EHE services to existing client base and the community for new clients collectively through the Board, following HRSA guidelines for targeted advertising.
6. Document a plan to have active client feedback attached to the Sub-Recipient's service delivery program.
7. Participate in the EHE Community Advisory Group meetings and other meetings scheduled by the Board.
8. Participate in an HIV community-based continuum of care, to the extent such a continuum exists.
9. The Subrecipient will use the EHE Eligibility policy when determining eligibility for services. Clients must have an HIV/AIDS diagnosis.
10. Make services available to any eligible individual without regard to ability to pay or health condition of the individual. Services will be provided to clients without discrimination on the basis of: HIV infection, race, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical or mental handicap, immigrant status, or any other basis prohibited by law.
11. Inform individuals of the availability of services funded by EHE, other HIV-related services provided by the Subrecipient, and to enhance access for such individuals to these services.
12. All agencies are required to have a client intake policy on file.
13. The Subrecipient is required to maintain an individual record for each client served. The record shall contain service details and all fields required by the RSR (Ryan White Service Report)
14. If a client requests to be served by another provider, the Sub-Recipient is required to:
 - a. Honor the request for transfer
 - b. Provide the client with a list of other community providers to choose from, and transfer a copy of all necessary client records to the new provider upon receipt of a request by the client or provider.

CAREWARE DATA

The Subrecipient responsibilities include the following:

1. Comply with CAREWare data entry requirements for client-level data, services input, EHB reporting, and eligible scope requirements identified by the Board.
2. All EHE data will be collected through CAREWare. It is expected that sub-recipients collect and clean the client level service data of all EHE clients monthly prior to the invoice submission for the service month.
3. Submit all required CAREWare forms as deemed necessary by the Board, such as user agreements and confidentiality forms for all employees utilizing the CAREWare system,

acknowledging compliance with policies and procedures as provided by the Board.

4. Ensure staff productivity levels are represented in CAREWare.

PROGRAM REPORTS

The Subrecipient responsibilities include the following:

1. Quarterly program compliance reports will be provided to Subrecipient thirty days after the end of each quarter. Subrecipients are expected to review, sign, and return no more than one week later. Items marked “non-compliant” will be addressed in the comments section Failure to address compliance issues may result in an award reduction in the next grant cycle.
2. Subrecipients whose programs provide the Board monthly or event-based program reports will submit to the Board on the 10th of the month following the dates of services. Demographic data are to be organized and unduplicated. Narrative responses are to be thoughtful and reflective of the services provided. Failure to properly report out on the services may be marked as “non-compliant” on quarterly compliance reports.
3. Biannual Program Reports will be submitted to the Board twice annually. Templates will be provided to the Subrecipient before the date of submission. Responses are to be thoughtful and reflective of the services provided. Failure to properly report at the 6-month deadline may be marked as “non-compliant” on quarterly compliance reports.
4. Annual Administrative Reports and EHE Triannual Aggregate Module Report are required by HHS/HRSA/HAB. The format for the Annual Administrative Reports will be provided to the Sub-Recipient by the Board with instructions on completion.

FISCAL REPORTS AND INVOICES

The Subrecipient responsibilities include the following:

1. Subrecipient will use the Subrecipient Certified Expenditure Report as well as other specified documents and provide the Board with copies of receipts or contracts as validation of expenditures when submitting requests for payment. Supporting documentation is required for all reimbursements.
2. Subrecipient shall maintain original documentation, such as time sheets, payroll journals, tax records, travel vouchers, vendor invoices, lease agreements, canceled checks, logs and receipts in a manner that will expedite an on-site fiscal monitoring of program costs.
3. Subrecipient must submit budget justification narrative that describes how categorical costs are determined, specific functions of the personnel, and justify equipment, travel, supplies and training costs. A budget justification is required for establishing budgets and budget revisions.
4. Report any staffing changes that impact the approved budget on file within three business days.
5. Review staff time and efforts to ensure appropriate percentages are being charged back to the grant.
6. Subrecipient administrative costs may not exceed 10% of total direct costs for any service category at any time during the grant year.
7. The services billed must match the services documented in the client record.

8. Travel expenses will be reimbursed at the current federal travel reimbursement rate.
9. Fiscal reports and invoices may not be approved or delayed by the Board if they are not submitted correctly. This includes invoices, narratives, receipts, and budget templates. Expenses must be approved in the budget narrative, and correspond with a line item within that approved budget.
 - a. Subrecipients who use gift cards, gas cards, and other incentives must **log** each provision.
 - b. Program participants who receive gift cards from Sub-Recipients must sign off upon receiving it.
 - c. Receipts are needed for all expenses to be reimbursed.

UNALLOWABLE COSTS

Expenses must be approved in the budget narrative, and correspond with a line item within that approved budget. The Subrecipient responsibilities include the following:

1. EHE program funds cannot be used to pay for PrEP or nPEP.
2. Costs of operating clinical trials of investigational agents or treatments.
3. Costs of funeral, burial, cremation or other related expenses.
4. Clothing purchases.
5. To purchase a vehicle.
6. Cash payments to intended recipients of services.
7. Purchasing or construction of real property.
8. Criminal defense legal services for criminal defense.
9. Direct maintenance expenses of privately owned vehicles or any other costs associated with a vehicle, such as lease or loan payments, vehicle insurance, or license registration fees.
10. Improvements to land, or to purchase, construct, or make permanent
11. Improvements to any building, except for minor remodeling.
12. Payment of personal property taxes.
13. Fundraising expenses.
14. International travel.
15. Payments for any item or service to the extent that payment has been made, or reasonably can be expected to be made with respect to that item or service under any State compensation program, insurance policy, Federal or State health program or by an entity that provides health services on a prepaid basis (except Indian Health Services or US Department of Veteran Affairs).
16. Incentive costs or payments (by check, gift card, or other mechanism) to volunteers or patients participating in a grant-supported project or program or to motivate individuals to take advantage of grant-supported health care or other services unless Subrecipient receives prior written consent of the Board.

17. Entertainment Costs.

18. Bad Debts.

19. To support Syringe Services Programs, inclusive of syringe exchange, access, and disposal.

Outreach programs which have HIV prevention education as their exclusive purpose, or broad-scope awareness activities about HIV services that target the general public.

Tracking Outcomes

LINKED TO CARE OUTCOME

Linked to Care can be defined as having one medical visit, CD4 test, or viral load test within the measurement year. All clients receiving services should be linked to care by meeting one of these three care markers, at a minimum.

PRESCRIPTION OF ANTIRETROVIRALS (ART) OUTCOME

All clients should be prescribed antiretroviral medication at the onset of their care. The client's ART prescription should be updated annually, at a minimum, in CAREWare.

VIRAL LOAD OUTCOME

A client's viral suppression is the ultimate goal of providing services. Viral suppression can be defined as <200 copies/ml and will be entered into CAREWare every six months, at a minimum, from the onset of EHE care for the duration of the project funding.

Personnel Qualifications

Each agency is responsible for establishing comprehensive job descriptions that outline the duties and responsibilities for each of the positions proposed in their program. All staff must be given a written job description with specific minimum requirements for their position. Agencies are responsible for providing staff with supervision and training to develop capacities needed for effective job performance (including respect for persons, client confidentiality [HIPAA], cultural responsiveness, and cultural humility). Staff must be able to work effectively with their clients, developing supportive relationships, facilitating access to needed services, and assisting clients in achieving their maximum possible level of independence in decision-making and retention in care.

Community Advisory Group

The EHE Community Advisory Group (CAG) plays a crucial role in the project by allowing direct community involvement and feedback for the Board from people with HIV and those with greater vulnerabilities to HIV infection. The whole group meets biannually, with subcommittees for both EHE Prevention and EHE Care meeting every other month. During the meetings, attendees receive program updates, data updates, trainings, education, and discuss successes and challenges of EHE. The meetings are open to the public, and it is strongly recommended that subrecipients invite clients, stakeholders, and community influencers to participate. CAG members are also invited to assist with planning.

Service Category Summaries

CORE SERVICES:

(OAHS) RAPID START ART

The rapid start of ART allows agencies to build capacity to ensure newly diagnosed or new-to-care clients can be given antiretroviral medication at their first appointment or interaction with the medical provider. The capacity building allows medical providers to cut down barriers that may prevent ART prescription upon first appointment or interaction so that a client may immediately begin their path towards viral suppression. Clients do not need to be eligible for Part A to receive EHE Rapid Start services. Rapid Start ART clients' viral load data is required to be tracked and entered into CAREWare from the onset of EHE care through the duration of the EHE project period.

INTENSIVE MEDICAL CASE MANAGEMENT

Intensive Medical Case Management (IMCM) is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. IMCM includes all types of case management encounters (e.g. face-to-face, phone contact, and any other forms of communication). Key activities include: initial assessment of service needs; development of a comprehensive, individualized care plan; timely and coordinated access to medically appropriate levels of health and support services and continuity of care; continuous monitoring to assess the efficacy of the care plan; re-evaluation of the care plan at least every 6 months with adaptations as necessary; ongoing assessment of the client's needs and personal support systems; treatment adherence counseling to ensure readiness for an adherence to complex HIV treatments; client-specific advocacy and/or review of utilization of services. IMCM services have as their objective of improving behavioral healthcare outcomes alongside providing collaborative care with psychiatry for clients whose mental health, developmental disability, and/or substance use issues create barriers to achieving viral suppression. Traditional Medical Case Management (MCM) services have as their objective to improve healthcare outcomes, whereas Non-Medical Case Management (NMCM) services have as their objective providing guidance and assistance in improving access to needed services.

(EIS) PEER NAVIGATION/CHW

Peer Navigators are community health workers who serve as a liaison, link, and intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A peer navigator can enhance the HIV care team by working in partnership with case managers, nurses, doctors, social workers, and other service providers to address the medical, social, and economic needs of people with HIV.

SUPPORT SERVICES:

MEDICAL TRANSPORTATION

The goal of Medical Transportation is to provide non-emergency transportation services to eligible clients receiving care in Cuyahoga County that enables them to access or be retained in core medical

and support services. Medical transportation can be provided through rideshares; such as Uber or Lyft. Subrecipients shall not bill the EHE program for direct cash payments, bus passes, gas cards, cash reimbursements to clients, direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle, or any other cost associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fee.

NONMEDICAL CASE MANAGEMENT

Nonmedical Case Management services provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Nonmedical Case Management services have the providing guidance and assistance in improving access to needed services, whereas Medical Case Management services have the objective of improving healthcare outcomes. The overall treatment goal is to provide housing and benefit coordination for people with HIV/AIDS that will enable medical adherence and stability for each individual client.

PSYCHOSOCIAL SUPPORT

Psychosocial support services provide individual and/or group support and counseling services to address clients' continuing behavioral and physical health concerns. Psychosocial support should be delivered by staff, volunteers, or peers to help clients access health and benefits information, develop coping skills, reduce feelings of social isolation, and increase self-determination and self-advocacy, helping improve the quality of life for participants.

EMERGENCY FINANCIAL ASSISTANCE

Emergency Financial Assistance (EFA) provides limited one-time or short-term payments to assist the client with an emergent need for paying for essential items or services to improve health outcomes, including: utilities, housing, food (including groceries and food vouchers), transportation, medication not covered by an AIDS Drug Assistance Program or AIDS Pharmaceutical Assistance, or another HRSA allowable cost needed to improve health outcomes (with prior approval through an exemption form). EFA must occur as a direct payment to an agency or through a voucher program. Direct cash payments to clients are not permitted.

(OTHER PROFESSIONAL SERVICES) LEGAL

Other Professional Services provide professional and consultant services by members of particular professions licensed and/or qualified to offer such services by local governing authorities in the form of legal services. Legal services can be provided to and/or on behalf of the HRSA RWHAP-eligible PWH and involving legal matters relating to or arising from their HIV disease. Legal matters may include: assistance with public benefits such as Social Security Disability Insurance (SSDI); interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWHAP; and preparation of healthcare power of attorney, durable powers of attorney, or living wills. Legal services exclude criminal defense and class-action suits unless related to access to services eligible for funding under the RWHAP.

INNOVATIVE SERVICES:

(OAHS) MOBILE HEALTH CLINICS

Mobile health clinics (MHCs) expand access to care and provide uninterrupted treatment in underserved populations by bringing medical services directly to them. MHCs deliver health care to different locations (i.e. mobile units or home visits) and thus provide medical services directly in multiple communities rather than in traditional, fixed clinic-based settings. MHCs can be cost-effective, while simultaneously reaching vulnerable populations like the uninsured or unhoused, addressing transportation barriers, and lessening intimidation of patients by traditional health settings. The service delivery model of MHCs acts as a means of reengaging and retaining PWH in Cuyahoga County who have fallen out of care.

Program Reports & Submissions

Report Name	Description	Occurrence	Responsible Party
Biannual Progress Report	Summarizes and updates on program service delivery and overall impact.	Every 6 months	Subrecipient to CCBH; CCBH to HRSA
Compliance Report	Summarizes compliance to scope of work.	Quarterly	CCBH to Subrecipient; Sign & Return
Deficiency Report	Review of CAREWare data and information per agency.	Bimonthly	CCBH (<i>Internal - shared with subrecipient if deficient</i>)
EHE Performance Report (RSR)	Recipient, service provider, and client level reports for a calendar year.	Annually	CCBH to HRSA
Implementation Plan	Summarizes protocols for service delivery per agency.	Annually; 30 days after award	Subrecipient to CCBH
Monitoring Report	Summarizes standards met, findings, and deficiencies of program audit.	Annually	CCBH to Subrecipient
Triannual Data Report	Aggregate counts of services received by clients.	Every 4 months	CCBH to HRSA

Financial Reports & Submissions

Report Name	Description	Occurrence	Responsible Party
Expenditure Report	Expense tracker to be submitted along with invoices and support documentation for reimbursement.	Monthly	Subrecipient to CCBH
Budget Narrative	Narrative justification with line-item budget to reflect the activities supported by the award, the staff working on services, and the total funds awarded.	Annually	Subrecipient to CCBH

Annual Monitoring Site Visit Process

PURPOSE OF THE SITE VISIT

The HRSA/HAB Division of Metropolitan HIV/AIDS Program National Monitoring Standards require that the Ending the Epidemic Recipient conduct an annual site visit with each Subrecipient to ensure compliance on the proper use of federal grant funds and adherence to fiscal, clinical, programmatic, and professional guidelines put in place.

SUBRECIPIENT RESPONSIBILITY

- Providers are required to maintain an individual case record or medical record for each client served.
- All billed services match services documented in client records.
- All records are kept in a secure place and in an organized fashion and available at the start of the monitoring visit.
- Providers review and are familiar with service monitoring tools.
- Assembling and preparing all necessary records and materials for completion of the service monitoring tools by the Recipient.
- Have knowledgeable staff available to answer questions that may arise.
- Make available to the Recipient all materials listed in Attachment A and Attachment B.
- Submit to the Recipient Fiscal Policies within one week of receipt of electronic notification of site visit.
- Provide timely follow-up when identified from the Recipient.

EHE RECIPIENT RESPONSIBILITY PRIOR TO THE VISIT

- Providers will be notified electronically no later than thirty days prior to an on-site visit of the date(s) and time(s) of the visit.

- The electronic notification will include **Attachment A – Fiscal Monitoring Site Visit Checklist, Attachment B – Program Monitoring and Site Visit Checklist.**
- The Recipient will review the previous year’s fiscal, program, and quality monitoring report and corrective action if applicable.
- No later than two (2) days before the monitoring site visit, the Recipient shall provide **Attachment D – EHE Monitoring Site Visit Random Sample Form** or the final list of records to be reviewed.

EHE RECIPIENT RESPONSIBILITY DURING THE SITE VISIT

CONDUCT OPENING CONFERENCE

Upon arrival at the monitoring location, Recipient staff will meet with appropriate provider staff to discuss the purpose of the visit, review prior year monitoring outcomes, and address any questions the provider staff may have. The provider staff will be asked to explain how their charts or electronic medical records are organized so that data is accurately collected.

PERFORM MONITORING

Recipient staff will review the requested charts and documents as outlined in the notification, using the monitoring tools. A random sample of client records is chosen for review as a means of verifying that services are being provided in accordance with established standards and recorded accurately. In order to ensure efficiency and accuracy of the monitoring process, appropriate provider staff must be available to Recipient staff when needed throughout the monitoring process.

EHE RECIPIENT RESPONSIBILITY FOLLOWING THE SITE VISIT

RECIPIENT WILL SEND A FORMAL WRITTEN REPORT OF THE SITE VISIT FINDINGS

- A formal written report summarizing the monitoring site visit, including findings and recommendations, will be sent to each provider within 30 days of the site visit.

PROVIDE TECHNICAL ASSISTANCE

- Recipient staff will offer to provide technical assistance training in areas where deficiencies were noted.

CONDUCT ADDITIONAL SITE VISITS AS NECESSARY

- Recipient office reserves the right to conduct additional site visits as necessary to verify the implementation of any recommended quality improvement activities.
- Recipient staff will conduct a Follow-Up Site Visit when a provider receives a score of less than 69% on the qualifying standards of the site visit report.
- Recipient staff will conduct a focused audit during any Follow-Up Site Visit within (6) six months following the adoption of a recommended Quality Improvement Plan.

MONITORING PERFORMANCE SCALE

Quality Score	Quality Rating	Follow-up Action
90-100%	Excellent – Findings exceed quality expectations	No action required.

80-89%	Effective – Findings meet quality expectations	No action required.
70-79%	Moderate Deficiencies – Findings are below quality expectations	Written Corrective Action Plan required within 30 days of receipt of report.
69% and below	Significant Deficiencies	Probationary period put in effect; Written Quality Improvement Plan is required within 30 days; Services will be re-monitored until the provider has addressed the finding and becomes compliant.

SIGNIFICANT DEFICIENCIES FOUND DURING VISIT

QUALITY IMPROVEMENT AND CORRECTIVE ACTION PLANS

- When a programmatic site visit leads to the discovery of serious concerns about the quality of services that might negatively impact the health and safety of clients, Recipient staff will meet with the provider. The Recipient staff will provide a detailed overview of the concerns. This meeting will determine the appropriate manner in which the findings should be addressed and the appropriate sanction, if any, which should be imposed until the findings have been corrected.
- A Monitoring Performance Scale is used to determine when Quality Improvement Plans and Corrective Action Plans are necessary. Both plans address areas of deficiency, discuss changes that will be made to address deficiencies, and include a timeframe for implementation. Recipient staff will evaluate the provider's written response and notify the provider in writing of any findings to which the provider's response is not adequate. Depending on the severity of the deficiency, more than one monitoring visit during the grant cycle may be required.
- Any provider scoring between 70% and 79% on a qualifying standard will be required to submit a written Corrective Action Plan (CAP) to address the deficient areas within 30 days from the date of receipt of the monitoring report. The CAP must be implemented by the provider within 30 days of submission. The CAP will then be monitored during targeted trainings and technical assistance, as well as routine site visits. Any agency that does not achieve a satisfactory score of 80% on any standard will be subject to a re-monitoring site visit after 6 months.
- Any provider receiving a quality score of 69% or below on a qualifying standard will require immediate follow-up. A written Quality Improvement Plan (QIP) will be required within 30 days of receipt of the monitoring report. The provider will have 30 days to implement the QIP from date of submission. The services will be re-monitored. Further action may be required if sub-recipient continues to have challenges.
- The "Plan-Do-Study-Act" (PDSA) quality improvement model will be used to initiate all quality improvement activities.

RANDOM SAMPLING

The sample population is randomly selected from a pool of unduplicated EHE clients who received services during the designated audit period. Please note that the random selection of unduplicated clients may change at the discretion of the Recipient staff. An **estimate** of sample sizes is listed below:

- 50-100% of files/charts for agencies with **20 clients or fewer**
- 25-50% of files/charts for agencies with **21 to 100 clients**
- 10-25% of files/charts for agencies with **101 to 500 clients**
- 3-10% of files/charts for agencies with **501 clients or more**

Please note, prior monitoring report outcomes may be considered and used to reduce the outlined sample size configurations listed above.

ADDITIONAL CONSIDERATIONS

NEWLY FUNDED SUBRECIPIENTS

- For newly funded Subrecipients in a grant year, the Recipient will conduct an orientation site visit within four months of commencement of services. This site visit is an opportunity for the Recipient staff to give an overview of the roles and responsibilities of the Recipient and Subrecipient.
- The orientation site visit will consist of a review of the monitoring tools, a review of the program, fiscal, and service delivery requirements.

PREVIOUSLY FUNDED SUBRECIPIENTS

- Because services are monitored in the year following the service delivery, an agency may no longer be under contract but may be required to participate in an on-site monitoring visit. The process outlined above will still be in effect for those agencies, however, corrective action plans will only need to be submitted for agencies wishing to apply for funding in the future.

General Program Requirements

The Subrecipients may not use funds to make cash payments to intended clients of core medical or supportive services. This prohibition includes cash incentives and cash intended as payment for RWHAP and EHE services. Where direct provision of the service is not possible or effective any alternative method of payment for services must be submitted to the Cuyahoga County Board of Health for approval. Alternative methods of payment cannot be exchanged for cash or used for anything other than allowable goods or services.

The parties expressly agree that in the event services commence on and after the effective date of agreement, but prior to the date of execution of the agreement, the parties expressly authorize payment for such services with the understanding that no such payment will be made by the Board until after receipt of a fully executed agreement.

Subrecipient understands and agrees that it will not be paid for services provided prior to the effective date of the Agreement. If, pursuant to a later audit by the grant funder, the funder rejects any payment made by the Board to the Subrecipient that is deemed by the funder to be in violation of the terms of this agreement, any amount deemed improperly paid to the Subrecipient shall be promptly reimbursed by the Subrecipient to the Board or, alternatively, the Board may use the amount improperly paid as a

set off against future payments by the Board to the Subrecipient.

Payment will be limited to those consumers eligible for such service and only for services as defined by The Ryan White Treatment Extension Act of 2009 (RW Act), The Cuyahoga Regional HIV Services Planning Council, the Health Resources Services Administration, and the Agreement as authorized by the Board.

The Subrecipient shall maintain original documentation, such as time sheets, payroll journals, tax records, travel vouchers, vendor invoices, lease agreements, canceled checks, logs and receipts in a manner that will expedite an on-site fiscal monitoring of program costs.

If the Subrecipient is contracting multiple service categories, the total dollar amounts reimbursable for each service category are intended specifically for those individual service categories. Award amounts of up to twenty percent (20%) for one service category may be transferred by the Subrecipient to another service category within the contract only with the written approval from the Board and in the final month of the contract.

The Subrecipient must adhere to the core service category expenditures in order to be reimbursed fully for the support category expenditures if and only if the grantee is in jeopardy of exceeding the federal mandated maximum award for support service categories.

The Agreement is conditional upon the availability of federal, state, or local grant funds that are appropriated or allocated for payment of the Agreement. If funds are not allocated and available for the continuance of the function performed by the Subrecipient hereunder, the products or services directly involved in the performance of that function may be terminated by the Board. The Board will notify the Sub-Recipient at the earliest possible time of any products or services that will or may be affected by a shortage of funds. No penalty shall accrue to the Board in the event this provision is exercised, and the Board shall not be obligated or liable for any future payments due or for any damages as a result of termination. Should the Health Resources Services Administration add additional conditions of award, the Board will amend the contract language.

NO ASSIGNMENT, TRANSFER, OR SUBCONTRACT

In performing the services specified under the terms of the Agreement, the Subrecipient shall not assign, transfer, delegate any of the work or services, nor subcontract the work out to any other entity, nor shall any subcontractor commence performance of any part of the work or services included in the Agreement without obtaining the prior written consent of the Board.

INDEPENDENT CONTRACTOR

No Subrecipient, employment, joint venture or partnership has been or will be created between the parties hereto pursuant to the terms and conditions of this agreement. Inasmuch as the Board is interested in the Subrecipient's end product, the Board does not control the manner in which the Subrecipient performs the contract. The Board is not liable for the workers' compensation or unemployment compensation payments required by Chapters 4123 and 4141 of the Ohio Revised Code, respectively. In addition, the Subrecipient assumes responsibility for all tax liabilities that result from compensation paid to the Subrecipient by the Board. The Board will report any payment made under this contract to the Internal Revenue Service on Form 1099.

No provision contained in the contract shall be construed as entitling the Subrecipient to participate in hospital plans, medical plans, sick leave benefits, vacation, and other benefits available to employees of the Board or to become a member of the Public Employees Retirement System (Chapter 145 of the Ohio Revised Code.).

INDEMNIFICATION

The Subrecipient agrees to indemnify and hold the Board, all of its departments, agents and employees harmless from any and all liabilities, obligations, claims, costs and expenses caused by or resulting from the Subrecipient's performance or nonperformance of the obligations or activities contemplated by the Agreement.

The Subrecipient shall reimburse the Board, all of its departments, agents and employees for any judgments or liens which may be obtained against the Board, all of its departments, agents and employees resulting from the Subrecipient's performance or non-performance of the obligations or activities contemplated by the Agreement, including judgments or liens for infringements of intellectual property rights of third parties.

The Subrecipient agrees to defend the Board, all of its departments, agents and employees against any such claims, legal actions, or liens if called upon by the Board to do so. The Subrecipient acknowledges that the Agreement involves the use of public funds and as such is subject to audit by public agencies granting funds to the Board. The Subrecipient shall fully indemnify and repay the Board for any reimbursed costs of the Subrecipient which are subsequently disallowed by the funding public agencies and which must be refunded by the Board to such agencies.

INSURANCE

Contractor will at all times during the Term and for a period of three (3) years after the expiration or termination of the Agreement, at its own cost and expense, carry, maintain, and have in force, covering all matters, claims, and losses associated with the Agreement and the performance of the Services, the minimum insurance and coverage limits, and Contractor will comply with all other requirements set forth.

UNRESOLVED FINDING FOR RECOVERY

Ohio Revised Code Section 9.24 prohibits the award of a contract to any party against whom the Auditor of the State has issued a finding for recovery, if the finding for recovery is "unresolved" at the time of the award. By executing this contract, the Contractor warrants that it is not now, and will not become subject to an "unresolved" finding for recovery under the Ohio revised Section 9.24 without notifying the Board of Health of such finding. A Finding for Recovery will result in immediate termination of this Agreement.

PROHIBITED AFFILIATIONS; SUSPENSION AND DEBARMENT

Contractor certifies, represents, and warrants that (a) none of the Contractor Parties is suspended and/or debarred from doing business with state and/or federal government programs and (b) all Contractor Parties have been cleared of debarment from the following websites, prior to executing this

contract and/or providing the services described herein to the Board:

- <http://www.sam.gov/>
- <http://oig.hhs.gov/fraud/exclusions.asp>

Contractor will check these websites on a monthly basis during the Term with regard to the Contractor Parties. If Contractor is notified of or otherwise becomes aware of a suspension and/or debarment during the Term, Contractor will notify the Board of such suspension and/or debarment as soon as practicable, but in no event later than five (5) days after Contractor becomes aware of such occurrence.

COMPLIANCE WITH CONTRACTOR EMPLOYEE WHISTLEBLOWER PROTECTIONS

Congress has enacted Pub. L. 112-239, January 2, 2013, which mandates a pilot program entitled, "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections." Pursuant to this law, the Subrecipient shall certify that it is in compliance with this law which certification shall verify that the Subrecipient did require all of its grantees, their subgrantees and subcontractors to:

1. Inform their employees working on any Federal award they are subject to the whistleblower rights and remedies of the pilot program;
2. Inform their employees in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and,
3. Contractors and grantees will include such requirements in any agreement made with a subcontractor or subgrantee.

ACKNOWLEDGEMENT OF FEDERAL FUNDING AND DISCLAIMER

The Subrecipient shall use the following acknowledgement and disclaimer on all products produced with HRSA funds:

"This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number and title for grant amount (specify grant number, title, total award amount and percentage financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government."

OWNERSHIP COPYRIGHT

The Subrecipient agrees to acknowledge the financial support of the Board on any publications, promotional brochures, media releases or other publicity materials produced with the resources from this agreement. That acknowledgement should be displayed in a prominent location and include, at a minimum, the Board logo.

Printing, dissemination, and/or publication of any material developed under the Agreement must be provided to the Board and be pre-approved by the Board.

Any item produced under this agreement with funds provided under the Agreement, including any documents, data, photographs and negatives, electronic reports/records, or other media, is the property of the Board, which has an unrestricted right to reproduce, distribute, modify, maintain and use the deliverables. The Subrecipient will not obtain copyright, patent, or other proprietary protection for the deliverables. The Subrecipient will not include in any deliverable any copyrighted matter in the manner proved in this agreement. The Subrecipient agrees the deliverable will be made freely available to the general public unless the Subrecipient determines pursuant to state or federal laws, that such materials are confidential.

CRIMINAL BACKGROUND CHECKS

Whenever applicable, the Subrecipient shall conduct background checks on all employees in direct service positions under the Agreement in accordance with applicable requirements so as to not knowingly employ staff who have been convicted or plead guilty to any of the crimes specified in ORC §3319.39(B) or other section of the ORC applicable to the Subrecipient. Failure to conduct such background checks may result in termination of the Agreement.

ANTI-KICKBACK STATUTE

The Subrecipient shall comply with the requirements of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 13207b(b).

STAFF CHANGES

Changes of Subrecipient staff supported in whole or in part by funds awarded through the Agreement, require prior written approval of the Board. If prior written approval is not obtained, related expenses may not be reimbursed.

SALARY LIMITATION

The Subrecipient shall not use funds awarded under this contract to pay the salary of an individual at a rate in excess the Executive Level II salary of the Federal Executive Pay scale, as required under the Consolidated Appropriations Act, 2012 (P.L. 112-74), December 23, 2011, which limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements.

UNIFORM ADMINISTRATIVE REQUIREMENTS, COST PRINCIPLES, AND AUDIT REQUIREMENTS FOR HHS AWARDS

Agencies must comply with all applicable provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements 2 CFR 200 as codified by HHS at 45 CFR Part 75 including submit audits if required to the Federal Audit Clearinghouse Bureau of the Census.

CERTIFICATION OF CLIENT ELIGIBILITY

It is the responsibility of the Subrecipient to determine and document client eligibility status in CAREWare. Agencies may not provide services under presumptive eligibility; eligibility must be confirmed prior to enrollment/recertification. If a client is eligible for other third party reimbursement, it

is the responsibility of the Subrecipient to bill the appropriate third party for services.

In any grant-related activity in which family, marital, or household considerations are, by statute or regulation, relevant for purposes of determining beneficiary eligibility or participation, grantees must treat same-sex spouses, marriages, and households on the same terms as opposite-sex spouses, marriages, and households, respectively. By "same-sex spouses," HHS means individuals of the same sex who have entered into marriages that are valid in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage.

By "same-sex marriages," HHS means marriages between two individuals validly entered into in the jurisdiction where performed, including any of the 50 states, the District of Columbia, or a U.S. territory or in a foreign country, regardless of whether or not the couple resides in a jurisdiction that recognizes same-sex marriage. By "marriage," HHS does not mean registered domestic partnerships, civil unions or similar formal relationships recognized under the law of the jurisdiction of celebration as something other than a marriage.

By statute, program funds may not be used for any item or service for which payment has been made or can reasonably be expected to be made by another payment source. Agencies must vigorously pursue client eligibility for other funding sources and third-party payers to extend finite grant resources to new clients and/or needed services. The Subrecipient shall document these enrollment efforts in a manner prescribed by the Board to ensure that the program only serves eligible clients.

PROGRAM PERFORMANCE REPORTING

The Subrecipient agrees to provide to the Board brief, periodic progress reports, as requested by the Board. Reports will be relative to the effective operation of the program. The Subrecipient shall ensure accountability for the services identified in this contract by submitting service and fiscal reports.

Fiscal Reports are required in the form of monthly invoices detailing the allowable billable services performed during the previous calendar month as outlined above. Site visits will be conducted to verify that the services billed were performed and properly documented and comply with service definitions.

Biannual Program Reports are required for each funded service.

Annual Administrative Reports and the Ryan White HIV/AIDS Program Services Report (RSR) are required by HHS/HRSA/HAB. The format for the Annual Administrative Reports will be provided to the Sub-Recipient by the Board with instructions on completion. All RSR data will be collected through CAREWare. It is expected that sub-recipients collect and clean the client level service data of all clients monthly.

Other additional information may be requested at any time by the Board.

Failure by the Subrecipient to produce timely and adequate reports will impact the Subrecipient's funding during the current contract period, as well as its eligibility for consideration for funding in subsequent years.

DATA SHARING AGREEMENTS AND SAFEGUARDING OF CLIENT RECORDS

Subrecipient agrees to adhere to the following terms and conditions:

The Subrecipient agrees that the use or disclosure by any party of any information concerning service recipients for any purpose not directly related with the administration of the Board or Subrecipient's responsibilities with respect to purchased services is prohibited except upon the express written consent of the individual being served.

The Subrecipient agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA), all of its relevant provisions and amendments and administrative rules applicable thereto in relation to the delivery, recording and billing of client health care and other applicable related clinical social services reimbursed by EHE funds.

If the Subrecipient is not a Covered Entity under HIPAA, the Subrecipient shall sign and comply with the terms of the Business Associate Agreement.

The Subrecipient will maintain and improve a shared system of protected health information and service utilization while observing all applicable laws and standards on privacy, confidentiality, and security.

The Subrecipient agrees to comply with all federal and state laws applicable to the Board and/or consumers of RW Act funded services concerning the confidentiality of consumers Personal Health Information (PHI), including but not limited to R.C. 5101.27(A) and related Ohio Administrative Code 5101:1-1-03. Violation of these laws may result in conviction for a misdemeanor of the first degree.

The Subrecipient, prior to gaining access to Protected Health Information (PHI), will ensure that all employees, independent contractors, and agents responsible for management of shared data will complete HIPAA privacy training.

The Subrecipient will enter client information into CAREWare, including Protected Health Information, in compliance with relevant state and federal law and assuming the information will be shared, accessed, or disclosed to other agencies contracted to provide services using Ryan White funds that have access to CAREWare for treatment, including coordination of care, or payment.

The Subrecipient will ensure client confidentiality requirements apply to all phases of the project.

ACCESS TO RECORDS

The Subrecipient shall retain, maintain and keep accessible all records relevant to the Agreement for a minimum of six (6) years, following Agreement termination, or full performance, or any longer period as may be required by applicable law, or until the conclusion of any audit, controversy or litigation arising out of or related to this Agreement, whichever is later. Subrecipient shall maintain all financial records in accordance with generally accepted accounting principles. All other records shall be maintained to the extent necessary to clearly reflect actions taken. During this record retention period, the Subrecipient shall permit authorized representatives from the Board and HHS access to the records at reasonable times and places for purposes of inspection, audit, examination and copying.

PROGRAM POLICIES AND GUIDELINES

The Board reserves the right to add, delete, or modify program policies and implementation guidelines in order to administer the program efficiently and in compliance with the Ryan White Act, HRSA Guidelines, EHE Manual, National Monitoring Standards, all applicable HIV/AIDS Bureau Policy Notices and Program letters, all applicable Federal and State laws, EHE Standards of Care, EHE Definitions, documented unmet need and service gaps within the Cuyahoga County jurisdiction, and priority setting or resource allocation decisions made by the Board.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The Subrecipient shall adhere to the National Standards on Culturally and Linguistically Appropriate Services, and, as required by EO 13166, August 11, 2000, the Subrecipient shall provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services.

ANTI-DISCRIMINATION AND EQUAL EMPLOYMENT OPPORTUNITY

The Subrecipient agrees that in the employment of labor, skilled or unskilled, under this contract, there shall be no discrimination exercised against any person because of race, religion, national origin, sex, ancestry, age, disability, sexual orientation, or veteran status, and that violation thereof shall be deemed a material breach of said contract.

The Subrecipient shall comply with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

The Subrecipient shall comply with the Age Discrimination Act of 1975, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in any program or activity receiving Federal financial assistance, and as supplemented by regulations codified at 45 CFR part 91.

The Subrecipient shall comply with Title IX of the Education Amendments of 1972, 20 U.S.C. 1681, 1682, 1683, 1685, and 1686, which provides that no person in the United States will, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance, and as supplemented by regulations codified at 45 CFR part 86.

TRAFFICKING VICTIMS PROTECTION

The Subrecipient shall comply with the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104).

MANDATORY DISCLOSURES

Consistent with 45 CFR 75.113, sub recipients must disclose, in a timely manner, in writing to the Board and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the

awarding agency and to the HHS OIG.

ACCESSIBILITY OF INFORMATION

The Subrecipient shall make all files, including captioning, audio descriptions, videos, tables, graphics/pictures, registration forms, presentations (both audio and video) or other types of proprietary format files – e.g., Adobe Portable Document Format (.pdf), Microsoft Office PowerPoint (.ppt) and Microsoft Excel (.xls), fully accessible to members of the public with disabilities. Technical and functional standards for accessibility are codified at 36 CFR Part 1194 and may be accessed through the Access Board’s website.

340B PROGRAM COMPLIANCE

Consistent with Departmental guidance, HRSA recipients that purchase, are reimbursed or provide reimbursement to other entities for outpatient prescription drugs are expected to secure the best prices available for such products and to maximize results for the grantee organization and its patients. Eligible health care organizations/covered entities that enroll in the 340B Program must comply with all 340B Program requirements and will be subject to audit regarding 340B Program compliance. The 340B Program requirements, including eligibility, can be found at www.hrsa.gov/opa/.

PARTICIPATION AGREEMENT

All providers of services available in the Medicaid State plan must have entered into a participation agreement under the State plan and be qualified to receive payments under such plan, or receive a waiver from this requirement.

FUNDING EXCLUSIONS AND RESTRICTIONS

The funding exclusions and restrictions are found in Exhibit B of the Agreement, attached hereto and incorporated fully herein by reference.

GRIEVANCE PROCEDURE

The Subrecipient shall provide the Board with written notification of any concerns or complaints. Where a conflict cannot be resolved, the Subrecipient may initiate a grievance process which shall consist of mediation and, if necessary, binding arbitration. Notification should be sent as provided in the section below.

NOTICES

All notices, invoices and correspondence which may be necessary or proper for either party shall be addressed as follows:

TO THE BOARD:

Cuyahoga County District Board of Health
Erin Lark Turcoliveri, Grants Supervisor

5550 Venture Drive
Parma Ohio 44130
(216) 201-2001 ext. 1504

TO THE SUB-RECIPIENT:

Name/Title
Address
City, State, Zip
Phone Number