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February 24, 2009

The Honorable Board of Supervisors  
County of Los Angeles  
383 Kenneth Hahn Hall of Administration  
500 West Temple Street  
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL OF 78 HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE  
DEFICIENCY SYNDROME CARE SERVICE AMENDMENTS AND TWO  
SOLE SOURCE AGREEMENTS  
(ALL SUPERVISORIAL DISTRICTS) (3 VOTES)**

**SUBJECT**

Request approval to amend 78 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome agreements to extend the terms and revise agreement amounts maximum obligations pursuant to the Department of Public Health–Office of AIDS Programs and Policy’s implementation of the Commission on HIV’s funding allocations, and to execute two sole source agreements for transitional case management services.

**IT IS RECOMMENDED THAT YOUR BOARD:**

1. Delegate authority to the Director of the Department of Public Health (DPH), or his designee, to execute amendments, substantially similar to Exhibit I, for 77 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) agreements that revise agreement maximum obligations pursuant to the DPH-Office of AIDS Programs and Policy’s (OAPP) implementation of the Commission on HIV’s (Commission) funding allocations, as noted on Attachment A, for a total maximum obligation of \$8,022,596, fully offset by State and federal funds and net County cost, and to extend the terms as follows: 1) effective March 1, 2009, through May 31, 2009, for 55 agreements which provide various program services, including capacity building consultation; case management family support; case management psychosocial; case management transitional;

client advocacy; legal services; training services, ambulatory outpatient; medical specialty services; oral healthcare (dental); transportation; language; and/or data management; 2) effective April 1, 2009, through May 31, 2009, for 21 agreements for treatment education and peer support services; and 3) effective July 1, 2009, through February 28, 2011, for one hospice/skilled nursing agreement.

2. Delegate authority to the Director of DPH, or his designee, to execute Amendment Number 2 to Agreement Number H-701059 (substantially similar to ~~Exhibit I~~ Exhibit II) with Watts Healthcare Foundation in the amount of \$206,648 for the provision of residential treatment services, effective upon execution by both parties, but no sooner than date of your Board's approval through February 28, 2010, 100 percent offset by Ryan White Program Part A funds.
3. Delegate authority to the Director of DPH, or his designee, to execute two sole source agreements with Center for Health Justice (CHJ) and Public Health Foundation Enterprises (PHFE), substantially similar to ~~Exhibit II~~ Exhibit I, for HIV/AIDS services jail-based transitional case management services, effective April 1, 2009, through May 31, 2009, for a total maximum obligation of \$36,250, 100 percent offset by Ryan White Program Part B funds.

### **PURPOSE/JUSTIFICATION OF THE RECOMMENDED ACTION**

The recommended actions will allow DPH to extend and/or amend existing HIV/AIDS service agreements, 55 of which are set to expire on February 28, 2009, to implement the Commission's funding allocations, and to execute two sole source agreements for the provision of transitional case management services. Of the remaining 23 existing agreements, 21 are set to expire on March 31, 2009, one will expire on June 30, 2009, and one will expire on February 28, 2010.

Ryan White Program funding priorities allocated by the Commission are implemented by OAPP with the goal of maximizing grant funds and meeting client needs. This process allocates Ryan White Part A and Part B funding resources to specific service categories. The Los Angeles Eligible Metropolitan Area (EMA) Ryan White Program Part A and Part B awards will be announced in February or March 2009. In advance of this announcement, OAPP has elected to extend contracts through May 31, 2009 for a majority of the contracts based on previous years' contract levels to ensure that there is no disruption of services. One agreement for ambulatory/outpatient medical services with Catalyst Foundation reflects a \$15,600 increase related to the immediate need for increased clinical supervision (eight hours per month to eight hours per week) for the three-month extension period. One agreement for residential treatment services and one agreement for skilled nursing/hospice are recommended for extensions through February 28, 2010 and February 28, 2011, respectively.

An extension will allow the Department of Public Health's Office of AIDS Programs and Policy (OAPP) to conduct service provider briefings to outline anticipated shifts to several areas of the HIV/AIDS system in coming months; will allow OAPP, in concert with the COH, to finalize intent on the implementation of a new Benefit Specialty service category; will allow OAPP to invest newly approved Minority AIDS Initiative Year 1 rollover funds (approved February 4, 2009); will allow OAPP to invest a recently announced MAI Year 3 award increase effective August 1, 2009 (approved February 12, 2009).

Capacity building and training services continue to be critical to ensure agency and workforce performance and responsiveness, and ensures that County investments are having the maximum impact, particularly in underserved areas. Peer support services are an important vehicle to ensure that persons living with HIV promote access to services among their peers. Improved health care access allows the County to mitigate expensive hospital and end-stage disease costs. These three service categories are expected to undergo significant structural change during the next 12 months, hence the request for only a one-year amendment.

The County's support of HIV/AIDS medical outpatient, medical specialty, oral health, treatment education, language and transportation services offers persons living with HIV important opportunities to treat and manage their health condition, remove barriers to medical care, and ensure maximum benefit of clinical episodes with enhanced treatment education and language services. Optimizing the care and treatment of persons living with HIV allows the County to mitigate expensive hospital costs, end-stage disease costs and is an important strategy to reduce HIV transmissions as persons who are medically compliant and who have lower viral loads are generally less likely to transmit HIV. A request for proposals (RFP) for medical services is expected to be released in May 2009.

Legal services allow the County to ensure that persons living with HIV are able to mitigate employment, housing, and benefit discrimination or unjustified denial of benefits. Supporting this service category allows the County to avert a growth in homelessness, cancellation of private health benefits, and optimizes enrollment in private insurance, Medicaid, and Medicare programs relieving the County of additional hospital and healthcare costs.

Data management services allows the County to appropriately quantify the delivery of services to persons living with HIV and offers an important tool to ensure accountability and productivity among contractors.

Client advocacy services allows for the broad dissemination of available County and non-County supported HIV prevention, care and treatment services to County residents. The County's support of transitional and psychosocial case management services ensures that persons living with HIV, particularly medium to high acuity, those who are

disenfranchised, and dual/multiple diagnosed persons within and outside of incarcerated settings, are able to successfully navigate and access medical, dental, housing and other services, thus slowing disease progression, averting hospital costs, mitigating homelessness, and lessening the rates of untreated mental illness and chemical dependency.

The County's support of hospice/skilled nursing services allows the delivery of end-stage intensive nursing or palliative care in a far more cost-effective manner than in a County hospital setting, and ensures the dignified treatment of County residents with no other option for care.

Approval of the Amendment with Watts Healthcare Foundation allows the County to ensure the ongoing delivery of critical residential substance abuse treatment services to residents of Service Planning Area (SPA) 6 that were previously delivered by Palms Residential Care Facility.

The County's support of transitional case management services ensures that County inmates living with HIV are successfully linked to medical and other services, that disease progression is slowed, that hospital costs are minimized/averted, that homelessness is mitigated, and that rates of untreated mental illness and chemical dependency are minimized.

### **Sole Source Contracts**

#### Transitional Case Management Services, (2) Sole Source Agreements

Additional transitional case management providers are necessary to provide an increased level of service in response to higher demand for services, and OAPP recommends entering into agreements with CHJ and PHFE in order to complement existing transitional case management providers. CHJ and PHFE currently or recently provided HIV prevention or transition services at the Los Angeles County Sheriff's Department's (LASD) Twin Towers Correctional Facility and/or Century Regional Detention Facility (locations with the highest concentration of HIV/AIDS patients), and they have a strong record of promoting inmate health as well as an established working relationship with LASD. These contracts are recommended through May 31, 2009 consistent with the other transitional case management agreement extensions.

OAPP also augmented contracts of existing agencies already providing services in the jails (JWCH, Minority AIDS Project, and Tarzana Treatment Center), and shifted the case management modality for Bienestar Human Services from adherence services to transitional case management services.

Existing OAPP solicitation priorities precluded the release of a transitional case management RFP within a timeframe that met the intended March 1, 2009, start date. OAPP did not release an RFP for this service earlier in 2008 as the funding level for this

category was uncertain. OAPP received written confirmation of the Commission's Year 19 allocations on September 9, 2008 (Attachment B).

Existing County policy and procedures require the timely submission of contracts for Board approval. This Board action was not scheduled for placement on the Board's agenda three weeks prior to its effective date as required due to delays by OAPP in completing the final contract allocations, and exacerbated by OAPP's efforts to align funding with current performance, client caseload, an ongoing assessment of countywide need and adjustments in service category funding.

#### Implementation of Strategic Plan Goals

This action supports Goal 6, Community Services and Goal 7, Health and Mental Health of the County Strategic Plan by supporting community based HIV/AIDS services for the residents of Los Angeles County.

#### **FISCAL IMPACT/FINANCING**

The total cost for the 77 amendments referenced under Recommendation Number 1 is \$8,022,596 and is comprised of an estimated \$4,646,718 in Ryan White Program Part A funding; \$1,273,306 in Ryan White Program Part B funding; \$105,345 in federal CDC HIV prevention funding; \$43,855 in State Standard Agreement for the AIDS Drug Assistance Program funding; \$606,900 in Ryan White MAI funding and \$1,346,472 in existing net County cost (NCC) funding.

The total cost of Amendment Number 2 to Agreement Number H-701059 with Watts Healthcare Foundation for the provision of residential treatment services is \$206,648 and is 100 percent offset by Ryan White Program Part A funds.

The total cost of the two sole source agreements is \$36,250 and is offset by Ryan White Program Part B funds.

Funding for these amendments and agreements is included in DPH's Fiscal Year (FY) 2008-09 Final Adopted Budget and will be requested in future FYs, as necessary.

#### **FACTS AND PROVISIONS/LEGAL REQUIREMENTS**

The Ryan White CARE Act of 1990 authorizes grants for the development, coordination, and operation of effective and cost efficient agreements for persons living with HIV/AIDS. Through the CARE Act, now the Ryan White Program, there are two sources of funding for Los Angeles County: Part A funds are awarded directly to the County and administered by OAPP and Part B funds are received by the State and are passed-through to the County to be administered locally by OAPP. Part B funds are awarded to the Los Angeles County EMA based on a funding formula developed by the State. The proposed changes align funding with the Commission's Year 19 allocations.

On February 21, 2006, your Board delegated authority to the Acting Director of Health Services (now DPH), or his designee, to execute an agreement with the Wells House Hospice Foundation, Inc. (Wells House) for hospice and skilled nursing services, effective March 1, 2006, through June 30, 2008.

On February 27, 2007, your Board approved amendments for the continued provision of vital HIV/AIDS care services for 53 agreements, which included legal services and training services, and extended the term for one year for the period of March 1, 2007 through February 29, 2008, for a total maximum obligation of \$46,156,406. Also approved, were 12 amendments for HIV/AIDS service agreements for service provider network services, consultant services and food services to extend the terms for the period of March 1, 2007 through February 29, 2008 for a total maximum obligation of \$2,257,350.

On August 14, 2007, your Board approved delegated authority to execute 31 amendments to various HIV/AIDS service providers contracted through February 2008, in order to align contract obligations with the funding allocation from the Commission in March 2007.

On December 11, 2007, your Board approved and instructed the Director of DPH, or his designee, to extend the agreement with Wells House, effective July 1, 2008, through June 30, 2009.

On February 19, 2008, your Board approved 85 amendments for the continued provision of HIV/AIDS care services to extend the term of: 1) 54 adult residential facility agreements for the period of March 1, 2008, through February 28, 2010, for a total of \$22,692,330; 2) 14 agreements for service provider networks, oral health, legal, training, and consulting services for the period of March 1, 2008, through February 28, 2009, for a total of \$3,142,894; and 3) 17 agreements for ambulatory/outpatient medical specialty services, medical nutrition therapy services, treatment education services, transportation services, case management, psychosocial services, and peer support services for the period of March 1, 2008, through February 28, 2009, for a total amount of \$2,072,038.

The development and release of a solicitation for ambulatory outpatient medical care services was contingent upon the completion of the Mercer outpatient medical services rate study. Completion of the rate study was significantly delayed and OAPP received the final rate study and recommended reimbursement rates in July 2008. Since this time, OAPP has been working with DPH leadership and members of the Medical Outpatient Provider Caucus for migrating to a fee-for-service reimbursement structure and to explore innovative strategies for using the Mercer recommended reimbursement rate as a foundation on which to build a performance incentive payment methodology for medical outpatient services. OAPP currently anticipates releasing the solicitation for ambulatory medical outpatient services in May 2009, with completion of the solicitation

process and new fee-for-service contracts brought before your Board for approval by February 2010.

Attachment A provides the funding allocations for each provider, SPA served, and provider performance. Attachment B is the Commission's September 9, 2008, notification to OAPP of its Year 19 allocations. Attachment C is the signed sole source checklist.

Exhibits I and II have been approved as to form by County Counsel.

**IMPACT ON CURRENT SERVICES (OR PROJECT)**

Approval of these actions will allow OAPP to continue to provide uninterrupted delivery of HIV/AIDS care to Los Angeles County residents.

**CONCLUSION**

DPH requires four signed copies of your Board's action.

Respectfully submitted,



Fol JONATHAN E. FIELDING, M.D., M.P.H.  
Director and Health Officer

JEF:rm

Attachments (5)

c: County Counsel  
Sheriff's Department  
Chief Executive Officer

COMMUNITY SERVICES  
BOARD OF SUPERVISORS

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FILED

HIV/AIDS RELATED SERVICES

ATTACHMENT A

Agency and Agreement Number	YR 18 Allocation	Allocation Term 1	Allocation Term 2	SPA	Supervisory District	Performance as of September 30, 2008
AMBULATORY/OUTPATIENT MEDICAL SERVICES - PART A, MAI, NCC & State Office of AIDS (ADAP) Term: 3/1/09 - 5/31/09						
AIDS Healthcare Foundation H-209006	\$ 7,892,627	\$ 1,973,157		1-8	1-5	Meeting some goals.
AIDS Healthcare Foundation (CHAIN) H-209007	\$ 523,724	\$ 130,931		1-8	1-5	Exceeding goals.
AltaMed Health Services H-209203	\$ 1,681,295	\$ 420,324		3,7	1	Meeting some goals.
Children's Hospital Los Angeles H-209022	\$ 144,141	\$ 36,035		4	3	Meeting some goals.
City of Long Beach H-209210	\$ 100,309	\$ 25,077		8	4	Exceeding goals.
City of Pasadena H-209212	\$ 1,028,454	\$ 257,114		3	1	Meeting goals.
El Proyecto del Barrio H-209031	\$ 344,171	\$ 86,043		2	3	Exceeding goals.
East Valley Community Health Center H-209088	\$ 591,019	\$ 147,755		3	1	Meeting goals.
Long Beach Memorial Miller Medical Center H-209237	\$ 220,236	\$ 55,059		8	4	Meeting goals.
Los Angeles Gay & Lesbian Community Service Center H-209013	\$ 3,250,076	\$ 812,519		4	3	Meeting some goals.
Northeast Valley Health Corporation H-209011	\$ 50,495	\$ 12,624		2	3	Meeting goals.
Northeast Valley Health Corporation H-209014	\$ 723,983	\$ 180,996		2	3	Meeting some goals.
St. Mary Medical Center H-209015	\$ 1,295,975	\$ 323,994		8	4	Exceeding goals.
Tarzana Treatment Center H-209018	\$ 189,574	\$ 47,394		2	3	Meeting some goals.
T.H.E. Clinic, Inc. H-209012	\$ 337,194	\$ 84,299		6	2	Exceeding goals.
The Catalyst Foundation H-300152	\$ 756	\$ 15,789		1	5	Exceeding goals.
Valley Community Clinic H-209017	\$ 63,112	\$ 15,778		2	3	Exceeding goals.
Watts Healthcare Corporation H-209575	\$ 153,789	\$ 38,447		6	2	Exceeding goals.
<b>Total</b>	<b>\$ 18,590,930</b>	<b>\$ 4,663,333</b>				

HIV/AIDS RELATED SERVICES

ATTACHMENT A

Agency and Agreement Number	YR 18 Allocation	Allocation Term 1	Allocation Term 2	SPA	Supervisory District	Performance as of September 30, 2008
<b>CASE MANAGEMENT/PSYCHOSOCIAL (formerly FAMILY SUPPORT) - PART B</b>						
AltMed Health Services Corporation H-206921	\$ 36,000	\$ 9,000		7	1	Exceeding goals.
Foothill AIDS Project H-206920	27000	6,750				Exceeding goals.
Long Beach Memorial Miller Medical Center H-209233	\$ 29,987	\$ 7,497		8	4	Meeting some goals.
Northeast Valley Health Corporation H-208023	\$ 37,016	\$ 9,254		2	3	Exceeding goals.
Public Health Foundation Enterprises, Inc. H-208541	\$ 340,555	\$ 85,139				Meeting goals.
<b>Total</b>	<b>\$ 470,558</b>	<b>\$ 117,640</b>				
<b>CLIENT ADVOCACY - CDC &amp; NCC</b>						
AIDS Project Los Angeles H700937	\$ 242,759	\$ 60,690		1-8	1-5	Meeting goals.
<b>Total</b>	<b>\$ 242,759</b>	<b>\$ 60,690</b>				
<b>CONSULTING - CDC &amp; NCC</b>						
Num Consulting, Inc. H-701011	\$ 800,000	\$ 200,000		1-8	1-5	Meeting goals.
<b>Total</b>	<b>\$ 800,000</b>	<b>\$ 200,000</b>				
<b>DATA MANAGEMENT - NCC</b>						
Automated Case Management Systems, Inc. H-204251	\$ 600,000	\$ 150,000		1-8	1-5	Meeting most goals.
<b>Total</b>	<b>\$ 600,000</b>	<b>\$ 150,000</b>				
<b>HOSPICE/SKILLED NURSING - PART B</b>						
Wells House Hospice Foundation, Inc. H-701867	\$ 601,920	\$ 435,832	\$ 653,742	1-8	1-5	Meeting goals.
<b>Total</b>	<b>\$ 601,920</b>	<b>\$ 435,832</b>	<b>\$ 653,742</b>			
<b>LANGUAGE - NCC</b>						
Greater Los Angeles Agency on Deafness H-700266	\$ 28,892	\$ 7,223		1-8	1-5	Meeting some goals.
Special Service for Groups H-700254	\$ 203,802	\$ 50,951		1-8	1-5	Meeting goals.
<b>Total</b>	<b>\$ 232,694</b>	<b>\$ 58,174</b>				
<b>LEGAL - NCC</b>						
HIV/AIDS Legal Services Alliance (HALSA) H-700230	\$ 370,433	\$ 92,608		1-8	1-5	Exceeding goals.
<b>Total</b>	<b>\$ 370,433</b>	<b>\$ 92,608</b>				

Agency and Agreement Number	YR 18 Allocation	Allocation Term 1	Allocation Term 2	SPA	Supervisorial District	Performance as of September 30, 2008
<b>ORAL HEALTH - PART A &amp; MAI</b> Term: 3/1/09 - 5/31/09						
AIDS Project Los Angeles H-204505	\$ 870,079	\$ 217,520		4	3	Exceeding goals.
Northeast Valley Health Corporation H-204507	\$ 112,655	\$ 28,164		2	3	Meeting goals.
USC School of Dentistry H-204756	\$ 119,663	\$ 29,916		6	2	Exceeding goals.
<b>Total</b>	<b>\$ 1,102,397</b>	<b>\$ 275,599</b>				
<b>SUBSTANCE ABUSE, RESIDENTIAL REHABILITATION - PART A</b> Term: 3/1/09 - 2/28/10						
Watts Healthcare Corporation H-701059	\$ 103,324	\$ 206,648		6	2	Meeting most goals.
<b>Total</b>	<b>\$ 103,324</b>	<b>\$ 206,648</b>				
<b>TRANSPORTATION - PART A</b> Term: 3/1/09 - 5/31/09						
Administrative Services Co-op H-208412	\$ 38,868	\$ 9,717		8	4	Fee-for-Service.
Independent Taxi Owners Association H-208020	\$ 144,032	\$ 36,008		1-8	1-5	Fee-for-Service.
San Gabriel Transit H-208019	\$ 47,844	\$ 11,961		3	1,5	Fee-for-Service.
United Independent Tax Drivers H-208018	\$ 128,865	\$ 32,216		1-8	1-5	Fee-for-Service.
<b>Total</b>	<b>\$ 359,609</b>	<b>\$ 89,902</b>				
<b>TRAINING - NCC</b> Term: 3/1/09 - 5/31/09						
Prototypes, A Center for Innovation in Health, Mental Health and Social Services H-206227	\$ 168,881	\$ 42,220		1-8	1-5	Meeting goals.
<b>Total</b>	<b>\$ 168,881</b>	<b>\$ 42,220</b>				
<b>TREATMENT EDUCATION - PART B &amp; NCC</b> Term: 4/1/09 - 5/31/09						
AIDS Healthcare Foundation H-209643	\$ 59,008	\$ 9,835		5	3	Meeting goals.
AIDS Project Los Angeles H-209099	\$ 97,631	\$ 16,272		4	2	Exceeding goals.
AIDS Service Center, Inc. H-209089	\$ 133,517	\$ 22,253		2,3,7	3,5	Meeting some goals.
AltaMed Health Services Corporation H-209874	\$ 53,749	\$ 8,958		3,7	1	Exceeding goals.
Bienestar Human Services, Inc. H-207251	\$ 217,831	\$ 36,305		2,3,4,7	1,3	Exceeding goals.
Charles R. Drew University of Medicine and Science H-209810	\$ 75,249	\$ 12,542		6,8	2,4	Meeting some goals.
City of Long Beach H-209912	\$ 53,036	\$ 8,839		8	4	Exceeding goals.
Center for Health Justice H-207986	\$ 60,000	\$ 10,000		4	1	Exceeding goals.
Common Ground - The Westside HIV Community Center H-210081	\$ 43,105	\$ 7,184		5	3	Exceeding goals.

HIV/AIDS RELATED SERVICES

ATTACHMENT A

Agency and Agreement Number	YR 18 Allocation	Allocation Term 1	Allocation Term 2	SPA	Supervisory District	Performance as of September 30, 2008
Los Angeles Centers for Alcohol and Drug Abuse H-300024	\$ 50,000	\$ 8,333		7	4	Meeting goals.
Minority AIDS Project H-212062	\$ 120,000	\$ 20,000		6	2	Exceeding goals.
Special Service for Groups H-209094	\$ 78,441	\$ 13,074		4	1	Meeting goals.
Tarzana Treatment Center H-209078	\$ 126,725	\$ 21,121		2,8	3,4	Exceeding goals.
Women Alive Coalition H-209090	\$ 122,874	\$ 20,479		2,4,6,7,8	1,2,3,4	Meeting some goals.
<b>Total</b>	<b>\$ 1,291,166</b>	<b>\$ 215,194</b>				
<b>PEER SUPPORT - NCC</b>						
Term: 4/1/09 - 5/31/09						
AIDS Project Los Angeles H-700260	\$ 53,865	\$ 8,978		1-8	1-5	Meeting goals.
Being Alive: People with HIV/AIDS Action Coalition H700252	\$ 53,771	\$ 8,962		1-8	1-5	Meeting goals.
Bienestar Human Services, Inc. H700280	\$ 111,767	\$ 18,628		1-8	1-5	Meeting goals.
Charles R. Drew Univ. of Medicine & Science H-700253	\$ 47,117	\$ 7,653		1-8	1-5	Meeting goals.
St. Mary Medical Center H-700236	\$ 109,530	\$ 18,255		8	4	Exceeding goals.
Tarzana Treatment Center H700268	\$ 53,853	\$ 8,976		1-8	1-5	Meeting goals.
Women Alive Coalition H-700248	\$ 46,592	\$ 7,765		1-8	1-5	Meeting goals.
<b>Total</b>	<b>\$ 476,495</b>	<b>\$ 79,416</b>				
<b>GRAND TOTAL</b>	<b>\$ 28,964,151</b>	<b>\$ 7,611,752</b>	<b>\$ 653,742</b>	<b>\$ 8,265,494</b>		



## LOS ANGELES COUNTY COMMISSION ON HIV

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www.hivecommission-la.info

September 9, 2008

To: Mario J. Perez, Director  
Office of AIDS Programs and Policy

From: Craig A. Vincent-Jones, Executive Director  
Los Angeles County Commission on HIV

Subject: YEAR 19 RYAN WHITE PART A AND B ALLOCATIONS

At its meeting on July 10, 2008, the Commission on HIV approved the following revised service category allocations for Year 19, and is forwarding them to the Office of AIDS Programs and Policy for implementation. The items in bold represent those service categories to which allocations were made.

Service Category	Year 19		Year 19 Allocation
	Priority Ranking Core Medical	Support Service	
<b>Medical Outpatient</b>	1		<b>58.0%</b>
ADAP Enrollment	2		0.0%
<b>Medical Specialty</b>	3		<b>1.5%</b>
Local Pharmacy Assistance	4		0.0%
<b>Benefits Specialty</b>		5	<b>2.0%</b>
<b>Oral Health Care</b>	6		<b>3.7%</b>
<b>Mental Health, Psychiatry</b>	7		<b>2.5%</b>
<b>Mental Health, Psychotherapy</b>	8		<b>6.5%</b>
<b>Case Management, Medical</b>	9		<b>1.5%</b>
Early Intervention Services	10		0.0%
Health Insurance Premium & Cost Sharing	11		0.0%
<b>Substance Abuse, Residential</b>		12	<b>6.5%</b>
Substance Abuse, Treatment	13		0.0%
<b>Case Management, Psychosocial</b>		14	<b>6.0%</b>
Residential, Transitional		15	0.0%
Residential, Permanent		16	NF <sup>1</sup>
<b>Transportation</b>	17		<b>1.9%</b>
<b>Treatment Education</b>	18		<b>3.3%</b>
<b>Medical Nutrition Therapy</b>	19		<b>1.0%</b>
<b>Nutrition Support</b>		20	<b>1.1%</b>

Service Category	Year 19 Priority Ranking		Year 19 Allocation
	Core Medical	Support Service	
Legal Services		21	0.0%
Case Management, Transitional		22	1.5%
Direct Emergency Financial Assistance		23	0.0%
Case Management, Housing <sup>2</sup>		24	0.0%
Language Services		25	0.0%
Skilled Nursing Facility <sup>3</sup>	26		2.0% <sup>4</sup>
Home Health Care	27		0.0%
Case Management, Home-based		28	1.0%
Hospice <sup>3</sup>	29		2.0% <sup>4</sup>
Child Care Services		30	0.0%
Workforce Entry/Re-entry Services <sup>2</sup>		31	0.0%
Rehabilitation Services		32	0.0%
Health Education/Risk Reduction		33	0.0%
HIV Counseling and Testing in Care Settings	34		0.0%
Outreach Services		35	0.0%
Referral Services		36	0.0%
Peer Support		37	0.0%
Respite Care		38	0.0%
Permanency Planning		39	NF <sup>1</sup>
Psychosocial Support Services <sup>2</sup>		40	0.0%
<i>(100% of all Service Dollars)</i>			100.0%

<sup>1</sup> Not fundable by Ryan White Program Parts A and B.

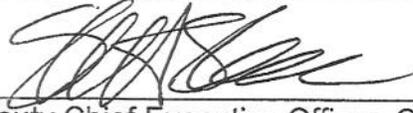
<sup>2</sup> Service category was not ranked in Year 18.

<sup>3</sup> In Year 18, Skilled Nursing Facility and Hospice were combined into one service category.

<sup>4</sup> The allocation is combined for these two service categories.

e: Michael Green  
 File

## SOLE SOURCE CHECKLIST

Check (√)	<p style="text-align: center;"><b>JUSTIFICATION FOR SOLE SOURCE PROCUREMENT OF SERVICES</b></p> <p><i>Identify applicable justification and provide documentation for each checked item.</i></p>
	<ul style="list-style-type: none"> <li>➤ Only one bona fide source for the service exists; performance and price competition are not available.</li> </ul>
√	<ul style="list-style-type: none"> <li>➤ Quick action is required (emergency situation)</li> </ul>
	<ul style="list-style-type: none"> <li>➤ Proposals have been solicited but no satisfactory proposals were received.</li> </ul>
	<ul style="list-style-type: none"> <li>➤ Additional services are needed to complete an ongoing task and it would be prohibitively costly in time and money to seek a new service provider.</li> </ul>
	<ul style="list-style-type: none"> <li>➤ Maintenance service agreements exist on equipment which must be serviced by the authorized manufacturer's service representatives.</li> </ul>
	<ul style="list-style-type: none"> <li>➤ It is most cost-effective to obtain services by exercising an option under an existing contract.</li> </ul>
	<ul style="list-style-type: none"> <li>➤ It is the best interest of the County (e.g., administrative cost savings, too long a learning curve for a new service provider, etc.).</li> </ul>
	<ul style="list-style-type: none"> <li>➤ Other reason. Please explain:</li> </ul>
	<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div data-bbox="370 1394 889 1528">             Deputy Chief Executive Officer, CEO         </div> <div data-bbox="1013 1394 1305 1528"> <div style="text-align: center;">2/21/09</div>           Date         </div> </div>

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)/  
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)  
CLIENT ADVOCACY SERVICES AGREEMENT**

Amendment No.   

THIS AMENDMENT is made and entered into this \_\_\_\_\_ day  
of \_\_\_\_\_, 2009,

by and between

COUNTY OF LOS ANGELES (hereafter  
"County"),

and

\_\_\_\_\_ (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "HUMAN  
IMMUNODEFICIENCY VIRUS (HIV)/ACQUIRED IMMUNE DEFICIENCY SYNDROME  
(AIDS) CLIENT ADVOCACY SERVICES AGREEMENT", dated \_\_\_\_\_ and  
further identified as Agreement No. H-000000, and any Amendments thereto (all  
hereafter "Agreement"); and

WHEREAS, it is the intent of the parties hereto to extend Agreement and provide  
other changes set forth herein; and

WHEREAS, said Agreement provides that changes may be made in the form of a  
written Amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties agree as follows:

1. This Amendment shall be effective on March 1, 2009.

2. The first paragraph of Paragraph 1, TERM, shall be amended to read as follows:

"1. TERM: The term of this Agreement shall commence on \_\_\_\_\_, and continue in full force and effect through \_\_\_\_\_, subject to the availability of federal, State, or County funding sources. In any event, County may terminate this Agreement in accordance with the TERMINATION Paragraphs of the ADDITIONAL PROVISIONS hereunder."

3. Paragraph 2, DESCRIPTION OF SERVICES, shall be amended to read as follows:

"2. DESCRIPTION OF SERVICES: Contractor shall provide the services described in Exhibit(s) \_\_, attached hereto and incorporated herein by reference."

4. Paragraph 3, MAXIMUM OBLIGATION OF COUNTY, Subparagraphs \_\_ and \_\_, shall be added to Agreement as follows:

"F. During the period of March 1, 2009 through February 29, 2010, the maximum obligation of County for all services provided hereunder shall not exceed \_\_\_\_\_ Dollars (\$\_\_\_\_\_). Such maximum obligation is comprised of One Hundred Twenty-One Thousand, Three Hundred Seventy-Nine dollars (\$\_\_\_\_\_ ) in federal Centers for Disease Control and Prevention funds and \_\_\_\_\_ Dollars (\$\_\_\_\_\_ ) in net County Cost funds. This sum represents the total maximum obligation of County as shown in Schedule 6, attached hereto and incorporated herein by reference.

G. During the period of March 1, 2010 through February 29, 2011, the maximum obligation of County for all services provided hereunder shall not

exceed \_\_\_\_\_ Dollars (\$\_\_\_\_\_). Such maximum obligation is comprised of \_\_\_\_\_ Dollars (\$\_\_\_\_\_ ) in federal Centers for Disease Control and Prevention funds and \_\_\_\_\_ Dollars (\$\_\_\_\_\_ ) in net County Cost funds. This sum represents the total maximum obligation of County as shown in Schedule \_\_, attached hereto and incorporated herein by reference.

5. Paragraph 6, COMPENSATION, shall be amended to read as follows:

"6. COMPENSATION: County agrees to compensate Contractor for performing services set forth in Schedules \_\_ and \_\_, and the COST REIMBURSEMENT Paragraph of this Agreement. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets."

6. Exhibits \_\_, SCOPES OF WORK FOR HIV/AIDS CLIENT ADVOCACY SERVICES, are attached to this Amendment and incorporated in Agreement by reference.

7. Schedules \_\_, BUDGETS FOR HIV/AIDS CLIENT ADVOCACY SERVICES, are attached to this Amendment and incorporated in Agreement by reference.

8. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by its Director of Public Health, and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By \_\_\_\_\_  
Jonathan E. Fielding, M.D. MPH  
Director and Health Officer

\_\_\_\_\_  
Contractor

By \_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Title \_\_\_\_\_  
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM  
BY THE OFFICE OF THE COUNTY COUNSEL  
RAYMOND G. FORTNER, JR.  
County Counsel

APPROVED AS TO CONTRACT  
ADMINISTRATION:

Department of Public Health

By \_\_\_\_\_  
Gary T. Izumi, Acting Chief  
Contracts and Grants

## EXHIBIT \_

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**HUMAN IMMUNODEFICIENCY VIRUS (HIV)  
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)  
CLIENT ADVOCACY SERVICES**

1. DEFINITION:

A. HIV/AIDS client advocacy services focus on assisting clients' entry into and movement through the care and prevention service systems within and outside of the CARE Act-funded service delivery network. Client advocacy services are intended to provide clients with the full range of options for the acquisition of needed resources and to facilitate clients' access, utilization, retention, and adherence to primary health care core services. Client advocacy services are designed to facilitate access to public and private benefits/entitlement programs supported by funding streams including, but not limited to the Ryan White CARE Act, for persons living with HIV/AIDS (PLWH/A). Client advocacy services are coordinated with all relevant service providers to maximize options for access to health care and financial support for PLWH/A throughout the eight (8) Service Planning Areas (SPAs) of Los Angeles County. In addition, client advocacy services will assist HIV/AIDS service providers to help individuals living with, affected by, and at risk for HIV/AIDS to easily identify, select, and access the most appropriate resource(s) available for HIV/AIDS treatment, care, prevention, counseling and testing, faith-based, and social services.

B. Client advocacy services include, but are not limited to the following activities:

(1) Maintenance of the *HIV L.A. Resource Directory for the Navigation of Health Care and Support Services*, hereafter referred to as *The Directory*, to assist consumers (individuals living with, affected by, or at risk for HIV/AIDS), and service providers to navigate through the care and prevention service systems. The Directory includes Fact Sheets detailing the services available through the various HIV service categories and how to access these services. The Directory and Fact Sheets shall be in printed and web-based formats and available in English and Spanish.

(2) Develop a special interactive portion of the website that assists consumers in understanding, identifying and applying for public and private benefits such as Medi-Cal, Social Security Disability Insurance, Supplemental Security Income, Health Insurance Payment Program, food stamps, etc.; and when appropriate, link PLWH/A to case management programs to ensure ongoing support for accessing appropriate resources.

2. PERSONS TO BE SERVED: HIV/AIDS client advocacy services shall be provided to individuals living with, affected by, or at risk for HIV/AIDS residing within Los Angeles County.

3. SERVICE DELIVERY SITE(S): Contractor's facility where services are to be provided hereunder is located at: \_\_\_\_\_  
90005.

Contractor shall maintain the electronic database (website), all printed materials, and related files utilized in association with this Agreement at said location and/or contracted sites for website and database. Contractor shall request approval from the Director of the Office of AIDS Programs and Policy (OAPP) in writing a minimum of thirty (30) days before terminating services at such location(s) and/or before commencing services at any other location(s).

A memorandum of understanding shall be required for service delivery site(s) on location(s) or property(ies) not owned or leased by the Contractor with the service provider who owns or leases such location or property. This shall include coordination with another agency, community based organization and/or County entity. Contractor shall submit memoranda of understanding to OAPP for approval at least thirty (30) days prior to implementation.

4. COUNTY'S MAXIMUM OBLIGATION: During the period of March 1, 2009 through February 28, 2011, that portion of County's maximum obligation which is allocated under this Exhibit for HIV/AIDS Client Advocacy services in Los Angeles County shall not exceed \_\_\_\_\_ Dollars (\$\_\_\_\_\_).

The contract term shall be two (2) twelve (12) month periods. The renewal options will be at the sole discretion of the Director of Public Health or his designee.

Continued funding beyond this term will be dependent upon Contractor performance and the availability of funding.

5. COMPENSATION: County agrees to compensate Contractor for performing services hereunder for actual reimbursable net cost as set forth in Schedule(s) \_\_\_\_\_. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

Payment for services provided hereunder shall be subject to the provisions set forth in the COST REIMBURSEMENT Paragraph of this Agreement.

6. CLIENT FEE SYSTEM: Contractor shall comply with provisions of Section 2605 (e) of Title 26 (CARE Act) which is entitled "Requirements Regarding Imposition of Charges for Services", incorporated into this Agreement as Exhibit \_\_\_\_.

7. SERVICES TO BE PROVIDED: Contractor shall provide HIV/AIDS client advocacy services to eligible individuals and service providers in accordance with procedures formulated and adopted by Contractor's staff, consistent with laws, regulations, and the terms of this Agreement. Contractor shall demonstrate cultural and linguistic competency in services that are appropriate for the target population(s). During each period of this Agreement, HIV/AIDS Client Advocacy services shall include, but are not limited to:

A. Developing, implementing, and maintaining HIV/AIDS client advocacy services in Los Angeles County. Contractor shall provide such services as described within Exhibit(s) \_\_\_\_, Scopes of Work attached hereto and incorporated herein by reference.

B. Promoting and conducting outreach activities to educate individuals living with, affected by, and at risk for HIV/AIDS and HIV/AIDS service providers regarding the availability of Client Advocacy services and resource materials. Promotional activities shall exclude the promotion of the contracted agency (e.g., the Contractor should limit the use of the agency's signage or logo).

C. Maintaining and regularly updating the comprehensive resource guide, *HIV L.A. Resource Directory* (The Directory), in printed and web-based formats, targeting HIV/AIDS service providers. Contractor shall ensure that updates to the information occur at a minimum of once every six (6) months, however providers may submit changes to Contractor at any time for inclusion on the website. Updated editions of the printed version shall be released at a minimum of twice per year.

(1) Contractor shall utilize already existing resources such as the "People's Guide," "Rainbow Resource Directory," and "INFO LINE" and create electronic links to websites of these resources when possible.

(2) Contractor shall ensure the design and organization of the printed resource directory is in magazine format, is user friendly, and enables individuals to easily locate resource information.

(3) Contractor shall ensure that The Directory contains resource information pertaining to HIV/AIDS treatment, care, prevention, counseling and testing, faith-based, and social services, including resources that are not funded through HIV funding.

(4) Contractor shall ensure that The Directory includes but is not limited to the following HIV/AIDS provider information: provider name, street address(es), telephone number, fax number, website address, brief description of services, and population(s) served.

(5) Contractor shall ensure that the directory includes, at a minimum, the following HIV/AIDS services and resources in Los Angeles County: medical care and treatment; AIDS Drug Assistance Program (ADAP) enrollment sites; clinical research; complementary therapies; home health services; oral health/dental; post-exposure prophylaxis; treatment adherence/education; case management (medical, psychosocial, and prevention); mental health (counseling and psychiatric treatment); substance use treatment and recovery; addictive behavior treatment; child care; food and nutrition; HIV counseling and testing; HIV educational skill building and training; HIV prevention, education and risk reduction; HIV/AIDS information and referral; HIV/AIDS related websites; HIV/AIDS planning groups; housing and residential; Housing Opportunities for Persons with AIDS (HOPWA); hotlines and crisis lines; legal and permanency planning; peer support; post-incarceration; public and private benefits/entitlement programs; care and services related to special population groups; spiritual resources; support groups; syringe exchange; translation/interpretation; transportation; work-related services; women;

infants and children; youth; and youth shelters and other youth assistance programs.

(6) Contractor shall ensure that the directory includes, at a minimum, information on and/or a description of: OAPP-funded services; non-CARE Act funded services; public and private benefits/entitlement programs; housing programs; medication/drug interactions and treatment; Americans with Disabilities Act; Health Insurance Portability and Accountability Act (HIPAA); anti-HIV discrimination laws and regulations; work service programs; emergency aid; crisis management; staff/skill development; OAPP capacity building initiative for service providers; a SPA and Health District map with zip code listing; HIV reporting regulations; OAPP Educational Services "HIV Educational Skills Building Guide"; People with HIV/AIDS Bill of Rights and Responsibilities; Los Angeles County adopted Standards of Care; funding and program cycles, such as Part A, Part B, CDC, and State; an index of services providers and phone numbers; and a common acronyms page.

(7) Contractor shall maintain a specific section in the directory to assist service providers in learning details and requirements necessary to make effective and appropriate referrals. This section shall also be included in the resource directory website.

(8) Contractor shall utilize already existing resources such as the "People's Guide," "Rainbow Resource Directory," and "INFO LINE" and create electronic links to websites of these resources when possible.

(9) Contractor shall research eligibility requirements of various services and resources, including public and private benefits/entitlement programs regarding eligibility criteria to assist individuals living with, affected by, or at risk for HIV/AIDS in accessing such services and resources.

(10) Contractor shall include client benefits information in the directory that contains a description of public and private benefits/entitlement programs available to PLWH/A in Los Angeles County and a detailed description of the eligibility criteria for these benefits/entitlement programs. For the purposes of this Agreement, client benefits/entitlement programs may include, but not be limited to, the following services and resources: CARE Act funded services; Medi-Cal; Medicare; Veterans Administration services; AIDS Drug Assistance Program (ADAP); pharmaceutical patient assistance programs; Los Angeles County providers third party insurance acceptance and coverage; Los Angeles County Ability-to-Pay (ATP) program; Health Maintenance Organizations (HMOs) HIV/AIDS specializations and coverage; private medical care and treatment options; HIV/AIDS medical specialists; oral health/dental specialists; Housing Opportunities for People with AIDS (HOPWA) funded

services; Section 8 Housing; Social Security Administration benefits/entitlement programs; Supplemental Security Income; CalWorks; Food Stamps; General Relief; and a detailed listing of benefits hotlines and support resources.

(11) Contractor shall develop and implement a plan for the comprehensive distribution of and access to The Directory for individuals living with, affected by, or at risk for HIV/AIDS, and service providers. Contractor shall ensure that the distribution of the directory reflects the geographic distribution of HIV/AIDS cases in Los Angeles County. Contractor shall maintain an inventory of distribution sites by zip code and SPA. Contractor shall report on the number of directories disseminated through each distribution site, as directed by OAPP.

(12) Contractor shall evaluate the outcome of the directory. Evaluation activities should include, but not be limited to reviewing and analyzing the readers' surveys and producing a report, and the analysis of the distribution and promotion plans, and website traffic. Analysis report shall be submitted to OAPP at the end of each term.

D. Developing, maintaining, and updating *Fact Sheets* to inform individuals living with, affected by, and at risk for HIV/AIDS, and service providers of available CARE Act funded services, non-CARE Act funded services, and public and private benefits/entitlement programs, and information about HIPAA. Such fact sheets shall describe the services available through each of the

various HIV/AIDS service categories and how to access these services to assist individuals living with, affected by, or at risk for HIV/AIDS to understand and effectively utilize the full benefits of the available services. The consumer fact sheets shall be provided in English and Spanish for inclusion in the printed consumer directories and the resource directory website.

(1) Contractor shall ensure that each fact sheet describes in detail the service category that is available, eligibility criteria for the service(s), step-by-step procedures to facilitate accessing the service(s), appeal process when services are denied, and grievance procedure when service delivery is not offered appropriately.

(2) Contractor shall include information on obtaining service/benefit/ entitlement program application forms and when possible, include these application forms, or provide information on how to obtain the forms with the fact sheets.

(3) Contractor shall ensure that The Directory website includes an option to review an alphabetical list of all consumer fact sheets and application forms that pertain to the HIV-related service(s) available on the website.

(4) Contractor shall provide the following service: After the website user has searched the database of available services on the resource directory website and found a match to a query, the user shall be offered

fact sheets applicable to the results of the query, through an interactive feature of the website.

(5) Contractor shall ensure that the fact sheets are reviewed and updated as needed, not less than once every six (6) months. Contractor shall post current fact sheets and materials on the website.

(6) Contractor shall evaluate the outcome of the fact sheets as detailed in the Scopes of Work, Exhibits\_\_\_\_ and \_\_\_\_.

E. Maintain and update The Directory website for HIV/AIDS-related services in Los Angeles County available in English and Spanish at the Internet website address known as [www.hivla.org](http://www.hivla.org) and [www.vihla.org](http://www.vihla.org).

(1) Contractor shall include a web-page notice to alert individuals who may be searching or browsing the World Wide Web. As directed by OAPP, a disclaimer shall be displayed prominently on the web locations that are most likely to be encountered by website users of the HIV/AIDS content or display a link which will take the user to a separate web-page displaying the HIV/AIDS content notice in its entirety. Additionally, any web-page that features links to web-pages not specifically funded by OAPP must have a pop-up window, which includes a disclaimer as directed by OAPP that appears when the user attempts to link with that web-page. Links which connect the user to web-pages that depict sexual activity or drug use for purposes other than the prevention of HIV or sexually transmitted diseases are expressly forbidden.

(2) Contractor shall collaborate with OAPP and OAPP-subcontracted information systems providers to translate the website referral data language into HIV Integrated Reporting System (HIRS) and Casewatch data language.

(3) Contractor shall ensure that the website contains links to maps and directions to service providers and links to key related Internet-based resources for website users.

(4) Contractor shall ensure that the website provides a search engine that facilitates easy navigation of the website.

(5) Contractor shall ensure that the website and its features are user-friendly and helpful to the user.

(6) Contractor shall update the database on an ongoing basis and review each listing in the entire database at a minimum of twice per year.

(7) Contractor shall collect and track data regarding utilization of the website and shall evaluate the outcome of website utilization.

F. Contractor shall develop and maintain a warm line service staffed by a bi-lingual client advocate(s), with experience in benefits counseling and service referrals, to aid clients, consumers, and service providers in accessing services and information, including appropriate service referrals. This warm line service shall feature a toll-free number and shall be accessible Monday through Friday within the hours of ten (10:00) A.M. to four (4:00) P.M. Callers outside these

hours shall be prompted to call back or leave a message so that a follow-up call can occur the following morning or within one business day.

(1) Contractor shall collect, track, and evaluate data regarding utilization of the warm line, as directed by OAPP.

8. ADDITIONAL REQUIREMENTS:

A. Contractor shall not utilize this Agreement and its associated funds for self-advertisement or self-promotion of its services and programs in any way that distinguishes it from any other HIV/AIDS service provider included in the printed and electronic comprehensive resource directories and fact sheets. Client advocacy services shall exclude the promotion of the contracted agency and Contractor shall limit the use of the agency's signage or logo.

B. Contractor shall develop a promotional campaign that includes, but is not limited to: announcing the availability of the resource directories, fact sheets, website, and trainings/forums; and promoting and educating individuals living with, affected by, and at risk for HIV/AIDS, and HIV/AIDS service providers regarding the availability and utilization of HIV/AIDS client advocacy services.

C. Contractor shall ensure that databases used to maintain client advocacy services shall include the technical capability to transfer data to data systems utilized by OAPP and shall utilize the 'Taxonomy of Human Services: A Conceptual Framework with Standardized Terminology and Definitions for the Field.' Databases created in connection with The Directory should be formatted in a manner that allows them to be used with GIS mapping software (e.g.,

ArcView, MapInfo) and shall be the property of Department of Public Health - OAPP.

D. As directed and approved by OAPP, Contractor shall provide the database and exchange information to the following groups, but not be limited to: OAPP, local planning groups, community-based organizations, service providers, and other relevant institutions.

E. At a minimum, Contractor shall ensure the database and printed Directories include HIV/AIDS-related services funded by Los Angeles County by service category.

F. Contractor shall ensure that client advocacy services are culturally and linguistically appropriate for the target population(s). Contractor shall develop and implement a plan for the use of other services to limit language and cultural barriers.

G. Contractor shall ensure that the printed resource directory, fact sheets, website language, and promotional materials are at the literacy level of seventh grade or lower.

H. Contractor shall ensure that The Directory, fact sheets, website language and promotional materials include the same program and resource information in both English and Spanish languages.

I. Contractor must design a model of client advocacy services that addresses and is reflective of the community being served. Contractor is expected to include PLWH/A in the development of client advocacy materials

(e.g., community advisory boards, consumer review of documents, focus groups, etc.).

J. Contractor shall develop and implement a distribution and access plan that includes, but is not limited to: the development and maintenance of The Directory database; ongoing distribution sites of the printed Directory and fact sheets; registration of the website address; establishment of search engines and links to similar or related websites; and how the website hits will be identified and reported.

K. Contractor shall ensure that all materials, curricula, presentations, and outlines developed for The Directory, fact sheets, and consumer trainings/forums are subject to review and approval by OAPP. All materials developed shall be the property of Department of Public Health - OAPP.

L. Contractor shall comply with the Centers for Disease Control's Interim Revision of Requirements for Content of AIDS-related written materials, pictorials, audiovisuals, questionnaires, survey instruments, and educational sessions, attached hereto and incorporated herein by reference as Exhibit C.

M. Contractor shall submit for approval such educational materials to OAPP at least thirty (30) days prior to the projected date of implementation. For the purposes of this Agreement, educational materials may include, but not be limited to, written materials (e.g., curricula, fact sheets, fliers), audiovisual materials (e.g., films, videotapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings).

N. Contractor shall obtain written approval from OAPP's Provider Services Support Division Chief for all educational materials, camera ready copies of The Directory and fact sheets, and website pages utilized in association with this Agreement prior to its implementation. Contractor shall submit such materials for approval at least thirty (30) days prior to the projected date of implementation.

(1) Letter of OAPP approval and materials will be kept on file.

(2) Failure of Contractor to abide by this requirement may result in the suspension of this Agreement at the Director's sole discretion.

9. CONTRACTOR'S SUBCONTRACT/CONSULTANT REQUIREMENTS:

Contractor shall ensure that subcontractors and consultants providing services under this Agreement shall commence services within ninety (90) days of the execution of this Agreement. Subcontract and consultant agreements shall be signed and dated by the Contractor's Director, or his/her authorized designee(s) prior to commencement of subcontracted and/or consultant services.

10. STAFFING REQUIREMENTS:

A. Contractor shall recruit linguistically and culturally appropriate staff to assist in the development of HIV/AIDS client advocacy materials. For the purposes of this Agreement, staff shall be defined as paid and volunteer individuals providing services as described in Exhibit F and Scopes of Work, attached hereto and incorporated herein by reference.

B. Contractor shall maintain and submit to OAPP recruitment records, to include, but not be limited to:

- (1) Job descriptions of all positions funded under this agreement;
- (2) Staff résumé(s);
- (3) Biographical sketch(es) as appropriate.

C. In accordance with the ADDITIONAL PROVISIONS attached hereto and incorporated herein by reference, if during the terms of this Agreement an executive director, program director, or a supervisory position becomes vacant, Contractor shall notify the OAPP Director in writing prior to filling said vacancy.

11. REPORTS: Subject to the reporting requirements of the REPORTS Paragraph of the ADDITIONAL PROVISIONS of this Agreement attached hereto, Contractor shall submit the following report(s):

A. Monthly Reports: As directed by OAPP, Contractor shall submit a signed hard copy of the monthly report and, as requested, the electronic format of the report and the STANDARD CLIENT LEVEL REPORTING Data for HIV/AIDS client advocacy services no later than thirty (30) days after the end of each calendar month. The reports shall clearly reflect all required information as specified on the monthly report form and be transmitted, mailed, or delivered to the Office of AIDS Programs and Policy, 600 South Commonwealth Avenue, 10th Floor, Los Angeles, California 90005, Attention: Financial Services Division, Chief.

B. Semi-Annual Reports: As directed by OAPP, Contractor shall submit a six (6)-month summary of the data in hard copy, electronic, and/or online format for the periods January through June and July through December.

C. Annual Reports: As directed by OAPP, Contractor shall submit a summary of data in hard copy, electronic, and/or online format for the calendar year due by the end of February of the following year.

D. As directed by OAPP, Contractor shall submit other monthly, quarterly, semi-annual, and/or annual reports in hard copy, electronic, and/or online format within the specified time period for each requested report. Reports shall include all the required information and be completed in the designated format.

12. COUNTY DATA MANAGEMENT SYSTEM: As directed by OAPP, Contractor shall utilize County's data management system to register client's demographic/resource data, enter service utilization data, collect medical and support service outcomes, and to record linkages/referrals to other service providers and/or systems of care. County's system will be used to standardize reporting, importing efficiency of billing, support program evaluation processes, and provide OAPP and participating contractors with information relative to the HIV/AIDS epidemic in Los Angeles County.

13. ANNUAL TUBERCULOSIS SCREENING FOR STAFF: Prior to employment or service provision and annually thereafter, Contractor shall obtain and maintain documentation of tuberculosis screening for each employee, volunteer, and consultant providing services hereunder. Such tuberculosis screening shall consist of a tuberculin

skin test (Mantoux test) and/or written certification by a physician that the person is free from active tuberculosis based on a chest x-ray.

Contractor shall adhere to Exhibit D, "Guidelines for Staff Tuberculosis Screening", attached hereto and incorporated herein by reference. Director shall notify Contractor of any revision of these Guidelines, which shall become part of this Agreement.

14. QUALITY MANAGEMENT PLAN: Contractor shall submit to OAPP within ninety (90) days of the receipt of this Agreement its written Quality Management (QM) plan. The QM plan shall describe the process for continually assessing the Contractor's program effectiveness in accomplishing contractor mission, goals, and objectives. The plan shall describe the process for the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable, Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports.

A. Quality Management Committee: The QM Committee shall develop, review, and revise the agency's QM plan on an annual basis. In addition, the QM Committee shall continually assess and make recommendations regarding the improvement of program services. It shall, at a minimum, be responsible for developing plans of corrective action for identified program deficiencies, discussing and acting upon process and outcome data results, and results from client feedback. The Committee shall consist of representatives of the program and agency such as clients, volunteers, program staff, management, consultants

and others (e.g., staff from other community-based organizations). The project coordinator(s) under this contract must be included as a Committee member. Committee membership shall be described, at a minimum, by title and role, and the constituency represented (i.e., staff, management, client). The Contractor shall review the Committee recommendations and ensure recommendations are appropriately implemented.

A separate Committee need not be created if the contracted program has established an advisory committee or the like, so long as its composition and activities conform to the criteria described in this Agreement.

The QM Committee activities shall be documented. Required documentation shall include but not be limited to agendas, sign-in sheets, and QM Committee meeting minutes (including date, time, topics discussed, recommendations, and corrective actions).

B. Written Policies and Procedures: The QM plan shall describe the process for reviewing and modifying written policies and procedures. In addition, the plan shall specify that policies be reviewed at a minimum of once a year, approved and signed by the Executive Director or designee.

Policies and procedures shall be based on essential program activities and scopes of work specific to this contract. Written policies and procedures shall be maintained in a manual and available for review at the time of a monitoring review.

C. Client Feedback: The QM plan shall include a mechanism for obtaining ongoing feedback from program participants regarding program effectiveness, accessibility, and client satisfaction. The QM plan shall describe the method(s) to be used for client feedback (e.g., satisfaction surveys, focus groups, interviews, etc.). Client feedback shall be collected on an ongoing basis or at a minimum of semi-annually. The QM plan shall describe how client feedback data will be managed by the QM Committee and used to make improvements to the program.

D. Program Staff: The QM plan shall describe the process for developing, training and monitoring staff performance. The QM plan shall specify that staff is evaluated annually.

E. Measurable Program/Service Process Outcome Indicators: Indicators are intended to measure:

(1) Process: How well the services are being provided.

(2) Outcome: The benefits or other results for clients that may occur during or after program participation.

By developing a set of indicators specific to each program, establishing a measurable minimum standard for each indicator, and conducting an assessment on the extent to which the indicator is met, the Contractor shall assess the quality of service delivery on an ongoing basis.

The QM Committee is responsible for developing and shall describe in its minutes, a plan of corrective action to address indicators that are marginally met

and describe how the results of the measurable data will be used to improve services. Process and outcome indicators shall be developed based on key activities described in the SERVICES TO BE PROVIDED Paragraph of this Exhibit. The QM plan shall require measurement of and include at a minimum the following measurable program and/or services indicators:

(1) Process: (a) ninety percent (90%) of The Directories will be distributed in each Service Planning Area (SPA) according to Contractor's approved distribution plan; (b) ninety percent (90%) of The Directories, for both English and Spanish languages, will be distributed in each Service Planning Area (SPA) according to the geographic distribution of AIDS cases; (c) one hundred percent (100%) of consumer fact sheets will contain a description of the service category, eligibility criteria for services(s), and step-by-step procedures to access the service; and (d) ninety-five percent (95%) of each database entry will include the following information: provider name, street address(es), telephone number, fax number, website address, brief description of services, and population(s) served.

(2) Outcome: (a) ninety percent (90%) of service providers evaluated will state that utilization of HIV/AIDS client advocacy services was useful in making appropriate referrals to CARE Act funded and non-CARE Act funded services;

F. QM Plan Implementation: Contractor shall implement its QM plan to ensure the quality of the services provided are assessed and improved on a continuous basis.

G. Quality Management (QM) Summary Reports: The QM plan shall include the requirement for two (2) brief and concise Quality Management Summary Reports, Mid-Year and Year-End. These reports shall be developed by the QM Committee and signed by the Executive Director. The following reports shall be made available to the OAPP Program Manager at the time of monitoring review or upon request by County:

(1) Mid-Year QM Summary Report shall, at a minimum, document:

- (a) Areas of concern identified by the QM Committee;
- (b) Program performance;
- (c) Results of process and outcome measurement;
- (d) Data collected from client feedback;
- (e) Results of plans of corrective action.

(2) Year-End QM Summary Report shall, at a minimum document:

- (a) Outcomes of implementing plans of corrective action for the previous six months;
- (b) Overall QM program performance.

15. CULTURAL COMPETENCY: Program staff should display non-judgmental, cultural-affirming attitudes. Program staff should affirm that clients of ethnic and cultural

communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.

SCHEDULE \_

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HIV/AIDS CLIENT ADVOCACY SERVICES

Budget Period  
March 1, 2009  
through  
February 29, 2010

Salaries	\$ 109,729
Employee Benefits	<u>\$ 22,704</u>
Total Salaries and Employee Benefits	\$ 132,433
Travel	\$ 3,360
Equipment	\$ 1,000
Supplies	\$ 500
Other	\$ 83,908
Consultants/Subcontracts	\$ 0
Indirect Cost	<u>\$ 21,558</u>
TOTAL PROGRAM BUDGET	\$ 242,759

During the term of this Agreement, any variation to the above budget must have prior written approval of the Office of AIDS Programs and Policy's Director. Funds shall only be utilized for eligible program expenses. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

SCHEDULE \_\_

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HIV/AIDS CLIENT ADVOCACY SERVICES

	<u>Budget Period</u> March 1, 2010 through <u>February 28, 2011</u>
Salaries	\$ 109,729
Employee Benefits	<u>\$ 22,704</u>
Total Salaries and Employee Benefits	\$ 132,433
Travel	\$ 3,360
Equipment	\$ 1,000
Supplies	\$ 500
Other	\$ 83,908
Consultants/Subcontracts	\$ 0
Indirect Cost	<u>\$ 21,558</u>
TOTAL PROGRAM BUDGET	\$ 242,759

During the term of this Agreement, any variation to the above budget must have prior written approval of the Office of AIDS Programs and Policy's Director. Funds shall only be utilized for eligible program expenses. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

Contract No. H-701059-3

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)/  
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)  
SUBSTANCE ABUSE RESIDENTIAL REHABILITATION AGREEMENT**

Amendment Number 3

THIS AMENDMENT is made and entered into this \_\_\_\_\_ day  
of \_\_\_\_\_, 2009,

by and between

COUNTY OF LOS ANGELES (hereafter  
"County"),

and

WATTS HEALTHCARE CORPORATION  
(hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) SUBSTANCE ABUSE RESIDENTIAL REHABILITATION AGREEMENT", dated March 1, 2005, and further identified as Agreement Number H-701059, and any Amendments thereto (all hereafter "Agreement"); and

WHEREAS, it is the intent of the parties hereto to extend Agreement and provide other changes set forth herein; and

WHEREAS, said Agreement provides that changes may be made in the form of a written Amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties agree as follows:

1. This Amendment shall be effective on March 1, 2009.
2. The first paragraph of Paragraph 1, TERM, shall be amended to read as

follows:

"1. TERM: The term of this Agreement shall commence on March 1, 2005 and continue in full force and effect through February 28, 2010, subject to the availability of federal, State, or County funding sources. In any event, County may terminate this Agreement in accordance with the TERMINATION Paragraphs of the ADDITIONAL PROVISIONS hereunder."

3. Paragraph 2, DESCRIPTION OF SERVICES, shall be amended to read as follows:

"2. DESCRIPTION OF SERVICES: Contractor shall provide the services described in Exhibits G and G-1, attached hereto and incorporated herein by reference."

4. Paragraph 3, MAXIMUM OBLIGATION OF COUNTY, Subparagraph E, shall be amended to read as follows:

"E. During the period of March 1, 2009 through February 28, 2010, the maximum obligation of County for all services provided hereunder shall not exceed Two Hundred Six Thousand, Six Hundred Forty-Eight Dollars (\$206,648). Such maximum obligation is comprised entirely of CARE Act Part A funds. This sum represents the total maximum obligation of County as shown in Schedule 5A, attached hereto and incorporated herein by reference."

5. Paragraph 7, COMPENSATION, shall be amended to read as follows:

"7. COMPENSATION: County agrees to compensate Contractor for performing services set forth in Schedule 5A, and the FEE-FOR-SERVICE

Paragraph of this Agreement. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets."

6. Paragraph 8, FEE FOR SERVICES REIMBURSEMENT, shall be amended to read as follows:

"8. PAYMENT – FEE-FOR-SERVICE REIMBURSEMENT: County shall compensate Contractor for performing services hereunder on a fee-for-service basis in the following manner:

A. Monthly Billing: Contractor shall bill County monthly in arrears. Billings shall include a financial invoice and all required programmatic reports and/or data. All billings shall clearly reflect all required information as specified on forms provided by County regarding the services for which claims are to be made and any and all payments made to Contractor by, or on behalf of, clients/patients. Billings shall be submitted to County within thirty (30) calendar days after the close of each calendar month. Within a reasonable period of time following receipt of a complete and correct monthly billing, County shall make payment in accordance with the fee-for-service rate(s) set out in the schedule(s) attached hereto.

(1) Payment for all services provided hereunder shall not exceed the aggregate maximum monthly payment set out in the schedule(s) for the corresponding exhibit attached hereto.

(2) No single payment to Contractor for services provided hereunder shall exceed the maximum monthly payment set out in

the schedule(s) for the corresponding exhibit, unless prior approval from Director to exceed the maximum monthly payment has been granted pursuant to Paragraph 8 of this Agreement. To the extent that there have been lesser payments for services under this Agreement, the resultant savings may be used to pay for prior or future monthly billings for services in excess of the maximum monthly payment in County's sole discretion.

(3) While payments shall be made in accordance with the fee-for-service rate(s) set out in the schedule(s) hereto, Contractor, if requested by County, State, or federal representatives must be able to produce proof of actual costs incurred in the provision of units of services hereunder.

(4) If the actual costs are less than the fee-for-service rate(s) set out in the schedule(s), Contractor shall be reimbursed for the actual costs.

B. Audit Settlements (Fee-for-Service):

(1) If an audit conducted by federal, State, and/or County representatives finds that units of service furnished hereunder are lower than units of service for which payments were made to Contractor by County, then payment for the unsubstantiated units of service shall be repaid by Contractor to County. For the purpose of this Paragraph 8, an "unsubstantiated unit of service" shall mean

a unit of service for which Contractor is unable to adduce proof of performance of that unit of service.

(2) If an audit conducted by federal, State, and/or County representatives finds that actual costs for a unit service provided hereunder are less than the County's payment than those units of service, then Contractor shall repay County the difference immediately upon request, or County has the right to withhold and or offset that repayment obligation against future payments.

(3) If within forty-five (45) calendar days of termination of the contract period, such audit finds that the units of service furnished hereunder are higher than the units of service for which payments were made by County, then the difference may be paid to Contractor, not to exceed the County Maximum Obligation.

C. The parties acknowledge that County is the payor of last resort for services provided hereunder. Accordingly, in no event shall County be required to reimburse Contractor for those costs of services provided hereunder which are covered by revenue from or on behalf of clients/patients or which are covered by funding from other governmental contracts or grants.

D. In no event shall County be required to pay Contractor for units of services that are not supported by actual costs.

E. In the event that Contractor's actual cost for a unit of service are less than fee for service rates fee-for-service rate(s) set out in the schedule(s), the Contractor shall be reimbursed for its actual costs only.

F. In no event shall County be required to pay Contractor more for all services provided hereunder than the maximum obligation of County as set forth in the MAXIMUM OBLIGATION OF COUNTY Paragraph of this Agreement, unless otherwise revised or amended under the terms of this Agreement.

G. Travel shall be budgeted and expensed according to applicable federal, State, and/or local guidelines. Prior authorization, in writing, shall be required for travel outside Los Angeles County unless such expense is explicitly approved in the contract budget. Request for authorization shall be made in writing to Director and shall include the travel dates, locations, purpose, agenda, participants, and costs.

H. Withholding Payment:

(1) Subject to the reporting and data requirements of this Agreement and the exhibit(s) attached hereto, County may withhold any claim for payment by Contractor if any report or data is not delivered by Contractor to County within the time limits of submission as set forth in this Agreement, or if such report or data is incomplete in accordance with requirements set forth in this Agreement. This withholding may be invoked for the current month

and any succeeding month or months for reports or data not delivered in a complete and correct form.

(2) Subject to the provisions of the TERM and ADMINISTRATION Paragraphs of this Agreement, and the exhibits(s) attached hereto, County may withhold any claim for payment by Contractor if Contractor has been given at least thirty (30) calendar days' notice of deficiency(ies) in compliance with the terms of this Agreement and has failed to correct such deficiency(ies). This withholding may be invoked for any month or months for deficiency(ies) not corrected.

(3) Upon acceptance by County of all report(s) and data previously not accepted under this provision and/or upon correction of the deficiency(ies) noted above, County shall reimburse all withheld payments on the next regular monthly claim for payment by Contractor.

(4) Subject to the provisions of the exhibit(s) of this Agreement, if the services are not completed by Contractor within the specified time, County may withhold all payments to Contractor under this Agreement between County and Contractor until proof of such service(s) is/are delivered to County.

(5) In addition to Subparagraphs (1) through (4) immediately above, Director may withhold claims for payment by Contractor

which are delinquent amounts due to County as determined by a cost report settlement, audit report settlement, or financial evaluation report, resulting from this or prior years' Agreement(s).

I. Contractor agrees to reimburse County for any federal, State, or County audit exceptions resulting from noncompliance herein on the part of Contractor or any subcontractor.

J. Fiscal Viability: Contractor must be able to carry the costs of its program without reimbursement from the contract for at least sixty (60) days at any point during the term of the contract.”

7. Exhibits G and G-1, SCOPES OF WORK FOR HIV/AIDS SUBSTANCE ABUSE RESIDENTIAL REHABILITATION SERVICES, are attached to this Amendment and incorporated in Agreement by reference.

8. Schedule 5A, BUDGETS FOR HIV/AIDS SUBSTANCE ABUSE RESIDENTIAL REHABILITATION SERVICES, are attached to this Amendment and incorporated in Agreement by reference.

9. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by its Director of Public Health, and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By \_\_\_\_\_  
Jonathan E. Fielding, M.D., MPH  
Director and Health Officer

WATTS HEALTHCARE CORPORATION  
Contractor

By \_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Title \_\_\_\_\_  
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM  
BY THE OFFICE OF THE COUNTY COUNSEL  
RAYMOND G. FORTNER, JR.  
County Counsel

APPROVED AS TO CONTRACT  
ADMINISTRATION:

Department of Public Health

By \_\_\_\_\_  
Gary T. Izumi, Chief  
Contracts and Grants

**EXHIBIT G**

**WATTS HEALTHCARE CORPORATION**

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)/  
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)  
SUBSTANCE ABUSE RESIDENTIAL SERVICES - RESIDENTIAL REHABILITATION**

1. DESCRIPTION: HIV/AIDS substance abuse residential, residential rehabilitation services provide twenty-four (24) hour, residential, non-medical services to individuals who are recovering from problems related to alcohol and/or other drug abuse and who need alcohol and/or other drug abuse treatment or detoxification services.

The purpose of this service is to assist individuals to achieve and maintain a life style free of substance abuse.

2. PERSONS TO BE SERVED: HIV/AIDS substance abuse – residential, residential rehabilitation shall be provided to indigent persons residing within Los Angeles County, diagnosed with HIV/AIDS who require a structured, controlled treatment environment because of the severity of the impairment caused by their substance abuse in accordance with Attachment 1, "Service Delivery Site Questionnaire", attached hereto and incorporated herein by reference.

3. COUNTY'S MAXIMUM OBLIGATION: During the period of March 1, 2009 through February 28, 2010 that portion of County's maximum obligation which is allocated under this Exhibit for HIV/AIDS substance abuse residential, residential rehabilitation shall not exceed Two Hundred Six Thousand, Six Hundred Forty-Six Dollars (\$206,648)

The contract term shall be one (1) twelve (12) month period. The renewal options will be at the sole discretion of the Director of Public Health or his designee. Continued funding beyond this term will be dependent upon Contractor performance and the availability of funding.

4. COMPENSATION: County agrees to compensate Contractor for performing services hereunder at the fee-for-service rate as set forth on Schedule 5A. Such rate includes reimbursement for all substance abuse residential rehabilitation services. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

Furthermore, for substance abuse residential rehabilitation services, the number of units of service billable will be the number of days an individual occupied a bed (physically present in the facility overnight), including either the first day of admission or the day of discharge, but not both, unless entry and exit dates are the same.

The unit of service that contractor must use to track service is the number of unduplicated clients and number of service days delivered. A "Resident Day" unit of service is defined as a twenty-four (24) hour period in which a resident receives housing and meals. Payment for services provided hereunder shall be subject to the provisions set forth in the FEE-FOR-SERVICE REIMBURSEMENT Paragraph of this Agreement.

5. LENGTH OF STAY: Based on the assessment of the client's need using the American Society of Addiction Medicine Patient Placement Criteria, as measured through the use of the California Treatment/Recovery Placement Indicator Assessment form, a client may move from one intensity level of services to another. The length of stay in

substance abuse residential rehabilitation is dependent upon the intensity level of the program offered.

A. High Level Intensity Program shall not to exceed eight (8) weeks [fifty-six (56) days], although an extension can be made as long as the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine Patient Placement Criteria. Any extensions require prior approval from Office of AIDS Programs & Policy (OAPP), Clinical Enhancement Services Division Chief. Requests shall be submitted on the one (1) page OAPP Client Treatment Extension Request form with required supportive documentation and shall be submitted a minimum of five (5) working days prior to reaching maximum stay limitations. At any point during treatment, the client may move to a lower level of residential treatment to outpatient treatment services or to aftercare services depending on his or her individual need.

B. Medium Level Intensity Program shall not to exceed twelve (12) weeks [eighty-four (84) days], although an extension can be made as long as the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine Patient Placement Criteria. Any extensions require prior approval from OAPP Clinical Enhancement Services Division Chief. Requests shall be submitted on the one (1) page OAPP Client Treatment Extension Request form with required supportive documentation and shall be submitted a minimum of five (5) working days prior to reaching maximum stay limitations. At any point during treatment the client may move to a higher or lower level of

residential treatment to outpatient treatment services or to aftercare services depending on his or her individual need.

C. Low Level Intensity Program shall not to exceed sixteen (16) weeks [one hundred twelve (112) days], although an extension can be made as long as the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine Patient Placement Criteria. Any extensions require prior approval from OAPP Clinical Enhancement Services Division. Requests shall be submitted on the one (1) page OAPP Client Treatment Extension Request form with required supportive documentation and shall be submitted a minimum of five (5) working days prior to reaching maximum stay limitations. At any point during treatment, the client may move to a higher or lower level of residential treatment to outpatient treatment services or to aftercare services depending on his or her individual need.

6. BED-HOLD POLICY: OAPP will permit Contractor to hold a client's bed in medical emergencies or for therapeutic reasons, as long as this is clearly documented in the client's chart and/or treatment plan. OAPP will reimburse for no more than two (2) one-night "bed-holds" per client per quarter under the following circumstances: (a) "bed-holds" cannot be carried over from one quarter for use in a future quarter; (b) OAPP cannot reimburse for a "bed hold" if the client does not return and continue to stay at the agency after the "bed-hold" occurs.

7. CLIENT FEE SYSTEM: Since Ryan White Care Act funds must be considered funds of last resort, Contractor must develop criteria and procedures to

determine client eligibility and to ensure that no other options for substance abuse residential rehabilitation services are available. Contractor must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal, Drug Medi-Cal) is being actively pursued, where applicable.

Contractor shall comply with provisions of Section 2605 (e) of Title 26 (CARE Act) which is entitled "Requirements Regarding Imposition of Charges for Services", incorporated into this Agreement as Exhibit B.

Contractor shall be responsible for developing and implementing a resident fee system. This fee system shall be submitted to OAPP within thirty (30) days of the execution of this Agreement for review and approval. Notwithstanding any other provisions of this Paragraph, Contractor shall pursue funding from public assistance and entitlement programs for which each County responsible resident may eligible.

8. SERVICE DELIVERY SITE: Contractor's facility where services are to be provided hereunder is located at: 8005 Figueroa Street, Los Angeles, California, 90003.

Contractor shall request approval from OAPP in writing a minimum of thirty (30) days before terminating services at such location(s) and/or before commencing services at any other location(s).

9. SERVICES TO BE PROVIDED: Contractor shall provide HIV/AIDS substance abuse residential, residential rehabilitation services to eligible clients in accordance with Chapter 5, Division 4, and Title 9 of the California Code of Regulations, procedures formulated and adopted by the Contractors staff. Services shall be consistent with State laws and regulations of the Los Angeles County Commission on

HIV Substance Abuse Residential Standards of Care and the terms of this Agreement. The program must be licensed by the Department of Alcohol and Drug Programs as a Residential Alcoholism or Drug Abuse Treatment Facility. Additionally, Contractor shall provide such services as described within Exhibit G-1, Scope of Work, attached hereto and incorporated herein by reference.

A. Services to be provided shall include, but not be limited to:

(1) Providing services to hearing impaired clients either directly or by referral. Services provided to referred clients, shall not be reimbursed hereunder.

If Contractor chooses to provide services directly to hearing impaired clients, Contractor shall:

(a) Either arrange formally to participate in a TTY/TDD relay system, or acquire its own TTY/TDD unit;

(b) List its TTY/TDD numbers on its stationery, in its brochures, advertising, and telephone directory listings, and in the Statewide TDD directory which is circulated in the California hearing impaired community;

(c) If services are provided directly to hearing impaired clients hereunder, Contractor shall provide sign-language interpreter services whenever necessary to enable such clients to participate in and benefit from substance abuse residential rehabilitation services.

B. Program Requirements: The program must ensure its ability to meet the needs of the client by meeting the following general requirements:

(1) For individuals in substance abuse residential rehabilitation programs who are HIV/AIDS infected, regular on-going transmission assessments shall be performed.

(2) For individuals in substance abuse residential rehabilitation programs who are assessed as "ready" for additional HIV/AIDS information, transmission risk and infection risk education shall be provided. Programs assessing readiness are encouraged to use Prochaska's Transtheoretical Model of Personal Change, which identifies six stages of personal change, including precontemplation, contemplation, preparation, action, maintenance, and termination. Prochaska et al. maintains that individuals move through predictable stages of change as they endeavor to overcome problem behaviors.

C. Intake: The intake determines eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake shall be completed in the first contact with the potential client. In addition, client intake shall include a medical history complete with CD4 count and viral load measurements, when available. If CD4 count and viral load measurements are not available at time of intake, staff shall attempt to produce them within thirty (30) days by searching the County' HIV data

management system, communication with the client's medical provider or linking client to HIV primary medical care.

(1) Required Documentation: Programs must develop the following forms in accordance with State and local guidelines. Signed, dated and completed forms are required for each client and shall be maintained in each client record: Release of Information (updated annually), Limits of Confidentiality, Consent to Receive Services, Client Rights and Responsibilities, and Client Grievance Procedures. Additionally, the client's record must include the client's HIV/AIDS diagnoses form, financial screening/proof of income, and verification of residency within Los Angeles County.

(2) Client Confidentiality: During the intake process and throughout HIV substance abuse residential rehabilitation service delivery, client confidentiality shall be strictly maintained and enforced. All programs shall follow Health Insurance Portability and Accountability Act (HIPAA) guidelines and regulations for confidentiality.

D. Assessment: Clients shall be assessed and their eligibility determined before being accepted for services. The person responsible for admissions must interview the prospective client and his/her authorized representative, if any, to document the following:

(1) For High Level Intensity Programs:

(a) Eligibility Determination: Persons eligible for substance abuse residential rehabilitation services must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of substance abuse or substance dependence and meet the following criteria:

(i) Withdrawal Potential - minimal risk of severe withdrawal;

(ii) Biomedical Conditions - none or stable; receiving concurrent medical monitoring for medical conditions;

(iii) Emotional/Behavioral Conditions - repeated inability to control impulses; requires structure to shape behavior;

(iv) Treatment Acceptance/Resistance - marked difficulty with or opposition to treatment with dangerous consequences if not engaged in treatment;

(v) Relapse Potential - high likelihood of relapse without close monitoring and support; and

(vi) Recovery Environment - environment is dangerous for recovery; client lacks skills to cope outside of a highly structured twenty-four (24)-hour setting.

(b) Assessment: Clients shall be assessed in order to obtain information required to recommend the most appropriate

course of treatment. The assessment process shall include utilization of the Addiction Severity Index as a functional assessment and the American Society of Addiction Medicine Patient Placement Criteria as a level of care assessment.

Assessments shall include, but not be limited to:

(i) Archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records;

(ii) Patterns of alcohol and drug (AOD) use;

(iii) Impact of AOD abuse on major life areas such as relationships, family, employment record, and self-concept;

(iv) Risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;

(v) Client HIV risk behavior and factors;

(vi) Current medical condition and relevant history, including emergency needs and specific information related to HIV medical care;

(vii) Mental health history and psychological test findings;

(viii) Educational and vocational background;

(ix) Suicide, health, or other crisis risk appraisal;

- (x) Client motivation and readiness for treatment;
- (xi) Client attitudes and behavior during assessment;
- (xii) Purified Protein Derivative (PPD) Tuberculin Skin Test and/or chest x-ray as required by Los Angeles County guidelines;
- (xiii) History of sexually transmitted diseases;
- (xiv) Current HIV medications and possible illicit drug interaction;
- (xv) Housing status;
- (xvi) Legal issues, including domestic violence and child welfare issues; and
- (xvii) Abilities, aptitudes, skills and interests.

In addition, the assessment shall include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor shall coordinate with the client's medical care provider to ascertain information regarding: medical history, results of a physical examination, and results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider shall

be made and a priority treatment plan item shall be developed for the client to seek and comply with medical care.

If the eligibility and assessment processes determine that the program cannot meet the needs of the client, a referral to an alternate provider must be made.

(c) Client Education: Programs shall provide education to clients and their families on an ongoing basis to include HIV 101; HIV prevention; HIV risk reduction practices; harm reduction; addiction education; licit and illicit drug interactions, including HIV medications; medical complications of substance use; hepatitis and other sexually transmitted diseases; medication adherence and nutrition; important health and self-care practices; developing a healthy sexual life, covering topics such as stigma, safer sex, disclosure and issues of domestic violence and sexual abuse; and information about referral agencies that are supportive of people living with HIV/AIDS (especially HIV support groups, twelve (12) step meetings and twelve (12) step alternatives.

(2) For Medium Level Intensity Programs:

(a) Eligibility Determination - Persons eligible for substance abuse residential rehabilitation services must have a DSM-IV

diagnosis of substance abuse or substance dependence and exhibit the following:

(i) Withdrawal Potential - no severe withdrawal risk;

(ii) Biomedical Conditions - none or stable; client is receiving concurrent medical monitoring for any medical conditions;

(iii) Emotional/Behavioral Conditions - mild to moderate severity; needs structure to allow focus on recovery;

(iv) Treatment Acceptance/Resistance - little awareness; client needs interventions to engage and stay in treatment;

(v) Relapse Potential - likelihood of relapse without close monitoring and support; and

(vi) Recovery Environment - environment is dangerous for recovery; client needs twenty-four (24)-hour structure to learn to cope.

(b) Assessment: Clients shall be assessed in order to obtain information required to recommend the most appropriate course of treatment. The assessment process shall include utilization of the Addiction Severity Index as a functional assessment and the American Society of Addiction Medicine

Patient Placement Criteria as a level of care assessment. The medium level intensity residential rehabilitation program may also use California Treatment/Recovery Placement Indicator Assessment Form and complete a comprehensive assessment that includes:

- (i) Archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records;
- (ii) Patterns of AOD use;
- (iii) Impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;
- (iv) Risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;
- (v) Client HIV risk behaviors and factors;
- (vi) Current medical condition and relevant history, including emergency needs and specific information related to HIV medical care;
- (vii) Mental health history and psychological test findings;
- (viii) Educational and vocational background;
- (ix) Suicide, health, or other crisis risk appraisal;

- (x) Client motivation and readiness for treatment;
- (xi) Client attitudes and behavior during assessment;
- (xii) PPD and/or chest x-ray as required by  
Los Angeles County guidelines;
- (xiii) History of sexually transmitted diseases;
- (xiv) Current HIV medications and possible illicit drug  
interactions;
- (xv) Housing status;
- (xvi) Legal issues, including domestic violence and  
child welfare issues; and
- (xvii) Abilities, aptitudes, skills and interests.

In addition, the assessment shall include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor shall coordinate with the client's medical care provider to ascertain information regarding medical history, results of a physical examination, and results of laboratory tests and follow up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider shall be made and a priority treatment plan item shall be

developed for the client to seek and comply with medical care.

If the eligibility and assessment processes determine that the program cannot meet the needs of the client, a referral to an alternate provider must be made. Client Education: Programs will provide education to clients and their families on an ongoing basis to include HIV 101, HIV prevention, HIV risk reduction practices, harm reduction, addiction education, including IV drug use, licit and illicit drug interactions, including HIV medications, medical complications of substance use, hepatitis and other sexually transmitted diseases medication adherence and nutrition, important health and self-care practices, developing a healthy sexual life, covering topics such as stigma, safer sex, disclosure and issues of domestic violence and sexual abuse and information about referral agencies that are supportive of people living with HIV/AIDS [especially HIV support groups, twelve (12)- step meetings and twelve (12)- step alternatives].

(3) For Low Level Intensity Programs:

(a) Eligibility Determination: Persons eligible for substance abuse residential rehabilitation services must have a DSM-IV diagnosis of substance dependence and exhibit the following:

(i) Withdrawal Potential - no withdrawal risk;

(ii) Biomedical Conditions - none or stable;

(iii) Emotional/Behavioral Conditions - none or minimal; not distracting to recovery;

(iv) Treatment Acceptance/Resistance - open to recovery, but needs structured environment to maintain therapeutic gains;

(v) Relapse Potential - likelihood of relapse without close monitoring and support; and

(vi) Recovery Environment - environment is dangerous but recovery achievable if structure is available.

(b) Assessment: Clients will be assessed in order to obtain information required to recommend the most appropriate course of treatment. The assessment process shall include utilization of the Addiction Severity Index as a functional assessment and the American Society of Addiction Medicine Patient Placement Criteria as a level of care assessment. The low level intensity residential rehabilitation program may also use California Treatment/Recovery

Placement Indicator Assessment Form and complete a comprehensive assessment that includes:

(i) Archival data on the client, including, but not limited to, prior arrests and contacts with the criminal justice system, as well as previous assessments and treatment records;

(ii) Patterns of AOD use;

(iii) Impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;.

(iv) Risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;

(v) Client HIV risk behaviors and factors;

(vi) Current medical condition and relevant history, including emergency needs and specific information related to HIV medical care;

(vii) Mental health history and psychological test findings;

(viii) Educational and vocational background;

(ix) Suicide health, or other crisis risk appraisal;

(x) Client motivational and readiness for treatment;

(xi) Client attitudes and behavior during assessment;

- (xii) PPD and/or chest x-ray as required by Los Angeles County guidelines;
- (xiii) History of sexually transmitted diseases;
- (xiv) Current HIV medications and possible illicit drug interactions;
- (xv) Housing status;
- (xvi) Legal issues, including domestic violence and child welfare issues; and
- (xvii) Abilities, aptitudes, skills and interests.

In addition, the assessment shall include gathering specific information about the medical status of the client related to his/her HIV/AIDS condition. After an appropriate signed confidentiality release is obtained from the client, the assessor shall coordinate with the client's medical care provider to ascertain information regarding: medical history, results of a physical examination and results of laboratory tests and follow-up required.

In the event the client does not have a medical care provider, immediate referral to a medical care provider shall be made and a priority treatment plan item shall be developed for the client to seek and comply with medical care.

(c) Client Education: Programs will provide education to clients and their families on an ongoing basis to include HIV 101, HIV prevention, HIV risk reduction practices, harm reduction, addiction education, including IV drug use, licit and illicit drug interactions, including HIV medications, medical complications of substance use, hepatitis and other sexually transmitted diseases medication adherence and nutrition, important health and self-care practices, developing a healthy sexual life, covering topics such as stigma, safer sex, disclosure and issues of domestic violence and sexual abuse and information about referral agencies that are supportive of people living with HIV and AIDS (especially HIV support groups, twelve (12)-step meetings and twelve (12)-step alternatives).

E. Contagious/Infectious Disease Prevention and Intervention: The client must meet the admission requirements of the County of Los Angeles Department of Public Health Tuberculosis Control Program. Clients shall be regularly observed and questioned about health status and symptoms that may indicate that the client has a contagious or infectious disease (other than AIDS). If a client is suspected of having a contagious or infectious disease, the client shall be isolated and a physician shall be consulted to determine suitability of the client's retention in the program.

F. General Services: Regardless of intensity of the program, services will emphasize the intersection between HIV and substance abuse, with special focus given to the psychosocial aspects of living with HIV and HIV prevention. Whenever possible, clients shall be provided gender and/or sexual identity-specific services or be referred to appropriate provider who provides such services. The program shall actively engage clients in treatment with an emphasis on:

(1) Interventions, activities or service elements uniquely designed to alleviate or preclude alcohol and/ or other drug problems in the individual, their family, and/or the community;

(2) The goals of physical health and well-being, practical life skills, including the ability to self-supporting, improved personal functioning, and effective coping with life problems (special emphasis will be given to HIV information and care);

(3) Social functioning, including improved relationships with partners, peers and family, socially acceptable ethics, and enhanced communication and interpersonal relationship skills;

(4) Improving the individual's self-image, esteem, confidence, insight, understanding, and awareness;

(5) Additional life skills such as communication, finance management, job training, hygiene, training in leisure skills, homemaking and parenting skills (including permanency planning and other HIV

custodial care issues), stress, relaxation, and anger management, physical fitness, and field trips.

The program must ensure that, to the maximum extent possible, the program staff provides information regarding community resources and their utilization. The program must maintain and make available to residents a current list of resources within the community that offer services that are not provided within the program. At a minimum, the list of resources includes medical, dental, mental health, public health, and social services, and where to apply for the determination of eligibility for State, Federal, or County entitlement programs. Referrals shall be made to these outside resources, as appropriate. Each program, regardless of intensity level at which it is licensed, must provide services including counseling sessions to clients, as reflected in the client's treatment/recovery plan.

In additional to general service requirements, specific service requirements include:

G. Specific Requirements in addition to the General Service

Requirements:

(1) High Level Intensity Programs:

(a) A minimum of eighty (80) hours of services per week shall be provided;

(b) A minimum of seven (7) ninety (90)-minute group sessions per week shall be provided. These groups will consist of group therapy or group process sessions facilitated or supervised by a licensed master's level mental health clinician at a minimum;

(c) A minimum of one (1) fifty (50)-minute individual session per week shall be provided;

(d) A minimum of seven (7) educational sessions per week shall be provided.

(2) Medium Level Intensity Programs:

(a) A minimum of forty (40) hours of services per week shall be provided;

(b) A minimum of five (5) ninety (90)-minute group sessions per week shall be provided. These groups will consist of group therapy or group process sessions facilitated or supervised by a licensed master's level mental health clinician at a minimum;

(c) A minimum of one (1) fifty (50)-minute individual session per week shall be provided; and

(d) A minimum of seven (7) educational sessions per week including a discharge planning group and transition group shall be provided.

(3) Low Level Intensity Programs:

(a) A minimum of twenty (20) hours of services per week shall be provided;

(b) A minimum one (1) ninety (90)-minute group session per week must be provided;

(c) A minimum of one (1) fifty (50)-minute individual session per week shall be provided; and

(d) A minimum of two (2) educational sessions per week including a discharge planning group and transition group shall be provided.

H. Treatment Plan: A collaborative treatment plan must be developed for all clients based upon the initial assessment. This treatment plan shall serve as the framework for the type and duration of services provided during the client's stay in the program and shall include the plan review and reevaluation schedule. Treatment plans will address necessary gender and/or sexual identity-specific services based on individual client need. Such services will be provided either on site or by linked referral. The program staff shall regularly observe each client for changes in physical, mental, emotional, and social functioning. The plan shall also document mechanisms to offer or refer clients with HIV/AIDS to primary medical services, case management and other supportive services.

(1) High Level Intensity Programs: The client must sign an admission agreement authorizing treatment within three (3) days of

admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include:

(a) An interim treatment plan which identifies the client's immediate treatment needs must be developed within three (3) days from the date of admission;

(b) Within ten (10) days from the date of admission, the counselor must develop a comprehensive treatment plan with long and short-term goals for the continuing treatment needs of each client;

(c) Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified;

(d) The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs;

(e) Treatment plan goals and objectives must be broken down into manageable, measurable units;

(f) The treatment plan must be reviewed and re-evaluated twenty-eight (28) days after development and every thirty (30) days thereafter or more often, if needed, as the client completes each phase of treatment;

(g) Each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.

(2) Medium Level Intensity Programs: The client must sign an admission agreement authorizing treatment within three (3) days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include:

(a) An interim treatment plan which identifies the client's immediate treatment needs must be developed within three (3) days from the date of admission;

(b) Within fourteen (14) days from the date of admission, the counselor must develop a comprehensive treatment plan with long- and short-term goals for the continuing treatment needs of each client;

(c) Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem areas identified;

(d) The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs;

(e) Treatment plan goals and objectives must be broken down into manageable, measurable units;

(f) The treatment plan must be reviewed and re-evaluated twenty-eight (28) days after development and every sixty (60) days thereafter or more often, if needed, as the client completes each phase of treatment;

(g) Each time the treatment plan is developed, reviewed, or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.

(3) Low Level Intensity Programs: The client must sign an admission agreement authorizing treatment within three (3) days of admission. A counselor must develop a treatment plan for each client with collaboration from the client. Treatment plan requirements include:

(a) An interim treatment plan which identifies the client's immediate treatment needs must be developed within three (3) days from the date of admission;

(b) Within twenty (20) days from the date of admission, the counselor must develop a comprehensive treatment plan with long and short-term goals for the continuing treatment needs of each client;

(c) Treatment plan goals and objectives must reflect problem areas identified in the assessment and reflect responses to the problem area identified;

(d) The treatment plan must be action-oriented, must identify the activities or tasks the client must complete in order to attain the recovery goal, and must reflect the client's changing needs;

(e) Treatment plan goals and objectives must be broken down into manageable, measurable units;

(f) The treatment plan must be reviewed and re-evaluated twenty-eight (28) days after development and every sixty (60) days thereafter or more often, if needed, as the client completes each phase of treatment;

(g) Each time the treatment plan is developed, reviewed or re-evaluated, it must be signed and dated by the counselor who developed or re-evaluated it and the client.

I. Referral Services: Programs providing all levels of intensity of substance abuse residential rehabilitation services will demonstrate active collaboration with other agencies to provide referral to the full spectrum of HIV-related services. Formal relationships with mental health providers are especially important for assistance in crisis management or psychiatric emergencies. In addition to primary medical services and case management, the program must

be linked to a continuum of HIV/AIDS care and services and must link and/or refer clients to these service options, including, but not limited to, mental health treatment, medical care, treatment advocacy, peer support, vocational training, education, treatment education, dental, legal and financial services. Referrals for services shall be made at any point at which the needs of the client cannot be met by the program within its established range of services. Programs will make available to clients information about public health, social services and where to apply for State, federal and/or County entitlement programs. In addition:

(1) If during intake it is determined that the needs of the client cannot be met by the program within the program's range of services, then a referral must be made to an alternate provider or venue of services; and

(2) If after admission observation or assessment reveals needs which might require a change in the existing level of service or possible discharge, referral, or transfer to another type of program, the program staff must consult with the appropriate specialist(s), as necessary, to assist in determining if such can be met by the program within the program's range of services or if a referral and transfer is required.

J. Support Services and Discharge Planning: Support services that are to be provided or coordinated must include, but not be limited to:

(1) Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living);

- (2) Health-related services (e.g., medical care, medication management, adherence, etc.);
- (3) HIV transmission risk assessment and prevention counseling;
- (4) Social services;
- (5) Recreational activities;
- (6) Meals;
- (7) Housekeeping and laundry;
- (8) Transportation; and/or
- (9) Housing.

Discharge planning will include collaboration with clients who have successfully completed residential rehabilitation to develop a written aftercare plan that includes specific substance abuse treatment recommendations utilizing various modalities and approaches, as well as referrals to appropriate services. Clients shall receive a copy of the plan, including active referrals to appropriate services. Clients shall leave knowing they are welcome to contact the program at any time. Programs shall develop mechanisms to ensure that they maintain contact with clients post-discharge.

Aftercare services provide a safety net for clients who are new to recovery while rebuilding their lives and living with HIV. Ideally, transitional or aftercare services shall be provided by a program counselor involved with the client's discharge planning and prior treatment. Services

are in the form of individual or group counseling and range from three (3) to twelve (12) months depending on client need. Sessions can address such issues as: substance abuse and HIV/AIDS information; relapse prevention; personal budgeting; program sponsor work; re-establishing support groups; exploring and supporting sexual identification and behavior; maintaining sobriety and medication adherence.

10. CONTRACTOR'S SUBCONTRACT/CONSULTANT REQUIREMENTS:

Contractor shall ensure that subcontractors and consultants providing services under this Agreement shall commence services within ninety (90) days of the execution of this Agreement. Subcontract and consultant agreements shall be signed and dated by the Contractor's Director, or his/her authorized designee(s) prior to commencement of subcontracted and/or consultant services.

11. REPORTS: Subject to the reporting requirements of the REPORTS Paragraph of the ADDITIONAL PROVISIONS of this Agreement attached hereto, Contractor shall submit the following report(s):

A. Monthly Reports: As directed by OAPP, Contractor shall submit a signed hard copy of the monthly report and, as requested, the electronic format of the report and the STANDARD CLIENT LEVEL REPORTING Data for services no later than thirty (30) days after the end of each calendar month. The reports shall clearly reflect all required information as specified on the monthly report form and be transmitted, mailed, or delivered to Office of AIDS Programs

and Policy, 600 South Commonwealth Avenue, 10th Floor, Los Angeles, California 90005, Attention: Financial Services Division, Chief.

B. Semi-annual Reports: As directed by OAPP, Contractor shall submit a six (6)-month summary of the data in hard copy, electronic, and/or online format for the periods January through June and July through December.

C. Annual Reports: As directed by OAPP, Contractor shall submit a summary of data in hard copy, electronic, and/or online format for the calendar year due by the end of February of the following year.

D. As directed by OAPP, Contractor shall submit other monthly, quarterly, semi-annual, and/or annual reports in hard copy, electronic, and/or online format within the specified time period for each requested report. Reports shall include all the required information and be completed in the designated format.

12. COUNTY DATA MANAGEMENT SYSTEM: Contractor shall utilize County's data management system to register client's eligibility data, demographic/resource data, enter service utilization data, medical and support service outcomes, and to record linkages/referrals to other service providers and/or systems of care. County's system will be used to invoice for all delivered services, standardize report, importing efficiency of billing, support program evaluation process, and to provide OAPP and participating contractors with information relative to the HIV/AIDS epidemic in Los Angeles County. Contractor shall ensure data quality and compliance with all data submission requirements.

13. PROGRAM RECORDS: Client records shall include: intake information consisting of personal, family, educational, drug, criminal and medical history (including current physical, urinalysis and HIV status); client identification data; diagnostic studies, if appropriate; a treatment plan which includes a problem list, short and long-term goals, and action steps generated by staff and client; assignment of a primary counselor; physician contact at least every forty-eight (48) hours; description of type and frequency of services including counseling and support services to be provided; a record of client interviews; referral services; and a discharge/transfer summary.

14. STAFFING REQUIREMENTS: All new staff must receive HIV/AIDS education within the first three (3) months of employment. In addition, all direct service staff must attend a minimum of sixteen (16) hours of HIV/AIDS training each year. All management staff must attend a minimum of eight (8) hours of HIV/AIDS training each year. All clerical and support staff must attend a minimum of eight (8) hours of HIV/AIDS training initially and four (4) hours each year thereafter.

As of January 1, 2008, at least a minimum of fifty percent (50%) of program staff providing counseling services in each alcohol or other drug program shall be certified pursuant to the requirements of California Code of Regulation, Title 9, Division 4, Chapter "8". The Substance Abuse Residential, Residential Rehabilitation program must have the following staff:

A. Direct Care Staff for High Level Intensity Program: The Contractor will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills

are performed by personnel who are licensed or certified to perform the service.

Direct Care Staff include:

(1) A counselor designated to perform admission, intake and assessment functions, including ongoing evaluation of the clients' treatment and care needs;

(2) A counselor responsible for oversight and provision of planned activities, including oversight of volunteers; and

(3) A staffing ratio of not less than one (1) counselor for every sixteen (16) clients enrolled in the program. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction and have specialized training in detoxification services. Clients will not be used to fulfill staffing requirements.

B. Administrative and Support Staff for high level intensity programs include:

(1) A program administrator or designee must be on-site during the normal work day;

(2) A registered nurse shall remain on-call twenty-four (24) hours a day;

(3) In programs where there are six (6) beds or fewer, a minimum of one (1) on-duty, awake staff is required;

(4) In programs where there are seven (7) to twenty (20) beds, a minimum of two (2) on-duty, awake staff is required.

(5) In programs where there are more than twenty (20) beds, a minimum of one (1) on-duty, awake staff is required for each additional sixteen (16) beds or portion thereof;

(6) Support staff, as necessary, to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds.

C. Direct Care Staff for Medium Level Intensity Program: The Contractor will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service. Direct Care Staff include: A counselor designated to perform admission, intake and assessment functions, including ongoing evaluation of the clients' treatment and care needs;

(1) A counselor responsible for oversight and provision of planned activities, including oversight of volunteer; and

(2) A staffing ratio of not less than one (1) counselor for every twenty-four (24) clients enrolled in the program. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction and have specialized training in

detoxification services. Clients will not be used to fulfill staffing requirements.

D. Administrative and Support Staff for Medium Level Intensity Program include:

(1) The program administrator or designee must be on-site or able to return telephone calls within one (1) hour and able to appear in person within two (2) hours;

(2) The medical director shall be on-call during regular business hours;

(3) The program administrator must ensure that whenever clients are present, at least one (1) on duty staff or resident manager is present;

(4) In programs where there are less than six (6) beds, a minimum of one (1) on-duty staff or resident manager is required during service provision hours;

(5) In programs where there are seven (7) to forty (40) beds, a minimum of two (2) on-duty staff or resident managers are required during service provision hours;

(6) In programs where there are more than forty (40) beds, a minimum of one (1) on-duty staff or resident manager is required for each additional forty (40) beds or portion thereof during service provision hours; and

(7) Support staff, as necessary, to perform office work, cooking, house cleaning, laundering and maintenance of buildings, equipment, and grounds.

E. Direct Care Staff for Low Level Intensity Program: The program will ensure that all direct services to clients are provided by staff trained in the provision of program services, and that all services requiring specialized skills are performed by personnel who are licensed or certified to perform the service.

Direct Care Staff include:

(1) A counselor designated to perform admission, intake, and assessment functions, including ongoing evaluation of the clients' treatment and care needs;

(2) A counselor responsible for oversight and provision of planned activities, including oversight of volunteer; and

(3) A staffing ratio of not less than one (1) counselor for every forty (40) clients enrolled in the program. Counselors may be nurses, psychologists, social workers, psychiatric technicians, trained counselors, or others as long as they have training or experience in treating persons with an addiction and have specialized training in detoxification services. Clients will not be used to fulfill staffing requirements.

F. Administrative and Support Staff for Low Level Intensity Program include:

(1) The program administrator or designee must be on-site or able to return telephone calls, within one and one-half (1½) hours and be able to appear in person within three (3) hours;

(2) The program administrator must ensure that whenever clients are present, at least one (1) on-duty staff is present;

(3) In facilities where there are less than six (6) beds, a minimum of one (1) on-duty staff is required during service provision hours;

(4) In facilities where there are seven (7) to forty (40) beds, a minimum of two (2) on-duty staff is required during service provision hours;

(5) In facilities where there are more than forty (40) beds, a minimum of one (1) on-duty staff is required for each additional forty (40) beds or portion thereof during service provision hours; and

(6) Support staff to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment, and grounds, as necessary.

G. Contractor shall adhere to all required direct care and administrative and support staff as outlined in this Agreement. Contractor shall report staffing pattern including any changes or additions in the OAPP monthly report.

Contractor shall submit a Plan of Corrective Action (POCA) to OAPP within thirty (30) days if not in compliance with established staffing requirements of contract and standard of care.

15. TUBERCULOSIS CONTROL: Contractor shall adhere to Exhibit C, "Tuberculosis Exposure Control Plan for Residential Facilities" as provided by the Los Angeles County Department of Public Health's Tuberculosis Control Program, attached hereto and incorporated herein by reference. Director shall notify Contractor of any revision of this Plan, which shall become part of this Agreement.

16. TUBERCULOSIS SCREENING FOR STAFF: Prior to employment or service provision and annually thereafter, Contractor shall obtain and maintain documentation of tuberculosis screening for each employee, volunteer, and consultant providing services hereunder. Such tuberculosis screening shall consist of a tuberculin skin test (Mantoux test) and/or written certification by a physician that the person is free from active tuberculosis based on a chest x-ray.

Contractor shall adhere to Exhibit D, "Guidelines for Staff Tuberculosis Screening", attached hereto and incorporated herein by reference. Director shall notify Contractor of any revision of these Guidelines, which shall become part of this Agreement.

17. NARCOTICS AND RESTRICTED DANGEROUS DRUGS: Contractor agrees to comply with all federal and State statutory requirements and regulations, concerning the storage, prescription, and administration of narcotics or restricted dangerous drugs.

18. EMERGENCY AND DISASTER PLAN: Contractor shall submit to OAPP within thirty (30) days of the execution of this Agreement an emergency and disaster plan, describing the procedures and actions to be taken in the event of an emergency,

disaster, or disturbance in order to safeguard residents and facility staff. Situations to be addressed in the plan shall include emergency medical treatment for physical illness or injury of residents, earthquake, fire, flood, resident disturbance, and work action. Such plan shall include Contractor's specific procedures for providing this information to all program staff.

19. EMERGENCY MEDICAL TREATMENT: Clients receiving services hereunder who require emergency medical treatment for physical illness or injury shall be transported to an appropriate medical facility. The cost of such transportation as well as the cost of emergency medical care shall not be a charge to nor reimbursable hereunder. Contractor shall have a written agreement(s) with a licensed medical facility(ies) within the community for provision of emergency services as appropriate. Copy(ies) of such written agreement(s) shall be sent to Los Angeles County Department of Public Health, Office of AIDS Programs and Policy, Clinical Enhancement Services Division.

20. PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES: Contractor shall adhere to all provisions within Exhibit E, "People with HIV/AIDS Bill of Rights and Responsibilities" ("Bill of Rights") document attached hereto and incorporated herein by reference. Contractor shall post this document and/or Contractor-specific higher standard at all provider's delivery service sites, and disseminate it to all patients/clients. A Contractor-specific higher standard shall include, at a minimum, all provisions within the "Bill of Rights". In addition, Contractor shall

notify and provide to its officers, employees, and agents, the "Bill of Rights" document and/or Contractor-specific higher standard.

If Contractor chooses to adapt this "Bill of Rights" document in accordance with Contractor's own document, Contractor shall demonstrate to OAPP, upon request, that Contractor fully incorporated the minimum conditions asserted in the "Bill of Rights" document.

21. QUALITY MANAGEMENT: Contractor shall implement a Quality Management (QM) program that assesses the extent to which HIV/AIDS services provided are consistent with federal (e.g., Public Health Services and CDC Guidelines), State, and local standards of HIV/AIDS care and/or prevention services. The QM program shall at a minimum:

- A. Identify leadership and accountability of the medical director or executive director of the program;
- B. Use measurable outcomes and data collected to determine progress toward established benchmarks and goals;
- C. Focus on linkages to care and support services;
- D. Track client perception of their health and effectiveness of the service received;
- E. Serve as a continuous quality improvement (CQI) process reported to senior leadership annually.

22. QUALITY MANAGEMENT PLAN: Contractor shall develop program on a written QM plan. Contractor shall develop **one (1)** agency-wide QM plan that

(1) Measurement of Quality Indicators – agency shall collect and analyze data measured from specific OAPP selected indicators:

(a) Percent of clients receiving the number of individual counseling sessions described in the individualized treatment plan (Baseline Benchmark: Ninety percent (90%) of clients);

(b) Percent of clients who have had at least one HIV-related medical care consultation during the substance abuse treatment period (Baseline Benchmark: One hundred percent (100%) of clients);

(c) Percent of clients who report satisfaction with the services they received ( Baseline Benchmark: Ninety percent (90%) of clients);

(d) Percent of clients completing the course of substance abuse treatment described in their individual plan that are successfully referred to the appropriate next level of care (Baseline Benchmark: Sixty percent (60%) of clients);

(e) Percent of clients whose treatment record documents education regarding harm-reducing and risk-reducing techniques for high-risk behaviors related to HIV (Baseline Benchmark: One hundred percent (100%) of clients).

In addition, the agency can measure other aspects of care and services as needed.

(2) Development of Data Collection Method – to include sampling strategy (e.g., frequency, percentage of sample sized), collection method (e.g., chart audits, interviews, surveys, etc.), and a data collection tool will be utilized for measuring aspects of care.

(3) Collection and Analysis of Data – analyzed results shall be reviewed and discussed by the QM committee. The findings of the data analysis shall be communicated with all program staff involved.

(4) Identification of Improvement Strategies – QM committee shall be responsible for identifying improvement strategies, tracking progress, and sustaining improvement.

E. Client Feedback Process: The QM plan shall describe the mechanism for obtaining ongoing feedback from clients regarding the accessibility and appropriateness of service and care. Feedback will also include the degree to which the service meets client needs and satisfaction. Client feedback shall be reviewed in the agency's QM Committee meetings on a regular basis for the enhancement of service delivery. Aggregate data is to be reported to the QM committee annually for continuous program improvement.

F. Client Grievance Process: Contractor shall establish policies and procedures for addressing and resolving client's grievances at the level closest to the source within agency. Grievance data is to be tracked, trended, and reported to the agency's QM committee for improvements of care and services at

minimum quarterly. The information is to be made available to OAPP's staff during program review.

G. Incident Reporting: Contractor shall comply with incident and or sentinel event reporting as required by applicable federal and State laws, statutes, and regulations. Contractor shall furnish to OAPP Executive Office, upon the occurrence, during the operation of the facility, reports of incidents and/or sentinel events specified as follows:

(1) A report shall be made to the appropriate licensing authority and to OAPP within the agency's next business day from the date of the event, pursuant to federal and State laws, statutes, and regulations.

Events reported shall include the following:

(a) Any unusual incident and sentinel event which threatens the physical or emotional health or safety of any client to include, but not limited be to, client suicide, medication error, delay in treatment, and serious client fall;

(b) Any suspected physical or psychological abuse of any client, such as child, adult, and elderly.

(2) The written report shall contain the following information:

(a) Client's name, age, and sex;

(b) Date and nature of event;

(c) Disposition of the case; and

(d) Staffing pattern at the time of the incident.

(3) Random Chart Audits: Sampling criteria shall be based on important aspects of care and shall be, at a minimum, ten percent (10%) or thirty (30) charts, whichever is less. Results of chart audits will be reported and discussed in the QM committee quarterly.

23. QUALITY MANAGEMENT PROGRAM MONITORING: To determine the compliance level, OAPP shall review contractor's QM program annually. A numerical score will be issued to the contractor's QM program based on one hundred percent (100%) as the maximum score. Contractor's QM program shall be assessed for implementation of the following components:

- A. Details of the QM plan (QM Objective, QM Committee, QM Approach Selection); Implementation of QM Program;
- B. Client Feedback Process;
- C. Client Grievance Process;
- D. Incident Reporting;
- E. Random Chart Audit (if applicable).

24. CULTURAL COMPETENCY: Program staff shall display nonjudgmental, culture affirming attitude. Program staff shall affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.

## SERVICE DELIVERY SITE QUESTIONNAIRE

## SERVICE DELIVERY SITES

TABLE 1

Site# 1 of 1

1	Agency Name:	Watts Healthcare Corporation		
2	President/CEO:	William Hobson		
3	Address of Service Delivery Site:	8005 Figueroa Street		
		Los Angeles	California	90003

4 In which Service Planning Area is the service delivery site?

- |                          |                           |                                     |                          |
|--------------------------|---------------------------|-------------------------------------|--------------------------|
| <input type="checkbox"/> | One: Antelope Valley      | <input type="checkbox"/>            | Two: San Fernando Valley |
| <input type="checkbox"/> | Three: San Gabriel Valley | <input type="checkbox"/>            | Four: Metro Los Angeles  |
| <input type="checkbox"/> | Five: West Los Angeles    | <input checked="" type="checkbox"/> | Six: South Los Angeles   |
| <input type="checkbox"/> | Seven: East Los Angeles   | <input type="checkbox"/>            | Eight: South Bay         |

5 In which Supervisorial District is the service delivery site?

- |                          |                               |                                     |                                  |
|--------------------------|-------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> | One: Supervisor Molina        | <input checked="" type="checkbox"/> | Two: Supervisor<br>Ridley-Thomas |
| <input type="checkbox"/> | Three: Supervisor Yaroslavsky | <input type="checkbox"/>            | Four: Supervisor Knabe           |
| <input type="checkbox"/> | Five: Supervisor Antonovich   |                                     |                                  |

6 Based on the number of resident days to be provided at this site, what percentage of your allocation is designated to this site? 100%

SERVICE DELIVERY SITE QUESTIONNAIRE  
**CONTRACT GOALS AND OBJECTIVES**

**TABLE 2\***

Enter number of Resident Days Contract Goals and Objective by Service Delivery Site(s).

Contract Goals and Objectives	Resident Days
Site	No. of Days
Site # 1	2,696
Site # 2	
Site # 3	
Site # 4	
Site # 5	
Site # 6	
Site # 7	
Site # 8	
Site # 9	
Site # 10	
<b>TOTAL</b>	<b>2,696</b>

\* Figures are based on a 12-month period.