

## **AIDS FOUNDATION OF CHICAGO**

**Request for Proposals for Treatment Coordinators:  
Ryan White HIV/AIDS Treatment Modernization Act Parts A and B  
February 29, 2008**

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## **I. Introduction**

The AIDS Foundation of Chicago (AFC) was established in 1985 to coordinate the local response to the AIDS epidemic in the Chicago area. In 1989, AFC was awarded a Health Resources and Services Administration (HRSA) demonstration grant to establish a coordinated system of case management services for people living with HIV and AIDS (PLWHA), which became known as the Northeastern Illinois HIV/AIDS Case Management Cooperative. With full participation of case management agencies in establishing common expectations and policies and procedures for case management services, the Northeastern Illinois HIV/AIDS Case Management Cooperative now consists of nearly 160 case managers at 55 agencies, and is funded primarily through the Ryan White HIV/AIDS Treatment Modernization Act (Ryan White) Parts A and B and through the Illinois Department of Human Services (IDHS) Division of Rehabilitation Services (DRS).

The basic philosophy of the Northeastern Illinois HIV/AIDS Case Management Cooperative is to provide comprehensive case management services to empower people living with HIV and AIDS to live healthy and independent lives. This is accomplished by ensuring clients are linked to primary medical care and other core clinical services (e.g. AIDS Drug Assistance Programs, oral health care, home health care, substance use, and mental health services), treatment coordination, and adherence counseling. Case managers assist their clients in applying for all benefits for which they may qualify, including Social Security Disability Income and Medicaid; facilitate access to emergency funds for utilities, rent, food, and transportation; identify medical and social service needs; and facilitate appropriate referrals. In the interest of providing seamless and continuous care throughout the course of an individual's periods of health and illness, AFC became the lead contractor for DRS case management, a Medicaid Waiver Program that provides reimbursement for case management and home services to keep individuals disabled by HIV and AIDS in their homes and out of more expensive nursing home care. Through the combination of grant-funded case management and fee-for-service DRS case management, AFC and individual agencies maximize all resources available to support case management.

### **A New Model of Case Management**

In light of growing nationwide recognition that case management has been identified by HRSA as a "core clinical service" that facilitates linkage to and maintenance of primary medical care services, AFC and the Chicago Department of Public Health (CDPH) have taken the leadership role in developing a new system of case management services that responds to changes in Ryan White Part A and Part B, is responsive to the levels of need of clients in the Chicago EMA, and maintains client access to benefits including transportation, emergency financial assistance (EFA), and emergency housing assistance (EHA). This new system emphasizes treatment and appointment adherence, facilitates active participation in primary medical care and other core clinical services, and monitors health outcomes with the goal of supporting clients as they become partners in their own care.

The purpose of this Request for Proposals (RFP) is to conduct a competitive bidding and pilot project process for the newly revised system of HIV case management services in the Chicago area, and specifically to test a new staff component to the system: Treatment Coordinators. Part A funds are awarded by HRSA directly to CDPH, who has delegated to AFC the responsibility of coordinating and administering the Northeastern Illinois HIV/AIDS Case Management Cooperative. This bidding process has been developed in accordance with guidelines set out by CDPH, and with the cooperation and support of the program and contracts staff at the Illinois Department of Public Health (IDPH), the Illinois Department of Human Services (DHS) and the AIDS Administrative Unit (AAU).

**All agencies interested in providing treatment coordinators must submit an application outlining qualifications in this area.** Agencies may submit only one proposal in response to this RFP. Eligible agencies may submit both an application in response to this RFP as well as a proposal in response to the Request for Proposals for Case Management Services issued on February 29, 2008. Details of the requirements for submitting an application are listed in the following pages.

**One original, six (6) copies, and one electronic copy (on a CD that is formatted on a Microsoft platform such as Word or Excel and that is not password protected) of the proposal must be received at the AIDS Foundation of Chicago office before 4:00 p.m., Thursday, April 10, 2008.** The original must be marked "original" and signed in blue ink. All copies must be marked "copies." The deadline is strictly enforced, and no exceptions will be granted for any reason. Proposals delivered after 4:00 p.m. will not be accepted or reviewed. **In addition, only organizations that submit the Intent to Apply are eligible to apply (please see section III).**

**Proposals must be addressed to:  
Cheryl Potts  
AIDS Foundation of Chicago  
411 South Wells Street, Suite 300  
Chicago, IL 60607**

**If you have any questions concerning this RFP please contact Cheryl at [cpotts@aidschicago.org](mailto:cpotts@aidschicago.org) or 312/922-2322 ext. 509.**

## **II. Available Funding**

Approximately \$600,000 will be available starting August 1, 2008 for treatment coordinator services provided through the Northeastern Illinois HIV/AIDS Case Management Cooperative. Approximately 10 full-time equivalent treatment coordinator positions will be funded at 8-12 clinics. It is expected that the contracts will begin on August 1, 2008 and will extend through March 31, 2009. Two additional 12-month amendments may be made based upon availability of funds and acceptable contract performance; amendments are not a guarantee of this project.

## **III. Eligible Agencies**

Treatment coordinator funds are available for medical clinics (or a network of clinics) and other outpatient primary care sites providing medical or other core clinical services in the Chicago metropolitan area. Agencies/clinics (or a network of clinics) are eligible to apply for one full-time equivalent (FTE) position if they provide services to at least 200 clients living with HIV who have been seen at least once within the past calendar year. Agencies/clinics (or a network of clinics) are eligible to apply for .5 full-time equivalent (FTE) position if they provide services to 50-199 clients living with HIV who have been seen at least once within the past calendar year. Exceptions to this will be considered only under geographical or cultural circumstances that limit the care options for clients in a certain region. The Chicago metropolitan area is defined as the city of Chicago and the counties of Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry, and Will. Eligible agencies include organizations with a 501(c)(3) Internal Revenue Service designation, units of local government, and hospitals and university-based programs. Eligible recipients include hospitals, community-based organizations, hospices, ambulatory care facilities, community health centers, migrant health centers, homeless health centers, substance abuse treatment and mental health programs.

Agencies located outside of the City of Chicago and in areas in the EMA with high HIV/AIDS morbidity (e.g., Aurora, Elgin, Joliet and Waukegan) are encouraged to apply, and providers within the City of Chicago are encouraged to establish linkages with suburban HIV/AIDS, and other health and social service providers. These linkages should be documented through individualized formal memoranda of agreement.

**In addition, only organizations that submit the Intent to Apply form are eligible to apply.** Agencies should submit the attached Intent to Apply form (see Appendix A) to the Treatment Coordinator Program at AFC **no later than Friday, March 21<sup>st</sup> at 4 p.m.** The form must identify the proposal contact person, mailing address, e-mail address, telephone number, and fax number. The intent to apply must also include the *projected* number of positions and funds being requested. **Agencies must submit the Intent to Apply form to be considered for funding. Submission of an Intent to Apply is not a guarantee of funding, nor does it require the agency to submit a proposal.**

While not required, applicants are strongly encouraged to attend the Bidders' Conference listed below (see Appendix E for more detailed location information):

**Wednesday, March 19, 2008 8:30 a.m. – 12:30 p.m. AIDS Foundation of Chicago**

#### **IV. Key Program Changes**

This section outlines some national and local changes that affect the Northeastern Illinois HIV/AIDS Case Management Cooperative and the development of the treatment coordinator model.

##### **New Case Management Program Design**

In an effort to address environmental factors, to retain what works in the current case management system, and to better coordinate treatment for clients, AFC is implementing a reconfigured case management continuum. This continuum will expand the capacity of the system to serve more clients, stabilize or improve client health indicators, and improve adherence to appointments and medication, among other outcomes. This newly designed system of case management will be comprised of three levels of case management: intensive case management, medical case management, and supportive services case management, all of which are complimented by treatment coordinators. (Please refer to Attachment H for an extensive description of the case management model.)

The three levels of case management form a continuum of case management services that includes an intensive case management model targeting clients with exceedingly high levels of need. The intensive case management programs include but are not limited to DRS home services, corrections re-entry, pregnant women living with HIV, and chronically-ill homeless individuals. Each intensive case management program has specific guidelines regarding service provision.

Ryan White Parts A and B will fund medical and supportive services case management and will support three main positions: medical case managers, supportive services case managers, and treatment coordinators. Medical case managers will provide a range of client-centered services that link clients with health care, clinical, psychosocial, and supportive services for clients living with HIV who are identified as having challenges with accessing and maintaining adherence to health care services. The coordination and follow-up of medical treatments is a key component of medical case management. Medical case managers will ensure timely and coordinated access to medically-appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family

members' needs and personal support systems. Medical case management includes the provision of treatment adherence education and counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary. It includes client-specific advocacy and review of utilization of services. This includes all types of case management contacts such as face-to-face, telephone, and collateral contact.

Supportive services case managers will provide advice and assistance in obtaining medical, social, community, legal, financial, and other needed supportive services to clients living with HIV who are identified as being stable in their core clinical care. Supportive services case management does not involve coordination and follow-up of medical treatments or provision of treatment adherence counseling as medical case management does. However, brief reassessments and ongoing reporting of basic health indicators will be a part of supportive services case management to ensure ongoing client stability in core clinical services. Supportive services case management contacts includes all types of case management such as face-to-face, telephone, and collateral contact.

Treatment coordinators will be the newest component of the case management continuum. Treatment coordinators will have limited direct contact with clients, but will provide the necessary communication between clinical providers and case managers regarding clients' access and adherence to medication and treatment adherence. Treatment coordinators will be based at health care clinics and will be responsible for reviewing client charts for necessary medical indicators. Treatment coordinators will be responsible for communicating these clinical indicators to case managers in an effort to create a comprehensive service plan that include treatment coordination and follow up. Treatment coordinators will be responsible for staffing case conferences, completing medical assessment forms, and updating health indicators in the client-level database. **Treatment coordinator positions are the only positions available for bidding through this RFP.**

## V. Federal and Local Priorities

Medical case management has been defined by HRSA and Ryan White as a "core clinical service" whose purpose is to facilitate linkages and maintenance of primary care and other core clinical services. This indicates a trend towards focusing case management services that are based on the medical needs and stability of clients and focus on treatment and appointment adherence, outcomes measurements, and client education. Based on this as well as the mandates from HRSA outlined above, agencies must demonstrate how they will address the following elements in their programs:

- **Linkage and Coordination with Ambulatory/Outpatient Medical Care, Mental Health, Substance Abuse, and Oral Health Care** Case-managed clients must be linked to or receiving ambulatory/outpatient medical care and other core clinical services. All case management providers must describe how they will ensure and document each client's enrollment in ambulatory/outpatient medical care, their relationships and linkages to medical providers, and how they intend to obtain ongoing medical information and laboratory indicators for their clients. Applicants for treatment coordinators must demonstrate documented success in tracking these clinical indicators.
- **Funds of Last Resort** Ryan White funds must be used as the funds of last resort, meaning Ryan White funds are expected to be utilized only when other funding sources have been exhausted. Since HRSA defines Ryan White as the payer of last resort, all Medicaid *eligible* providers must be certified as Medicaid providers. When applicable, case management agencies funded under

this program are expected to make all efforts to pursue third-party payments for services subject to this agreement, including Medicaid, Medicare, and private insurance. Funds provided for services pursuant to this contract are restricted for clients with HIV who have no other means of payment available. More information on third party reimbursement is available at [www.hrsa.gov](http://www.hrsa.gov).

- **Client Level Reporting** All treatment coordinator providers must be able to track and report demographic, medical and other service data by individual client. AFC maintains a client-level database and is implementing client-level reporting for case management encounters, taxicab rides, and the distribution of food vouchers and fare cards in the 2008-09 contract year. All treatment coordinators will be required to submit comprehensive on-line evaluations of clinical indicators for each client, and to submit ongoing appointment adherence information.
- **Linkage to HIV Testing Sites** All case management agencies funded under this program are required to establish and maintain appropriate relationships with facilities in their respective geographic areas that represent key points of access to the health care system. These facilities include but are not limited to HIV testing sites, hospital emergency rooms, detoxification centers, substance abuse treatment facilities, STD clinics, adult and juvenile detention centers, homeless shelters, federally qualified health centers (FQHC), and community health centers.
- **Suburban Access to Services** The Chicago Area HIV Services Planning Council (the Council) has identified a need to ensure access to Part A services in metropolitan areas outside of the City of Chicago. Areas identified are **Aurora, Cicero, Elgin, Evanston, Harvey, Joliet, Oak Park and Waukegan**, and their surrounding areas. Agencies in these areas are encouraged to submit applications to provide case management and treatment coordinator services, and to consider co-locating these services with other funded services.

## VI. Funding Requirements

In addition to the federal priorities outlined above, AFC and its advisory bodies have developed program requirements for ensuring an effective continuum of case management services. Priority consideration will be given to agencies who can demonstrate ongoing, significant collaboration with other clinics and case management programs.

These, along with the following requirements, have been identified as priorities by AFC. The following requirements will influence the review criteria of the proposals and should be considered when designing your program and preparing your narrative response to this RFP:

- Participation in quality management (QM) and quality improvement (QI) activities at both an agency level as well as a systems level. This includes but is not limited to participation in annual client satisfaction surveys, cooperation in identifying clients for focus groups, participation in annual peer site visits, and implementing a QM/QI programs. Quality management plans must specifically include treatment coordinator activities. More detailed expectations regarding quality management for providers are detailed on page 11.
- All agencies funded for treatment coordinators must demonstrate individualized memoranda of agreement with other partner case management and core clinical service agencies. Memoranda of agreement must be specific and tailored to each site. Standardized, generic memoranda of agreement will not be accepted. More detailed expectations regarding the memoranda of agreement are detailed on page 11.
- Treatment coordinators are required to complete the Case Management Competencies training with a passing grade as determined by the Case Management Competencies Training Policy. Any treatment coordinator who fails the curriculum will not be reimbursed as a treatment coordinator.

- All treatment coordinators must attend at least 6 trainings during the contract year, with one of those trainings being the Midwest AIDS Training and Education Center (MATEC) Treatment Adherence training. All AFC-funded supervisors will be required to attend at least one training during the contract year in addition to six Contract Administrators meetings.
- All treatment coordinators will be required to enter complete and accurate data into the client-level database on a timely basis. (Please refer to Direct Data Entry Agreement, Appendix J.)

## **VII. Service Category Definition and Allowable Activities**

Treatment coordinators are the newest component of the case management continuum. Treatment coordinators will have little direct contact with clients, but will provide the necessary communication between clinical providers and case managers regarding clients' access and adherence to medication and treatments. Treatment coordinators will be based at health care clinics and will be responsible for reviewing client charts for necessary clinical indicators. Treatment coordinators will be responsible for communicating these clinical indicators to case managers in an effort to create a comprehensive service plan that includes treatment coordination and follow up. Treatment coordinators will be responsible for staffing case conferences, completing medical assessment forms, and updating clinical indicators in the client-level database (as defined by AFC's standard operating procedures.) Treatment coordinators must be located at clinics (or a network of clinics) providing medical or other core clinical services to at least 50 clients living with HIV who have been seen at least once within the past calendar year (please refer to page 4 Eligible Agencies). Exceptions to this will be considered only under geographical or cultural circumstances that limit the care options for clients in a certain region. Applicants must also justify a request for a clinic that serves less than 200 clients by clearly outlining the population served, the limitations on recruiting additional clients, and the lack of other geographic or culturally-appropriate provider. Applicants must also identify how they will coordinate with other external clinical providers (i.e., private practice medical providers, mental health providers, or substance use) that will increase the workload of a treatment coordinator at that specific clinic. Agencies applying for funding for a treatment coordinator position must be able to bill for Medicaid and Medicare eligible expenses (i.e. if direct treatment adherence assessments are done with clients.) The responsibilities of a treatment coordinator include, but are not limited to:

- Have little if any direct client contact, but work in a team with 5-10 case managers (based either at the clinic or in the community).
- Review client medical records and charts based on outline HRSA performance indicators and in accordance with Public Health Service Guidelines.
- Track client appointment adherence at the clinic.
- Complete the Medical Assessment form at least every six months for all case managed clients at the clinic (for medical and supportive services case managers).
- Communicate with case managers to create and sustain service plans that address treatment issues. Priority will be given to issues facing newly diagnosed clients entering medical case management.
- At a minimum, conduct monthly case conferencing with medical case managers.
- Communicate medication and treatment adherence issues identified by the medical case manager back to the clinician. Priority is given to addressing issues for clients who are newly diagnosed with HIV.
- Input data into the client-level database.
- Build relationships with private practice medical providers who are providing clinical treatment to case managed clients and assist in facilitating communication between providers and case managers.

*Qualifications:* Treatment coordinators must be trained professionals and have at least an RN, NP, PA, LCSW, LCPC, MSW or MPH. Exceptions will be made to the degree requirement on a case-by-case basis. Regardless of the degree, **all** treatment coordinators must have a minimum of three to five years experience working in a clinical setting with experience reviewing medical records (electronic or conventional). Candidates with experience in an HIV-specific clinical setting and/or a thorough understanding of Public Health Service (PHS) guidelines are preferred.

*Meetings and Training:* All treatment coordinator agencies must attend and participate in all Contract Administrator meetings convened by AFC.

Treatment coordinators are required to complete the Case Management Competencies training with a passing grade as determined by the Case Management Training Policy. Any treatment coordinator who fails the curriculum may have one other attempt at the training. If a treatment coordinator has been certified through the Competencies training and is re-hired after an absence from the Cooperative of greater than two years, he/she must repeat the entire training. In addition, all treatment coordinators must attend at least 6 trainings during the contract year, with one of those trainings being the MATEC Treatment Adherence Training.

**VIII. Technical Reporting and Other Requirements**

All treatment coordinator agencies will be required to submit monthly program reports, voucher on a monthly basis, provide monthly service utilization data (either through export to Excel or web-based data entry), and participate in all AFC-sponsored training and technical assistance events. In addition, agencies must be Medicaid certified (if applicable) and document that Ryan White is the payer of last resort.

AFC’s client-level data system runs on workstations using Internet Explorer 5.5 or higher. Adobe Acrobat Reader is required to print Crystal Reports to your local printer (Available free from Adobe). Content transmission/communication between the workstation and the web servers is performed using SSL “Secure Socket Layer.” This ensures proper authentication and encrypted data transmission providing a “Secure” application environment for sensitive client data. This is the same technology that is used to secure Credit Card transactions over the Internet.

Given these specifications, agencies will be required to collect, manage, and submit client-level data and demonstrate the following minimum information system capacity at all non-mobile sites:

Description	Minimum	Optimum
User PC	Pentium 100mhz	Pentium III 600mhz+
Memory	64 MB (12 MB free when other apps open)	128 MB+ (24 MB+ free when other apps open)
Free Disk Space	10 MB	10 MB+
Windows Versions	Windows 98 with updated TCP/IP and Winsock	Windows 2000 or Windows XP
Networking	TCP/IP	TCP/IP
Software (free)	Internet Explorer 5.5, Adobe Acrobat Reader	Internet Explorer 5.5, Adobe Acrobat Reader
Internet Connection	56KB Modem (Dial-up)	High Speed – DSL, T1 or Cable

## IX. Instructions for Completing the Program Narrative

**Format Instructions** Follow these instructions in completing your narrative:

- Narrative should not exceed 10 pages in length (not including cover page or attachments);
- Use at least 1.5 line spacing and at least 11-point font size (charts not smaller than 10-point font);
- Have margins of at least ¾ inch on all sides;
- Include a table of contents reflecting major categories and corresponding page numbers;
- Attach only supporting documentation requested or directly related to narrative;
- Sequentially number the entire narrative including all the attachments;
- Do not submit any bound documents (rubber bands or binder clips are acceptable); and
- Narrative should be on 8 ½“ x 11” paper. Do not submit brochures, DVDs, or videotapes.

A. Program Narrative - A narrative of no more than **10** double-spaced pages addressing the following (page allotment is for narrative only; it does not include the financial and supportive attachments outlined below):

1. Define briefly the agency’s mission, history, and the proposed program’s target population (including the number of people living with HIV who received clinical care in the past year), service area and service setting and provide basis for your choices. Describe the array of clinical services available at this agency.
2. Define the proposing agency’s ability to adapt the revised standard operating procedures to implement the new treatment coordinator program. Include a program plan for recruiting working with case managers to identify clients who require assistance with adhering to medical care and treatment adherence.
3. Describe the mechanisms that will ensure coordination of services between the clinic-based treatment coordinator and case managers. Be sure to address not only how case managers at your agency will interact with the treatment coordinator, but also how the treatment coordinator will communicate and coordinate with case managers from other agencies (especially regarding client data sharing and service planning.)
4. Describe the agency’s ability to monitor client treatment and medication adherence, as well as work with AFC and the identified evaluator(s) to collect the necessary evaluation data assessing the program process and ability to stabilize or increase medical outcomes.
5. Describe the agency’s ability to operate on a reimbursement basis, to provide services before reimbursement is provided, and maintain accountability for Ryan White Act funds.
6. Describe the agency’s current ability to track clinical indicators through direct data entry into AFC’s client-level data system or other existing client-level tracking systems, if any, utilized at the agency.
7. Describe the proposed staffing structure for the program, including whether or not the program will require hiring additional staff or will utilize current staff or contractors. If your agency plans to hire additional staff, please describe the hiring process and how you will be able to expedite the process.
8. Describe the clinical and administrative supervision structure for the treatment coordinator.
9. Describe the agency’s quality management plan and document that that services are consistent professional, clinical, and professional guidelines for best practice. Describe the agency’s system for collecting and analyzing client-level data for the purposes of program improvement. Describe recent quality management/improvement efforts and any implemented changes as a result of quality management/improvement efforts. Describe use of professional development/corrective action plans if applicable.

B. Financial Documents

1. A line item program budget together with a brief budget narrative explaining each line item, including a personnel justification (please see Appendix D.)
2. An applicant’s most recent audited financial statements. \* **(Please note: To be submitted only if you are not a currently-funded in the Northeastern Illinois Case Management Cooperative.)**
3. An applicant’s most recent year-to-date agency summary financial statement. \* **(Please note: To be submitted only if you are not a currently-funded in the Northeastern Illinois Case Management Cooperative.)**

C. Supporting Materials

1. The attached AFC proposal cover sheet and completed proposal checklist as the top two pages of each of the six (6) copies of the submission;
2. A copy of applicant's 501(c)(3) letter of determination from the Internal Revenue Service;
3. Resumes of current employees who will be assigned to the proposed project;
4. Program and/or job descriptions including supervision structure. For positions that will need to be hired, include an explanation of expedited hiring process and proposed orientation plan.
5. Memoranda of Agreement Matrix (see Appendix G);
6. Memoranda of Agreement – Included in this must be individualized agreements or a plan to addressing priorities for developing agreements for principle agencies you work will with, especially with regards to case management collaborations. Identified priorities should be based on core clinical services, defined by HRSA, and number of clients seen by agency. Agreements should address the following factors that include but are not limited to:
  - o The services(s) to be provided, the number of participants to be served, the period in which the services(s) will be provided, and, if known, the monetary value of the services;
  - o Specific, identified contact staff for both agencies, including the extent of the authority and responsibility both will take in the collaboration;
  - o Mechanisms for referral and referral tracking; and
  - o Mechanisms for service coordination (i.e. case conferencing) and of data sharing.
7. Agency Quality Management Plan.

X. **Review Criteria and Scoring**

Proposals for treatment coordinator services will be reviewed and scored by an independent review panel comprised of community members. This independent review panel will evaluate the application based on set scoring criteria. Reviewers will consider the completeness and clarity of the responses to each individual section. Reviewers will consider the content as it responds to the expectations outlined in the individual sections of the “Federal and Local Priorities” and “Funding Requirements” as noted on pages 5-8. **A proposal can be scored on a range of 0 being the lowest and 100 being the highest, with the following maximum point spread:**

Agency Background	5 points
Program Work Plan	35 points
Coordination of Services with Case Management	35 points
Established Memoranda of Agreement	15 points
Quality Management and Program Evaluation	5 points
Ability to Track Client-Level Clinical Indicators	5 points
<b>Total</b>	<b>100 points maximum</b>

Priority consideration will be given to agencies who can assure a coordination of services with other case management and clinical service providers. AFC will also ensure that treatment coordinator services are accessible throughout the EMA and reserves the right to prioritize agencies that reach underserved populations in highly impacted communities.

**XI. Contact Information and Submission Requirements**

**One original and six (6) copies of the proposal must be received at the AIDS Foundation of Chicago office before 4:00 p.m., Thursday, April 10, 2008.** The original must be marked “original” and signed in blue ink and all copies must be marked “copies.”

Any programmatic questions regarding this narrative should be referred to:

**Cheryl Potts  
AIDS Foundation of Chicago  
411 South Wells, Suite 300  
Chicago, IL 60607  
312/922-2322 x 509**

**ABSOLUTELY NO APPLICATIONS ARRIVING LATER THAN 4:00 PM APRIL 10, 2008  
WILL BE ACCEPTED OR CONSIDERED FOR FUNDING.**

Thank you for your interest in applying for treatment coordinator services. Please feel free to contact AFC with any questions you may have.

Appendix A

# AIDS Foundation OF CHICAGO

## INTENT TO APPLY FOR TREATMENT COORDINATOR SERVICES Northeastern Illinois HIV/AIDS Case Management Cooperative

If, after reviewing the accompanying Request For Proposals (RFP) you have determined that your organization is eligible to apply for funding and that you will submit the required application for qualifications requesting funding, please notify AFC of your intent before:

**Friday, March 21, 2008 at 4 p.m.**

Filing of this notification of intent to apply is **required** in order to ensure that there will be an adequate number of review panels to evaluate the submission and make funding recommendations. Complete this page and **fax** or mail it to:

**Cheryl Potts  
AIDS Foundation of Chicago  
411 South Wells, Suite 300  
Chicago, IL 60607  
(FAX) 312/922-2916**

Agency Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Phone#: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Contact Fax #: \_\_\_\_\_

Estimated Amount of Request:      \$ \_\_\_\_\_ / # of FTEs \_\_\_\_\_ Treatment Coordinators

**Please note: Agencies must submit this Intent to Apply form to be considered for funding. The submission of this Intent to Apply form is not a guarantee of funding, nor does it require the agency to in turn submit a proposal.**

**Appendix B**

**Northeastern Illinois HIV/AIDS Case Management Cooperative  
Application for Treatment Coordinator Services**

**Application Cover Sheet**

**1. Agency Information:**

Agency Name: \_\_\_\_\_ Tax ID # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Person to Contact Regarding this Application \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ e-mail \_\_\_\_\_

Current funding source(s) (check all that apply)

RW Part A \_\_\_\_\_ RW Part B \_\_\_\_\_ DRS \_\_\_\_\_ Other RW (specify) \_\_\_\_\_

HOPWA \_\_\_\_\_ HUD \_\_\_\_\_ AFC \_\_\_\_\_ Other (specify) \_\_\_\_\_

**2. Program Description:**

Treatment Coordinators \_\_\_\_\_ #FTE

**Target Population/Community Area:**

**Projected Number of People Served:**

**Proposed Staffing Summary (include staff positions and names, if able):**

**3. Requested Amount:** \_\_\_\_\_

**Name of Executive Director** \_\_\_\_\_

**Executive Director Signature** \_\_\_\_\_

## Appendix C

Attach to your proposal as page 2

### Eligibility

Is your agency:

- |    |  |           |          |
|----|--|-----------|----------|
| 1. | Ryan White eligible agency                                 | Yes _____ | No _____ |
| 2. | Technically able to operate AFC's client-level data system | Yes _____ | No _____ |
| 3. | A 501(c)3 not-for-profit agency                            | Yes _____ | No _____ |
- Tax Id Number (EIN): \_\_\_\_\_

### Proposal Check List

- |     |   |       |
|-----|---|-------|
| 3.  | Program Narrative                                   | _____ |
| 4.  | Line Item Program Budget                            | _____ |
| 5.  | Budget Narrative                                    | _____ |
| 6.  | Most Recent Audit *                                 | _____ |
| 7.  | Most Recent Agency Financial Statement*             | _____ |
| 8.  | Memoranda of Agreement (both Matrix and agreements) | _____ |
| 9.  | 501(c)(3) Letter                                    | _____ |
| 10. | Project Workplan/Timetable                          | _____ |
| 11. | Staff Resumes                                       | _____ |
| 12. | Job Descriptions                                    | _____ |
| 13. | Quality Management Plan                             | _____ |

**PLEASE BE SURE YOU SUBMIT ONE ORIGINAL AND FIVE (5) COPIES OF THE PROPOSAL AND ALL ATTACHMENTS.**

\* Please note: To be submitted only if you are not a currently-funded Northeastern Illinois Case Management Cooperative agency.)

## Appendix D

### Budget Forms and Instructions

This budget section provides the format for the required *12-month* line item budget and budget narrative explaining how each line item will be expended. Funded agencies will receive reimbursement for services on a monthly basis. **Attach the Budget Form to your proposal with your Budget Justification.** Funds may be requested to support the following costs:

- Program staff salaries and fringe benefits;
  - Treatment coordinator salaries are to be determined by individual agencies depending on experience and qualifications;
  - Fringe Benefits will be supported 100% if possible. Annual increases in either salaries or fringe rates will be dependent on annual funding levels;
- Local travel for staff, reimbursed at the agency's rate, for travel to local training activities and case manage case conferencing, is generally estimated at \$100/FTE for Chicago agencies, and \$150/FTE for non-Chicago providers;
- Up to 5% of the total salary, fringe, and travel may be requested in operating costs and other program-specific expenses (e.g., rent, utilities, insurance.)

NOTE: It is a legislative requirement, as defined through Ryan White, that funds may not be used to make direct payments to recipients of services. Funds may not be used to make payment for any item or service if payment has already been made or can reasonably be expected to be made under any State compensation program, any insurance policy or any Federal or State health benefits program or by an entity that provides health services on a pre-paid basis. (42USC 300ff-15(a)(6)). Funds may not be used to supplant third-party reimbursement.

The budget form, found on the following page must be completed. There are no page limits for the budget forms. In addition, a detailed budget justification must also be completed.

**[AGENCY NAME]**  
**AIDS Foundation of Chicago Treatment Coordinator**  
**Annual (12-month) Proposed Budget**

*Please prepare the following budget based on a 12-month award. Please note that initial contracts will begin August 1, 2008 and will run for a partial year. AFC will establish this partial contract and the subsequent 12-month contracts (if applicable) generated from 2009-2010 and 2010-2011 based on this proposed budget.*

**1. PROGRAM PERSONNEL AND FRINGE BENEFITS**

<b>Name and Title</b>	<b>Annual Salary</b>	<b>% Time On Project</b>	<b>Salary Requested</b>
	\$	%	\$
	\$	%	\$
<b>Total Salaries</b>			<b>\$</b>
Fringe Benefits (___ % of salaries)			\$
<b>Total Personnel Costs</b>			<b>\$</b>

**2. TRAVEL**

Local Travel for Case Manager (\$100 for Chicago x ___ FTE) (\$150 for Suburban Cook/Collar Co. x ___ FTE)	\$
<b>Total Travel</b>	<b>\$</b>

**3. PROGRAMMATIC OPERATING COSTS**

Programmatic Operating Costs @ 5% of total personnel and travel	\$
<b>Total Programmatic Operating Costs</b>	<b>\$</b>
<b>TOTAL BUDGET</b>	<b>\$</b>

**Sample Agency XYZ**  
**AIDS Foundation of Chicago Treatment Coordinator**  
**Annual (12-month) Proposed Budget**

*Please prepare the following budget based on a 12-month award. Please note that initial contracts will begin August 1, 2008 and will run for a partial year. AFC will establish this partial contract and the subsequent 12-month contracts (where applicable) generated from 2009-2010 and 2010-2011 based on this proposed budget.*

**1. PROGRAM PERSONNEL AND FRINGE BENEFITS**

<b>Name and Title</b>	<b>Annual Salary</b>	<b>% Time On Project</b>	<b>Salary Requested</b>
Joe Smith, Treatment Coordinator	\$60,000	100%	\$ 60,000
Jane Jones, Supervisor	\$80,000	25%	\$ 20,000
<b>Total Salaries</b>			<b>\$ 80,000</b>
Fringe Benefits (20% of salaries)			\$ 16,000
<b>Total Personnel Costs</b>			<b>\$ 96,000</b>

**2. TRAVEL**

Local Travel for Case Manager (\$100 for Chicago x 1 FTE)	\$ 100
(\$150 for Suburban Cook/Collar Co. x 0 FTE)	\$ 0
<b>Total Travel</b>	<b>\$ 100</b>

**3. PROGRAMMATIC OPERATING COSTS**

Programmatic Operating Costs @ 5%	\$ 4,805
<b>Total Programmatic Operating Costs</b>	<b>\$ 4,805</b>

**TOTAL BUDGET** **\$100,905**

## Appendix E

# AIDS Foundation OF CHICAGO

### Bidders' Conference Announcement

The AIDS Foundation of Chicago is announcing that funds will be available for 2008-2009 under a Request for Proposals (RFP) to provide treatment coordinator services to support the Northeastern Illinois Case Management Cooperative. Approximately \$600,000 will be available starting August 1, 2008 for treatment coordinator services. Treatment coordinators will be the newest component of the case management continuum. Treatment coordinators will have limited direct contact with clients, but will provide the necessary communication between clinical providers and case managers regarding clients' access and adherence to medication and treatment adherence. Treatment coordinators will be based at health care clinics and will be responsible for reviewing client charts for necessary medical indicators. Treatment coordinators will be responsible for communicating these clinical indicators to case managers in an effort to create a comprehensive service plan that includes coordination and follow up. Coordinators will be responsible for staffing case conferences, completing medical assessment forms, and updating health indicators in the client-level database.

The RFP will be released on February 29, 2008 and will be mailed to all currently funded ambulatory outpatient care grantees, all Chicago Department of Public Health Part A applicants, and all member agencies of the Service Providers Council (SPC). If you would like to request a copy of the RFP, please contact:

**Cheryl Potts**  
**AIDS Foundation of Chicago**  
**411 South Wells, Suite 300**  
**Chicago, IL 60607**  
**312/922-2322 ext. 470 or [cpotts@aidschicago.org](mailto:cpotts@aidschicago.org)**

**All agencies interested in providing treatment coordinator services must submit an application.** Agencies may submit only one proposal in response to the RFP. Eligible agencies may submit both an application in response to this RFP as well as a proposal in response to the Request for Proposals for Case Management Services issued on February 29, 2008. Details of the requirements for submitting a proposal are listed in the RFP.

**Proposals must be received at the AIDS Foundation of Chicago office before 4:00 p.m., Thursday, April 10, 2008.** The deadline is strictly enforced, and no exceptions will be granted for any reason. Proposals delivered after 4:00 p.m. will not be accepted or reviewed. **In addition, only organizations that submit an intent to apply are eligible to apply (please see RFP for intent to apply form).**

One Bidders' Conference has been scheduled for this RFP. **Attendance at a Bidders' Conference is not mandatory, but in order to ensure space you are strongly encouraged to contact AFC at 312/922-2322 ext. 509 to pre-register.**

**Thursday, March 20, 2008    9:30 a.m. – 12:00 p.m.    AIDS Foundation of Chicago, 411 South Wells**

A complete list of questions and answers will be posted on AFC's website after the Bidders' Conference. In addition to the scheduled Bidder's Conference, AFC will also post the materials from the conferences on-line for those who are unable to attend.

**Appendix F**

**Program Workplan Template  
Fiscal Year 2008-2009**

**Agency:** \_\_\_\_\_

**Program Contact:** \_\_\_\_\_

*Please use additional sheets as necessary*

<b>Goal A:</b>			
<b>Objective</b>	<b>Target Date</b>	<b>Lead</b>	<b>Status</b>
A.1.			
A.2.			
A.3.			
<b>Goal B:</b>			
<b>Objective</b>	<b>Target Date</b>	<b>Lead</b>	<b>Status</b>
B.1.			
B.2.			
B.3.			

**Appendix G**

**Memoranda of Agreement Matrix  
Fiscal Year 2008-2009**

**Agency:** \_\_\_\_\_

**Program Contact:** \_\_\_\_\_

*Please use additional sheets as necessary*

<b>Collaborating Agency</b>	<b>Services Coordinated</b>	<b>Case Management Agency</b>	<b>Lead Staff</b>	<b>Priority Areas Addressed</b>

## Northeastern Illinois HIV/AIDS Case Management Program Design

### Purpose

In an effort to address environmental factors, to retain what works in the current case management system, and to better coordinate treatment for clients to ensure appropriate access to and utilization of clinical services, AFC is implementing a reconfigured case management continuum, which will expand the capacity of the system to serve more clients, stabilize or improve client health indicators, and improve adherence to appointments and medication, among other outcomes.

### Guiding Principles

#### Retaining what works in the Current System:

- **Continuum of case management** without disruption of services. By coordinating more than ten different case management programs, AFC is able to transition clients between programs based on need without a disruption in services. In many instances, clients are able to retain services at the same agency, and sometimes with the same case manager, throughout changes in their level of need.
- **One client to one case manager.** This guaranteed ability to ensure non-duplication of services maximizes the services to the community and ensures consistent monitoring of care. This is key to ensuring adequate capacity in the system.
- **Commitment to geographic parity.** Nearly 22% of case management services are located in the Collar Counties. In addition, the Cook County-funded case management agencies are located in geographically diverse areas to ensure access to services. This also ensures that we can provide accessible, culturally appropriate services.
- **Commitment to a community-based model** that relies on coordination with clinical staff, but does not require case managers to be clinicians. The rationale for this is that the interventions will be the basis for stabilizing and improving health outcomes, not the individual case managers. The system, by virtue of the structure and training capacity, will support paraprofessionals and professionals alike in the provision of services. The system neither needs nor can afford a model based solely on licensed mid-level clinicians
- **Commitment to address all health issues of clients in a holistic way,** including psychosocial challenges and cultural diversity matters through a well-trained system of case managers.
- **The highest quality centralized data management.** By enabling all case managers to have direct data entry into a centralized system that maintains exceptional quality assurance mechanisms, AFC can ensure timely and accurate reporting on services. To expand on this current strength of the system, AFC will be implementing a new database system that will allow for much more comprehensive capturing and analysis of important health information for each client. Ideally, this new system can be used to capture comprehensive service utilization and health outcomes data across the entire system.
- **Ongoing provision of professional training and development opportunities.** AFC currently provides over 80 training opportunities a year for all the case managers in the system. The training program brings in leading local experts in a variety of clinical and social topics that greatly impact the work of the case managers. This already intensive training model will be

expanded to include a competencies curriculum that will test and ensure that each and every case manager in the system has a minimum level of skill and knowledge that will assist them in providing high quality case management services.

### **Proposed changes to the System:**

- Move away from emergency responsive case management that has as a principal focus on the social needs of clients, and move towards a **chronic disease management model** that emphasizes the integration of the client's clinical service plans with case management activities. This model will have an emphasis on outcome measures at the client, agency, and systems levels.
- A specific emphasis on **treatment coordination** that has the goal of establishing and ensuring ongoing access to a medical home for each and every case managed client. The foundation for treatment coordination will be built on systematic communication between clinical providers and case managers with the purpose of coordinating service plans and tracking referrals. This will require that providers serving people with HIV, across all levels and across all funding streams, participate in open and ongoing dialogue that advances the services plans for all shared clients.
- Determining if newly diagnosed clients should be enrolled in an **early intervention program** with a period of intensive or medical case management to connect them immediately to clinical services and support adherent behavior early in their treatment. (ARTAS/ARTAS II projects)
- Establish a **medical model of case management** as opposed to the current social service model. By this, we mean that clients will no longer be the sole drivers of the service plan, but must be willing to participate in monitoring Public Health Standards (PHS) and HRSA guidelines. All services, whether clinical or supportive, will be provided or accessed through case management with the purpose of increasing or stabilizing the client's health outcomes.
- Re-define the goal of case management to not only establish client stability, but ultimately **self management in their HIV care** and other chronic medical conditions. This will require significant emphasis on client education from initial intake into case management and through ongoing, client education regarding self care.

### **Roles**

The newly redesigned case management continuum will be staffed by three main positions: medical case managers, supportive services case managers, and treatment coordinators. These positions are in addition to the pre-existing and unchanging intensive case management models. Medical case managers will provide a range of client-centered services that link clients with health care, clinical, psychosocial, and supportive services for clients living with HIV who are identified as having challenges with accessing and maintaining adherence to health care services. The coordination and follow-up of medical treatments is a key component of medical case management. Medical case managers will ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, collateral contact.

Supportive services case managers will provide advice and assistance in obtaining medical, social, community, legal, financial, and other needed supportive services to clients living with HIV who are identified as being stable in their clinical care. Supportive services case management does not involve coordination and follow-up of medical treatments, as medical case management does. However, brief reassessments and ongoing reporting of basic health indicators will be a part of supportive services case management to ensure ongoing client stability in clinical services. Supportive services case management includes all types of activities including face-to-face, phone contact, and collateral contact.

Treatment coordinators will be the newest component of the case management continuum. Treatment coordinators will have no direct contact with clients, but will provide the necessary communication between clinical providers and case managers regarding clients' access and adherence to medication and treatment adherence. Treatment coordinators will be based at health care clinics and will be responsible for reviewing client charts for necessary medical indicators. Treatment coordinators will be responsible for communicating these clinical indicators to case managers in an effort to create a comprehensive service plan that include treatment coordination and follow up. Treatment coordinators will be responsible for staffing case conferences, completing medical assessment forms, and updating health indicators in the client-level database.

The following are the titles and roles of the proposed major constituents of the case management system. Neither these positions nor their corresponding roles are meant to be exhaustive in any way, but are to provide clarity in boundaries between positions and provide a foundation of activities.

#### Treatment Coordinators

- Based at major HIV health clinics that provide clinical services to clients living with HIV throughout the EMA.
- Have little if any direct client contact, but will be working in a team with 5-10 case managers (based either at the clinic or in the community).
- Must be trained professionals and have at least an RN, NP, PA, LCSW, LCPC, MSW or MPH. Exceptions will be made to the degree basis on a case-by-case basis. All treatment coordinators must also have a minimum of three to five years experience working in a clinical setting with experience reviewing medical records (electronic or conventional).
- Review client medical records and charts based on outline HRSA performance indicators and in accordance with Public Health Service Guidelines.
- Track client appointment adherence at the clinic.
- Complete the Medical Assessment form for all case managed clients at the clinic.
- Input data into the client-level database.
- Communicate with medical case managers to create and sustain service plans that address treatment issues. May include case conferences with the medical case managers.
- Establish mechanisms for communicating with case managers, such as conducting monthly case conferencing with case managers.
- Communicate medication and treatment adherence issues identified by the medical case manager back to the clinician.
- Identify clients who have fallen out of care and communicate this to the case managers.
- Build relationships with private practice doctors who are providing clinical treatment to case managed clients and assist in facilitating communication between providers and case managers.
- Be employed by and receive ongoing clinical supervision from clinic but also be accountable to program staff at AFC for policies and procedures of the Coop.

## Medical Case Managers

- Based at community based organizations, clinics, health departments, and hospitals.
- Caseloads of 25-35 clients.
- Relate to the assigned treatment coordinator to help determine client's need for ongoing treatment coordination. Case managers receive clinical supervision from on-site case management supervisor and ongoing coordination from AFC program staff.
- Conduct initial and ongoing intake and acuity assessments, medication and treatment adherence assessments, and medical assessment, in addition to maintaining appropriate documentation of eligibility for the system.
- Develop service plans with clients that integrate medication and treatment adherence into services.
- Participate in case conferencing or other coordinated communication mechanism with treatment coordinators in an effort to develop appropriate service plans.
- Provide referral and linkages to necessary services, with a specific emphasis on clinical core services and access to medical and income benefit programs.
- Track to ensure that all made referrals have been completed by the client.
- Develop client personal and medical support systems.
- Provide basic counseling and education to clients regarding HIV treatment, with specific emphasis on developing the client's advocacy skills to self-advocate and participate in their treatment plan.
- Monitor treatment and medication adherence for all clinical services.
- Assess clients for basic treatment readiness and refer to appropriate treatment specialist.
- Input all data into the client-level database.
- Communicate all areas of concern and noncompliance with treatment regimens to the appropriate treatment coordinator and/or clinician.
- Assist in stabilizing the social factors that cause noncompliance with treatment regimens.
- Follow up on clients who have been identified by the clinical provider or treatment coordinator as those clients who have been "lost to care".

## Support Services Case Managers

- Based at community-based organizations, clinics, health departments, and hospitals.
- Caseloads of 75-100 clients
- Conduct initial and ongoing intake, acuity assessments and medical indicators assessments, in addition to maintaining appropriate documentation of eligibility for the system.
- Develop service plans that are based upon the Social Determinants of Health acuity score that focus on access to supportive services only.
- Provide referral and linkages to necessary supportive services.
- Develop client personal support systems.

## **Requirements of the System**

The following elements will be required for any agency applying for funding under the new model:

- All agencies funded for treatment coordination, medical case management, and/or supportive services case management must demonstrate collaborative agreements with other partner case management and clinical service agencies. Collaborative agreement must be specific and tailored to each site. Standardized, generic Memorandums of Understanding will not be accepted.

- Treatment coordinators must be located at clinics (or a network of clinics) providing medical or other clinical services clients living with HIV who have been seen at least once within the past calendar year.
- Agencies applying for funding for a treatment coordinator position must be able to bill for Medicaid and Medicare eligible expenses (i.e. treatment adherence assessment.)
- AFC will fund a minimum case management team comprised of 2 FTE case managers and .25 case manager supervisor. AFC will not fund stand-alone FTEs in any given organization. *Part C and D funded case managers can be proposed to meet the minimum case management team requirements. However, the proposed Part C and D case managers must adhere to all of the policies and procedures for case managers as outlined in the Standard Operating Procedures for the Northeastern Illinois Case Management Cooperative.*
- Case management teams must provide at least two levels of case management (intensive, medical, and/or supportive services) at their site. For ease of client transition, it is strongly recommended that if an agency only provides two levels of case management, that they be consecutive among the continuum of case management (for example, medical and supportive services case management, but not intensive and supportive services case management.)
- Individual case managers can provide two levels of case management, such as intensive and medical case management. Again, for ease of client transition, it is strongly recommended that if this occurs, that the levels be consecutive among the continuum of case management.
- Treatment coordinators, medical case managers, and supervisors are required to complete the Case Management Competencies training with a passing grade as determined by the Case Management Competencies Training Policy. Any case manager who fails the curriculum may be able to provide supportive services case management, but will not be reimbursed as a medical case manager. Agencies will be required to submit Individual Professional Development Plans for case managers who fail all or portions of the Competencies Training.
- All case managers must attend at least 12 trainings during the contract year, with one of those trainings being the MATEC Treatment Adherence training. All supervisors will be required to attend at least one training during the contract year in addition to six Contract Administrators meetings.
- All case managers will be required to enter complete and accurate data into the client-level database on a timely basis.

## Activities

- Screening – Done by AFC at initial referral. Basic screening for eligibility and to determine general access to care by client. Referral to appropriate case management agency (and level) made by AFC staff.
- Intake/Reassessment – Done by case manager at intake and again at least every six months or when there is a significant change in the client’s circumstances. Gathers eligibility documentation and demographic information. Also gathers clinical information that can be tracked longitudinally (i.e. medical providers and health insurance). Also provides a baseline to begin developing the service plan, administering the acuity scale, and identifying red-flags for further clinical referral. Necessary consents and ROI’s signed.
- Acuity scale – Administered by the case manager at intake and six-month assessment. The acuity scale is broken into two sections: Clinical Indicators and Social Determinants of Health. The Clinical Indicators section will determine which level of case management (medical or supportive services) the client will be assigned to. The Clinical Indicators section will be the

driving force behind the service plan and will allow case managers to focus on the necessary treatment coordination needed. The Social Determinants of Health section will measure a client's needs in the supportive services areas that include housing, transportation, legal services, etc. This section will also contribute to the acuity score of a client to determine the level of need within the already assigned level of case management. These needs will also be captured in the service plan for each client.

- Medical Assessment – Administered by the case manager and intake and every six months following. In August 2008, this will be completed by the treatment coordinator and returned to the case manager. Until this time, case managers must get these completed and returned from the client's primary medical care provider. This activity helps to capture ongoing clinical indicators for clients including the CD4 and Viral Load. It is also used to determine a client's level of disability due to HIV, which in turn can make them eligible for programs including HAP and EFA.
- Service Planning – Case manager creates and review based on the client-level database generated minimum service plan based on the acuity scale. Emphasizes clinical goals and objectives.
- Referrals/Follow-up – Case manager conducts based on the service plan. Agencies must develop mechanisms that can be used between case manager, treatment coordinators, and other clinical providers to determine if referrals are actualized.
- Documentation – Case manager documents in client chart and Treatment Coordinator documents in the medical record. Both document in the client-level database.
- Client education – Done at initial intake by case manager and ongoing as needed.

## **Outcome Measures**

The following are recommended outcomes that can be measured through the newly re-tooled case management system. These outcomes are broken into two categories: health outcomes and social determinants of health outcomes. Unlike other chronic diseases, HIV care and treatment are known to be complicated by complex social and environmental factors. Given this, it is necessary to track both categories of outcomes to ensure the overarching goal of moving clients towards self-management.

These outcomes are draft outcomes based on HRSA recommended ambulatory care performance indicators, currently tracked case management indicators, and currently tracked supportive housing program measure. These are broad areas that require additional specificity regarding the measures for the outcomes, the baseline/benchmarks for each area, and the methods for tracking. These are the minimum measures and are not to be confused with best practices.

### **Health Outcomes:**

- Medical visit at least every 6 months
- Clinical appointment adherence
- CD4/Viral Load test at least every 6 months
- PCP for CD4+ <200
- Clients prescribed/adherent to HAART
- Pregnant women with HIV on ARV
- Oral exam every 12 months
- Competed Hepatitis A/B vaccination series
- Hepatitis C screen (when? At dx or every year?)
- PAP at least every 12 months

- TB screening since HIV diagnosis
- Syphilis test at least every 12 months
- Adherence counseling (HRSA recommends every 6 months)
- Lipid screen every 12 months for patients on HAART
- HIV+ risk reduction counseling every 12 months

**Social Determinants of Health:**

- Housing stability
- Income stability
- Health care benefits
- Legal stability
- Basic living needs and activities of daily living
- Transportation stability

**Outputs:**

- Number of client contacts
- Progress on client service plan
- Client access to transportation/EFA/etc.

## Appendix I

### DRAFT EXHIBIT A Ryan White Agreement

1. Employ # FTE case managers to provide comprehensive case management services to HIV+ individuals.
2. Comprehensive case management is defined to mean a standardized process of client-centered assessment, medical treatment coordination, medication adherence and readiness assessments, case planning, service coordination, referral, advocacy, and follow-up through which the multiple medical and other service needs of persons affected by HIV disease are met. The Subcontractor agrees to provide comprehensive case management in accord with the Standard Operating Procedures of the Northeastern Illinois HIV/AIDS Case Management Cooperative, an unincorporated collective of service providers formed and affiliated through the Service Providers Council of the AFC.

At a minimum, the Subcontractor's case management policies, procedures, and practices must include the following:

- a. Promoting the availability of case management services in the Subcontractor's service area and/or to its special population;
- b. Eligibility verification, including initial medical verification and ongoing medical coordination and assessment to determine eligibility;
  - c. *Determination of client acuity score at intake and every six months thereafter, documenting the appropriate ongoing frequency and type of contact;*
- d. Case Management intake and related assessments;
- e. Service planning: which is defined as the development and mutual agreement to a goal-oriented standardized instrument derived from client assessments, including the Case Management Cooperative Acuity Scale, and medical treatment and medication adherence assessments. This service planning tool must include: client name, area of need clearly identified, ranking order of needs, goal steps for the clients and case managers identified separately, target dates, client and case manager's signatures, deadline for review of the plan (to be no less than every six months);
- f. Client care monitoring that addresses all goal identified in Part e above, that is reported through Direct Data Entry by the subcontractor;
- g. Clinical and administrative supervision, including regular reviews of case manager charts (with no less than 100% of case manager charts reviewed on a yearly basis), and **a minimum of four hours of case management supervision per month**. Supervision may be provided in individual or group settings. Supervision will address client care and case manager job performance and skill development. Supervision that includes a review of client files must be available for review at the Administrative Review during the annual agency site visit. The description of the supervision session must be documented in either separate files or the client record and be made available at utilization review;
- h. Reassessment and revision of service planning, including the implementation of new assessments to be completed a minimum of once with each client during this contract year;
- i. Confidentiality and release of client information, with the Client Consent to Enroll to be completed and electronically documented in Factors for every active case management client during this contract year;

- j. Documentation and recordkeeping, both in the client-level database and in client charts;
- k. Client rights and responsibilities; and
- l. Quality assurance and quality improvement activities, to include but not limited to written responses to all data reports extracted from the client-level database that demonstrate an agencies ability, or lack thereof, to report case management activities electronically.

AFC shall provide the Subcontractor with a current copy of the Standard Operating Procedures of the Northeastern Illinois HIV/AIDS Case Management Cooperative upon request from the Subcontractor. The Subcontractor shall provide AFC with a copy of its case management policies and procedures within sixty (60) days of the execution of this Agreement, or upon request from AFC. If requested by the Subcontractor, AFC program staff shall be available to provide technical assistance to the Subcontractor for the development or revision of the Case Management Policies and Procedures.

- 3. Upon giving written consent to receive case management services, each individual client served by the Subcontractor shall receive a written statement of client rights and responsibilities. The written statement must include the following information: A) what case management services are; B) what the Subcontractor expects from its clients in order for them to receive case management services on an ongoing basis; C) the Subcontractor's client grievance procedure; D) contact names and phone numbers for individuals at the AFC and at the Subcontractor that can assist the client if the client has a complaint; and E) **The Client Grievance Project** for the Case Management Cooperative agencies will be managed by the Center for Conflict Resolution (CCR). CCR provides conciliation and mediation services by a neutral individual to assist the primary parties to discuss and problem solve in hopes of finding resolution. CCR provides an opportunity for clients to choose a confidential process to discuss their concern(s) with the agency in the presence of a mediator to create options and find a mutually-agreeable solution. This service is in addition to the current internal grievance procedure available at individual agencies and clients can choose to access CCR's service at any point in the grievance process. **If a client has a concern about agency services, they may contact CCR through the following toll-free number: 1-866-CARE-212.** The client grievance procedure, the name and phone number of the agency grievance officer, and the Client Grievance Project's phone number will be prominently posted at each agency.
- 4. The Subcontractor agrees to actively participate in the case management quality assurance/improvement program of the Northeastern Illinois HIV/AIDS Case Management Cooperative. AFC agrees to provide the Subcontractor with a copy of all policies and procedures and standardized forms related to this quality assurance/improvement program. If requested by the Subcontractor, AFC program staff will provide technical assistance to the Subcontractor to enable the Subcontractor to implement the quality assurance/improvement program.
- 5. The Subcontractor must attend and participate in all AFC Contract Administrator meetings convened by the Program Director. *Due to the importance of these meetings and their content, attendance will be monitored and may be cause for probationary measures by AFC.*
- 6. The Subcontractor's case manager(s) shall attend and participate in all AFC case manager training meetings convened by the Program Director or its designee deemed required. AFC case manager training meetings shall not exceed a total of 10 hours in any four week period during the contract period except as noted below. *Due to the importance of these meetings and their content, attendance will be monitored and may be cause for probationary measures by AFC.*

7. When the Subcontractor hires a new case manager during the contract period, the Subcontractor will provide AFC with the new case manager's resume in order for the case manager to be added to the Factors database. Medical case managers and case management supervisors are required to complete the Case Management Competencies training with a passing grade as determined by the Case Management Training Policy. Any case manager who fails the curriculum may have one other attempt at the training. After two failed attempts, the case manager will be able to provide support services case management, but will not be reimbursed as a medical case manager. Agencies will be responsible for reassigning and staffing the medical caseload of a case manager who is unable to successfully complete the training. If a case manager has been certified through the Competencies training and is re-hired after an absence from the Cooperative of greater than two years, he/she must repeat the entire training.
  
8. The Subcontractor agrees to provide case management services to clients eligible for the Illinois Division of Rehabilitation Services (DRS) AIDS Medicaid Waiver program when such clients are referred to Subcontractor by the AFC. In order to provide these services, the Subcontractor agrees to employ at least one case manager that has been trained by the DRS AIDS Medicaid Waiver program and is deemed qualified to provide case management services by the DRS program. Further, the Subcontractor agrees to maintain a separate, contractual agreement with the AFC governing the provision of case management services to DRS AIDS Medicaid Waiver clients.
  
9. The Subcontractor shall disclose to AFC the identities and amounts of any and all other sources of grant funding, reimbursement, or other income generated to support the case management position(s) funded through this Agreement. In no event shall the Subcontractor be reimbursed from this Agreement any amount that will result in funding a case management position for more than 100% time. In the event that the case manager(s) funded under this Agreement is/are funded at 100% time and that case manager is also providing case management services under the DRS program, the monthly amount reimbursed under this Agreement will be reduced by \$118.55 per DRS client served by the case manager over the maximum in that given month beginning with March DRS services. Case manager can provide a combination of case management services, with the understanding that a maximum of 100% of the case manager's position can be funded. The maximum number of clients that each case manager may have for which no reduction will be made shall be as follows:

<u>% Funded Through This Agreement</u>	<u>Maximum No. of DRS Clients</u>
100%	5
75%	10
50%	20
25%	30

<u>% MCM Funded Through This Agreement</u>	<u>Maximum No. of MCM Clients</u>
100%	35
75%	25
50%	17
25%	9

<u>% SSCM Funded Through This Agreement</u>	<u>Maximum No. of SSCM Clients</u>
100%	100
75%	75
50%	50
25%	25

10. The Subcontractor shall provide AFC-funded transportation services to its eligible case managed clients in a manner wholly consistent with the Transportation Policies and Procedures of the Northeastern Illinois HIV/AIDS Case Management Cooperative. AFC will provide the Subcontractor with a copy of the Transportation Policies and Procedures and standardized forms related to transportation services. If requested by the Subcontractor, AFC program staff will provide technical assistance to the Subcontractor to enable the Subcontractor to implement these services. Failure to follow AFC Transportation Policies and Procedures shall result in suspension of access to transportation services for Subcontractor’s clients, and could result in reduction of reimbursement for case management services rendered.
  
11. The Subcontractor shall provide AFC-funded emergency client assistance services to eligible case managed clients in a manner wholly consistent with the Emergency Client Assistance Policies and Procedures of the Northeastern Illinois HIV/AIDS Case Management Cooperative. AFC agrees to provide the Subcontractor with a copy of the Emergency Client Assistance Policies and Procedures and standardized forms related to emergency client assistance services. If requested by the Subcontractor, AFC program staff will provide technical assistance to the Subcontractor to enable the Subcontractor to implement these services. Failure to follow AFC Emergency Client Assistance Policies and Procedures shall result in suspension of access to emergency client assistance services for Subcontractor’s clients.
  
12. The Subcontractor agrees to provide client level service information to AFC electronically through participation in Direct Data Entry or through the importing of electronic data. Prior to the commencement of direct data entry at the Subcontract site, the Subcontractor agrees to continue to provide AFC all monthly service reports and intakes and reassessments for clients receiving services under this agreement. Agencies must submit to AFC a STATIC IP address for the purposes of connecting to our software application. Agencies who enter data directly into AFC’s client-level database must meet the minimal technical/workstation/security specifications, which are outlined in the **DIRECT DATA ENTRY PARTNER AGENCY AGREEMENT** provided by AFC.

## Appendix J

### DIRECT DATA ENTRY AND SERVICES AGREEMENT

This Direct Data Entry and Services Agreement (this “Agreement”) is entered into as of \_\_\_\_\_, 2006 (the “Effective Date”) by and between AIDS Foundation of Chicago (“AFC”) and \_\_\_\_\_ (the “Agency”).

#### RECITALS

A. The Northeastern Illinois HIV/AIDS Case Management Cooperative (the “Cooperative”) is a partnership and referral network in the Chicago area comprised of case management providers, linked by central administration and support.

B. The Cooperative’s Governance Committee (the “Governance Committee”) provides leadership to the Cooperative and functions in an advisory capacity to AFC’s staff. The Governance Committee has approved a document entitled Case Management Standard Operating Procedures (the “Standard Operating Procedures”), to which both AFC and the Agency are bound.

C. AFC is the administering agency for the Cooperative, providing case management services.

D. The Agency is a contractor of AFC and provides direct case management and other services to people living with HIV.

E. AFC has licensed the CLIENT-LEVEL DATABASE Case Management software (“CLIENT-LEVEL DATABASE”) to administer its case management services. Access to the CLIENT-LEVEL DATABASE Case Management software (“CLIENT-LEVEL DATABASE”) is provided by AFC to certain of its contractors as an area-wide case management tool to improve human service delivery in the Chicago metropolitan area. Such access to CLIENT-LEVEL DATABASE is designed to facilitate the coordination and provision of case management, data collection, and policymaking for the Cooperative and the Cooperative’s community partners.

F. CLIENT-LEVEL DATABASE provides a tool to collect longitudinal client-level data that is grounded in the actual experiences of persons living with HIV and the service providers who assist them throughout the Chicago metropolitan area. CLIENT-LEVEL DATABASE facilitates the analysis of information that is gathered from people living with HIV throughout the service provision process to generate an unduplicated count and other aggregate (void of any identifying client level information) information that can be made available to policy makers, service providers, advocates, and consumer representatives.

G. The Agency desires to submit client-level data (e.g., demographic information, assessments/reassessments, and monthly service data) to AFC through CLIENT-LEVEL DATABASE, and AFC desires to receive such data from the Agency, all on the terms and conditions of this Agreement.

## TERMS AND CONDITIONS

1. **AFC Responsibilities:** AFC shall, directly or through its contractors, provide the Agency with access to CLIENT-LEVEL DATABASE as set forth below.

A. **License:** AFC will obtain the requisite licenses (if any are required) for the Agency to (i) remotely access and input data into CLIENT-LEVEL DATABASE using a Citrix or equivalent remote access solution, and (ii) use the documentation accompanying CLIENT-LEVEL DATABASE (the “CLIENT-LEVEL DATABASE Documentation”), all under the terms and conditions of this Agreement.

B. **System Performance:** In connection with its providing the Agency with access to CLIENT-LEVEL DATABASE under this Agreement, AFC shall be responsible for the following services:

i. **Planning/Implementation:** project management, planning, development and documentation. AFC will conduct these activities with input from the Governance Committee and its Contract Administrators at bi-monthly meetings.

ii. **Interface Development and Testing:** development and testing of mechanisms that allow for non-CLIENT-LEVEL DATABASE data systems can import data successfully into CLIENT-LEVEL DATABASE.

iii. **Technical Support Services:** general CLIENT-LEVEL DATABASE account management, server management, server monitoring, disk monitoring, network management, and network infrastructure management.

iv. **General Operations Management:** some support services through AFC’s Program Associate staff, change control/change management, disaster recovery, and external hosting requirements.

v. **Database Administration Services for CLIENT-LEVEL DATABASE:** design, installation, and upgrades; database administration; backup and recovery; monitoring/tuning; security; emergency problem resolution and assistance(emergency defined as a connectivity problem requiring assistance within 24 hours); data movement; documentation.

vi. **Website/URL availability:** AFC will use commercially reasonable efforts to provide the Agency with access to CLIENT-LEVEL DATABASE Monday through Saturday 8am – 6pm Central Time. Any additional access time must be requested in writing from AFC Program Director, which may be withheld in AFC’s reasonable judgment.

C. **Direct Data Entry / CLIENT-LEVEL DATABASE Training:** AFC shall work and cooperate with the Agency to provide initial policy, procedures, and software training to all of the Agency’s CLIENT-LEVEL DATABASE users following the execution of this Agreement. Thereafter AFC will provide at least quarterly policy and procedural training opportunities for the Agency’s new CLIENT-LEVEL DATABASE users and/or and of its CLIENT-LEVEL DATABASE users requiring updated training.

D. Data Reporting and Analysis: AFC shall use the data provided by the Agency via CLIENT-LEVEL DATABASE to:

- i. Develop standard reports for use by the Agency and the Governance Committee, as well as for those entities which fund AFC, including Chicago Department of Public Health and the Health Resource Services Administration;
- ii. Develop a reasonable number of custom reports for each direct data entry partner agency, that will meet the needs of providers as a whole based on requests from the Governance Committee;
- iii. In addition to the training discussed in Section 1.B. of this Agreement above, provide periodic training for report writers identified by the Agency to learn how to create custom reports using CLIENT-LEVEL DATABASE;
- iv. Provide a confidential and secured mechanism to allow the Agency to export the data it entered into CLIENT-LEVEL DATABASE into a static database for the Agency's own use; and
- v. Comply with any legal requirements which necessitate the use of such data.

**2. Agency Responsibilities:**

A. Initial Responsibilities: Prior to the Agency's implementation and/or use of CLIENT-LEVEL DATABASE, the Agency shall:

- i. Participate in a Contract Administrator's orientation;
- ii. Obtain an executed Direct Data Entry End User Agreement (an "End User Agreement") in the form attached hereto as Exhibit A from each staff member who will use CLIENT-LEVEL DATABASE and deliver the same to AFC;
- iii. Assign a qualified and responsible employee to receive training and certification to act as the Agency's CLIENT-LEVEL DATABASE Technical Administrator, and assign CLIENT-LEVEL DATABASE administration tasks to this individual on an ongoing basis;
- iv. Develop an agency-level information security protocol acceptable to AFC;
- v. Obtain the minimum levels of hardware, connectivity, and system support for each site authorized to access CLIENT-LEVEL DATABASE, as required by AFC's agreement to use CLIENT-LEVEL DATABASE and as further set forth on Exhibit B, attached hereto;
- vi. Submit names for CLIENT-LEVEL DATABASE user licenses and training, if applicable, according to the Password Schedule and agency decisions about users; and
- vii. Work and cooperate with AFC's CLIENT-LEVEL DATABASE Program Director to format any pre-existing data sets data for migration into CLIENT-LEVEL DATABASE (if necessary).

B. Additional Responsibilities: Prior to providing user access to any of its employees, the Agency shall:

- i. Determine appropriate CLIENT-LEVEL DATABASE use and assign the user name and individual passwords to all Agency staff required to enter data into CLIENT-LEVEL DATABASE on behalf of the Agency; and
- ii. Ensure that any potential user successfully completes Direct Data Entry Policy and Application training prior to accessing CLIENT-LEVEL DATABASE in any form, including access to CLIENT-LEVEL DATABASE data by working alongside an authorized CLIENT-LEVEL DATABASE user.
- iii. Ensure that the Agency has submitted a signed and executed an End User Agreement for all users.

C. Ongoing Responsibilities: On an ongoing basis, the Agency shall:

- i. Ensure that all of its CLIENT-LEVEL DATABASE users attend ongoing Direct Entry policy and application training, as specified in the Case Management contract attached hereto as Exhibit C (for the avoidance of doubt, such contract is and remains in full force and effect and is not amended or otherwise modified by the terms of this Agreement);
- ii. Notify the AFC Program Director or his designee about any personnel/user changes (e.g. resignation, termination, inappropriate use that results in loss of system privileges) related to the Agency's CLIENT-LEVEL DATABASE users that affect system access within twenty-four (24) hours of the personnel/user change; and
- iii. Maintain connectivity and equipment that interfaces with CLIENT-LEVEL DATABASE and/or Citrix, as specified in the Standard Operating Procedures;
- iv. Continually work with AFC staff to ensure that Agency-provided client data is complete and accurate; and
- v. Continually ensure that the Agency's employees, agents and other representatives comply with all Federal, State and local statutes, regulations and ordinances relating to their performance under this Agreement, including without limitation their use of CLIENT-LEVEL DATABASE, the data entered and stored therein, and any reports generated therefrom.

D. Data Collection and Entry Protocols: The Agency shall:

- i. Collect accurate client-level minimum data elements, as such elements are communicated to the Agency from time to time, for all AFC-funded case management programs operated by the Agency that primarily serve persons who are living with HIV or affected by HIV;
- ii. Submit data to AFC by entering client-level data into CLIENT-LEVEL DATABASE within seven (7) business days of client interaction to ensure proper timeliness of service provision tracking data; and

iii. Abide by all other data collection and entry protocols, as specified in the Standard Operating Procedures.

E. Compliance with Law; Confidentiality: The Agency shall:

i. Comply with all Federal, State and local statutes, regulations and ordinances relating to the confidentiality of client records and privacy, including, without limitation, the Illinois AIDS Confidentiality Act and the Health Information Portability and Accountability Act (“HIPAA”), and ensure that its employees, agents and other representatives comply with the same;

ii. At all times comply with the confidentiality obligations found in the Cooperative’s Confidentiality Protocol as set forth in the Standard Operating Procedure;

iii. Notify each client in writing about the purposes and uses of the data to be collected and entered into CLIENT-LEVEL DATABASE under this Agreement and the client’s right to choose not to participate and provide each client with a copy of the Agency’s privacy policy / notice;

iv. Not predicate access to services on an individual’s decision about consenting to the use, entry or release of data into and/or from CLIENT-LEVEL DATABASE;

v. Obtain written client authorization for data sharing using the Consent to Receive Services Client Authorization Form found in the Standard Operating Procedures; and

vi. Maintain all written client authorizations in the client files, as specified by the Standard Operating Procedures, and follow all other rules and procedures found in the Standard Operating Procedures.

**3. Data Ownership & Release Policies:**

A. Data Ownership:

i. The applicable client of the Agency ultimately retains ownership of any identifiable client-level information that is stored within CLIENT-LEVEL DATABASE. If the client consents to share data, the client, or the Agency on behalf of the client, has the right to later revoke permission to share his/her data without affecting his/her right to service. Client data can be deleted upon client’s request, if client so chooses, by notifying the Agency (in which case, the Agency shall promptly notify AFC) or AFC’s Program Director or his designee; provided, however, that such data cannot and will not be removed from previously generated reports.

ii. Identifiable client-level data may only be stored within CLIENT-LEVEL DATABASE in accordance with the Client Consent to Receive Case Management Services and other provisions of the Standard Operating Procedures.

iii. Upon termination of this Agreement, the Agency will retain ownership of the identifiable client-level data that has been submitted in CLIENT-LEVEL DATABASE. AFC’s Program Director or its designee shall make reasonable accommodations to assist the Agency to export their data in a format that is usable in an alternative database.

B. Data Use:

i. Both AFC and the Agency shall comply with all Federal and State confidentiality regulations that protect client records and privacy, and further respect and protect client confidentiality by following the Confidentiality Protocol, as specified by the Cooperative's Standard Operating Procedures, when releasing any data generated from provider data collected in CLIENT-LEVEL DATABASE.

ii. Without limiting the generality of the foregoing paragraph, to the extent Agency is a "covered entity" as that term is defined under HIPAA, it must comply with all rules and regulations concerning the storage, use and disclosure of protected health information.

iii. AFC has the right to use client-level data entered by the Agency to generate and release aggregate reports that are required by AFC's funders.

**4. Limitations on the Use of CLIENT-LEVEL DATABASE; Ownership of Software:**

A. CLIENT-LEVEL DATABASE may be used only on computers owned, leased, or otherwise controlled by the Agency, and may only be accessed by one of the Agency's authorized users. The Agency will not, and will not permit others to: (a) copy CLIENT-LEVEL DATABASE or any portions thereof; (b) use CLIENT-LEVEL DATABASE other than as permitted in this Agreement; (c) use CLIENT-LEVEL DATABASE to process the data of a third party; (d) modify, disassemble, reverse engineer, decompile or translate CLIENT-LEVEL DATABASE or any portions thereof; (e) sell, assign, sublicense, lease, pledge, rent or otherwise share the Agency's rights under this Agreement; (f) create any derivative works based upon CLIENT-LEVEL DATABASE; (g) modify, obscure or remove any proprietary or confidentiality notices on CLIENT-LEVEL DATABASE or any reports generated from CLIENT-LEVEL DATABASE; or (h) use, copy distribute or allow the use of CLIENT-LEVEL DATABASE on any public or semi-private network, unless such use is agreed to in writing by AFC and its licensors.

B. Except as expressly authorized by AFC, the Agency may not copy or distribute the CLIENT-LEVEL DATABASE Documentation except to the extent required to maintain a backup copy and for internal training of its staff. The Agency acknowledges that the unauthorized copying of the CLIENT-LEVEL DATABASE Documentation, in whole or in part, and the acquisition and use of unauthorized copies may be both criminal and civil offenses for which AFC and/or AFC's licensors may take legal action. AFC and/or its licensors have the right to trace serial numbers on CLIENT-LEVEL DATABASE Documentation at any time and in any reasonable manner.

C. The Agency acknowledges that CLIENT-LEVEL DATABASE and the CLIENT-LEVEL DATABASE Documentation contains proprietary, trade secret and confidential information belonging exclusively to AFC's licensors. Title to, ownership of and all proprietary rights in CLIENT-LEVEL DATABASE and all updates thereto and copies thereof, including translations or compilations or partial copies, are reserved to and will at all times remain with AFC's licensor. The Agency shall not disclose CLIENT-LEVEL DATABASE or the ideas, techniques and concepts contained therein to any third party without the prior written consent of AFC or its licensors.

D. The Agency agrees to hold CLIENT-LEVEL DATABASE and all passwords which enable the Agency to access CLIENT-LEVEL DATABASE in confidence, to access CLIENT-LEVEL

DATABASE and maintain all related passwords in a secure environment and take all reasonable precautions to maintain security in order to prevent unauthorized use or disclosure. The Agency shall inform its employees, agents and representatives having access to CLIENT-LEVEL DATABASE of the Agency's limitations, duties, and obligations regarding nondisclosure and use of CLIENT-LEVEL DATABASE. The Agency agrees to maintain the integrity of all copyright, trade secret or other proprietary notices of AFC's licensors in CLIENT-LEVEL DATABASE and/or affixed to or imprinted on physical media and embodiments thereof, and to take no action inconsistent with the copyright and trade secret ownership rights of AFC's licensors.

**5. Term of This Agreement:** This Agreement shall remain in effect for a period of three (3) years from the Effective Date, unless earlier terminated by either party upon thirty (30) days written notice to the other party; provided, however, that AFC may terminate this Agreement immediately upon written notice to the Agency in the event the Agency breaches its obligations of privacy or confidentiality or compliance with law under this Agreement. Upon the expiration or termination of this Agreement for any reason, the Agency shall immediately (i) return all CLIENT-LEVEL DATABASE Documentation to AFC, (ii) purge any copies (temporary or otherwise) of CLIENT-LEVEL DATABASE and any portions thereof from all computers, storage media and device on which the Agency has placed or allowed others to place such copies, and (iii) certify to AFC in writing that the Agency has complied with the foregoing.

**6. Indemnity:**

A. The Agency, at its expense, will indemnify, defend and hold harmless AFC and its affiliates and any of their officers, directors, employees, agents, consultants and other representatives (collectively, the "Indemnified Parties") from all liabilities, costs, losses, damages and expenses (including reasonable attorneys' and experts' fees and expenses) and will reimburse such fees and expenses as they are incurred, in connection with any claim or action threatened or brought against the Indemnified Parties to the extent arising out of or relating to any claim that the Agency has breached this Agreement or any representation, warranty or agreement contained herein. The Agency will have the right to conduct the defense of any such claim or action and all negotiations for its settlement or compromise except that AFC may, in its sole discretion, participate in the defense of any such claim or action at AFC's expense.

B. Without limiting the foregoing, the Agency may not, without AFC's prior written consent, settle, compromise or consent to the entry of any judgment in any such commenced or threatened claim or action, unless such settlement, compromise or consent: (i) includes an unconditional release of the relevant Indemnified Parties from all liability arising out of such commenced or threatened claim or action; and (ii) is solely monetary in nature and does not include a statement as to, or an admission of fault, culpability or failure to act by or on behalf of, any Indemnified Party or otherwise adversely affect any Indemnified Party. If the Agency fails to appoint an attorney within ten (10) days after AFC has notified the Agency of any such claim or action, or after the Agency becomes aware of such claim or action, whichever is earlier, AFC will have the right to select and appoint an alternative attorney and the reasonable cost and expense thereof will be paid by the Agency.

**7. Disclaimer and Limitation of Liability:**

A. AFC DOES NOT WARRANT, AND SPECIFICALLY DISCLAIMS ANY REPRESENTATION THAT CLIENT-LEVEL DATABASE, CLIENT-LEVEL DATABASE

DOCUMENTATION, OR THE REPORTS GENERATED FROM CLIENT-LEVEL DATABASE WILL MEET AGENCY'S REQUIREMENTS, THAT AGENCY'S USE OF CLIENT-LEVEL DATABASE WILL BE UNINTERRUPTED OR ERROR-FREE, OR THAT DATA ENTERED INTO OR PROCESSED USING CLIENT-LEVEL DATABASE WILL NOT BECOME CORRUPTED OR LOST. AFC MAKES NO WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, NONINFRINGEMENT, AND/OR TITLE IN CONNECTION WITH CLIENT-LEVEL DATABASE, CLIENT-LEVEL DATABASE DOCUMENTATION AND THE REPORTS GENERATED FROM CLIENT-LEVEL DATABASE, AND ANY SUCH WARRANTIES ARE HEREBY DISCLAIMED. CLIENT-LEVEL DATABASE, CLIENT-LEVEL DATABASE DOCUMENTATION AND THE REPORTS GENERATED FROM CLIENT-LEVEL DATABASE ARE PROVIDED ON AN "AS IS" BASIS.

B. IN NO EVENT WILL AFC BE LIABLE TO AGENCY FOR ANY ACTUAL, DIRECT, SPECIAL, INCIDENTAL, INDIRECT, EXEMPLARY OR CONSEQUENTIAL DAMAGES WHATSOEVER (INCLUDING, WITHOUT LIMITATION, DAMAGES FOR LOSS OF BUSINESS PROFITS, BUSINESS INTERRUPTION, LOSS OF BUSINESS INFORMATION, OR ANY OTHER PECUNIARY LOSS) ARISING OUT OF AFC'S BREACH OF THIS AGREEMENT, AGENCY'S USE OF OR INABILITY TO USE CLIENT-LEVEL DATABASE, OR AGENCY'S LOSS OF DATA, WHETHER ARISING IN TORT (INCLUDING NEGLIGENCE), CONTRACT OR ANY OTHER LEGAL THEORY, EVEN IF AFC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

**8. Notices:** All notices under this Agreement shall be in writing and shall either be delivered by certified mail, return receipt requested, nationally recognized overnight courier (e.g., FedEx), all charges prepaid, confirmed facsimile or email. Except as otherwise provided in this Agreement, such notices shall be deemed given when mailed or deposited with a nationally recognized overnight courier. Notices of change of address shall be effective only after the actual receipt thereof.

A. Notice to AFC: All notices and communications given to AFC under this Agreement shall be addressed to:

Roman Buenrostro  
Program Director, AIDS Foundation of Chicago  
411 S. Wells Suite 300, Chicago. IL 60602  
Telephone: 312-922-2322  
Facsimile: 312-922-2916  
Email: rbuenrostro@aidschicago.org

B. Notices to the Agency: All notices and communications given to the Agency under this Agreement shall be addressed to:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_  
Facsimile: \_\_\_\_\_

Email: \_\_\_\_\_

**9. Choice of Law; Jurisdiction:** This Agreement shall be deemed to be executed in the State of Illinois and construed and governed by and under the laws of the State of Illinois, without regard to its conflicts of laws principles. Any action, suit, or other legal proceeding which is commenced to resolve any matter arising under or relating to any provision of this Agreement shall be commenced and prosecuted only in a federal or state court located in Cook County, Illinois, and the parties consent to the jurisdiction and venue of such a court. Process in any action or proceeding referred to in the preceding sentence may be served on any party anywhere.

**10. Audit Rights:** During the term of this Agreement, and for a period of five (5) years thereafter, upon reasonable notice to the Agency, AFC and/or its licensor shall have the right, at AFC's and/or its licensor's expense, to audit the Agency's computer systems and other records relating to Agency's performance and/or compliance with the terms of this Agreement, at their place of keeping, upon advance notice during the Agency's regular business hours for the purpose of assuring the Agency's compliance with the terms of this Agreement.

**11. General Terms:**

A. This Agreement, including its recitals and exhibits, constitutes the entire agreement of AFC and the Agency concerning the subject matter hereof and supersedes any prior oral or written agreements pertaining to the subject matter of this Agreement. This Agreement may not be modified, changed or discharged in whole or in part, except in an agreement in writing signed by AFC and the Agency.

B. No delay or omission by AFC in exercising any right under this Agreement will operate as a waiver of that or any other right. To be given effect, a waiver must be in writing and delivered to the Agency in accordance with the terms of Section 8. A waiver or consent given by AFC on any one occasion is effective only in that instance and will not be construed as a bar to or waiver of any right on any other occasion.

C. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement. If a court of competent jurisdiction determines that any restriction in this Agreement is overbroad or unreasonable under the circumstances, such restriction shall be modified or revised by such court to include the maximum reasonable restriction allowed by law.

D. This Agreement shall be deemed to have been drafted by both parties. The rule that an agreement is interpreted against the drafting party shall not apply. The headings of the sections of this Agreement are included for ease of references only, are not part of this Agreement and are not to be used in the construction and interpretation of the terms hereof.

E. Neither party may assign this Agreement without the prior written consent of the other party. This Agreement shall inure to the benefit of the parties hereto and to their respective heirs, executors, administrators, successors and permitted assigns.

F. Sections 2E, 3B, 4C, 4D, and 6-11 of this Agreement shall survive the expiration or termination of this Agreement for any reason.

G. This Agreement may be executed in two counterparts, each of which shall be deemed an

original for all purposes, and together shall constitute one and the same document. Facsimile signatures shall be relied on as original signatures in all respects.

H. Nothing contained in this agreement shall constitute or be deemed or construed to constitute a partnership or other fiduciary relationship between, or a joint venture by, AFC and the Agency, or constitute either party as the employer, agent or legal representative of the other.

By signing this Agreement, the Agency agrees to abide by all aspects of this Agreement as well as all policies documented in the Standard Operating Procedures. The Agency also agrees to take sole responsibility for managing the use of CLIENT-LEVEL DATABASE by its employees, agents and representatives to ensure their compliance with all policies that affect their work.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

AIDS Foundation of Chicago

[INSERT NAME OF AGENCY]

By: \_\_\_\_\_

By: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

## Exhibit A

### **Direct Data Entry End User Agreement**

Agency Name: \_\_\_\_\_ (the “Agency”)

User Name: \_\_\_\_\_

User Title: \_\_\_\_\_

The Agency and AIDS Foundation of Chicago, recognize the primacy of client needs in the collection and management of direct client data. These needs include both the need continually to improve the quality of HIV case management services, and the need to vigilantly maintain and respect client confidentiality, treating the personal data of our most vulnerable populations with respect and care.

CLIENT-LEVEL DATABASE users have a moral and a legal obligation to ensure that the data they collect is being collected, accessed, and used appropriately and in compliance with law. It is also the responsibility of each CLIENT-LEVEL DATABASE user to ensure that client data is only used for the ends to which it is collected, ends that have been made explicit to clients and are consistent with the mission to assist families and individuals in our community to meet their HIV related needs. Proper user training, adherence to the Northeastern Illinois HIV/AIDS Case Management Standard Operating Procedures Manual (the “Manual”), and a clear understanding of client confidentiality are vital to achieving these goals.

Relevant points regarding client confidentiality include, but are not limited to:

- o Notify each client in writing about the purposes and uses of the data to be collected and entered into CLIENT-LEVEL DATABASE and the client’s right to choose not to participate and provide each client with a copy of the Agency’s privacy policy / notice;
- o A client consent form consistent with that found in the Manual must be signed by each client whose data is to be entered into CLIENT-LEVEL DATABASE;
- o Client consent may be revoked by that client at any time through a written notice;
- o No client may be denied services for failure to provide consent for CLIENT-LEVEL DATABASE data collection;
- o Clients have a right to inspect, copy, and request changes in their CLIENT-LEVEL DATABASE electronic record;
- o Clients may delete or halt the use of their records in CLIENT-LEVEL DATABASE, by notifying their Agency Administrator and AFC Program Director;
- o CLIENT-LEVEL DATABASE Users may not share client data, either electronically, verbally or in writing, with individuals or agencies that are not members of the Northeastern Illinois HIV/AIDS Case Management Cooperative without obtaining written permission from that client;
- o Excluding agency duplication prevention information (name, last four digits of social security number, birth date) CLIENT-LEVEL DATABASE users may not share client data with any case

management agency without obtaining prior written permission from the client;

- o CLIENT-LEVEL DATABASE users will maintain client data in such a way as to protect against revealing the identify of clients to unauthorized agencies, individuals or entities; and
- o Any CLIENT-LEVEL DATABASE user found to be in violation of the Security Policies and Procedures as set forth in the Manual, or the points of client confidentiality in this User Agreement, may be denied access to CLIENT-LEVEL DATABASE, in addition to any other remedies that such user's employer, the client or others may have against such user.

Furthermore:

- o All CLIENT-LEVEL DATABASE users shall respect client confidentiality as per the Northeastern Illinois HIV/AIDS Case Management Cooperative's policies and procedures as set forth in the Manual and all applicable laws, rules and regulations.
- o All CLIENT-LEVEL DATABASE users are to store passwords in separate locations for all log-in screens to Citrix and CLIENT-LEVEL DATABASE.
- o Passwords are to be a combination of letters and numbers.
- o Passwords are to be changed in accordance with the Policies and Procedures as set forth in the Manual.
- o Passwords are not to be maintained on or near the computer they are used for.
- o Passwords are to be guarded at each site by the Agency administrator responsible for CLIENT-LEVEL DATABASE access and treated with the highest level of security by each CLIENT-LEVEL DATABASE user.
- o Any security compromise by a CLIENT-LEVEL DATABASE user is grounds for suspension of data entry privileges, and/or probation as per the Policies and Procedures as set forth in the Manual.

I affirm the following (initial each statement, as a sign of understanding):

\_\_\_ 1. I have been trained in the use of the CLIENT-LEVEL DATABASE software.

\_\_\_ 2. A copy of the Northeastern Illinois HIV/AIDS Case Management Policies and Procedures Manual (the "Manual") has been furnished to me. I have read and will abide by all policies and procedures in the Manual. To the extent the Manual is updated or amended, I will read and abide by all such updates and/or amendments.

\_\_\_ 3. I will maintain the confidentiality of client data in CLIENT-LEVEL DATABASE as outlined above and in the Manual.

\_\_\_ 4. I will only collect, enter and extract data in CLIENT-LEVEL DATABASE relevant to the

delivery of services to people living with HIV.

\_\_\_ 5. I will only collect and enter and data in CLIENT-LEVEL DATABASE for which the client has consented in writing in accordance with the policies and procedures set forth in the Manual.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Exhibit B

### Minimum Technical Requirements

#### **Workstation Specifications:**

Computers interfacing with Citrix and CLIENT-LEVEL DATABASE must meet the minimum desktop specifications below.

- Operating System: Windows XP Pro Service Pack 2 (Recommended), Windows 2000 Pro with Service Pack 4 or Windows XP Service Pack 2.
- Processor and Memory: Minimum specifications required to run the selected operating system
- Video: Color monitor (17" Recommended) with graphics card that supports 1024 x 768-display resolution, 256 Colors or better.
- Web Browser: MS Internet Explorer 5.5, Service Pack 2 / MS Internet Explorer 6.0 / or MS Internet Explorer 6.01, Service Pack 1

#### **Internet Specifications:**

Agencies directly entering data must have internet connectivity for each workstation that will be accessing the CLIENT-LEVEL DATABASE server. To optimize performance, all agencies are encouraged to secure a high speed internet connection with, at a minimum, a cable or DSL/ISDN connection. Agencies with very low expected volume may be able to connect using a dial-up connection; however, AFC cannot guarantee satisfactory performance with this option. Agencies must also secure a static Internet Provider address and provide this to AFC prior to initial Citrix client sever installation.

Agencies considering or using a wireless internet configuration must employ higher security measures, such as WEP encryption. Wireless settings must be documented as part of the information security protocol, and should be verified or approved by the AIDS Foundation Program Director prior to CLIENT-LEVEL DATABASE access.

#### **Security Specifications:**

All workstations directly accessing CLIENT-LEVEL DATABASE and any workstation that is on a network that has a workstation(s) directly accessing CLIENT-LEVEL DATABASE must have:

- Operating System Updates. Operating system updates must be downloaded and applied automatically or on a regular basis.
- Adequate firewall protection and apply all critical virus and system updates automatically.
- Virus protection software. Virus definitions must be updated automatically.
- Anti-spyware software. Spyware definitions must be updated automatically.
- Submit regular documentation via monthly agency reports that updates have been completed on spyware and virus protection.

This Exhibit may be updated from time to time by AFC upon written notice to the Agency.