City of Columbia

701 East Broadway, Columbia, Missouri 65201

Agenda Item Number: B 372-15
Department Source: Public Health & Human Services
To: City Council
From: City Manager & Staff
Council Meeting Date: 12/7/2015
Re: Missouri Department of Health and Senior Services
HIV Prevention Contract AOC15380158 Amendment #02

Documents Included With This Agenda Item

Council memo, Resolution/Ordinance, Exhibit to the Resolution/Ordinance
Supporting documentation includes: None

Executive Summary

An ordinance authorizing the City Manager to sign Amendment #02 to the HIV Prevention Contract #AOC15380158 between the City of Columbia and the Missouri Department of Health and Senior Services. The amendment renews the contract for a one-year period of January 1, 2016 through December 31, 2016. The contract amount shall not exceed $124,903 for the contract period.

Discussion

HIV Prevention program funding enables the Department of Public Health and Human Services to provide HIV testing and counseling, outreach education and technical assistance to 33 north-central Missouri counties.

Fiscal Impact

Short-Term Impact: This is grant funding. There is no impact on the General Fund.
Long-Term Impact: None

Vision, Strategic & Comprehensive Plan Impact

Vision Impact: Health, Social Services and Affordable Housing
Strategic Plan Impact: Not Applicable
Comprehensive Plan Impact: Not Applicable

Suggested Council Action

Should the Council agree with staff recommendations, an affirmative vote is in order.

Legislative History

This contract is renewed annually and has been in place for over twenty years.

City of Columbia

701 East Broadway, Columbia, Missouri 65201

Stephanie K Browning

Department Approved

City Manager Approved

Introduced by _____

First Reading _____ Second Reading _____

Ordinance No. _____ Council Bill No. _____B 372-15_____

AN ORDINANCE

authorizing Amendment No. 2 to the program services contract with the Missouri Department of Health and Senior Services for HIV prevention; and fixing the time when this ordinance shall become effective.

BE IT ORDAINED BY THE COUNCIL OF THE CITY OF COLUMBIA, MISSOURI, AS FOLLOWS:

SECTION 1. The City Manager is hereby authorized to execute Amendment No. 2 to the program services contract with the Missouri Department of Health and Senior Services for HIV prevention for the period of January 1, 2015 through December 31, 2016. The form and content of the amendment to the program services contract shall be substantially as set forth in "Exhibit A" attached hereto and made a part hereof. Any actions taken by or on behalf of the City in connection with such program services contract prior to the date of this ordinance are hereby approved and ratified.

SECTION 2. This ordinance shall be in full force and effect from and after its passage.

PASSED this _____ day of _____, 2015.

ATTEST:

_____ _____

City Clerk Mayor and Presiding Officer

APPROVED AS TO FORM:

_____

City Counselor

Exhibit A

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

PROGRAM SERVICES CONTRACT

This contract is entered into by and between the State of Missouri, Department of Health and Senior Services (Department/state agency) and the below named entity/individual (Contractor). The contract consists of the contract signature page, the scope of work; any attachments referenced and incorporated herein; the terms and conditions; and any written amendments made in accordance with the provisions contained herein. This contract expresses the complete agreement of the parties. By signing below, the Contractor and Department agree to all the terms and conditions set forth in this contract.

To the extent that this contract involves the use, in whole or in part, federal funds, the signature of the Contractor's authorized representative on the contract signature page indicates compliance with the Certifications contained in Attachment A which is attached hereto and is incorporated by reference as if fully set forth herein.

Tracking #	**Contract Title:**
41061	HIV PREVENTION

Contract Start:	**Contract End:**	**Questions/Please Contact:**
1/1/2015	12/31/2016	PROCUREMENT UNIT @ (573)751-6471

Contract #:	**Amend #:**
AOC15380158	02

PLEASE VERIFY/COMPLETE - TYPE OR PRINT - SIGNATURE REQUIRED

NAME OF ENTITY/INDIVIDUAL (Contractor)		
COLUMBIA/BOONE COUNTY HEALTH DEPARTMENT		
DOING BUSINESS AS (DBA) NAME		
MAILING ADDRESS		
1005 WEST WORLEY		P O BOX 6015
CITY, STATE, and ZIP CODE		
COLUMBIA	MO	65205-6015
REMIT TO (PAYMENT) ADDRESS (if different from above)		
CITY, STATE, and ZIP CODE		

CONTACT PERSON	EMAIL ADDRESS
PHONE NUMBER	FAX NUMBER
TAXPAYER ID NUMBER (TIN)	DUNS NUMBER
*****0810	071989024
CONTRACTOR'S AUTHORIZED SIGNATURE	DATE
PRINTED NAME	TITLE
DEPARTMENT OF HEALTH AND SENIOR SERVICES DIRECTOR OF DIVISION OF ADMINISTRATION OR DESIGNEE SIGNATURE	DATE

AMENDMENT #02 TO CONTRACT AOC15380158

CONTRACT TITLE: HIV Prevention

CONTRACT PERIOD: January 1, 2016 through December 31, 2016

1. The Department of Health and Senior Services hereby exercises its option to renew the above referenced contract for the period of January 1, 2016 through December 31, 2016.

2. Delete the Scope of Work, including any Attachments and Exhibits, and the Terms and Conditions in their entirety and replace with the revised Scope of Work, including any Attachments and Exhibits, and the Terms and Conditions, which is attached hereto and incorporated by reference as if fully set forth herein.

HIV Prevention
Columbia/Boone County Health Department

1. GENERAL

1.1 The contract amount shall not exceed $124,903.00 for the period of January 1, 2016 through December 31, 2016.

1.2 The Department has determined this contract is subrecipient in nature as defined in 2 CFR § 200.330. To the extent that this contract involves the use, in whole or in part, of federal funds, the Contractor shall comply with the special conditions contained in Attachment B, which is attached hereto and is incorporated by reference as if fully set forth herein.

1.3 Unless otherwise stated in this contract, the Contractor shall use the below information for any correspondence regarding this contract:

Program Name: Bureau of HIV/STD/Hepatitis
Program Contact: Joyce Hooker
Address: 930 Wildwood Dr., PO Box 570, Jefferson City, MO 65102-0570
Phone: 573-526-9537
Email: joyce.hooker@health.mo.gov

2. PURPOSE

2.1 To establish a contract between the Missouri Department of Health and Senior Services, Section for Disease Prevention (hereinafter referred to as the Department/state agency) and the City of Columbia-Boone County Health Department (hereinafter referred to as the Contractor) to provide a comprehensive Human Immunodeficiency Virus (HIV) prevention program for Missouri in accordance with the current regional HIV prevention plan which is submitted to the Department.

2.2 The North Central Region consists of the following counties: Adair, Audrain, Boone, Callaway, Camden, Chariton, Clark, Cole, Cooper, Gasconade, Howard, Knox, Lewis, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Pike, Putnam, Ralls, Randolph, Saline, Schuyler, Scotland, Shelby, and Sullivan.

3. DELIVERABLES AND OUTCOMES

3.1 The Contractor shall assure delivery of the components of the comprehensive HIV Prevention Program according to the standards, policies, and procedures in the *HIV Prevention Procedure Manual (*Attachment C), attached hereto and incorporated by reference as if fully set forth herein.

3.2 The Contractor shall conduct Quality Assurance activities according to the *HIV Prevention Procedure Manual*, Section 2.0.

3.3 The Contractor shall request Technical Assistance as outlined in the *HIV Prevention Procedure Manual*, Section 3.0.

3.4 The Contractor shall assure financial accountability according to the *HIV Prevention Procedure Manual*, Section 4.0.

3.5 The Contractor shall assure HIV Planning activities are conducted according to the *HIV Prevention Procedure Manual*, Section 5.0.

3.6 The Contractor shall assure Health Education Risk Reduction activities are conducted according to the *HIV Prevention Procedure Manual*, Section 6.0.

3.7 The Contractor shall assure HIV Testing activities are conducted according to the *HIV Testing Program Procedure Manual* previously provided by the Department.

3.8 The Contractor shall assure Partner Services are conducted according to the *HIV Prevention Procedure Manual*, Section 8.0.

3.9 The Contractor shall assure Evaluation activities are conducted according to the *HIV Prevention Procedure* Manual, Section 9.0.

3.10 The Contractor shall assure Prevention for HIV Infected Persons programs are conducted according to the *HIV Prevention Procedure Manual*, Section 10.0.

3.11 The Contractor shall assure Condom Distribution activities are conducted according to the *HIV Prevention Procedure Manual*, Section 11.0.

4. DEPARTMENT RESPONSIBILITIES

4.1 The Department shall provide the Contractor with comprehensive HIV Program policies, procedures, forms, and standards of practice through the issuance of the *HIV Prevention Procedure Manual*. The Department shall provide advance written notice of any updates.

4.2 The Department shall provide technical assistance as outlined in the *HIV Prevention Procedure Manual*, Section 3.0.

5. REPORTS

5.1 Contractor shall submit the required reports outlined in and according to the schedule contained in the *HIV Prevention Procedure Manual*.

5.2 The Contractor shall submit a Subrecipient Annual Financial Report (Attachment D, which is attached hereto and is incorporated by reference as if fully set forth herein). For a contract period of twelve months or less, the Contractor shall submit this report at the time the final invoice is due. For a contract period over twelve months, the Contractor shall submit this report annually and at the time the final invoice is due.

6. BUDGET AND ALLOWABLE COSTS

6.1 The Department will reimburse the Contractor for an amount not to exceed the total contract amount for only the allowable costs in the budget categories stated in Attachment E, which is attached hereto and incorporated by reference as if fully set forth herein.

6.2 The Department reserves the right to reallocate or reduce contract funds at any time during the contract period due to underutilization of contract funds or changes in the availability of program funds. The Department will provide the Contractor with thirty (30) days prior written notification of any reallocation.

6.3 If the Contractor identifies specific needs within the Scope of Work, the Contractor may rebudget up to 10% of the total budget between object class categories of the budget without obtaining prior written approval of the Department. Such rebudgeting by the Contractor shall not cause an increase in the indirect cost category. The Contractor and the Department must agree to a written contract amendment for an increase to the indirect cost category or any other rebudgeting.

6.4 Indirect costs

6.4.1 Indirect costs are those associated with the management and oversight of any organization's activities and are a result of all activities of the contractor. Indirect costs may include such things as utilities, rent, administrative salaries, financial staff salaries, and building maintenance.

6.4.2 The Contractor shall not bill the Department for indirect costs that exceed 8% of the modified total direct costs as defined in 2 CFR § 200.68.

a. Modified Total Direct Cost Method (MTDC) means all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and subawards and subcontracts up to the first $25,000 of each subaward or subcontract (regardless of the period of performance of the subawards and subcontracts under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs, and the portion of each subaward and subcontract in excess of $25,000. Other items may only be excluded when necessary to avoid a serious

inequity in the distribution of indirect costs, and with the approval of the cognizant agency for indirect costs.

6.4.3 It is the Contractor's responsibility to correctly apply the indirect rate to the applicable direct costs claimed on each invoice.

6.5 The Department will reimburse the Contractor for transportation provided by personal vehicles (mileage) at either the current IRS rate for mileage reimbursement or the mileage reimbursement rate set by the Contractor's internal policy, whichever is lower.

6.6 The Contractor shall follow competitive procurement practices.

6.7 The Contractor shall abide by the state established meal per diem for both in-state and out-of-state meals. Per diem rates can be found at: http://oa.mo.gov/acct/MealPerDiem.htm.

6.8 Allowable program costs (direct operations costs) for HIV Prevention activities and administrative costs under this contract shall be limited to costs allowed by the guidelines, regulations and policies of the Department and the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) under the HIV Prevention program and appropriate OMB circulars.

7. INVOICING AND PAYMENT

7.1 If the Contractor has not already submitted a properly completed Vendor Input/Automated Clearing House Electronic Funds Transfer (ACH-EFT) Application, the Contractor shall complete and submit this Application. The Department will make payments electronically to the Contractor's bank account. The Department may delay payment until the Vendor Input/ACH-EFT Application is received from the Contractor and validated by the Department.

7.1.1 A copy of the Vendor Input/ACH-EFT Application and completion instructions may be obtained from the Internet at: https://www.vendorservices.mo.gov/vendorservices/Portal/Default.aspx.

7.1.2 The Contractor must fax the Vendor Input/ACH-EFT Application to: Office of Administration, Division of Accounting at 573-526-9813.

7.2 The Contractor shall invoice the Department on the Contractor's original descriptive business invoice form. The Contractor shall use uniquely identifiable invoice numbers to distinguish an invoice from a previously submitted invoice.

7.2.1 A sample invoice form is provided in Attachment E. The Contractor shall indicate an invoice number for each invoice submitted in the following format: HIVPmmyy. For

example, an invoice submitted for the month of March 2016 would have the following invoice number: HIVP0316.

7.2.2 All invoices submitted to the Department shall include the fiscal officer's signature under the following statement: "The attached report is a true and correct statement of expenditures under the above stated contract for the period. Further, all expenditures were made in accordance with the provisions set forth in the contract."

7.3 The Contractor shall submit invoices monthly. Invoices shall be due no later than forty-five (45) days following the month in which the Contractor provided services or purchases were made under the contract, unless prior written approval has been made by the Department. The Contractor shall perform the services prior to invoicing the Department.

7.4 The Contractor shall submit invoices and reports to:

Missouri Department of Health and Senior Services
Division of Community & Public Health
Bureau of HIV, STD, and Hepatitis
Attn: Joyce Hooker
P.O. Box 570
Jefferson City, MO 65102-0570

7.5 The Contractor shall submit the final invoice within thirty (30) calendar days after the contract ending date. The Department shall have no obligation to pay any invoice submitted after the due date.

7.6 If the Department denies a request by the Contractor for payment or reimbursement, the Department will provide the Contractor with written notice of the reason(s) for denial.

7.7 The Contractor agrees that any audit exception noted by governmental auditors shall not be paid by the Department and shall be the sole responsibility of the Contractor. However, the Contractor shall have the right to contest any such exception by any legal procedure the Contractor deems appropriate. The Department will pay the Contractor all amounts which the Contractor may ultimately be held entitled to receive as a result of any such legal action.

7.8 Notwithstanding any other payment provision of this contract, if the Contractor fails to perform required work or services, fails to submit reports when due, or is indebted to the United States government, the Department may withhold payment or reject invoices under this contract.

7.9 If the Contractor receives an overpayment by the Department, the Contractor shall issue a check made payable to "DHSS-DA-Fee Receipts" and mail the check to:

Missouri Department of Health and Senior Services
Division of Administration, Fee Receipts
P.O. Box 570
920 Wildwood Drive
Jefferson City, Missouri 65102-0570

7.10 If the Department used a federal grant to pay the Contractor, the Catalog of Federal Domestic Assistance (CFDA) number assigned to the grant and the dollar amount paid from the grant is available on the State of Missouri Vendor Services Portal under the Vendor Payment section at https://www.vendorservices.mo.gov/vendorservices/Portal/Default.aspx. The CFDA name is available at https://www.cfda.gov/?s=program&mode=list&tab=list.

8. AMENDMENTS

8.1 Any changes to this contract shall be made only through execution of a written amendment signed and approved by an authorized signatory of each party.

9. RENEWALS

9.1 The Department shall have the right, at its sole option, based upon available funding and Contractor performance during the prior contract period, to renew the contract for one (1) additional one-year period. In the event the Department exercises this option, all terms and conditions, requirements and specifications of this contract shall remain the same and apply during the renewal period.

10. MONITORING

10.1 The Department reserves the right to monitor the Contractor during the contract period to ensure financial and contractual compliance.

10.2 The Contractor must attend CDC mandated quality assurance update trainings. The Department shall provide advance written notice.

10.3 The Contractor shall submit to the Department, within thirty (30) days of receiving the written findings of the Department, an action plan for correction of reported findings if the Contractor is found to be in noncompliance with terms of this contract. Depending upon the severity of Contractor noncompliance, the Department may withhold payment of contract invoices, pending the Contractor's implementation of a corrective action plan approved by the Department, or terminate this contract with or without cause.

10.4 If the Department deems a Contractor to be high-risk, the Department may impose special conditions or restrictions on the Contractor, including but not limited to the following: withholding authority to proceed to the next phase of the project until the Department receives evidence of acceptable performance within a given contract period; requiring additional, more detailed financial reports or other documentation; additional project monitoring; requiring the Contractor to obtain technical or management assistance; or establishing additional prior approvals from the Department. The Department may impose special conditions or restrictions at the time of the contract award or at any time after the contract award. The Department will provide written notification to the Contractor prior to the effective date of the high-risk status.

11. DOCUMENT RETENTION

11.1 The Contractor shall retain all books, records, and other documents relevant to this contract for a period of three (3) years after final payment or the completion of an audit, whichever is later, or as otherwise designated by the federal funding agency and stated in the contract.

11.2 The Contractor shall allow authorized representatives of the Department, State, and Federal Government to inspect these records upon request.

11.3 If the Contractor is subject to any litigation, claim, negotiation, audit or other action involving the records before the expiration of the three (3) year period, the Contractor shall retain the records until completion of the action and resolution of all issues which arise from it, or until the end of the regular three (3) year period, whichever is later.

11.4 If the Department is subject to any litigation, claim, negotiation, audit or other action involving the records, the Department will notify the Contractor in writing to extend the Contractor's retention period.

11.5 The Department may recover any payment it has made to the Contractor if the Contractor fails to retain adequate documentation.

12. CONFIDENTIALITY

12.1 The Contractor shall safeguard Protected Personally Identifiable Information (PII) as defined in 2 CFR § 200.82. The Contractor agrees it will assume liability for all disclosures of Protected PII and breaches by the Contractor and/or the Contractor's subcontractors and employees.

12.2 The Contractor shall comply with provisions of Attachment F, as attached hereto and incorporated by reference as if fully set forth herein, in regards to the Health Insurance Portability and Accountability Act of 1996, as amended.

12.3 The Contractor shall abide by all Missouri Laws, Department rules, and policies established in the Communicable Disease Investigative Reference Manual, and HIV/AIDS Surveillance Confidentiality and Security Manual pertaining to confidentiality and security of patient records.

13. LIABILITY

13.1 The relationship of the Contractor to the Department shall be that of an independent Contractor. The Contractor shall have no authority to represent itself as an agent of the Department. Nothing in this contract is intended to, nor shall be construed in any manner as creating or establishing an agency relationship or the relationship of employer/employee between the parties. Therefore, the Contractor shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, workers compensation, employee insurance, minimum wage requirements, overtime, or any other applicable employee related obligation or expense, and shall assume all costs, attorney fees, losses, judgments, and legal or equitable imposed remedies associated with the matters outlined in this paragraph in regards to the Contractor's subcontractors, employees and agents. The Contractor shall have no authority to bind the Department for any obligation or expense not specifically stated in this contract. This provision is not intended to waive any claim of sovereign immunity to which a public entity would otherwise be entitled to under Missouri law.

13.2 The Contractor shall be responsible for all claims, actions, liability, and loss (including court costs and attorney's fees) for any and all injury or damage (including death) occurring as a result of the Contractor's performance or the performance of any subcontractor, involving any equipment used or service provided, under the terms and conditions of this contract or any subcontract, or any condition created thereby, or based upon any violation of any state or federal statute, ordinance, building code, or regulation by Contractor. However, the Contractor shall not be responsible for any injury or damage occurring as a result of any negligent act or omission committed by the Department, including its officers, employees, and assigns. This provision is not intended to waive any claim of sovereign immunity to which a public entity would otherwise be entitled to under Missouri law.

14. PUBLICATIONS, COPYRIGHTS, AND RIGHTS IN DATA AND REPORTS

14.1 If the Contractor issues any press releases mentioning contract activities, the Contractor shall reference in the release both the contract number and the Department. If the Contractor creates any publications, including audiovisual items, produced with contract funds, the Contractor shall give credit to both the contract and the Department in the publication. The Contractor shall obtain approval from the Department prior to the release of such press releases or publications.

14.2 In accordance with the "Steven's Amendment" in the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, the Contractor shall not issue any statements, press release, request for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money unless it clearly states the following:

14.2.1 The percentage of the total costs of the program or project which will be financed with Federal money; and

14.2.2 The percentage of the total costs of the program or project which will be financed by nongovernmental sources.

14.3 If the Contractor develops any copyrighted material as a result of this contract, the Department shall have a royalty-free, nonexclusive and irrevocable right to publish or use, and to authorize others to use, the work for Department purposes or the purpose of the State of Missouri.

15. AUTHORIZED PERSONNEL

15.1 The Contractor shall be responsible for assuring that all personnel are appropriately qualified and licensed or certified, as required by state, federal or local law, statute or regulation, respective to the services to be provided through this contract; and documentation of such licensure or certification shall be made available upon request.

15.2 The Contractor shall only utilize personnel authorized to work in the United States in accordance with applicable federal and state laws. This includes but is not limited to the Immigration Reform and Control Act of 1986 as codified at 8 U.S.C. § 1324a, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) and Section 274A of the Immigration and Nationality Act. If the Contractor is found to be in violation of these requirements or the applicable laws of the state, federal and local laws and regulations, and if the State of Missouri has reasonable cause to believe that the Contractor has knowingly employed individuals who are not eligible to work in the United States, the state shall have the right to cancel the contract immediately without penalty or recourse and suspend or debar the Contractor from doing business with the state. The state may also withhold up to twenty-five percent of the total amount due to the Contractor. The Contractor agrees to fully cooperate with any audit or investigation from federal, state or local law enforcement agencies.

15.3 Affidavit of Work Authorization and Documentation: Pursuant to section 285.530, RSMo, if the Contractor meets the section 285.525, RSMo definition of a "business entity" (http://www.moga.mo.gov/statutes/C200-299/2850000525.HTM), the Contractor must affirm the Contractor's enrollment and participation in the E-Verify federal work authorization program with respect to the employees hired after

enrollment in the program who are proposed to work in connection with the services requested herein. The Contractor should complete applicable portions of Exhibit 1, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization, as attached hereto and incorporated by reference as if fully set forth herein. The applicable portions of Exhibit 1 must be submitted prior to an award of a contract.

15.4 If the Contractor meets the definition of a business entity as defined in section 285.525, RSMo pertaining to section 285.530, RSMo the Contractor shall maintain enrollment and participation in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the contracted services included herein. If the Contractor's business status changes during the life of the contract to become a business entity as defined in section 285.525, RSMo pertaining to section 285.530, RSMo then the Contractor shall, prior to the performance of any services as a business entity under the contract:

15.4.1 Enroll and participate in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services required herein; AND

15.4.2 Provide to the Missouri Department of Health and Senior Services the documentation required in the exhibit titled, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization affirming said company's/individual's enrollment and participation in the E-Verify federal work authorization program; AND

15.4.3 Submit to the Missouri Department of Health and Senior Services a completed, notarized Affidavit of Work Authorization provided in the exhibit titled, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization.

15.5 In accordance with subsection 2 of section 285.530 RSMo, the Contractor should renew their Affidavit of Work Authorization annually. A valid Affidavit of Work Authorization is necessary to award any new contracts.

16. TERMINATION

16.1 The Department, in its sole discretion, may terminate the obligations of each party under this contract, in whole or in part, effectively immediately upon providing written notification to the Contractor if:

16.1.1 State and/or federal funds are not appropriated, continued, or available at a sufficient level to fund this contract; or

16.1.2 A change in federal or state law relevant to this contract occurs; or

16.1.3 A material change of the parties to the contract occurs; or

16.1.4 By request of the Contractor.

16.2 Each party under this contract may terminate the contract, in whole or in part, at any time, for its convenience without penalty or recourse by providing the following written notice.

16.2.1 The Department will provide written notice to the Contractor at least thirty (30) calendar days prior to the effective date of such termination.

16.2.2 The Contractor shall provide written notice to the Department at least sixty (60) calendar days prior to the effective date of such termination.

16.3 In the event of termination, all documents, data, reports, supplies, equipment, and accomplishments prepared, furnished or completed by the Contractor pursuant to the terms of the contract shall, at the option of the Department, become the property of the Department. The Contractor shall be entitled to receive compensation for services and/or supplies performed in accordance with the contract prior to the effective date of the termination and for all non-cancelable obligations incurred pursuant to the contract prior to the effective date of the termination.

CERTIFICATIONS AND SPECIAL PROVISIONS

1. GENERAL

1.1 To the extent that this contract involves the use, in whole or in part, federal funds, the signature of the Contractor's authorized representative on the contract signature page indicates compliance with the following Certifications and special provisions.

2. CONTRACTOR'S CERTIFICATION REGARDING SUSPENSION AND DEBARMENT

2.1 The Contractor certifies that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any Federal department or agency pursuant to 2 CFR Part 180.

2.2 The Contractor shall include these certification requirements regarding debarment, suspension, ineligibility, and voluntary exclusion in all lower tier covered transactions.

2.3 If the Contractor enters into a covered transaction with another person at the next lower tier, the Contractor must verify that the person with whom it intends to do business is not excluded or disqualified by:

2.3.1 Checking the System of Award Management (SAM) https://www.sam.gov; or

2.3.2 Collecting a certification from that person; or

2.3.3 Adding a clause or condition to the covered transaction with that person.

3. CONTRACTOR'S CERTIFICATION REGARDING LOBBYING

3.1 The Contractor certifies that no Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

3.2 The Contractor certifies that no funds under this contract shall be used to pay for any activity to support or defeat the enactment of legislation before the Congress, or any State

or local legislature or legislative body. The Contractor shall not use any funds under this contract to pay for any activity to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government.

3.3 The Contractor certifies that no funds under this contract shall be used to pay the salary or expenses of the Contractor, or an agent acting for the Contractor who engages in any activity designed to influence the enactment of legislation or appropriations proposed or pending before the Congress, or any State, local legislature or legislative body, or any regulation, administrative action, or Executive Order issued by the executive branch of any State or local government.

3.4 The above prohibitions include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

3.5 If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any Federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

3.6 The Contractor shall require that the language of this section be included in the award documents for all subawards at all levels (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

3.7 This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CONTRACTOR'S CERTIFICATION REGARDING A DRUG FREE WORKPLACE

4.1 The Contractor certifies it shall provide a drug free workplace in accordance with the Drug Free Workplace Act of 1988, 41 U.S.C. Chapter 81, and all applicable regulations.

CERTIFICATIONS AND SPECIAL PROVISIONS

The Contractor is required to report any conviction of employees under a criminal drug statute for violations occurring on the Contractor's premises or off the Contractor's premises while conducting official business. The Contractor shall report any conviction to the Department within five (5) working days after the conviction. Submit reports to:

Missouri Department of Health and Senior Services
Division of Administration, Grants Accounting Unit
P.O. Box 570
920 Wildwood Drive
Jefferson City, Missouri 65102-0570

5. CONTRACTOR'S CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

5.1 The Pro-Children Act of 1994, (Public Law 103-227, 20 U.S.C. §§ 6081-6084), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The Pro-Children Act also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The Pro-Children Act does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the Pro-Children Act may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

5.2 The Contractor certifies that it will comply with the requirements of the Pro-Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro-Children Act.

5.3 The Contractor agrees that it will require that the language of this certification be included in any subcontract or subaward that contains provisions for children's services and that all subrecipients shall certify accordingly. Failure to comply with the provisions of the Pro-Children Act law may result in the imposition of a civil monetary penalty of up to $1,000 per day.

6. CONTRACTOR'S CERTIFICATION REGARDING NON-DISCRIMINATION

CERTIFICATIONS AND SPECIAL PROVISIONS

6.1 The contractor shall comply with all federal and state statutes, regulations and executive orders relating to nondiscrimination and equal employment opportunity to the extent applicable to the contract. These include but are not limited to:

6.1.1 Title VI of the Civil Rights Act of 1964 (P.L. 88-352, 42 U.S.C. § 2000d *et seq.*) which prohibits discrimination on the basis of race, color, or national origin (this includes individuals with limited English proficiency) in programs and activities receiving federal financial assistance and Title VII of the Act which prohibits discrimination on the basis of race, color, national origin, sex, or religion in all employment activities;

6.1.2 Equal Pay Act of 1963 (P.L. 88 -38, as amended, 29 U.S.C. § 206 (d));

6.1.3 Title IX of the Education Amendments of 1972, as amended (20 U.S.C §§ 1681-1683 and 1685-1686) which prohibits discrimination on the basis of sex;

6.1.4 Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*) which prohibit discrimination on the basis of disabilities;

6.1.5 The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107) which prohibits discrimination on the basis of age;

6.1.6 Equal Employment Opportunity – E.O. 11246, as amended;

6.1.7 Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Compliance Requirements;

6.1.8 Missouri Governor's E.O. #05-30 (excluding paragraph 1, which was superseded by E.O. #10-24);

6.1.9 Missouri Governor's E.O. #10-24; and

6.1.10 The requirements of any other nondiscrimination federal and state statutes, regulations and executive orders which may apply to the services provided via the contract.

7. CONTRACTOR'S CERTIFICATION REGARDING EMPLOYEE WHISTLEBLOWER PROTECTIONS

7.1 The contractor shall comply with the provisions of 41 U.S.C. 4712 that states an employee of a contractor, subcontractor, grantee, or subgrantee may not be discharged,

demoted or otherwise discriminated against as a reprisal for "whistleblowing". In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

7.2 The contractor's employees are encouraged to report fraud, waste, and abuse. The contractor shall inform their employees in writing they are subject to federal whistleblower rights and remedies. This notification must be in the predominant native language of the workforce.

7.3 The contractor shall include this requirement in any agreement made with a subcontractor or subgrantee.

8. CLEAN AIR ACT

8.1 The Contractor shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 *et seq.*) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 *et seq.*).

SUBRECIPIENT SPECIAL CONDITIONS

1. The Department of Health and Senior Services has determined that this contract is subrecipient in nature as defined in the 2 CFR § 200.330. To the extent that this contract involves the use, in whole or in part, of federal funds, the Contractor shall comply with the following special conditions.

1.1 The Contractor shall comply with all applicable implementing regulations, and all other laws, regulations and policies authorizing or governing the use of any federal funds paid to the Contractor through this contract. The Contractor shall ensure compliance with U.S. statutory and public policy requirements, including but not limited to, those protecting public welfare, the environment, and prohibiting discrimination. See the Federal Agency's Notice of Grant Award at http://health.mo.gov/contractorresources/nga for the terms and conditions of the federal award(s) governing this contract. Refer to the Contract Funding Source(s) report enclosed with the contract for a listing of the applicable federal award numbers.

1.2 In performing its responsibilities under this contract, the Contractor shall fully comply with the Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (2 CFR Part 200, as applicable, including any subsequent amendments.

1.3 The Contractor shall send a copy of any audit report to the Department of Health and Senior Services, Division of Administration, P.O. Box 570, Jefferson City, MO 65102 each contract year if applicable. The Contractor shall return to the Department any funds disallowed in an audit of this contract.

1.4 The Contractor shall comply with the public policy requirements as specified in the Department of Health and Human Services (HHS) Grants Policy Statement which is incorporated herein as if fully set forth.
http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf

1.5 The Contractor shall be responsible for any disallowances, questioned costs, or other items, including interest, not allowed under the federal award or this contract. The Contractor shall return to the Department any funds disallowed within six months of notification by the Department to return such funds.

1.6 The Contractor shall notify the Department in writing within 30 days after a change occurs in its primary personnel involved in managing this contract.

SUBRECIPIENT SPECIAL CONDITIONS

1.7 The Contractor shall notify the Department in writing of any violation of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting federal monies under this contract. Failure by the Contractor to disclose such violations may result in the Department taking action as described in 2 CFR § 200.338 Remedies for Noncompliance.

1.8 The Contractor shall comply with Trafficking Victims Protection Act of 2000 (22 U.S.C. Chapter 78), as amended. This law applies to any private entity. A private entity includes any entity other than a State, local government, Indian tribe, or foreign public entity, as defined in 2 CFR § 175.25. The subrecipient and subrecipients' employees may not:

1.8.1 Engage in severe forms of trafficking in persons during the period of time that the award is in effect;

1.8.2 Procure a commercial sex act during the period of time that the award is in effect; or

1.8.3 Use forced labor in the performance of the award or subawards under the award.

1.8.4 The Contractor must include the requirements of this paragraph in any subaward made to a private entity.

1.9 The Contractor shall comply with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations, as applicable.

1.10 A Contractor that is a state agency or agency of a political subdivision of a state and its contractors must comply with Section 6002 of the Solid Waste Disposal Act (42 U.S.C. § 6962), as amended by the Resource Conservation and Recovery Act (P.L. 94-580). The requirements of Section 6002 relate solely to procuring items designated in the guidelines of the Environmental Protection Agency (EPA) at 40 CFR Part 247.

1.11 The Contractor shall provide its Data Universal Numbering System (DUNS) number to the Department. If the Contractor is an exempt individual as per 2 CFR § 25.110(b), the Contractor shall notify the Department of its exemption. Pursuant to 2 CFR Part 25, no entity may receive a subaward unless the entity has provided its DUNS number. The Department shall withhold the award of this contract until the Contractor submits the DUNS number to the Department and the Department has verified the DUNS.

1.12 Equipment

SUBRECIPIENT SPECIAL CONDITIONS

1.12.1 Title to equipment purchased by the Contractor for the purposes of fulfilling contract services vests in the Contractor upon acquisition, subject to the conditions that apply as set forth in 2 CFR § 200.313. The Contractor must obtain written approval from the Department prior to purchasing equipment with a cost greater than $1,000. The repair and maintenance of purchased equipment will be the responsibility of the Contractor. Upon satisfactory completion of the contract, if the current fair market value (FMV) of the equipment purchased by the Contractor is less than $5,000, the Contractor has no further obligation to the Department. The Contractor may sell or retain items it purchased with a current FMV greater than $5,000, but the Contractor may be required to reimburse the Department for costs up to the current value of the equipment.

1.12.2 Equipment purchased by the Department and placed in the custody of the Contractor shall remain the property of the Department. The Contractor must ensure these items are safeguarded and maintained appropriately, and return such equipment to the Department at the end of the program.

HIV PREVENTION PROCEDURE MANUAL

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HIV PREVENTION PROCEDURE MANUAL

Introduction

This manual has been developed to ensure that there are comprehensive, written policies and procedures for the following Comprehensive HIV Prevention Program Components:

- HIV Planning
- Health Education/Risk Reduction (HE/RR)
- HIV Testing Services
- Partner Services
- Evaluation
- HIV Positives
- Condom Distribution

The policies and procedures in this manual have been developed to ensure that all HIV prevention activities are delivered in an appropriate, competent and sensitive manner. These policies and procedures are intended to be available to state and local health department program staff and their contractors. Training on these policies and procedures will be provided on an annual basis.

Missouri Department of Health and Senior Services (DHSS) program staff is responsible for reviewing and revising the manual on a yearly basis. All contractors will be notified by email when edits are made to this manual and will be responsible for ensuring that they are aware of the edits.

Quality Assurance

The term "quality assurance" as used in this manual, refers to the activities that provide evidence to ensure that basic standards are met when implementing a comprehensive HIV prevention program. A comprehensive HIV prevention program should include the following elements:

- HIV Planning
- HIV Testing Services inclusive of Partner Services
- HE/RR interventions for both HIV positives and high risk negatives that include: Diffusion of Effective Behavioral Interventions (DEBI) programs, other model programs, Individual Level Interventions (ILI) and Group Level Interventions (GLI), intensive Outreach, Community Level Interventions (CLI), Structural Level Interventions (SLI), Biomedical Interventions (BMI), and Health Communication/Public Information (HC/PI) on a limited basis.
- Evaluation efforts that include data collection and analysis through CDC Evaluation and Monitoring System.

Regional Lead Agencies (RLA) are required to share DHSS protocols with all subcontractors. Protocols may be enhanced with regional requirements, pending approval of DHSS. DHSS will assess protocol adherence and program quality through contract monitoring. DHSS will provide a written summary of results.

The RLA will submit to DHSS, within 30 days of receiving the written findings of DHSS, an action plan for correction of reported findings, if necessary. Depending upon the severity of noncompliance, DHSS may withhold payment of contract invoices, pending the RLA's implementation of a corrective action plan approved by DHSS, or terminate the contract.
The RLA must assure quality programming through contract monitoring for regional subcontractors (if applicable). Contract monitoring reports for subcontractors must be submitted to DHSS as follows:

- By **September 15** of current year: Documentation of contact monitoring for the time period of January through June

- By **March 15** of following year: Documentation of contract monitoring for the time period of July through December.

The RLA must attend CDC mandated quality assurance update trainings as necessary. Trainings will use the HIV Prevention Procedure Manual as a guide. Expenses should be billed to the contract, pending DHSS approval.

Technical Assistance

Technical assistance (TA) is crucial to HIV Prevention planning and programming. TA encompasses expert programmatic, scientific, and technical support for the design, implementation, and evaluation of HIV prevention interventions and programs. CDC funds a national Technical Assistance Providers Network to assist HIV Planning Groups (HPG) and HIV prevention programming. The process for obtaining TA includes:

1. TA is requested by the RLA on behalf of the Regional Planning Advisory Group (RPAG) via a request form submitted to the State Planner. (Appendix 1)

2. The State Planner assesses expertise across the state to fill the request.

3. If local or state expertise cannot fill the request, the State Planner consults with the CDC Project Officer to obtain TA from a national provider or CDC.

4. The State Planner coordinates TA with RLA and provider.

5. Expenses should be billed to the contract, pending DHSS approval.

Financial Accountability

RLAs must be fiscally accountable for expenditures.

- Budget proposals should be based on annual budget tables. The RLA must use the state budget table provided within the HIV Prevention Contract. This table is due to DHSS after the receipt of a final draft of the regional intervention plan.

- The RLA shall submit to DHSS uniquely identifiable invoices for payment processing. The particular invoice or bill must be distinguished by invoice number from a previously submitted invoice or bill. Invoices must be submitted monthly and must be postmarked no later than forty-five (45) days following the month in which services were provided or purchases made, unless prior written approval has been given by DHSS. DHSS shall have no obligation to pay any invoice that is not received in accordance with the above requirement.

DHSS will monitor contractor expenses to ensure timely invoicing and appropriateness of expenditures. If contractors are under spent by **August 1st** of the fiscal year, a plan to ensure usage of funding is required. This plan must be submitted no later than **August 31st**. If this plan is not submitted and implemented, DHSS may reallocate excess funding from that region.

HIV Planning Process

The HIV Planning process is essential and works in tandem with Health Education/Risk Reduction services. According to CDC's *Revised HIV Planning Guidance*, HIV Planning strengthens prevention programs:

- To increase meaningful community involvement in prevention planning
- To improve the scientific basis of program decisions; and
- To target resources to those communities at highest risk for HIV transmission/acquisition.

HIV Planning Group (HPG)

The HIV Planning process is one of the primary means to ensure that HIV programming will have broad community input, overview, and endorsement. To enable this process to be accomplished, the following activities are implemented:

1. Recruitment to the HPG follows the principles of Parity, Inclusion, and Representation (PIR).

2. An annual membership survey is conducted to verify PIR and identify gaps in membership, which will be utilized when recruiting new members. New members are recruited through advertising and word of mouth on a regional level.

3. The HPG is made up of elected regional reps and At Large members who represent the prioritized populations. A gallery of non-voting experts in areas such as behavioral science, epidemiology, government, and minority health assists in the planning process.

4. A new member orientation is provided on a quarterly basis to enable members to participate in the planning process. A mentoring program supports new members.

5. Conflict of Interest (Appendix 2) and Dispute Resolution (Appendix 3) processes.

6. The HIV Planning Process is governed through by-laws (Appendix 4) that have been created and approved by the HPG. *Robert's Rules of Order* (Appendix 5) are utilized in conjunction with established operating principles (Appendix 6).

7. The HPG exercises its duty to assure that a comprehensive, targeted, and effective HIV Prevention Plan is created, submitted, and used to provide effective interventions and strategies to serve the most at risk populations. This procedure follows the sequence below:

    - A Review Committee is selected
    - The application and plan are submitted to the Review Committee
    - The Committee reviews and makes official recommendations to the HPG for concurrence by simple majority.

8. Standing committees will elect co-chairs, follow a standard agenda format (Appendix 7), and develop an annual scope of work.

For more information regarding the planning process, refer to the *CDC Revised HIV Planning Guidance.* A copy is available upon request.

Regional Prevention Advisory Group (RPAG)
The regional HIV Planning process supports statewide efforts through an effective local approach to HIV prevention. The RLA, through RPAG, is responsible to assure the following:

1. Appoint a local health department co-chair (a member of the RLA staff or a regional planner) and an elected community (non-health department) co-chair to facilitate the RPAG meetings. The RLA shall assure the co-chairs attend all HPG meetings. Expenses should be billed to the contract, pending DHSS approval.

2. Appoint five (5) elected regional representatives **(St. Louis and Kansas City)** or two (2) elected regional representatives **(Southeast Region, Northwest Region)** or three (3) elected regional representatives **(Southwest Region, North Central Region)** to serve on the HPG and attend all HPG meetings. Expenses should be billed to the contract, pending DHSS approval.

3. Assure all At-Large and alternate At-Large members attend all HPG meetings. Expenses should be billed to the contract, pending DHSS approval.

4. Assure that RPAG meetings are convened at least quarterly. Expenses should be billed to the contract, pending DHSS approval.

5. Assure that a Regional Point Person is identified and adheres to the protocol (Appendix 8).

6. Assure participation on the RPAG by individuals who are representatives of the priority populations identified in the regional HIV/STD prevention plan. Each region must have at least ten percent (10%) participation from the affected/infected community. It is recommended that these members are not employees of the RLA or its contractors.

7. Demonstrate community participation and general parity (all members equally prepared to participate fully in the process) through completion of membership characteristic surveys (Appendix 9). Surveys must be completed quarterly and forwarded to DHSS by:

    - March 31st
    - June 30th
    - September 30th
    - December 31st

8. Demonstrate multiple ways to include and incorporate input from priority populations regarding the RPAG process and planning, and a commitment to maintaining parity.

9. Assure that meeting evaluations are completed by all RPAG members and forwarded to DHSS no later than 30 days after each RPAG meeting. Evaluations must be modeled after the HPG meeting evaluation (Appendix 10).

10. Assure that two (2) HIV Planning Process Evaluations for the RPAG process are conducted using a standardized tool (Appendix 11) provided by DHSS and are forwarded to DHSS by April 30 and October 31 of each contract year.

11. Develop a yearly work plan task list with the RPAG (Appendix 12). Work plans are due by January 31 of each calendar year.

12. Assure that the regional advisory process includes participation by diverse community stakeholders, including evaluators, behavioral scientists, and members of government agencies, business community, faith community, civic groups, community-based organizations and community coalitions.

13. Assure that the RPAG conducts community assessments for all regional priority populations in accordance with the *Revised HIV Planning Guidance*. Community assessments must be conducted and outcomes reported to DHSS. The timeline for community assessment development will be determined and provided by the HPG prior to implementation.

14. Assure that interventions are prioritized by the RPAG, according to CDC guidelines for priority populations, current regional needs assessments, HIV/STD epidemiologic data, behavioral theories, cost analysis, input from people living with HIV disease, and community values. Planned interventions must give priority to unmet needs within the region and those programs that are supported by research and meet characteristics of effective interventions as outlined in the CDC *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*.

15. Produce a Comprehensive Regional Plan and/or enhancements to the Plan for HIV Prevention interventions based upon the following standards developed by DHSS:

    - 60% of interventions should be ILI and CLI, giving priority to DEBIs/Procedural Guidance Interventions as identified at www.cdc.gov.
    - 20% of interventions should be GLI and outreach interventions for priority populations.
    - 20% of interventions should be HC/PI and "other" which encompasses social marketing campaigns, presentations and internet outreach.
    - Enhancements must follow the plan template (Appendix 13) and guidance from DHSS.

- Inclusion of a condom distribution plan with active engagement of clients. Prioritize and coordinate the plan to target HIV positive persons and HIV negative persons at highest risk of acquiring HIV infection.

In addition, RLAs must:

- Integrate STD education into HIV interventions and provide STD education opportunities to RPAG.
- Participate with DHSS in an assessment of the HIV Planning Group model which utilizes local health departments as lead agents for HIV Planning.
- Present budget and expenditure data, including subcontractor information, at each RPAG meeting.

Monitoring Requirements
The RLA must participate in contract monitoring site visits. The RLA must complete and submit to DHSS a quarterly intervention progress report. This report should be shared with the RPAG to monitor plan implementation and prepare plan enhancements.

Reporting Requirements
The RLA shall provide DHSS with the following:

- RPAG membership form by March 31 of the contract year, and as membership changes, submitted with the regional HIV/STD Prevention Plan.
- RPAG bylaws and operating procedures by January 30 of each contract year. These should reflect the newly structured HPG bylaws and operating principles.
- RPAG meeting schedule by January 30 of each contract year, and meeting minutes within 30 days after each meeting.
- RPAG work plans by January 30 of each contract year.
- HIV prevention planning process evaluations (twice per year).
- HIV prevention planning meeting evaluations within 30 days of each meeting.
- Projected programmatic budget for the regional plan by August 15 of each contract year.

The RLA shall provide the following written reports through HPG representatives or regional co-chairs at statewide HPG meetings:

- Community assessment results by April HPG meeting
- Regional plans or enhancements by July 31 of each contract year
- Condom distribution plan by January 1 of each contract year
- Regional projected budgets with regional plans by July 31 of each contract year
- Final budget must be shared with the RPAG by January 15 of each contract year.
- Regional Report Forms after four quarterly meetings
- Progress reports on regional intervention plans by March 1 of each contract year
- Membership characteristic survey reports within ten days of completion

Health Education Risk Reduction

Health Education/Risk Reduction or HE/RR ensures implementation of HIV prevention interventions that are scientifically based in behavioral theory with evidence of effectiveness targeting populations most at risk for contracting and/or spreading HIV/STDs. HE/RR activities include Individual, Group and Community Level interventions designed specifically to promote change in behavior to reduce the risk of contracting or spreading HIV. HE/RR also consists of interventions for HIV prevention that focus on outreach efforts, health communication and public information efforts as well as other interventions consisting of internet outreach and HIV prevention material distribution.

Intervention Development

Interventions are developed and prioritized based upon findings from the community assessment and the Annual Epidemiological Profile.

In order to assure that interventions throughout the State are both effective and appropriate for specific, targeted populations, all regions follow the template for intervention plans.

To ensure that interventions provide target populations with sufficient skills to reduce populations the following standards must be followed:

Intervention Standard	Description
60% = EBIs/Homegrown ILIs, CLIs and SLIs, Biomedical Interventions	60% of all interventions delivered for a specific population must be met for individual, community level and structural level interventions. Priority must be given to DEBIs/Procedural Guidance/ Biomedical interventions for these levels as available.
20% = Homegrown GLIs, Outreach	20% of all interventions delivered for a specific population must be met for group level and outreach, giving priority to DEBIs/Procedural Guidance interventions as available.
20% HCPI/Other	20% can be presentations, community wide events, social marketing, internet interventions etc.

Annual plans should be followed to increase the number of DEBIs and other model programs per region. Each region should strive for 80% of planned interventions to be DEBIs, other model programs, and/or procedural guidance programs. Due to changes by the Centers for Disease Control and Prevention (CDC), Prevention for Positive Interventions are priority. High Impact Interventions are also prioritized, as are those that reach the most people at a given time. The RPAG shall develop outcome objectives for all individual and group level interventions according to the regional plan and submit objectives to DHSS for approval in July 31 of each year.

CRCS: see Prevention for HIV Infected Individuals.

Each region is required to implement proven effective interventions for the state prioritized populations. At least 80% of planned interventions will be DEBI and/or model programs. These interventions have been proven effective through research studies that showed positive behavioral outcomes (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, in order to show positive outcomes could be attributed to the interventions. With input from the researchers, the materials necessary to implement the interventions have been packaged into user-friendly kits. With the appropriate training and intervention package, service providers increase opportunities to conduct effective HIV/STD/Viral Hepatitis prevention programs in their communities.

HE/RR and DEBI trainings, (in-state and out-of-state) should be provided to RPAG members, subcontractors, and agencies who deliver HE/RR services to enhance effectiveness of interventions and programs. The RLA and subcontractor staff must be trained to implement DEBI interventions. The RLA is responsible for site arrangements, participant facilitation, refreshments, and training announcements with directions to training location.

For interventions that are not DEBI or model programs and do not have adequate evaluation components, elements of successful interventions (as listed in the Compendium for Effective HIV Prevention Interventions located on the CDC website www.cdc.gov.) must be included.

Social Marketing:
Each region should conduct social marketing campaigns that include media messages and mobilization strategies. Social marketing campaigns should be outlined in the Plan and subsequent enhancements to include information on messages, target audience, and methods of promotion.

Relevant information about all events planned in the region for national days of recognition should be provided to DHSS no later than one month before the activities are implemented.

HE/RR Program Material:
To assure that all programs and interventions meet community standards, are appropriate for the prioritized population, understandable, and culturally competent, the following protocols should be followed:

1. All programmatic materials must be submitted to the Statewide HIV Prevention Programmatic Material Review Board every quarter. Materials submitted for review must be submitted at least two weeks before the quarterly HPG Program Review Panel meeting. Materials submitted after this timeframe will not be reviewed.

2. Materials must be written on a fourth to sixth grade level of comprehension, when possible.

Recruitment of Clients for HE/RR Interventions:
CDC places an emphasis on using model programming for interventions delivered to at risk populations. Many of these model programs include individual and group level interventions are included and require a commitment of participation by the populations served. Recruitment plans for interventions should be included in the regional and state HIV prevention plans. CDC has developed a guide to assist with recruitment efforts. The guide can be requested by calling 573-751-6439 or going to www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm.

Recruitment approaches include:

- **Internal resources**. Criteria should be developed that will trigger a referral within the agency. Providers within the agency should assess clients to determine prevention needs and make appropriate referrals. Targeted messages should also be developed that can be delivered by staff/volunteers within the agency to potential clients and/or mass messaging strategies (i.e., display posters throughout the agency).
- **Referral networks**. Relationships can be established with service providers that the target population is most likely to access. Formal agreements can be developed with appropriate service providers for screening and referrals. Tailored and targeted materials can be provided to referral partners that advertise programs and services.
- **Outreach**. Locations where potential clients congregate can be venues to advertise programs. Recruitment through outreach should be evaluated for safety issues. Health fairs and community events can be recruitment venues for intensive interventions and peers can be utilized as outreach recruiters to promote programs.

Intervention Levels

ILIs have the following elements:

- ✓ Individual risk assessment
- ✓ One-on-one HIV Prevention Counseling, resulting in a plan for behavior change
- ✓ Skill development
- ✓ Skill building exercises during counseling session
- ✓ Referral to other services

GLIs have the following elements:

- ✓ Skill building with practice sessions.
- ✓ Groups of 20 or less who share similar backgrounds/experiences (i.e., gay men of color, female IDUs, etc.).
- ✓ Single or multiple sessions.

Outreach interventions have the following elements:

- ✓ Delivered in settings where the target population gathers (i.e., bars, hair salons, pubs, community centers, parks, etc.).
- ✓ Distribute information supplies to the target population without the opportunity to speak to them individually or, in groups of 1-5 people with brief prevention messages.

HC/PI interventions include the following large audience venues:

- EleHIV Testing Programonic Media - via radio, TV, infomercials, public service announcements (PSAs).
- Print Media - newspapers, posters, magazines, pamphlets, print ads, billboards, signage on buses, taxis, etc.
- Hotline - telephone service, which offers information, referrals, and prevention counseling to individuals.
- Clearinghouse – interactive eleHIV Testing Programonic outreach systems using telephone, mail, and Internet web presentations.
- Lectures.

Structural Level Interventions (SLI): Designed to implement or change laws, policies, physical structures, social or organizational structures, or standard operating procedures to affect environmental or societal change.

Biomedical Interventions (BMI): Use of medical, clinical, and public health approaches to moderate biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV and/or decrease HIV infectiousness.

Community Level Interventions (CLI): Designed to change community norms and behavior to reduce factors that put individuals as a community at risk for HIV infection.

"Other" Interventions: Designed to change social norms and create community support for HIV prevention. Per CDC, any intervention that does not meet the previous criteria for interventions is to be placed in this category.

Community Mobilizations: Develop community motivation and support for HIV prevention efforts.

- ✓ **Social Marketing** – A multi-level campaign that targets a specific community or segment of the community with a clearly defined message (i.e., radio spots, TV ads, magazine ads, and billboard messages developed to promote HIV testing among Hispanic teens ages 14-18).
- ✓ **Community Wide Events** – Educational events in a community (either general or targeted) that promote HIV/STD information, awareness, and services (i.e., town hall meetings, health fairs, exhibits, etc.).

- ✓ **Policy Interventions** – The enactment of policies and/or procedures to-promote prevention efforts (i.e., a high school policy to make condoms available in restrooms or nurse's office.).
- ✓ **Condom/Literature Drop Off** –Provide condoms, safer sex packets, brochures, information cards, etc. where the target population frequents or engages in high risk activities (i.e., crack houses, shooting galleries, bars, parks, strolls, spas, etc.).
- ✓ **Passive Outreach** - Outreach that does not include personal contact with individuals but provides an array of prevention messages and materials to a broad audience.
- ✓ **Internet/Chat Rooms** – Host chat rooms or visit established chat rooms to promote HIV prevention, conduct risk reduction counseling, and provide information about transmission.
- ✓ **Other** - Additional interventions that meet the definition but are not listed above.

HE/RR Reports:

- Intervention and outreach log sheets are due according to the following schedule:
    - April 15 (January-March)
    - July 15 (April-June)
    - October 15 (July-September)
    - January 15 (October-December)

    All log sheets must be maintained on site for one calendar year after completion.

- A calendar of interventions by the first of each month. The calendar should include programs by subcontractors, if applicable.

- The Agency Readiness Self-Assessment (Appendix 14) by no later than February 15 of each contract year.

- A region-wide HE/RR program plan based upon the region's HIV/STD prevention plan is due no later than July 15th of each contract year. The program shall be guided by the *Essential Characteristics of Health Education/Risk Reduction Programs.*

Additional HE/RR Requirements

- Participate in the DHSS annual HE/RR Contractor meeting.
- Assure HE/RR Prevention Programs and services are provided by staff and volunteers who are sensitive to, and reflective of, priority populations.
- Track unduplicated clients for all DEBI programs by collecting individual level data. Additional information is located in the Statewide Comprehensive HIV/STD Prevention Plan. The Intervention Log Sheet (Appendix 15) can be used or modified by region. Modified forms must be submitted to DHSS for approval before use.
- Submit client level data for all DEBI interventions (group and individual level). DHSS will supply forms to collect data; forms cannot be altered without prior approval by DHSS.

- Assure HE/RR Prevention Programs are based on behavioral theory targeted to priority populations, with consideration of community values and input from people living with HIV.
- Provide behavioral risk screening followed by individual and group level evidence-based interventions to high risk negatives and discordant couples.
- Track outreach and HC/PI interventions conducted on the Outreach Log Sheet (Appendix 16). The Log Sheet can be used or modified by region. Modified forms must be submitted to DHSS for approval before use.

HIV Testing Program

HIV Testing Services

In an effort to provide effective services to any and all clients, the HIV Testing Program has established the following goals:

1. To increase the early detection of HIV infection for those infected
2. To prevent HIV infection for those at risk
3. To decrease the transmission of HIV from those infected

Collaboration with other HIV Care and Prevention programs is essential for success. The HIV Testing Program is dedicated to a holistic approach to curb the HIV epidemic and strives to assist and support the processes of other HIV-related programs, including HPG, HIV Care/Case Management, and Sexually Transmitted Disease Prevention.

DHSS contracts with and provides funds for six lead agencies and their subcontractors to provide HIV testing services. HIV testing services are provided at no charge to clients. The HIV Testing Program includes in-house and outreach services and offers blood and oral testing through standard and rapid testing methods. Four of the six contracted agencies offer services anonymously, as mandated by state statute which can be found at www.moga.mo.gov/statutes/c100-199/1910000686.htm. Other publicly funded agencies may submit specimens to the Missouri State Public Health Laboratory (SPHL) for HIV testing at no charge to the provider or client. The SPHL also processes HIV testing for non-public agencies for a nominal fee.

The HIV Testing Program staff serve in a statewide capacity and should be contacted with questions and concerns regarding HIV counseling, testing, and referrals. The staff work closely with regional Disease Intervention Specialists (DIS) in an effort to provide quality and timely services.

The HIV Testing Program Procedure Manual contains specific protocols, standards and regulations pertaining to this program component. The manual can be requested by calling 573-751-6439.

Partner Services

Partner Services consists of interviewing individuals infected with HIV/STDs to identify those still at risk (whether through direct exposure or indirect involvement) to offer testing, counseling, and treatment (as appropriate).

Partner Services are offered to individuals who are infected with HIV/STD, to their partners, and to others who are at increased risk for infection in an effort to prevent transmission of these diseases and to reduce suffering from their complications. Services include:

- providing information about current infection(s) and other STDs;
- ensuring confidential notification, appropriate medical attention, and appropriate social services referrals
- providing referrals to testing and treatment services for partners and other high-risk individuals;
- assisting with referrals to HIV Care/Case Management programs (when appropriate);
- developing risk reduction plans to reduce the likelihood of acquiring future STDs;
- providing referrals to additional medical or social services; and
- defining and targeting the at-risk community while assuring complete confidentiality for the patient

Partner Services are offered to clients by Disease Intervention Specialists (DIS). DIS are located throughout the state (Appendix 17) to assure that the delivery of Partner Services is timely and efficient. Confidentiality is strictly maintained.

Partner Services goals are in accordance with the current CDC Comprehensive STD Prevention Services (CSPS) Grant:

- Interview at least 95% of all HIV cases reported in jurisdiction. Complete and submit DHSS approved documentation according to DHSS DIS Protocols.
- Re-interview at least 80% of all newly diagnosed HIV positive individuals that received an original interview. Follow protocols described in the CDC STD Employee Development Guide and DHSS DIS Protocols.
- Maintain an HIV contact index of 1.5 (number of contacts initiated divided by number of cases interviewed).
- Maintain an HIV cluster index of at least 0.5 (number of clusters initiated divided by number of cases interviewed).
- Locate and counsel/examine at least 85% of new HIV contacts.
- Locate and counsel/examine at least 40% of HIV cluster suspects and/or associates.
- Refer HIV positive individuals to HIV Care /Case Management services according to DHSS protocols.

HIV PREVENTION PROCEDURE MANUAL

Evaluation

All funded lead agencies and their subcontractors are required to evaluate thier services. Evaluations should encompass:

Process Evaluations

- State approved instruments are to be used for both the HPG process and HE/RR funded programs.
- If a region elects to develop tracking instruments for HE/RR programs, prior approval by DHSS must be obtained.

Program Evaluations

- Use of the CDC Evaluation & Monitoring System to verify programs are implemented accoriding to the HIV Prevention Plan.

Outcome Monitoring Evaluations

- All outcome-monitoring instruments are to include an HIV knowledge assessment, a client satisfaction component, and how participants learned about the interventions.
- When available, CDC evaluation tools must be used. If not available, DHSS approved tools must be used.
- The RPAG shall be responsible for implementing state provided protocols for outcome monitoring. Any request for modification of protocols shall be sent to DHSS.
- The RPAG shall be responsible for implementation of outcome monitoring tools for all DEBI interventions and state specified group level interventions as agreed upon.

The following chart outlines the various evaluations:

Category	Evaluation Instrument	Timeline for Submission
HPG		
Meeting Evaluations	Missouri HIV/STD Prevention HPG Meeting Evaluation Form make sure all are "attachment" and appropriate number)	Months meetings are held.
CDC Membership and Community Planning Process Review Process Evaluations	Community Planning Survey	Annually
CDC budget information	CDC Evaluation and Monitoring System Variables	Annually
New member information	New Member Application	At time of member application for HPG membership
Group affiliation	Disclosure of Membership	At time of application for

	Form	HPG membership, and annually thereafter.
Review of grant and application for concurrence	Grant/Application Review Forms	Annually
Regional progress and issues	Regional Report Forms (Appendix 18)	Quarterly, submitted at the Statewide HPG
Regional budget	Regional Budget Submission Form	Annually
Process Implementation Monitoring		
Program materials distributed for prevention programs	Program Material Review Form (Appendix 19)	As needed.
Regional Plans	Plan Development Template (timeline and process) (Appendix 13)	Annually
Data from interventions delivered and populations reached	Intervention Log Sheets (Appendix 15)	Per intervention and submitted quarterly
Review of plan implementation progress	Quarterly Reports	Quarterly
Referral Tracking Agreements – interagency/inter program	Memorandums of Understanding	Annually
Program Implementation Evaluation		
Program implementation tracking	The CDC Evaluation and Monitoring System, in Phase II implementation will be used to monitor this evaluation	N/A
Outcome Monitoring		
Tracking outcomes of Prevention Programs	Correct condom use and risk reduction negotiation outcome monitoring instruments for model/DEBI/EBI programs (Appendix 20)	Quarterly; instruments administered per intervention delivered

CDC Evaluation and Monitoring System

The use of the CDC web-based system for reporting data and evaluation is required. In order to successfully implement the evaluation system and meet reporting requirements, the following guidelines will apply:

1. The RLA is required to participate in designated trainings for each implementation phase of the evaluation system. These programs include the following:

    - HE/RR Interventions
    - HIV Testing
    - Partner Services
    - Comprehensive Risk Counseling Services (CRCS)

2. The RLA and funded subcontractor, in consultation with DHSS, will determine which staff members require training. The RLA will assist with training of subcontractors.

    - RLAs are responsible for notifying DHSS of any staff changes for the purpose of trainings, access, or removal from the evaluation system.
    - DHSS will apply for approval of staff that needs access to the evaluation system. DHSS will supply the agency with application forms.
    - The RLA will enter annual regional plans into the CDC evaluation system by December 31 of each year and a review of agency and other program information by January 31 of each year and enter updates as needed.

The RLA will be responsible for entering client and program implementation data for the respective region. Each year, CDC requires data is submitted by:

Additional Responsibilities

1. The RPAG shall develop outcome objectives for all individual and group level interventions according to the regional plan and submit objectives to the State Community Planner for approval in July 31 of each year.

2. The RPAG shall be responsible for implementing state provided protocols for outcome monitoring. Any request for modification of protocols shall be sent to the Statewide Community Planner and Statewide Evaluator.

3. The RPAG shall be responsible for implementation of outcome monitoring tools for all DEBI interventions and state specified group level interventions as agreed upon.

4. The RLA shall monitor accuracy of data submitted by subcontractors for the CDC evaluation system and ensure that data used for evaluation is submitted on a quarterly basis.

5. Each region will identify at least one key staff person to be trained and responsible for entering data into the CDC Evaluation System by no later than January 1 of each contract period.

6. Each region will follow the procedures and use the forms agreed upon with the Statewide Evaluation coordinator for collecting data to be entered into the CDC system.

7. Each region will maintain a trained staff person to enter data and notify the Statewide Evaluation Coordinator of staff changes and arrange trainings as needed. These persons will read and sign the rules on confidentiality and send signed statements to the Statewide Evaluation Coordinator.

8. The RLA shall enter annual regional plans into the CDC evaluation system by December 31 of each year and a review of agency and other program information by January 31 of each year and enter updates as needed.

9. The RLA shall assure compliance with all CDC reporting requirements as they pertain to the implementation of the CDC Evaluation System. All Evaluation System data must be entered into the system according to the following schedule:

    - January 10
    - April 10
    - July 10
    - October 10

10. All system users are required to comply with CDC requirements and guidelines for confidentiality and security procedures. DHSS is responsible for distributing guidelines to evaluation system users.

11. The RLA will monitor accuracy of data submitted by subcontractors for the CDC evaluation system and ensure that data used for evaluation is submitted on a quarterly basis.

12. The RLA will comply with all CDC reporting requirements for the implementation of the CDC Evaluation System. All Evaluation System data must be entered according to the following schedule:

    - January 10
    - April 10
    - July 10
    - October 10

Prevention for HIV Infected Persons

Comprehensive Risk Counseling and Services (CRCS) are designed to assist HIV positive and high risk negative individuals to reduce risk behaviors and address the psychosocial and medical needs that contribute to risk behavior or poor health outcomes.
CRCS, formerly Prevention Case Management (PCM), is a client-centered prevention activity that provides intensive, ongoing, individualized prevention counseling, support, and referrals. Priority for CRCS should be given to individuals at highest risk for HIV infection. CRCS delivered by the RLA and its subcontractors must be implemented per CDC guidance found at www.cdc.gov/hiv.
DHSS supports the implementation of the Learning Immune Function Enhancement (L.I.F.E.) program. This program includes group workshops and individual client counseling sessions that focus on risk reduction behaviors and medication adherence for positive clients. Two staff members are required to implement this program: one to facilitate the workshops and counseling sessions included in the program; and one to coordinate programmatic activities, prepare reports, and ensure quality of the program. For detailed staffing requirements, see Appendix 21.

If conducting the optional Shanti L.I.F.E. HIV Self-Management 101 Workshop, the RLA must assure implementation as directed by DHSS.

The RLA should encourage linkage to HIV Care, treatment and prevention services for individuals who test HIV positive or who are currently living with HIV/AIDS.

If the L.I.F.E. program is implemented in the region, a quarterly report must be submitted describing implementation. The report must include information on weekly client numbers and other aspects of program implementation. Refer to Appendix 22 for the Report of Weekly Missouri Agency Consultation Meetings report format.

Condom Distribution

Condom distribution programs can be cost-effective structural interventions that provide communities with the resources they need to prevent the spread of HIV. Making condoms widely available is integral to successful HIV prevention. Condom distribution programs have been shown to increase condom availability and use among a wide range of populations, including youth and adult males, commercial sex workers, and those who engage in risky sexual activities.

An effective condom distribution program can change the way a community thinks about and engages in safe sex behavior. Condom distribution programs should strive to make condoms:

Available
Ensure that condoms are available in the environment where members of the target population frequent or engage in high risk activities (i.e. crack houses, shooting galleries, bars, parks, strolls, spas, etc.).

Accessible
Ensure unrestricted access to condoms by providing free condoms that are conveniently located in multiple locations.

Acceptable
Ensure that the norms within a community support the use of condoms and the various types are acceptable to community members.

Condom Distribution Guidelines (Appendix 23) provided by DHSS, based on the CDC Condom Distribution Toolkit, must be followed.

Condoms should be included in individual and group level interventions for high risk negatives and discordant couples.

Community based interventions (according to the current comprehensive HIV Prevention Plan) should include active condom distribution programs.

Condom distribution must include active engagement of clients and must be prioritized and coordinated to target HIV positive individuals and high risk negatives.

The RLA will assure that all designated staff attends training on the Condom Distribution Toolkit by no later than January 1 of each contract year. The RLA must submit a condom distribution plan by January 1 of each contract year.

Appendix 1
HIV/STD Prevention
Technical Assistance Request Form

Region: **Lead Agency:**

Technical Assistance Request:

- ☐ HIV Planning/Capacity Building Specifics:
- ☐ Evaluation Specifics:
- ☐ HE/RR and Intervention Development Specifics:
- ☐ HIV Testing Specifics:
- ☐ Condom Distribution Specifics:
- ☐ HC/PI Specifics:
- ☐ Resource Development Specifics:
- ☐ Other:_____

Preferred dates for TA:

Who, in your region needs training?

Is this a request for onsite training in your region? ___Yes ___No

Is this a request to attend a specific training? ___Yes ___No

If yes, which training are you interested in attending?

Which of the following can you provide for the training?

- ☐ **Location**
- ☐ **Refreshments**
- ☐ **Promotion/Publicity**
- ☐ **Handouts**
- ☐ **Flip Chart/Markers**
- ☐ **LCD Projector and Screen**
- ☐ **DVD Player/Monitor**

Comments:

Signatures:_____ Date of Request:_____

Mail, Email or Fax Completed Forms to Sandy Hentges, DHSS, BHSH, 930 Wildwood Drive, Jefferson City, MO 65109 or Sandra.Hentges@health.mo.gov or 573-751-6447

Appendix 2
MISSOURI HIV Planning Group
Conflict of Interest Policy

Definition:

A conflict of interest can be defined as a conflict between one's obligation to the public good and one's self interest, whether that interest be a of a professional nature, personal interest, or interest of family or friend. A conflict of interest occurs when an appointed or elected individual knowingly takes action or makes a statement intended to influence the conduct/decisions of the public body of which he or she is a member. If the member's action in any way confers any financial or programmatic benefit to the member or the organization, person, program, etc. the member is affiliated with, a conflict of interest does exist.

Due to the intricate pattern of agency connections, contractual and sub-contractual relationships between local health departments and community based organizations, and the inevitability of conflict of interest, the following is suggested to make the community planning process as nonpartisan as possible. This policy also addresses the potential for conflict of interest in letting of contracts and the distribution of prevention funds through the HIV/STD community planning process.

- Membership of the State Level Planning Body and the membership of its regional subcommittees with voting rights as defined by each region's charter shall complete the attached member profile form listing their agency affiliations. These affiliations may include but are not limited to family members on staff of a given agency, participation on agency board of directors, officers of agencies, volunteer relationships with agencies. The member profile form, including this conflict of interest understanding, shall be completed annually and updated as necessary. MDHSS staff shall keep this form on file and provide it to other voting HPG members and the state community co-chairs when requested in situations involving conflict of interest.

- The Membership of the State Level Planning Body or regional subcommittees shall make such affiliations known prior to any group discussions concerning specific agencies or like services delivered by their affiliated agency. Membership shall not be excluded from participating or advocating in group discussions concerning services, which are delivered by agencies with which they are affiliated.

- The conflict of interest disclosure form, as well as issues that arise, will be reviewed by state co-chairs to determine whether or not a member has a conflict of interest

- In situations where a voting member has a conflict of interest, as defined above, that member shall refrain from voting.

- Members found to be in violation of this conflict of interest policy shall be asked to refrain from such violations. If the member consistently fails to comply with such requests, and has at least three verbal reprimands from any state co-chairperson, cumulatively during the length of their membership, the member shall have their participation rights (voting) revoked for one year (12 months) following the third and final reprimand.

- Members who represent a particular agency and have violated the conflict of interest policy will lose their participation rights for twelve months. State co-chairs will be responsible for notifying the member's employer by certified mail of their employee's violation, their conflict, and the corrective measures that were taken and will be adhered to in the future. This letter will then be drafted and sent out within 30 days of the third reprimand.

I understand the above and agree to comply with the provisions set forth.

_____ _____

(Voting Member) (Date)

Appendix 3
Dispute Resolution for the Missouri HIV Prevention Group

Despite careful prevention efforts, disagreements and conflict inevitably result from working with people from diverse backgrounds. Therefore, it is imperative to have a system in place that can allow for dispute resolution without negative consequences to any parties involved. Outside mediators will be provided at the request of either party involved. All disputes must be submitted in writing, clearly and objectively defining terms of the dispute. Disputes must be submitted to one of the three state co-chairs. There are eight principles to dispute resolution, and they are listed below:

1. Maintain a climate of fairness and mutual respect.
2. Distinguish between the person and the problem at hand.
3. Identify and build upon areas of mutual agreement.
4. Distinguish between interests and positions. (Often times, positions are the cause of dispute. In order to separate out interests from positions, one must clearly strive to understand what the motivating factors are behind adamant positions. It is these motivating factors that are the interests at hand.)
5. Develop options for mutual gain. (Once issues are understood, the members must work together to develop options through informal brainstorming for mutual gain for all parties involved.)
6. Use objective criteria such as fairness, effectiveness, and factual information that may have scientific merit for discussion and decision-making.
7. Establish a common goal that includes the concerns of all parties involved.
8. Either party involved in the dispute can choose to pursue grievance procedures or can chose to withdraw from the dispute resolution process at any time.

Please Note: Disputes need to go through this process no later than the next scheduled Community Planning Meeting. In some instances, special meetings may be called to resolve disputes within two weeks with written documentation that clearly defines issues and concerns disputed.

If these steps are followed, the group must decide on an option for mutual gain that has met at least some of the interest of all participants. **This consensus decision will then be recorded in a role-call vote of HPG voting members if deemed necessary by the mediator and statewide co-chairs.** If consensus is not reached through the steps taken above, grievance procedures will be initiated.

Appendix 4
State of Missouri
HIV Planning Group By-Laws
Revised November 2012

Preamble:

On February 24, 2000, the State Level Community Planning Group (CPG) voted to adopt a new structure. This structure encompasses one official Community Planning Body ***with six regional*** *prevention advisory groups or RPAGs. To ensure the HPG leadership effectively represents the planning business of the state, the planning group will be chaired by one state appointed co-chair, one elected rural community co-chair, and one elected urban community co-chair. As a result, bylaws are amended and passed through the newly enacted Structure Work Group Subcommittee to reflect the structure change and to clarify roles and responsibilities of Community Planning Members. The amended bylaws have been ratified and approved by the State Level Community Planning Group as of September 21, 2000.*

Note: Due to the new structure of the State Level Community Planning Group, only one letter of concurrence is required to CDC with the grant application.

Name

The name shall be the "Missouri HIV Planning Group." (HPG)

Mission

The mission of the Missouri HIV Planning Group is to inform the development or update of the HD's Jurisdictional HIV Prevention Plan that will contribute to the reduction of new HIV infections address the challenges of the epidemic and maximize the effectiveness of current HIV prevention methods by:

- Identification of appropriate stakeholders
- Engaging in a results-oriented process
- Ensuring that the goals of the National HIV/AIDS Strategy are achieved
- Utilizing a High Impact Prevention (HIP) approach
- Developing, implementing, and monitoring a jurisdictional plan

Roles and Responsibilities

A. HIV Planning Group

The State Level HIV Planning Group (HPG) shall:

- Serve as the official planning body for Missouri.

- Delineate technical assistance and capacity development needs for effective community participation in the planning process.

- Elect the community co-chairs who will work with the Health Department designated co-chair.
- Ensure membership structure achieves community and key stakeholder representation (parity and inclusion).
- Ensure information is presented in a clear and comprehensive manner.
- Inform the development or update of the Jurisdictional HIV Prevention Plan.
- Submit a letter of concurrence, concurrence with reservations, or non-concurrence.

Subcommittees:
The Statewide HPG will have six permanent subcommittees that will address issues of a procedural nature on behalf of the full HPG and will present reports to the full HPG for discussion and approval. There will be five ad hoc subcommittees that will work on tasks if the need arises for subcommittees to address a specific issue. There is an official enrollment period for those who want to join a subcommittee and that period runs through the March/April HPG meeting. Until someone officially enrolls, they are welcome to participate as gallery members to the committees that interest them. However, priority of input will be given to official members first. The five permanent subcommittees are:

1. **Structure**
   Duties:
   a. By-laws
   b. Resource development.
   c. Resource inventory development.
   d. Intervention strategies.
   e. Receive information on Evaluation Web and program updates from program evaluator.
   f. Assist with implementation of statewide needs assessment.
   g. Work jointly and provide support with MOPACC and other subcommittees as needed.

2. **At-Large**
   a. Recruitment of At-Large members as needed (Please note: that if a person is applying to fill an At-Large seat for individuals living with HIV, s/he must be willing to disclose their HIV+ status to the HPG.) All disclosures of HIV status made to the HPG will be kept private/confidential, and on a need to know basis only.
   b. Assist with the updating of the African Emergency Response Plan and the Hispanic Statement of Need on as needed basis.
   c. Ensure at-large maintains function of providing PIR to statewide body.
   d. Plan for or share information on events for national days of recognition such as National HIV Testing Day.
   e. Plan for or share information on events for national days of recognition such as National HIV Testing Day.

3. MOPACC (Missouri Prevention and Care Collaboration)

a. To facilitate and support a process for coordinating HIV prevention and care planning resources and activities in order to maximize the outcomes of both prevention and care groups.
b. Work jointly with the structure workgroup in planning processes such as community assessment and prioritization of populations and interventions particularly those interventions specifically for HIV positive individuals.
c. Update as needed strategies that promote collaborative prevention and care activities.

4. Membership Committee

a. Plan for and participate in new member and refresher orientations during quarterly HPG meetings.
b. Ensure that updated materials are used for new member orientation.
c. Responsible for ensuring Parity (Fairness), Inclusion and representation over the entire HPG body through the implementation and analysis of membership characteristic surveys and epidemiological data. Recruitment of gallery members is also included in this process.
d. Ensure proper implementation of the point person and mentor programs as an extension of new member orientation.
e. Ensure that each regional prevention advisory group conducts orientations that are consistent with and reflective of the statewide orientation process by providing materials and tools to be used regionally.
f. Assist in decision making for removal of committee members who are not fulfilling their participation obligations.
g. Ensure engagement of stakeholders that are key to the HIV planning process.

5. STD Subcommittee

a. Provide to the HPG and its RPAG's a master annual calendar of all testing events and major community events to assist these groups in their prevention planning activities.
b. Disseminate a Best Practices for STD Prevention to assist the HPG and RPAGs in the planning.
c. Assess accessibility of STD testing and prevention services for the Hispanic communities in Missouri.
d. Work with the Bureau of HIV/STD/Hepatitis to develop and disseminate to the HPG, RPAGs and Community providers protocols on providing testing technologies to their consumers.
e. Ensure that annually membership on the STD committee includes at least one representative from the HPG and/or Gallery from each region.

6. Youth Subcommittee

a. To provide the state's STD and HIV Prevention programs with ideas, input, and recommendations for strategies, techniques, and messages to more effectively reach Missouri's diverse youth populations and successfully instill STD/HIV Prevention concepts. This is to be accomplished through the identification of best practices regarding HIV/STD/Teen Pregnancy prevention curricula from other states.
b. To develop, as a group, recommendations to the state for a comprehensive multi-tiered (school-based, community-based, and peer-based) STD/HIV Prevention Education for Youth program.
c. Identify existing community-based youth programs to build partnerships
d. Provide ongoing support to schools and community-based programs
e. To gather and share information, opinions, and feedback from the various communities you live in and work with also utilizing input from Youth Advisory Committees in order to make the group process more inclusive and representative of Missouri's diverse youth populations.

The five current ad-hoc subcommittees are listed as follows:

1. Urban

Duties: (for corresponding regions)

a. Assist with the statewide implementation of needs assessment
b. Serve as an "approval board" for recommendations put forth by the Structure Workgroup to the full body HPG.
c. Evaluation as needed.
d. Share ideas between regions on ways to increase capacity, intervention development and enhancement, and improve planning processes.

2. Rural

Duties: (for corresponding regions)

a. Assist with the statewide implementation of needs assessment
b. Serve as an "approval board" for recommendations put forth by the Structure Workgroup to the full body HPG.
c. Evaluation as needed.
d. Share ideas between regions on ways to increase capacity, intervention development and enhancement, and improve planning processes.

3. Jail Collaboration

a. Assess the need for HIV/STD prevention information
b. Collaboration with jail facilities and AIDS prevention service organizations (ASO) to identify unmet HIV/STD prevention needs.
c. Provide for technical assistance as necessary to local sheriffs/jails about HIV/STD prevention issues and intervention strategies for inmates and staff.
d. Evaluate success of prevention efforts in this setting and strategize for the creation of new and innovative prevention programming.

4. Mental Health

a. Assist in statewide Mental Health and Health collaborative educational efforts.
b. Develop resources and intervention strategies for clients that engage in drug use to reduce their risk of contracting HIV/STDs
c. Ensure client access to essential private and community services and resources.
d. Work collaboratively with Mental Health providers to promote knowledge and facilitate information exchange between HIV Care and Prevention providers.
e. Provide technical assistance regarding mental health issues when planning and prioritizing interventions for target, at-risk populations.

5. Women's Subcommittee

Address women's issues related to HIV and STD prevention primarily in the African American community with a focus on HIV + women.

Subcommittee Processes

- ***Each voting and official HPG member will be required to belong to at least one subcommittee. The subcommittees will be subject to all the provisions of the by-laws described here.***
- ***Each committee will elect two co-chairs to facilitate the group process. Committee co-chair election will alternate years for election so that at least one experienced co-chair remains during any given cycle.***
- ***Co-chairs will serve a one-year term of office with an option of serving up to two (2) consecutive terms maximum provisional upon committee vote.***
- ***If a person has 2 or more unexcused absences from either a subcommittee meeting or a subcommittee conference call, the subcommittee co-chair must submit that concern to the membership committee for consideration or recommendation for removal from that committee. All recommendations for removal must then be sent for final determination to the state urban and rural co-chairs for final determination of removal from the subcommittee. If the absences occur within the membership committee itself, then the committee's co-chair will submit that concern to the state urban and rural community co-chairs to make a determination for removal.***

B. Regional Prevention Advisory Body

- The following regions are strongly encouraged by the State Level HPG to represent the scope of the epidemic within their region:

1. North Central
2. Kansas City
3. Northwest
4. St. Louis
5. Southeast
6. Southwest

- Each Regional Prevention Advisory Body is responsible for electing representatives and alternates to attend State Level HPG Meetings. In the absence of a regional prevention advisory body, the lead agency that holds a contract with the administrative agent will be responsible for assurance of regional representation to the statewide planning group.

- The requirements of representation for each region are as follows: **North Central – 3 reps, Kansas City – 5 reps, Northwest – 2 reps, St. Louis – 5 reps, Southeast – 2 reps, and Southwest - 3 reps.**

- Provide the representatives at the state level with a concise view of the desires of the regional advisory group in relation to prevention planning.

- Must ensure that the regional point person program is maintained for the assistance of new regional advisory group members and/or statewide HPG members.

C. Administrative Agent

The Missouri Department of Health and Senior Services, as grantee of Federal HIV prevention funding, will be the designated Administrative Agent. The roles and responsibilities of the Administrative Agent are as follows:

- Convene and support a diverse, statewide community-planning group that represents the current and projected HIV epidemic in the State of Missouri. Using the ability to work with diverse populations including those that are HIV positive and of priority risk populations.

- Assure the occurrence of local community leaders in developing annual regional prevention plans, ensure that the needs of all the regions are taken into account in developing statewide needs assessments, assess and respond to regional technical assistance needs, and assure regional process evaluations are conducted.

- Primary responsibility for the planning and development of the HIV prevention grant. Develop grants for the Section as assigned.

- Assist the Bureau as a coordinator for special projects/pilot studies.

- Work closely with collaborative partners on the national and state levels such as the CDC, Department of Mental Health, and Department of Corrections.

- Develop grant opportunities for the Section.

- Work with Section's fiscal program to develop annual contracts with lead agency health departments and conduct contract-monitoring reviews.

- Collaborate with STD/HIV/AIDS staff and local health departments and community planning groups for the integration of STD prevention programming into the Community Planning Process.

- Collaborate with STD/HIV/AIDS colleagues to provide planning tools such as the ***epidemiological profile***, process and program evaluation formats, needs assessment formats and other appropriate materials to state and local planning groups. Standardize tools for easy compilation and statewide analysis.

- Assure the training and preparation of local co-chairs and planners to conduct local planning processes.

- Monitor the timely completion of RPAG/Lead agency reports as per annual contract requirements.

- Communicate actively with Section regarding team outcomes and projects. Assure regular communication with Center for Local Public Health and districts.

D. HPG Members

1. State Level Representatives & Alternate State Representatives
   - Report the needs and interests of the Statewide HIV Planning Group (HPG) to the Regional Prevention Advisory Group (RPAG) in the absence of the voting Regional Rep.
   - Deliver RPAG reports to the Statewide HPG in the absence of the voting Regional Rep.
   - Actively participate in statewide meetings.
   - Evaluate regional concerns, recommendations and plans.
   - Maintain awareness of national and state guidance for the community planning process.
   - Uphold the bylaws of the Missouri Statewide HPG.
   - To process information at the State level and assist in the development of statewide prevention priorities for populations and interventions.
   - Deliver information to the State Level HPG from the regional advisory group he/she participates in.
   - Reports the needs and interests of the State level HPG back to the Regional Prevention Advisory Groups when applicable.
   - Assure that Missouri DHSS allocates CDC HIV prevention funds according to the state plan that is inclusive of each regional HIV prevention plan.
   - Provide information necessary to develop the funding application to the CDC as needed.
   - Alternate Representatives can vote only when given proxy in writing by a state representative and in the absence of a Regional Representative. Alternates' responsibilities rest as a non-voting member (other than by proxy.)
   - Must attend yearly HPG refresher orientation

2. At-large Representatives and Alternates
   - Represents statewide the at-risk and diverse populations of Missouri.
   - Reviews state and regional prevention plans from the at-large perspective.
   - Works with regional planning groups to provide technical assistance for incorporating at-risk perspectives, representation and needs into their planning efforts.
   - Attends and contributes to statewide HPG meetings.
   - Participates in at-large meetings and serves on at least one committee.
   - Ensure at large maintains the function of providing Parity, Inclusion and Representation (PIR) to statewide body
   - Works with the HPG to develop annual goals and comprehensive prevention plan.
   - Represents the HPG to the various at-risk and diverse populations of Missouri.
   - Responsible for recruitment and retention of new at-large members as positions need to be filled.
   - Ensure prevention needs of Hispanic populations through the implementation, monitoring, and updating of the Hispanic/Latino statement of need.
   - Ensure provision of resources and information to promote all national HIV prevention days of observance.
   - Assistance in monitoring and updating the existing African American Emergency Response Plan.
   - Assist as needed in new member orientations.
   - Ensure prevention materials are available in languages that fit our target populations.
   - Alternate At-Large votes only in the absence of voting At-Large members either with a proxy given in writing from the absent member.
   - Must attend yearly HPG refresher orientation

3. Governmental Advisors
   - Statewide advisors will be selected by the Structure Work Group to provide their expertise to the HPG.
   - Provide expertise in designated fields when the HPG needs additional information.
   - Report findings or information in a timely fashion as requested by State HPG.
   - One individual from each governmental agency is required to participate within the newly established subcommittees at quarterly Statewide HPG Meetings.
   - Statewide Governmental Advisors must follow protocol set forth in representative roles and responsibilities.
   - Must attend yearly HPG refresher orientation

4. Gallery Members
   - Share expertise with the State Level Planning Body through the participation at State Level Planning Body Meetings.
   - Contribute to discussion upon acknowledgement of a state level co-chair. Voting members take precedent over gallery in speaking order when a motion is under discussion.
   - Gallery members wishing to address items not listed on the written agenda must receive prior permission of the co-chairs before addressing such items.
   - Voting members take precedent over gallery in speaking order when a motion is under discussion.
   - Provide information as needed through participation in State Level Meetings as well as through strongly encouraged subcommittee participation.
   - Share expertise perspectives as they relate to HIV/AIDS prevention in Missouri for populations most at risk.
   - Must attend yearly HPG refresher orientation

E. Co-Chairpersons

HPG co-chairs provide leadership for the participatory process. There are two elected co-chairpersons, one representing the community rural regions and one representing community urban regions, as well as the State Health Department's Prevention Planning Coordinator (PCC). The co-chairs are equally responsible for:

- Providing leadership to HPG members.
- Facilitating meetings, lead discussions, and ensure a participatory process is followed.
- Develop meeting agendas.
- Work closely with the HD staff to:
  - Ensure necessary data are provided on a timely basis to the HPG
  - Ensure HPG members understand the NHAS
  - Assist the HD in achieving the NHAS goals
- Lead the developing of the engagement process and inform the development/update of the jurisdictional HIV prevention plan.
- Work with the state HD Co-Chair in identifying and recruiting new At-Large Promote implementation of the engagement process.
- Draft the letter of concurrence, concurrence with reservations or non-concurrence.
- Participate in discussions with CDC when the HPG does not provide a letter of concurrence or when the engagement process is not aligned with NHAS goals.
- Read and be familiar with the CDC Guidance for Community Planning.

Voting Members

Composition

There will be a total of 36 voting members of the State Level Community Planning Body: 10 representatives from the urban regional advisory bodies, 10 representatives from the rural regional advisory bodies and 16 At-Large members.

Election & Term

1) State Level Representatives
   - There shall be a total of twenty state level representatives with 2 elected by the Northwest and Southeast regions, 3 elected by Southwest and North Central regions, and 5 elected by each of the urban advisory groups.
   - Of the representatives elected by the Regional Advisory Bodies, there should be one from each region that will serve in the alternate role.
   - Term of office is for one year and can be renewed for up to five years and eligible for another 5 years after a 1year hiatus.
2) At-Large Representatives
   - There shall be a total of 10individuals that reflect the target populations prioritized in the current Jurisdictional Plan, and 6 youth, ages 18-24, from the 6 regions of the state and three alternates based upon regional variances. A slate of potential representatives is prepared according to the statewide epidemic and/or prioritized target populations, as well as the expertise that is needed in order to fulfill CDC's mandate for PIR. This slate of nominees is prepared by the existing at-large subcommittee, presented to the HPG for approval; and voted on at the subsequent HPG meeting.
   - Term of office is for one year and can be renewed up to five years and eligible for another 5 years after a 1year hiatus.

3) Co-Chairpersons
   - Nominations for Co-chair shall come from voting HPG members only. Nominees for the position of urban and rural co-chair cannot be directly funded lead agency staff.
   - Nominations for Co-Chair shall open/be accepted during the 2nd to the last HPG meeting of the calendar year, and remain open until the beginning of the subsequent HPG meeting (the last meeting of the calendar year). Immediately following the closing of nominations, presentation of nominee's credentials shall occur, with voting taking place just prior to the closing of the meeting. Newly elected Co-Chairs shall assume office immediately.
   - Co-chairs shall hold the position for a term of one year with the option of re-election for an additional term. No one region may hold more than two consecutive terms of office as co-chairs.

Open Positions/Vacancies

Open positions of HPG Regional Representatives shall be filled at the Regional HPG Advisory level.

The At-Large Co-Chairs shall facilitate the process of filling any At-Large Representative vacancies.

All vacancies, Co-chair and/or representatives must be filled within a two-month period. Extensions of vacancies shall be acceptable only if good reason can be established and continuance is granted by a simple majority vote of the HPG.

Removal

Removal of State Representatives
The State Planning Group shall have the right to remove any statewide representative or any state level co-chairperson if just cause exists. Just cause may include but is not limited to:

- Continued absence from meetings of the State Level Planning Body, two unexcused meetings within a term shall be sufficient to determine just cause for removal. Exceptions may be made in special circumstances with the provision of a written explanation and with the consent of the State Level Planning Body membership.
- Continued intentional violation of the Conflict of Interest Policy, as defined within said policy.
- If obstructive behavior (this is defined as personal attacks, not letting a speaker finish their comments and interrupting while they are speaking, not speaking briefly and to the point on questions being considered) occurs by any HPG member, that person will receive two warnings from the HPG Co-Chairs. Once the second warning has been issued, the member will immediately halt the obstructive behavior or risk being removed from the HPG for up to one year as deemed on a case by case basis by the membership committee. In the event that physical attacks take place from one member to another, the instigator will be automatically removed from their position for an indefinite period of time.
- Continued lack of participation in the State Level Subcommittees, lack of participation in appointed subcommittees, or other failures to establish productivity.

A two-third (2/3)-majority vote of the HPG voting members is required for removal of an individual who has just cause as mentioned in the preceding paragraphs above. Just cause reasoning will be provided in writing to the Regional Advisory Body from the State Level Planning Body.

Resignation

A HPG member may vacate a position with submittal of resignation by the Regional HPG Advisory Body in writing to the HPG Co-chair at the next State Planning Body Meeting.

Meetings

All HPG meetings will be governed by these bylaws. The process during meetings will follow Robert's Rules of Order.

General

The Statewide HPG shall meet quarterly. The HPG and MODHSS will set meeting dates and times.

Special Meetings
Special Meetings may be called by the concurrence of the co-chairs. A one-week notice must be given. In cases of extreme emergency with the concurrence of the co-chairs a phone poll may be conducted.

Records
All records of the planning body shall be open for inspection by the public. The planning body shall keep minutes of all proceedings including attendance and such other records as necessary to the conduct of business.

Conduct
Meetings shall be conducted in an orderly manner. All meetings are open to the general public. All members of the planning body are expected to participate.

Voting
Each of the 36 voting members shall be entitled to one vote each. A simple majority will determine all votes, unless otherwise mandated in these by-laws.

Quorum
A quorum of 51% of the state HPG voting members must be present at all times for any voting to be conducted at any meeting of the planning body. Each region is responsible for having full representation at each meeting for its entirety. If a region is unable to fulfill this responsibility, its contract will reflect the lack of full representation.

Proxies
A Regional Representative must present a written proxy delivered to the Prevention Planning Coordinator at the opening of each Statewide HPG meeting if they are to have their region's Alternate Representative vote in their absence. Regional representatives who are in need of a proxy in a region that has no alternate reps or the alternate reps are not available to attend the state HPG meeting may request a proxy from either the local health department co-chair, community co-chair, or a seasoned member of the HPG to be determined at the local level. **(Seasoned is defined as being a HPG member for 2 years or more)** The At-Large members also must present a written proxy delivered to the Prevention Planning Coordinator at the opening of each Statewide HPG meeting if they plan to have an alternate At-Large vote in their absence.

Motions
Motions may be made by any voting member and must follow parliamentary procedure set out in Robert's Rules of Order in order to be approved. Approval requires a simple majority, except in cases of changes to the bylaws or article, which require a two-thirds majority. Voting will be conducted by a voice vote. If a dispute ensues then a simple show of hands will be sufficient to settle the dispute. A vote by ballot if requested shall be honored. All motions and votes shall be reflected in the minutes.

Records
All records of the planning body shall be open for inspection by the public. The planning body shall keep minutes of all proceedings including attendance and such other records as necessary to the conduct of business.

Conduct
Meetings shall be conducted in an orderly manner. All meetings are open to the general public. All members of the planning body are expected to participate.

By-Law Amendments
A two-thirds majority may make amendments to these articles or bylaws. All amendment decisions must be introduced during a general HPG meeting and then voted on at a subsequent meeting.

Ratification
These Articles of Association and Bylaws go into effect upon a two-thirds majority vote of the planning body.

Dissolution
The planning body may be dissolved upon a two-thirds majority vote of the planning body. If the planning body votes for dissolution, it will be the responsibility of the Administrative Agent to establish a new planning body to be in compliance with the HIV Planning Guidance as established by the Centers for Disease Control and Prevention. Selection of members shall be made using an open process as established in the Guidance.

Conflict of Interest
See attached conflict of interest policy.

Appendix 5
Excerpts from *Robert's Rules of Order*

BEGINNING THE MEETING:
The Chairs call the meeting to order. Recognition to speak, make motions, or act is at their discretion. The Chairs set the agenda, manage the agenda and may, at their discretion, change the order or items and decide what is and is not legitimate new business. The Chairs have full discretion to decide what is and what in not pertinent to any item on the agenda.

MOTIONS:
To make a motion, a member of the group must be recognized to speak by the Chairs. The format of a motion is "Mr. or Ms. Chair, I move that...". The Chairs may not make motions.

SECONDING A MOTION:
To move forward, a motion has to be seconded by a member of the group (not staff). The Chairs may not second a motion. If there is no second, the motion dies at that time.

DISCUSSION:
After a motion has been made, it is "on the floor". It may be discussed by anyone who is recognized to speak by the Chairs.

CALLING THE QUESTION: Any member of the group (Not Chairs) may "call the question". This effectively ends all discussion of the original motion. A motion to call the question may be made at any time as long as there is a motion on the table. There is no discussion of a "call the question". It must be seconded and, if seconded, is immediately voted on. If it passes, the Chairs proceed directly to a vote on the original motion. If the "call the question" fails, then discussion of the motion proceeds.

A POINT OF ORDER: A point of order is an attempt to be recognized by the Chairs in order to make a statement or ask a question. It overrides all other business. Having been recognized to speak on a point of order, the speaker must not address the motion on the floor, but only the process or procedures being used to handle that motion. For example, pointing out that a motion violates the By-Laws for the group, is illegal or that a motion is not being processed correctly. Once resolved, the group returns to the original discussion.

AMENDING A MOTION: Any speaker may move to amend the motion on the table. If the person making the original motion accepts the amendment as a friendly amendment, the motion is carried. If the person rejects the amendment, it must be voted on. A motion to amend must be resolved before the original motion can be called and passed or rejected.

ADJOURNING:
In some very formal groups, there is a motion to adjourn, which is then voted on. In other groups, the Chairs have full discretion to adjourn the meeting as they see fit.

Appendix 6
OPERATING PRINCIPLES

1. **One person speaks at a time.**
2. **The chair must recognize speakers.**
3. **If more than one person wishes to speak, a sequence will be established by the chair.**
4. **Personal attacks or comments directed at any member are inappropriate.**
5. **Let all speakers finish their thought without interruptions.**
6. **Speak briefly and to the point on questions being considered.**
7. **Refrain from repeating a point that has already been made.**
8. **The meeting will begin and adjourn on time.**
9. **Points of clarification may be made at any time.**
10. **Once the question has been called, there will be no further discussion.**
11. **For items to be discussed, they must be placed on the agenda.**
12. **Respectful engagement and decorum must be maintained at all times.**
13. **At any time, we can change these communication patterns.**
14. **Board sets ground rules.**
15. **Representatives take precedent over gallery in speaking order when a motion is under discussion.**
16. **Cell phone must be turned off or put on vibrate during meeting.**
17. **Side conversation should be taken out into the hall or into another room.**

Appendix 7

Agenda

Name of Subcommittee Meeting Here

Date
Time

Facilitator and Secretary:

Please bring:

Agenda topics

Time allotted	Who is presenting and/or participating

Appendix 8
Regional Point Person Program

Job Description-A Point Person shall act in the following capacity:

- Initiate and/or oversee the fax, email, or mailing of pertinent literature to new HPG members prior to their first HPG meeting. Local Health Departments should assist with this Task
- Encourage mixing with other Regional Representatives during HPG meetings
- Serve as a reliable source for communication between the State Health Department and their individual region, and vice-versa.
- Set example of Teamwork
- Possess leadership qualities (reliable, good communication skills, non-judgmental, etc)
- Have knowledge of Local and State resources
- Continue to support new members for two consecutive meetings, and as needed thereafter.
- Support new HPG members through information sharing, answering questions, assisting in Navigating the process, etc.
- Attend at least one state HPG orientation per calendar year and all if possible local RPAG orientations.
- Assist in facilitating local orientations
- Maintain a roster with "contact information" that includes current terms in office of local RPAG members with their chosen RPAG committees. This is to be submitted to the Chair of the membership committee upon each change in members
- Make every effort to connect through face-to-face discussions with new HPG members
- Fill this position for a one-year term, with option for renewal (there is **No** limit on number of terms). Any suggested changes or removals of the point person should be brought to the attention of the State Planner by the lead agency (in writing).

  * **<u>Please Note:</u> A "Mentor" is utilized at the State HPG Meetings, while a "Point Person" is utilized at *each* of the regions of Missouri**

Suggested Point Persons for each region:

1. Samantha Hughes: *Kansas City Region*
2. Dustin Hampton: *North Central Region*
3. Marlin Martin: *Southwest Region*
4. Dale Wrigley: *St. Louis Region*
5. Mitzi Teliczan: *Northwest Region*
6. Crystal Robinson: *Southeast Region*

Appendix 9
Missouri HIV/STD Prevention Community Planning Group

RPAG Representation - Member Characteristics

The information on this form will be kept confidential and used for the purpose of assessing epidemic and expertise balance on the Regional Planning Advisory Group (RPAG). This form will be sent to the Statewide Community Planner and then destroyed following compilation and information will be disseminated in an anonymous, statistical format only.

MEMBER NAME _____

Member Type

__ Regional Community Co-Chair
__ Regional Health Department Co-Chair
__ Regional Representative
__ Regional HPG *Alternate* Representative
__ Regional General Membership

Planning Region (if applicable)

__ North Central
__ Kansas City
__ Northwest
__ St. Louis
__ Southeast
__ Southwest

Race/Ethnicity
__ White
__ African American/Black American
__ Hispanic/Latino/Mexican American
__ Native American/Alaskan Native
__ Asian/Pacific Islander
__ Other - Please specify: _____

Geographic Representation
__ Urban/Small City
__ Rural

Date of Birth _____ Age ____ Gender __ male __ female __ transgender

Please check all that apply:
__ Gay __ Lesbian __ Bisexual __ Heterosexual

Please check all that apply:
__ Current Substance/Drug Abuser
__ Former Substance/Drug Abuse
__ Current High-risk Sexual Behavior
__ Former High-risk Sexual Behavior
__ Living with HIV
__ Have had an STD (Gonorrhea, Chlamydia, Syphilis, etc.)
__ Current Sex Worker
__ Former Sex Worker
__ Person Living with AIDS
__ Currently Living with an STD (Herpes, HPV, etc. - not HIV)

Governmental Representation
__ State Health Department
__ Local Health Department
__ Mental Health Agency
__ Corrections Agency
__ Do not represent an agency
__ State/Local Educational Agency
__ Youth Services Agency
__ State/Local Substance Abuse Agency
__ Other Govt. Agency
__ Other Non-Govt. Agency

Do you participate in Care activities: __Yes __No

If your answer is yes, please indicate below on what level or in what Care programs you participate:

_____

HIV PREVENTION PROCEDURE MANUAL

Appendix 10

Sample

Regional Advisory Group Meeting
September 29-30, 2003

EVALUATION FORM

Rating Scale: 5 = Excellent 1 = Poor

- **OVERALL RATING FOR MEETING & FACILITIES**

What is your overall evaluation of the meeting?	5	4	3	2	1
How would you rate the atmosphere of the meeting?	5	4	3	2	1
How would you rate the materials/information provided?	5	4	3	2	1

- HOTEL

How would you rate the sleeping rooms?	5	4	3	2	1
How would you rate the meeting rooms?	5	4	3	2	1
How would you rate the meals?	5	4	3	2	1

If you answered 2 or 1 to any of the above questions, please explain why: _____
_____
_____
_____
_____
_____

Suggestions on how we can make it better: _____
_____
_____
_____
_____
_____

HIV PREVENTION PROCEDURE MANUAL

DAY 1

Subcommittee Meetings:

Were the objectives for this meeting clear and understandable?	5	4	3	2	1
Was this meeting useful in developing common tasks?	5	4	3	2	1

What would have been more helpful for this meeting?_____
_____
_____

Orientation

Were the objectives for this meeting clear and understandable?	5	4	3	2	1
How would you rate the usefulness of this meeting?	5	4	3	2	1
Was this process helpful in understanding the RPAG process?	5	4	3	2	1

What would have been more useful to increase your understanding?_____
_____
_____

Subcommittee Meeting:

Were the objectives for this meeting clear and understandable?	5	4	3	2	1
Were the objectives for this meeting met?	5	4	3	2	1

What would have made this meeting more useful to you?_____
_____
_____

Workgroups

Will this information be useful or beneficial to you?	5	4	3	2	1
Was this meeting helpful in discussion of future activities for The Hispanic Declaration of Crisis and events for National Hispanic AIDS Awareness Day?	5	4	3	2	1

Comments:_____
_____
_____

HIV PREVENTION PROCEDURE MANUAL

DAY 2

Presentations:

Did you gain a clear understanding of the grant process? 5 4 3 2 1

What were the most useful, informative aspects of the information presented?_____
_____

List any ideas you have on how to improve the grant process for next year:_____
_____
_____
_____
_____

Evaluation Update:

How useful was the evaluation findings and information
for your statewide planning efforts? 5 4 3 2 1 N/A

How useful was the evaluation findings and information
for your regional planning efforts? 5 4 3 2 1 N/A

Please share your comments/questions/concerns:_____
_____
_____

Appendix 11

Missouri HIV/STD Prevention Regional Planning Group (RPG) Process Evaluation

County Code

Regions: 1=Central, 2=KC, 3=NE, 4=NW, 5=SE, 6=SW, 7=St. Louis

Date: _____

A B C D E F G H I J K L M N O P Q R

Ethnicity/race:

White
African-American/Black
Asian/Pacific Islander
Native American/Alaskan Native
Hispanic/Latino
Other _____

Please darken all circles with a #2 lead pencil ONLY.

MEMBER CHARACTERISTICS

Gender: A=male, B=female and C=transgender
Sexual Orientation: A=heterosexual, B=gay, C=bisexual and D=lesbian
Age Range: A=25 or younger, B=26-35, C=36-45, D=46-55, E=56+
Member Type: A=voting member-RPG, B=non-voting member-RPG

EVALUATION STATEMENTS

For questions 1 and 2: Yes = A, No = B

1. I have been through a formal new member orientation for Community Planning.
2. I am familiar with the CDC Guidance Document for Community Planning.

Scale: A=strongly agree, B=agree, C=disagree, D=strongly disagree and E=not applicable

3. I have a clear understanding of the community planning structure in Missouri, including how regional planning is integrated into the statewide planning process.
4. Our RPG membership process is inclusive (anybody can join).
5. My RPG values collaboration with other groups/organizations.
6. Our RPG membership is representative of the population infected and/or at risk of infection with HIV, AIDS, and STDs in our region.
7. I feel our RPG is sensitive to cultural issues.
8. Our RPG welcomes and encourages diversity among the membership.
9. I feel I have a say in our RPG's decision-making process.
10. The RPG has provided valuable resources and information to me that I otherwise would not have received.
11. Our lead agency is doing a good job of facilitating Community Planning in our region.
12. I have been given the opportunity to take a leadership role in the RPG.
13. I am gaining leadership skills as a result of my participation in the RPG.

	• 2012 Workplan/Task List for HPG, RPAG, and HIV Prevention Programming in Missouri	
JANUARY	➢ Each region should submit technical assistance (TA) needs to Sandy by the 15th. ➢ Quarterly reports and outreach log sheets due by the 15th. ➢ Each region is responsible for submitting yearly RPAG schedule or schedule changes ➢ If there were changes to the RPAG by-laws made, they must be submitted by the 15th of January. ➢ Each region is now responsible for submitting a yearly task list that models this one by January 29, 2012. ➢ Submission of calendar of interventions each month by the 1st. ➢ End of year contract monitoring conference calls ➢ **Don't forget to conduct your new member orientations! This needs to happen in every region!!**	1/2/12: Submission of calendar of interventions 1/15/12: TA needs, meeting schedules and quarterly reports due to Sandy 1/29/12: Submission of yearly regional advisory group task list
FEBRUARY	➢ *Regions need to begin preparation for the **budget discussion for 2013**.* ➢ Submission of calendar of interventions each month by the 1st. ➢ Be prepared for conference call with subcommittees! ➢ Need to prioritize which committees will meet this year given the lack of two HPG meetings.	2/1/12: Submission of calendar of interventions 2/23/12: February special HPG meeting possibly by webinar *Continue Data Entry into CDC Evaluation System*
MARCH	➢ Review committee sign ups and prepare for April HPG. ➢ Submission of calendar of interventions each month by the 1st. ➢ Regions need to continue working with CDC Evaluation System	3/1/12: Submission of calendar of interventions
APRIL	➢ Statewide HPG Meeting. ➢ Submission of calendar of interventions each month by the 1st. ➢ All subcommittees to revisit their goals and objectives. ➢ New at large to attend the April HPG meeting. ➢ **Continue and wrap up implementation of key informant interviews** ➢ Don't forget to submit regional reports at April HPG meeting! ➢ Quarterly reports and outreach log sheets due by the 15th. ➢ Fill out Co-Chairs survey ➢ **Plan events for National HIV Testing Day on June 27.** ➢ **All members must attend member orientation refresher at the HPG meeting in April**	4/1/12: Submission of calendar of interventions 4/15/12: Quarterly Reports Due 4/19/12-4/20/12: HPG Meeting 4/12: During New Member Orientation, all new members must fill out membership characteristic survey and must be taught how to fill out an expense report form. 4/12: Co-Chair's Survey
MAY	➢ Submission of calendar of interventions each month by the 1st ➢ Contract Monitoring Site Visits to Regional Lead Agencies ➢ **Regions to submit data from key informant interviews by no later than May 10, 2012** ➢ Interim Progress Report due to CDC	5/1/12: Submission of Calendar of Events
JUNE	➢ Submission of calendar of interventions each month by the 1st ➢ **Be prepared to implement plan changes in order to align with the National Strategy and CDC Guidance.** ➢ **Prepare for events around National HIV Testing Day June 27.** ➢ Outcome Monitoring will continue to be implemented in all regions.	6/27/12: National HIV Testing Day 6/1/12: Submission of Calendar of events

	• 2012 Workplan/Task List for HPG, RPAG, and HIV Prevention Programming in Missouri	
JULY	➢ Submission of calendar of interventions each month by the 1st ➢ Quarterly Reports due by the 15th. ➢ Budget Review. ➢ Regional plans due for each target population by July 31. ➢ **Plan for Observation of National Hispanic/Latino AIDS Awareness Day**	7/01/12 Submission of Calendar of Events 7/15/12 Quarterly Reports Due **7/30/12 Regional Plan Enhancements Due**
AUGUST	➢ Submission of calendar of interventions each month by the 1st ➢ Plan Review. ➢ Grant Review. ➢ Final Regional Plans due no later than August 5th. ➢ Statewide HPG Meeting August 30-31, 2012..Held in place of September's meeting due to fluctuating due dates for FOA.	8/01/12: Submission of Calendar of Events 8/05/12: Final Plans Due from Regions 8/30/12-8/31/12: September HPG Meeting held early for concurrence vote on IPR. 8/30/12: During New Member Orientation, all new members must fill out membership characteristic survey
SEPTEMBER	➢ Submission of calendar of interventions each month by the 1st ➢ NOTE: September HPG meeting has been changed to August. ➢ Progress report submitted to the CDC for fiscal year 2012.	9/01/12: Submission of Calendar of Events 9/12: IPR Submission
OCTOBER	➢ Submission of calendar of interventions each month by the 1st ➢ Quarterly reports due by the 15th. ➢ **National Hispanic/Latino AIDS Awareness Day this month. Please implement planned events accordingly.** ➢ **Begin planning events for World AIDS Day**	10/01/12: Submission of Calendar of Events 10/15/12: Quarterly Reports Due
NOVEMBER	➢ Submission of calendar of interventions each month by the 1st	The HPG meeting will not be held in this month. See you next year
DECEMBER	➢ **World AIDS Day** ➢ Notification of 2012 CDC Award received by MDHSS. ➢ Begin Planning for the New Plan!!!!!	12/01/12: World AIDS Day

Appendix 12
2011-2015 Plan Template

This template is provided in order to streamline and provide consistency to the planning process. For the next five-year plan, we want to have a plan that is comprehensive and well written.

The Populations focused on were prioritized in the November HPG Meeting that took place in 2009. The populations prioritized for planning are as follows:

Urban Priority Populations	Rural Priority Populations	Positive Priority Populations
Black MSM	White MSM	Positive Black MSM and partners
White MSM	Black MSM	Positive White MSM and partners
Hispanic MSM	Hispanic MSM	Positive Hispanic MSM and partners
Black Females HRH/IDU	Black Females HRH	Positive Black Females and partners
		For Urban: Positive Black Females HRH/IDU

- ***Please stick with the populations prioritized by the Structure Workgroup and Statewide HPG. If your region only has epi trends for two out of the four populations chosen, justify with epi information and plan interventions for those two populations. When we ask for justification, please provide it in Section II of the plan and also as part of the introduction in Section IV of the plan with interventions.***

You may choose regional variances to focus on specific to disease trends in your region. The variances to choose from are as follows:

Urban:
Black Male HRH
White Female IDU
Hispanic Female HRH
Hispanic Female IDU
White Female HRH
Hispanic Male IDU
Hispanic Male HRH
White Male IDU
White Male HRH

Rural:
Black Female IDU
White Female IDU
White Female HRH
Black Male IDU
Hispanic Female IDU
White Male IDU
Black Male HRH
Hispanic Female HRH
Hispanic Male IDU
Hispanic Male HRH
White Male HRH

The intervention levels within this plan are prioritized in the following way:

1. ***Individual and Group: 60% of interventions planned must consist of individual and group level***
2. ***Outreach: 20% of interventions planned must consist of outreach level***
3. ***HC/PI: 20% of interventions planned must consist of HC/PI level***

The percentages were arrived at during the April 2001 HPG meeting according to the evaluation plan and formally approved by the structure workgroup in February 2002. Also, please keep in mind that with these percentages, it is the actual number of times you deliver a specific intervention versus the number of interventions that makes up the percentage.

Section I: Introduction and Overview of the Regional Community Planning Group Advisory Process (This will include a brief overview of your regional planning process encompassing the counties covered, the most at risk populations in your region and a little about the advisory group itself talking about the membership and agency makeup along with collaborative partnerships with members of other agencies in the community)

Section II: Regional Epi Profile Information for HIV/AIDS and STDS
(Include the information from State Epi Profile for your region)

Section III: Needs Assessment/Resource Inventory/Gap Analysis
(This section should give us an overall idea of which groups were targeted for needs assessment, what instruments were used, and the overall results. This is only for additional needs assessments you have done within your region since our statewide key informant interviews conducted in 2010. If you have done a resource inventory separate from the state inventory, you would include a basic summary of prevention services available and who provides the services in your region. Just a little blip about that would be fine and you may consult the resource inventory done at the state level or additional sources within your region. Gap analysis is after doing needs assessment and resource inventory, what gaps still exist in your regions and for what targeted populations are services limited. (You may just want to speak about gaps if you have done additional needs assessments within your region.)

Section IV: Intervention Section: Because this is a multiple year plan, interventions for all four prioritized populations need to be laid out with an introduction piece as follows in the **example below**:

"For Year 2011, the **individual level** interventions for white MSM will encompass the following prioritized elements." List them from the prioritized elements attached to this template and then go ahead with your goal, objective, outcome objective, activities, science base, needs assessment documentation and evaluation mechanism.

Things to Keep in Mind:

For each year in the five-year plan, we will concentrate on ensuring that the elements in the attachment to this template are a part of the interventions chosen. This only applies to the interventions that are not DEBIs. Sixty percent of interventions must be DEBIs or procedural in nature or regionally developed ILI and GLI.

It would be very helpful to list all intervention levels together this time. For example: For each population, list all individual level intervention levels, than group, than outreach etc…

At the beginning of each intervention, include a table with a listing of all interventions for each population planned each year of the five year cycle.

Sample template follows:

Target Population: *(Should include estimated age range, gender, and race as well)*

Intervention Type: *(DEBI, ILI, GLI, Outreach only. HC/PI will look a little different because we don't have to be as specific) (For Outreach Interventions, please estimate how many condoms, safer sex kits, brochures, supplies, etc… you are planning to use in your intervention and* ***remember in order for it to be classified as outreach, you must ensure at the minimum, some kind of verbal, educational exchange with the target population)***

Goal: *(Broad)*

Objective: *(Must be measurable, time-phased, and specific)*

Outcome Objective: *(For Individual and Group Level Interventions Only) (What are the expected outcomes of the intervention. The projection must be measurable. Ex: At least 60% of participants involved in the workshop will be able to demonstrate through role-play condom negotiation skills)*

Activities/Strategies: *(What are you going to do to implement this intervention)*

Science Base: *(Use taxonomy provided)*

Evaluation Mechanism: *(Only for individual and group level interventions. How you are going to measure the effectiveness of your intervention i.e. pre and post tests, HIV testing numbers, surveys…)*

List the findings in the needs assessment that corresponds to the planned intervention for each population.

Example:

Target Population: African American Heterosexual Men

Intervention Type: DEBI

Goal: To provide a series of group level interventions through various gathering places to young, African American Heterosexual Men in order to focus on reduction of risk for HIV/STDs.

Objective: To provide a total of three **Many Men Many Voices** interventions to a total of 50 African American Heterosexual Men in places where they gather that focus on safer sex negotiation skills building in the Kansas City region by December 2010.

Outcome Objective: At least 60% of participants who attend these interventions will be able to effectively demonstrate through role-play safer sex negotiation skills as a result of this intervention.

Activities: Prepare safer sex kits and information to be disseminated. Arrange location for interventions and provide role-play for participants to practice negotiation skill learned in these trainings

Science Base: Empowerment Theory

Evaluation Mechanism: All participants will be asked to complete both pre and post test surveys to assess knowledge and skills gained through this intervention.

Needs Assessment Correspondence: This intervention corresponds to key findings in the 2010 Missouri Needs Assessment.

For Outreach Level Interventions, the format should be as follows:

Targeted Population: White MSM

Intervention Type: Outreach Level

Total Outreach Interventions to Be Conducted:

Goal: (*Broad)*

Objective: (*Specific, time-phased and measurable including the number of individuals within a population you want to reach as well as the age groups with this intervention. Remember, in order for an intervention to be classified as an outreach, you must ensure educational interaction between the target population and the person conducting the outreach. Condom drop offs are not outreach and should go under the "other" category)*

Activities/Strategies: *(What do you need to do to implement the intervention)*

Science Base: *(Use Taxonomy Provided)*

Example:

Target Population: White MSM

Intervention Type: Outreach Level

Total Outreach Interventions to Be Conducted: 22

Goal: To conduct outreach level interventions to white MSM in the Kansas City Region that will ensure a decrease in HIV risk-taking behavior.

Objective: To conduct 22 outreach interventions consisting of street outreach that includes distribution of safe sex kits and HE/RR information exchange to 100 white MSM in the Kansas City Region by December 31, 2011.

Activities/Strategies: Work with KCRPAG volunteers to gather materials for safer sex kits and put them together. Prepare to demonstrate the importance of the items in the kit and explain their proper usage.

Science Base: Diffusion of Innovation Theory

Needs Assessment Correspondence: This intervention corresponds to key findings in the 2010 Missouri Needs Assessment.

For HC/PI and Community Level Interventions, the format should be as follows:

Targeted Population:

Intervention Type: *HC/PI or General Community*

Total HC/PI Interventions to Be Conducted:

Goal: *(Broad)*

Objective: *(Specific, time-phased and measurable including the number of individuals within a population you want to reach as well as the ages groups with this intervention)*

Activities/Strategies: *(What do you need to do to implement the intervention)*

Science Base: *(Use Taxonomy Provided)*

Example:

Target Population: African American Women

Intervention Type: Health Communication/Public Information

Total Number of HC/PI to be conducted: 32

Goal: To provide African American Women with HC/PI level interventions to increase awareness of risk and prevention strategies.

Objective: To conduct one presentation at a beauty shop to approximately 10 AA Women to raise awareness of HIV risk and stress the importance of empowerment.

Activities: Collaborate with MDOH to gather educational information for the presentation.

Science Base: Theory of Reasoned Action

Needs Assessment Correspondence: This intervention corresponds to key findings in the 2010 Missouri Needs Assessment.

For "Other" Interventions, the format should be as follows:

Targeted Population:

Intervention Type: *"Other"*

Total "Other" Interventions to Be Conducted:

Goal: *(Broad)*

Objective: *(Specific, time-phased and measurable including the number of individuals within a population you want to reach as well as the ages groups with this intervention)*

Activities/Strategies: *(What do you need to do to implement the intervention?)*

Science Base: *(Use Taxonomy Provided)*

Example:

Target Population: Heterosexual African American Women at Risk Ages 20-39

Intervention Type: Other

Total "Other" Interventions to Be Conducted: 3

Goal: To provide Heterosexual African American Women with interventions to increase awareness of risk and prevention strategies.

Objective: To establish at least 1 Internet chat room to reach 350 African American Women At Risk ages 20-39 with risk reduction information and health education messages by December 31, 2003.

Activities: Work with OIS to set up chat room and gather appropriate educational materials

Science Base: Diffusion of Innovation Theory

Needs Assessment Correspondence: This intervention corresponds to key findings in the 2010 Missouri Needs Assessment.

Example of Summary of Interventions to be Included before Intervention Section IV Regional Plan

Appendix 13
2011-2015 Outline of Interventions for the St. Louis Comprehensive Plan

Target Populations	2011	2012	2013	2014	2015
African American Heterosexual Women	L.I.F.E. (Learning Immune Function Enhancement), PCM (Prevention Case Management) SISTA (Sisters Informing Sisters About Topics on AIDS), VOICES / VOCES, RAPP (Real AIDS Prevention Project), ILI (Individual Level Intervention), Active Outreach, HC/PI (Health Communication / Public Information), HIV TESTING PROGRAM (Counseling Testing and Referral)	L.I.F.E., PCM, SISTA, VOICES/VOCES, RAPP, ILI, Active Outreach, HC/PI, HIV TESTING PROGRAM, Community Promise, Healthy Relationships ***Addition of Community Promise and Healthy Relationships**	L.I.F.E., PCM, SISTA, VOICES/VOCES, RAPP, ILI, Active Outreach, HC/PI, HIV TESTING PROGRAM, Community Promise, Healthy Relationships	L.I.F.E., PCM, SISTA, VOICES/VOCES, RAPP, ILI, Active Outreach, HC/PI, HIV TESTING PROGRAM, Community Promise, Healthy Relationships	L.I.F.E., PCM, SISTA, VOICES/VOCES, RAPP, ILI, Active Outreach, HC/PI, HIV TESTING PROGRAM, Community Promise, Health Relationships, POL (Popular Opinion Leader) ***Addition of POL***
Men Of Color who have Sex with Men (MOCSM)	L.I.F.E., PCM, Many Men Many Voices (3MV), POL, ILI, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention)	L.I.F.E., PCM, 3MV, POL, ILI, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP ***Addition of RAPP***	L.I.F.E., PCM, Many Men Many Voices 3MV, POL, ILI, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP, Healthy Relationships ***Addition of Healthy Relationships***	L.I.F.E., PCM, 3MV, POL, ILI, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP, Healthy Relationships	L.I.F.E., PCM, 3MV, POL, ILI, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP, Healthy Relationships

White MSM	L.I.F.E., PCM, Mpowerment, ILI, POL, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention)	L.I.F.E., PCM, Mpowerment, ILI, POL, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP ***Addition of RAPP****	L.I.F.E., PCM, Mpowerment, ILI, POL, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP, Healthy Relationships ***Addition of Healthy Relationships****	L.I.F.E., PCM, Mpowerment, ILI, POL, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP, Healthy Relationships	L.I.F.E., PCM, Mpowerment, ILI, POL, HC/PI, Active Outreach, HIV TESTING PROGRAM, Other (Internet Chat Room Intervention), RAPP, Healthy Relationships

Appendix 14
AGENCY READINESS SELF-ASSESSMENT

The following is a brief self-assessment intended to assist agencies (e.g., CBOs) to determine if they currently possess the capacity, or can build the capacity, to adopt and implement the DEBI intervention. Please read each item and then place a check mark (√) in only one response column.

Capacities and Resources Needed for Debi Program	Yes, we have this capacity (1)	We do not presently have this capacity, but can build the capacity (2)	No, we do not have this capacity (3)
1. Agency serves populations prioritized in the DEBI model who are at risk of HIV infection due to their sexual risk taking behaviors.			
2. At least one staff person who is skilled at facilitating the intervention and may be a peer of the target population who may participate in the intervention.			
3. Agency has the capacity to collect, maintain and process monitoring and outcome data.			
4. Meeting space to conduct intervention.			
5. Access to a VCR and television			
6. Access to condom demonstration training models or commonly used substitutes (e.g. bananas or cucumbers for the male condom, condoms).			
7. Low cost incentives for intervention participation (e.g., small stipends; transportation passes; snacks at group sessions and childcare at group sessions).			
8. A means to track your program activities (i.e., recruitment of clients, sessions delivered).			

If all of your responses were in column 1 ("Yes, we have this capacity") or column 2 ("We do not presently have this capacity, but can build the capacity"), your agency is likely "ready" for this intervention.

This is a general checklist used to assist agencies in assessing their intervention capacity. More specific intervention model checklists can be provided upon request from MDHSS.

HIV PREVENTION PROCEDURE MANUAL

Appendix 15
Intervention Log Sheet

Date: **Location**: __ CBO/ASO __Corrections __Drug Treatment __ Health Clinic
__School __Community (Bars, Parks etc.) __ Other (describe):_____

Agency conducting intervention: In the Plan___

Intervention Level: __Individual __Skills Building Workshop __Outreach / passive
(20 or less attending) active _____# of groups 1-5
Number of planned sessions per workshop & number attending each session (for individual and group level only) _____1 _____2 _____3+ _____ refused pre-test

Target population intervention was planned for: ____AAMSM ____WMSM
____ Hetero Women of Color ____Hetero Men of Color **OTHER**: ___MSM/IDU ___IDU
___General Public ___Pregnant/at risk for pregnancy HIV+ ____High Risk Heterosexual women

Unduplicated	African American	American Indian Native Alaskan	Asian	Pacific Islander	White	Hispanic	Other
<19							
M							
F							
T							
NT							
20-29							
M							
F							
T							
NT							
30+							
M							
F							
T							
NT							
Age Unknown							
M							
F							
T							
NT							
Totals							

Materials and number distributed: ____condoms ____safer sex kits ____promotional items
____bleach/safer injection kits ____brochures/informational material _____other:_____
REFERRALS: # of full time staff providing intervention_____ # of part-time staff _____
# of volunteers_____

HIV PREVENTION PROCEDURE MANUAL

Outreach Log Sheet

Date:_____
Agency/Health Department Name_____

Target Population intervention was planned for:
____AAMSM ____WMSM _____ Hetero Women of Color ____Hetero Men of Color
OTHER: ___MSM/IDU ___IDU ___General Public ___ Pregnant/at risk for pregnancy HIV+
___ High Risk Heterosexuals

HC/PI (Health Communication/Public Information)

(It is expected that numbers reached will be duplicated numbers for these interventions)

Presentations/Lectures: # conducted _____ #reached_____

EleHIV Testing Programonic Media: Broadcast # conducted _____
#reached_____ (estimated)
# of times aired_____

Print media # conducted _____ #reached_____ (estimated)
# of different types of media used_____

Hotline #reached_____

Clearinghouse #reached_____

# of full time staff providing intervention____ # of part-time staff _____ # of volunteers___

Other Interventions

	# conducted	Major accomplishments
Community Mobilization:		
Social Marketing Campaign:		
Community Wide Events (includes health fairs & exhibits):		
Policy Intervention:		
Structural Intervention:		
Internet/Chat rooms:		
Risk Reduction materials Drop Off:		
Additional Interventions (specify and define):		

# of full time staff providing intervention_____ # of part-time staff ____# of volunteers____

Appendix 16

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

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Bureau Chief
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Bureau of HIV/STD/Hepatitis
STD Program Jurisdiction
2012

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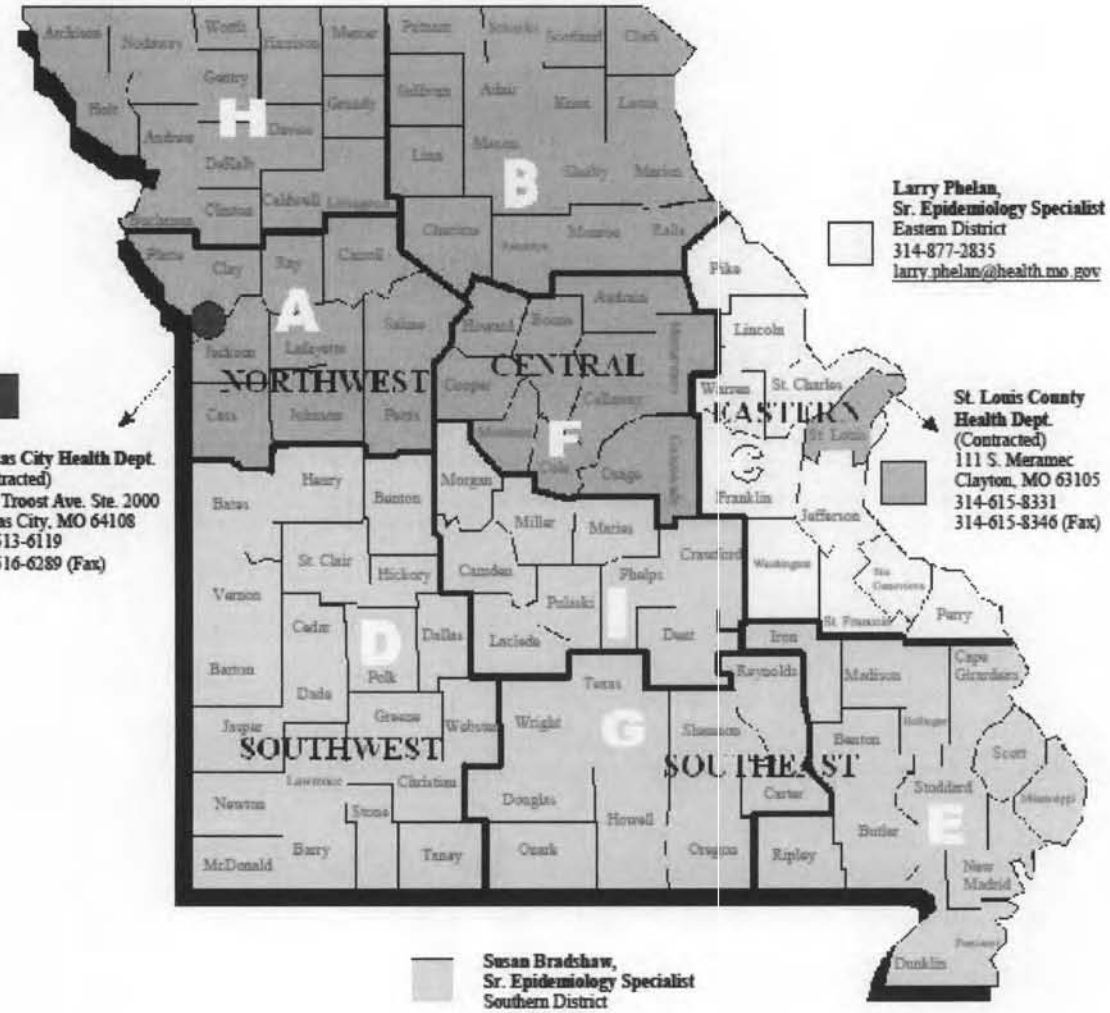

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(Contracted)
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Appendix 17

Regional Lead Agency - Progress Report

Date: _____

Region: _____

Reported by: _____

Please provide a brief progress report by target population for programs/intervention activities accomplished by the lead agency and/or subcontractors according to the regional plan since the last CPG meeting:

_____

Report challenges/difficulties your region is encountering in implementing the regional plan and your proposed solution(s) and/or technical assistance plan:

_____

Other significant events/issues in your region:

_____

Appendix 18
Program Material Review

Section 1: Must be completed by the submitter of the material

The following material is submitted for review per the requirements explained in *Content of AIDS-Related Written*

bmitted by: Agency:

Type of material? (Check all that apply.)

☐ Written- brochures, pamphlets, fliers ☐ Pictorials - photographs, slides, drawings, paintings, billboard advertisements/posters

☐ Audiovisual - motion pictures, videotape, audiocassettes, compact dics, radio/television/public service announcements

☐ Survey/questionnaire ☐ Curricula/outline for educational sessions ☐ Website ☐ Other

Title of mat **Edition if applicable:**

Is the material new or in use?

☐ New ☐ In use prior to 9/02 (Provisional approval is granted until further notice.)

What is intended use of material? (Check all that apply.)

☐ Health communication/Public information ☐ Individual level intervention

☐ Targeted outreach ☐ Group level intervention

Who is the intended audience? (Check all that apply.)

Gender:	☐ Male	☐ Female	☐ Transgender			
Race:	☐ Black	☐ White	☐ American Indian, Alaskan Native	☐ Asian, Pacific Islander	☐ Other/Unknown	
or Hispanic:	☐ Yes	☐ No				
Age:	☐ <18	☐ 18-24	☐ 18-39	☐ 20-39	☐ 40 +	☐ Other/Unknown
isk Factors:	☐ MSM	☐ IDU	☐ Heterosexual	☐ Mother with/at-risk of HIV	☐ Other/Unknown	

Section 2: Must be completed by Program Review Panel

Is the message within the material clear and non-judgmental? ☐ Yes ☐ No ☐ Not applicable

Comment:

Do the terms in the material enhance the audience's understanding of risk behaviors and the ways that they can reduce their

Comment: ☐ Yes ☐ No ☐ Not applicable

Does the material include information about the harmful effects of promiscuous sexual activity and intravenous substance

Comment: ☐ Yes ☐ No ☐ Not applicable

Does the material promote or encourage, directly, homosexual or heterosexual activity or intravenous substance abuse?

Comment: ☐ Yes ☐ No ☐ Not applicable

Does the curricula/outline for educational sessions include activities in which attendees participate in sexually suggestive

Comment: ☐ Yes ☐ No ☐ Not applicable

Does the material provide accurate information about the various means to reduce an individual's risk of exposure to, or to

Comment: ☐ Yes ☐ No ☐ Not applicable

If the material targets young people in schools or in other settings, is it guided by the principles contained in " Guidelines for

Comment: ☐ Yes ☐ No ☐ Not applicable

The Program Review ☐ Approved ☐ Not approved

Signature: Date: _____

Appendix 19
Condom Distribution Quarterly Assessment

Site: Date: Primary Target Population:

Is this a convenient place for you to get condoms?
___Yes ___No

How did you find out that condoms were available at this place? (adjust to the region)
___Friend
___Website
___Noticed the display and knew they were available
___Flyer
___Poster

How frequently did you come here to get condoms in the last 3 months?
___Daily
___Weekly
___Monthly
___About every 6 weeks or longer
___I did not get condoms here in the last 3 months

Did you come here in the last 3 months to get condoms and they were not available?
___Yes ___No

How frequently do you use condoms?
___At least once a day
___2-3 times a week
___At least once a week
___3-4 times a month
___At least once a month
___I do not use condoms often
___I do not use condoms

What other places would you suggest for having condoms available? (Use back of page if necessary)

Are you ___Male ____Female ___Transgender

Do you identify as __African American/Black __Asian/Pacific Islander
__Native American/American Indian __White
Are you Hispanic ? __Yes __No

Are you ___19 or younger
___20's
___30's
___40's
___50's
___60 or older

Were your sex partners in the last 3 months ___ Male ___Female ___Both ___No partners

Appendix 20
Staffing Requirements of Agencies Implementing the L.I.F.E. Program®

All agencies implementing the L.I.F.E. Program® must agree to the following staffing requirements:

- Staff Positions: A minimum of 2 agency staff is required to operate the L.I.F.E. Program®: one L.I.F.E.® Coordinator and one L.I.F.E.® Facilitator.

  (1) The L.I.F.E.® Coordinator has responsibility for overall program implementation and coordination, which includes supervising other L.I.F.E.® staff, coordinating the logistics of program implementation, and serving as the sole agency contact person with the Shanti L.I.F.E. Institute staff. Additionally, the Coordinator provides direct client services as both group facilitator and individual health counselor. Because many of the program Cofactors are potentially stressful mental health issues (e.g., unresolved grief), this position requires credentials (education, training and clinical experience) in counseling clients with HIV/AIDS in both group and individual sessions. This position may be filled by a psychologist or other mental health counselor, social worker, nurse, health educator, or similar background. The L.I.F.E.® Coordinator position requires approximately 10-12 hours/week (0.3 FTE) while the program workshops are running, and 5-6 hours/week (0.15 FTE) when the workshops are not running.

  (2) The L.I.F.E.® Facilitator provides direct client services in both group workshops and individual health counseling components of the program, attends L.I.F.E.® staff meetings, and otherwise assists with program logistics. This position may be filled by any staff member with experience and skill in providing direct services to clients with HIV/AIDS; peer counselors without formal educational credentials may be used, including volunteers, provided that the L.I.F.E. Coordinator assesses their knowledge and skill, and approves them for direct clinical work with clients. The L.I.F.E.® Facilitator position requires approximately 10 hours/week (0.25 FTE) while the program workshops are running, and 5-6 hours/week (0.15 FTE) when the workshops are not running.

- Number of Facilitators Required per Client:. One trained L.I.F.E. facilitator is required for each 10 program participants (The Coordinator counts as a facilitator.) Thus, a minimum program sees 20 clients/workshop, with 2 facilitators servicing 10 clients each; while a maximum program sees 40 clients/workshop, with 4 facilitators servicing 40 clients each. Additional L.I.F.E.® Facilitators may be added to the program staff as needed, provided that they are trained and certified by the Shanti L.I.F.E. Institute.

- Staff training and certification: All facilitators of the L.I.F.E. Program® must receive a 3-day training program sponsored by the Shanti L.I.F.E. Institute, at the conclusion of which the staff will be certified as a "L.I.F.E.® Health Counselor". That certification will be valid for 2 years. One-day update trainings are required every two years as a mechanism for the L.I.F.E. Institute to do quality assurance, and for the "L.I.F.E.® Health Counselors" to experience professional development and learn updated information on the psycho-social cofactors and other aspects of the L.I.F.E.® health curriculum.

- Required meeting structure – In order to insure the quality and integrity of program implementation, each agency must conduct two meetings weekly (minimum 30 minutes) during the program workshops: (1) a Preparation Meeting to review the structure and content of the next upcoming meeting, which staff will be doing which program components, rehearsal, and basic logistics; and (2) a Debriefing Meeting to review the strengths and weaknesses of each program component of the just-completed meeting, and to identify issues for consultation with the Shanti L.I.F.E. Institute staff.

Appendix 21
REPORT OF WEEKLY MISSOURI AGENCY CONSULTATION MEETING

Between Missouri agency L.I.F.E. Coordinator and Shanti Liaison Missouri Agency Name & site #:_____ L.I.F.E. Coordinator Name: _____

Date of Phone consult _____ Start Time _____ Stop Time _____ Total minutes _____

L.I.F.E. Program cycle #: _____ Start Date: _____ Stop Date: _____ Meeting #(s): _____

(1) Review of L.I.F.E. Program Components – Cofactor covered in meeting: _____

- InfoBullets:
- Experiential Exercise:
- Large Group Discussion:
- Weekly Risk and Adherence Forms:
- Social Break:
- Small Group Discussion:
- PIPs:
- Closing exercise:

(2) Process Data

- Agency facilitators present: _____
- # of clients in attendance: _____ Attendance sheets faxed to Shanti? _____
- Total # clients still enrolled: _____ Weekly forms faxed to Shanti? _____
- Results re follow-up of clients who missed meetings:
- Mid-point evaluation at meeting #8 – administered and faxed to Shanti? _____

(3) Clinical / client Issues – L.I.F.E. cofactor health counseling; any issues with clients that might require consultation / referral to medical or mental health professionals

(4) Missouri Agency Staff Issues (showing up, competent, enough staff, skills building needed, etc.):

(5) Outreach and program promotion (how done, when start next, etc.):

(6) Information Management - Online measures / Clinical Charts / Medical data:

(7) Budget / financial issues:

Appendix 22

Condom Distribution Guidelines

The national strategy prioritizes as a deliverable, condom distribution and access for HIV positive populations. In addition it can be done for HIV high risk populations. It is important to review the vision the National Strategy has in mind and the ways we may want to focus our distribution. To find some places and leave condoms is NOT what the grant or strategy has in mind. It is to be a more integrated approach.

Social Marketing: You want to have a concurrent social marketing strategy to accompany your distribution. As we know funding is tight, in regards to HIV positive populations you want to at least do one or more of the following

- Advertise on your website where condoms are available through your program
- Every intervention you do with any positive populations you have condoms available and accessible
- Print business cards with location info on distribution sites. Create a plan on where you want to distribute these, and to whom, based on their contact with HIV positive individuals
- Develop at a minimum a slogan for your campaign, and preferably a logo. This should become part of your marketing on your website, business cards, etc (See Washington DC HD for their condom distribution campaign).
- Educate your prevention partners and other referral sources about the condom distribution program and sites

Sites: Your primary focus is HIV positive populations per the statewide target populations. MO has additionally decided to extend this program to High Risk Negatives. In PART I of the grant application we have given an initial plan for distribution, justification and any ordinances/laws that may need to be addressed. However we will be expected to broaden our approach and change sites as needed. Here are some additional ideas on how to do this

- Use your epi data especially in the two major metros, to determine where the highest concentration of HIV positive individuals live. If possible adopt the St. Louis model that uses a zip code map. Ideally this would be prioritized by a map of communal viral loads, but at this time we can at least begin with zip codes where HIV positive individuals live in large numbers, especially in the 2 metros and possibly Springfield.

For rural areas, doctor's offices and clinics that are primary providers to HIV positive individuals and case management offices can be priority sites. Also if you have support groups, insure they are always present each week.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

Subrecipient Annual Financial Report

1. Contractor Name and Complete Address			
2. Contract Number	3. Contract Period (MM/DD/YY)		4. Contractor Identifying Number (optional)
	From:	To:	
5. DUNS Number	6. EIN	7. Report Type	
		☐ Annual ☐ Final	

8. Transactions	
Contract Expenditures:	
8a. Total contract funds authorized:	
8b. Total expenditures:	
8c. Unspent balance of contract funds (line a minus b):	$0.00
Match Requirements:	
8d. Total match required:	
8e. Total match expenditures:	
8f. Remaining match to be provided (line d minus e):	$0.00

9. Remarks: Attach any explanations deemed necessary.

10. Certification: By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal Award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).

11a. Typed or Printed Name and Title of Authorized Certifying Official of the Contractor	11b. Telephone (Including Area Code)	11c. Email Address
11d. Signature of Authorized Certifying Official of the Contractor		11e. Date Report Submitted (MM/DD/YY)

MO 580-3091 (12-14)

YOUR LETTERHEAD HERE

HIV PREVENTION

INVOICE #: HIVP_____

BILL TO: Missouri Department of Health and Senior Services
Bureau of HIV, STD, and Hepatitis
Attention: Joyce Hooker
930 Wildwood Dr., PO Box 570
Jefferson City, MO 65102-0570

REMIT TO: *Add your agency's name and address where the payment is to be sent*

CONTRACT #: _____ FOR THE MONTH OF: _____

	PERSONNEL /FRINGE	TRAVEL/ MEETINGS	SUBCONTRACTS (if applicable)	OPERATING EXPENSE	INDIRECT	TOTAL
BUDGET	$73,277.00	$5,350.00	$0.00	$37,024.00	$9,252.00	$124,903.00
CURRENT MONTH EXPENDITURE						
TOTAL PREVIOUSLY INVOICED						
EXPENDITURES TO DATE						
REMAINING BALANCE						

The attached report is a true and correct statement of expenditure under the above stated contract for the invoice period. Further, all expenditures claimed were made in accordance with the provisions set forth in the contract.

_____
FISCAL OFFICER'S SIGNATURE

1. Business Associate Provisions

1.1 Health Insurance Portability and Accountability Act of 1996, as amended - The state agency and the contractor are both subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively, and hereinafter, HIPAA) and all regulations promulgated pursuant to authority granted therein. The contractor constitutes a "Business Associate" of the state agency. Therefore, the term, "contractor" as used in this section shall mean "Business Associate."

1.1.1 The contractor agrees that for purposes of the Business Associate Provisions contained herein, terms used but not otherwise defined shall have the same meaning as those terms defined in 45 CFR Parts 160 and 164 and 42 U.S.C. §§ 17921 *et. seq.* including, but not limited to the following:

a. "Access", "administrative safeguards", "confidentiality", "covered entity", "data aggregation", "designated record set", "disclosure", "hybrid entity", "information system", "physical safeguards", "required by law", "technical safeguards", "use" and "workforce" shall have the same meanings as defined in 45 CFR 160.103, 164.103, 164.304, and 164.501 and HIPAA.

b. "Breach" shall mean the unauthorized acquisition, access, use, or disclosure of Protected Health Information which compromises the security or privacy of such information, except as provided in 42 U.S.C. § 17921. This definition shall not apply to the term "breach of contract" as used within the contract.

c. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the contractor.

d. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the state agency.

e. "Electronic Protected Health Information" shall mean information that comes within paragraphs (1)(i) or (1)(ii) of the definition of Protected Health Information as specified below.

f. "Enforcement Rule" shall mean the HIPAA Administrative Simplification: Enforcement; Final Rule at 45 CFR Parts 160 and 164.

g. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

h. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).

i. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

j. "Protected Health Information" as defined in 45 CFR 160.103, shall mean individually identifiable health information:

- (i) Except as provided in paragraph (b) of this definition, that is: (i) Transmitted by electronic media; or (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

- (ii) Protected Health Information excludes individually identifiable health information in (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity (state agency) in its role as employer.

k. "Security Incident" shall be defined as set forth in the "Obligations of the Contractor" section of the Business Associate Provisions.

l. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C.

m. "Unsecured Protected Health Information" shall mean Protected Health Information that is not secured through the use of a technology or methodology determined in accordance with 42 U.S.C. § 17932 or as otherwise specified by the secretary of Health and Human Services.

1.1.2 The contractor agrees and understands that wherever in this document the term Protected Health Information is used, it shall also be deemed to include Electronic Protected Health Information.

1.1.3 The contractor must appropriately safeguard Protected Health Information which the contractor receives from or creates or receives on behalf of the state agency. To provide reasonable assurance of appropriate safeguards, the contractor shall comply with the business associate provisions stated herein, as well as the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) and all regulations promulgated pursuant to authority granted therein.

1.1.4 The state agency and the contractor agree to amend the contract as is necessary for the parties to comply with the requirements of HIPAA and the Privacy Rule, Security Rule, Enforcement Rule, and other rules as later promulgated (hereinafter referenced as the regulations promulgated thereunder). Any ambiguity in the contract shall be interpreted to permit compliance with the HIPAA Rules.

1.2 Permitted Uses and Disclosures of Protected Health Information by the Contractor:

1.2.1 The contractor may not use or disclose Protected Health Information in any manner that would violate Subpart E of 45 CFR Part 164 if done by the state agency, except for the specific uses and disclosures in the contract.

1.2.2 The contractor may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the state agency as specified in the contract, provided that such use or disclosure would not violate HIPAA and the regulations promulgated thereunder.

1.2.3 The contractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1) and shall notify the state agency by no later than ten (10) calendar days after the contractor becomes aware of the disclosure of the Protected Health Information.

1.2.4 If required to properly perform the contract and subject to the terms of the contract, the contractor may use or disclose Protected Health Information if necessary for the proper management and administration of the contractor's business.

1.2.5 If the disclosure is required by law, the contractor may disclose Protected Health Information to carry out the legal responsibilities of the contractor.

1.2.6 If applicable, the contractor may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B).

1.2.7 The contractor may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so.

1.2.8 The contractor agrees to make uses and disclosures and requests for Protected Health Information consistent with the state agency's minimum necessary policies and procedures.

1.3 Obligations and Activities of the Contractor:

1.3.1 The contractor shall not use or disclose Protected Health Information other than as permitted or required by the contract or as otherwise required by law, and shall comply with the minimum necessary disclosure requirements set forth in 45 CFR § 164.502(b).

1.3.2 The contractor shall use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the contract. Such safeguards shall include, but not be limited to:

a. Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract;

b. Policies and procedures implemented by the contractor to prevent inappropriate uses and disclosures of Protected Health Information by its workforce and subcontractors, if applicable;

c. Encryption of any portable device used to access or maintain Protected Health Information or use of equivalent safeguard;

d. Encryption of any transmission of electronic communication containing Protected Health Information or use of equivalent safeguard; and

e. Any other safeguards necessary to prevent the inappropriate use or disclosure of Protected Health Information.

1.3.3 With respect to Electronic Protected Health Information, the contractor shall use appropriate administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that contractor creates, receives, maintains or transmits on behalf of the state agency and comply with Subpart C of 45 CFR Part 164, to prevent use or disclosure of Protected Health Information other than as provided for by the contract.

1.3.4 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), the contractor shall require that any agent or subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the contractor agrees to the same restrictions, conditions, and requirements that apply to the contractor with respect to such information.

1.3.5 By no later than ten (10) calendar days after receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall make the contractor's internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by, or received by the contractor on behalf of the state agency available to the state agency and/or to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the HIPAA Rules and the contract.

1.3.6 The contractor shall document any disclosures and information related to such disclosures of Protected Health Information as would be required for the state agency to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 42 USCA §17932 and 45 CFR 164.528. By no later than five (5) calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall provide an accounting of disclosures of Protected Health Information regarding an individual to the state agency. If requested by the state agency or the individual, the contractor shall provide an accounting of disclosures directly to the individual. The contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the state agency upon request.

1.3.7 In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, the contractor shall, within five (5) calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set. However, if requested by the state agency, the contractor shall provide access to the Protected Health Information in a designated record set directly to the individual for whom such information relates.

1.3.8 At the direction of the state agency, the contractor shall promptly make any amendment(s) to Protected Health Information in a Designated Record Set pursuant to 45 CFR 164.526.

1.3.9 The contractor shall report to the state agency's Security Officer any security incident immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. For purposes of this paragraph, security incident shall mean the attempted or successful unauthorized access, use, modification or destruction of information or interference with systems operations in an information system. This does not include trivial incidents that occur on a daily basis, such as scans, "pings," or unsuccessful attempts that do not penetrate computer networks or servers or result in interference with system operations. By no later than five (5) days after the contractor becomes aware of such incident, the contractor shall provide the state agency's Security Officer with a description of any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan of action for approval that describes plans for preventing any such future security incidents.

1.3.10 The contractor shall report to the state agency's Privacy Officer any unauthorized use or disclosure of Protected Health Information not permitted or required as stated herein immediately upon becoming aware of such use or disclosure and shall take immediate action to stop the unauthorized use or disclosure. By no later than five (5) calendar days after the contractor becomes aware of any such use or disclosure, the contractor shall provide the state agency's Privacy Officer with a written description of any remedial action taken to mitigate any harmful effect of such disclosure and a proposed written plan of action for approval that describes plans for preventing any such future unauthorized uses or disclosures.

1.3.11 The contractor shall report to the state agency's Security Officer any breach immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. By no later than five (5) days after the contractor becomes aware of such incident, the contractor shall provide the state agency's Security Officer with a description of the breach, the information compromised by the breach, and any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan for approval that describes plans for preventing any such future incidents.

1.3.12 The contractor's reports required in the preceding paragraphs shall include the following information regarding the security incident, improper disclosure/use, or breach, (hereinafter "incident"):

a. The name, address, and telephone number of each individual whose information was involved if such information is maintained by the contractor;

b. The electronic address of any individual who has specified a preference of contact by electronic mail;

c. A brief description of what happened, including the date(s) of the incident and the date(s) of the discovery of the incident;

d. A description of the types of Protected Health Information involved in the incident (such as full name, Social Security Number, date of birth, home address, account number, or

disability code) and whether the incident involved Unsecured Protected Health Information; and

e. The recommended steps individuals should take to protect themselves from potential harm resulting from the incident.

1.3.13 Notwithstanding any provisions of the Terms and Conditions attached hereto, in order to meet the requirements under HIPAA and the regulations promulgated thereunder, the contractor shall keep and retain adequate, accurate, and complete records of the documentation required under these provisions for a minimum of six (6) years as specified in 45 CFR Part 164.

1.3.14 Contractor shall not directly or indirectly receive remuneration in exchange for any Protected Health Information without a valid authorization.

1.3.15 If the contractor becomes aware of a pattern of activity or practice of the state agency that constitutes a material breach of contract regarding the state agency's obligations under the Business Associate Provisions of the contract, the contractor shall notify the state agency's Security Officer of the activity or practice and work with the state agency to correct the breach of contract.

1.3.16 The contractor shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the contractor or its employee(s), agent(s) or subcontractor(s). The contractor shall reimburse the state agency for any and all actual and direct costs and/or losses, including those incurred under the civil penalties implemented by legal requirements, including but not limited to HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act, and including reasonable attorney's fees, which may be imposed upon the state agency under legal requirements, including but not limited to HIPAA's Administrative Simplification Rules, arising from or in connection with the contractor's negligent or wrongful actions or inactions or violations of this Agreement.

1.4 Obligations of the State Agency:

1.4.1 The state agency shall notify the contractor of limitation(s) that may affect the contractor's use or disclosure of Protected Health Information, by providing the contractor with the state agency's notice of privacy practices in accordance with 45 CFR 164.520.

1.4.2 The state agency shall notify the contractor of any changes in, or revocation of, authorization by an Individual to use or disclose Protected Health Information.

1.4.3 The state agency shall notify the contractor of any restriction to the use or disclosure of Protected Health Information that the state agency has agreed to in accordance with 45 CFR 164.522.

1.4.4 The state agency shall not request the contractor to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA and the regulations promulgated thereunder.

1.5 Expiration/Termination/Cancellation - Except as provided in the subparagraph below, upon the expiration, termination, or cancellation of the contract for any reason, the contractor shall, at the discretion of the state agency, either return to the state agency or destroy all Protected Health Information received by the contractor from the state agency, or created or received by the contractor on behalf of the state agency, and shall not retain any copies of such Protected Health Information. This provision shall also apply to Protected Health Information that is in the possession of subcontractor or agents of the contractor.

1.5.1 In the event the state agency determines that returning or destroying the Protected Health Information is not feasible, the contractor shall extend the protections of the contract to the Protected Health Information for as long as the contractor maintains the Protected Health Information and shall limit the use and disclosure of the Protected Health Information to those purposes that made return or destruction of the information infeasible. If at any time it becomes feasible to return or destroy any such Protected Health Information maintained pursuant to this paragraph, the contractor must notify the state agency and obtain instructions from the state agency for either the return or destruction of the Protected Health Information.

1.5.2 Breach of Contract – In the event the contractor is in breach of contract with regard to the business associate provisions included herein, the contractor agrees that in addition to the requirements of the contract related to cancellation of contract, if the state agency determines that cancellation of the contract is not feasible, the State of Missouri may elect not to cancel the contract, but the state agency shall report the breach of contract to the Secretary of the Department of Health and Human Services.

EXHIBIT 1
BUSINESS ENTITY CERTIFICATION, ENROLLMENT DOCUMENTATION, AND AFFIDAVIT OF WORK AUTHORIZATION

BUSINESS ENTITY CERTIFICATION:
The contractor must certify their current business status by completing either Box A or Box B or Box C on this Exhibit.

BOX A:	To be completed by a non-business entity as defined below.
BOX B:	To be completed by a business entity who has not yet completed and submitted documentation pertaining to the federal work authorization program as described at http://www.dhs.gov/files/programs/gc_1185221678150.shtm.
BOX C:	To be completed by a business entity who has current work authorization documentation on file with a Missouri state agency including Division of Purchasing and Materials Management.

Business entity, as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, is any person or group of persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage, or livelihood. The term "**business entity**" shall include but not be limited to self-employed individuals, partnerships, corporations, contractors, and subcontractors. The term "**business entity**" shall include any business entity that possesses a business permit, license, or tax certificate issued by the state, any business entity that is exempt by law from obtaining such a business permit, and any business entity that is operating unlawfully without such a business permit. The term "**business entity**" shall not include a self-employed individual with no employees or entities utilizing the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo.

Note: Regarding governmental entities, business entity includes Missouri schools, Missouri universities (other than stated in Box C), out of state agencies, out of state schools, out of state universities, and political subdivisions. A business entity does not include Missouri state agencies and federal government entities.

BOX A – CURRENTLY NOT A BUSINESS ENTITY

I certify that _____ (Company/Individual Name) **DOES NOT CURRENTLY MEET** the definition of a business entity, as defined in section 285.525, RSMo pertaining to section 285.530, RSMo as stated above, because: (check the applicable business status that applies below)

- ❒ I am a self-employed individual with no employees; **OR**
- ❒ The company that I represent employs the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo.

I certify that I am not an alien unlawfully present in the United States and if _____ (Company/Individual Name) is awarded a contract for the services requested herein under HIV Prevention and if the business status changes during the life of the contract to become a business entity as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, then, prior to the performance of any services as a business entity, _____(Company/Individual Name) agrees to complete Box B, comply with the requirements stated in Box B and provide the Department of Health and Senior Services with all documentation required in Box B of this exhibit.

Authorized Representative's Name (Please Print)	Authorized Representative's Signature
Company Name (if applicable)	Date

EXHIBIT 1, continued

(Complete the following if you DO NOT have the E-Verify documentation and a current Affidavit of Work Authorization already on file with the State of Missouri. If completing Box B, do not complete Box C.)

BOX B – CURRENT BUSINESS ENTITY STATUS

I certify that _____ (Business Entity Name) **MEETS** the definition of a business entity as defined in section 285.525, RSMo, pertaining to section 285.530.

Authorized Business Entity Representative's Name (Please Print)	Authorized Business Entity Representative's Signature
Business Entity Name	Date
E-Mail Address	

As a business entity, the contractor must perform/provide each of the following. The contractor should check each to verify completion/submission of all of the following:

- ❒ Enroll and participate in the E-Verify federal work authorization program (Website: http://www.dhs.gov/files/programs/gc_1185221678150.shtm; Phone: 888-464-4218; Email: e-verify@dhs.gov) with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services required herein; AND

- ❒ Provide documentation affirming said company's/individual's enrollment and participation in the E-Verify federal work authorization program. Documentation shall include EITHER the E-Verify Employment Eligibility Verification page listing the contractor's name and company ID OR a page from the E-Verify Memorandum of Understanding (MOU) listing the contractor's name and the MOU signature page completed and signed, at minimum, by the contractor and the Department of Homeland Security – Verification Division. If the signature page of the MOU lists the contractor's name and company ID, then no additional pages of the MOU must be submitted; AND

- ❒ Submit a completed, notarized Affidavit of Work Authorization provided on the next page of this Exhibit.

EXHIBIT 1, continued

AFFIDAVIT OF WORK AUTHORIZATION:

The contractor who meets the section 285.525, RSMo, definition of a business entity must complete and return the following Affidavit of Work Authorization.

Comes now _____ (Name of Business Entity Authorized Representative) as _____ (Position/Title) first being duly sworn on my oath, affirm _____ (Business Entity Name) is enrolled and will continue to participate in the E-Verify federal work authorization program with respect to employees hired after enrollment in the program who are proposed to work in connection with the services related to contract(s) with the State of Missouri for the duration of the contract(s), if awarded in accordance with subsection 2 of section 285.530, RSMo. I also affirm that _____ (Business Entity Name) does not and will not knowingly employ a person who is an unauthorized alien in connection with the contracted services provided under the contract(s) for the duration of the contract(s), if awarded.

In Affirmation thereof, the facts stated above are true and correct. (The undersigned understands that false statements made in this filing are subject to the penalties provided under section 575.040, RSMo.)

Authorized Representative's Signature	Printed Name
Title	Date
E-Mail Address	E-Verify Company ID Number

Subscribed and sworn to before me this _____ (DAY) of _____ (MONTH, YEAR). I am commissioned as a notary public within the County of _____ (NAME OF COUNTY), State of _____ (NAME OF STATE), and my commission expires on _____ (DATE).

Signature of Notary	*Date*

EXHIBIT 1, continued

(Complete the following if you have the E-Verify documentation and a current Affidavit of Work Authorization already on file with the State of Missouri. If completing Box C, do not complete Box B.)

BOX C – AFFIDAVIT ON FILE - CURRENT BUSINESS ENTITY STATUS

I certify that _____ (Business Entity Name) **MEETS** the definition of a business entity as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, and have enrolled and currently participates in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services related to contract(s) with the State of Missouri. We have previously provided documentation to a Missouri state agency or public university that affirms enrollment and participation in the E-Verify federal work authorization program. The documentation that was previously provided included the following.

- ✓ The E-Verify Employment Eligibility Verification page OR a page from the E-Verify Memorandum of Understanding (MOU) listing the contractor's name and the MOU signature page completed and signed by the contractor and the Department of Homeland Security – Verification Division
- ✓ A current, notarized Affidavit of Work Authorization (must be completed, signed, and notarized within the past twelve months).

Name of **Missouri State Agency** or **Public University*** to Which Previous E-Verify Documentation Submitted: _____

(*Public University includes the following five schools under chapter 34, RSMo: Harris-Stowe State University – St. Louis; Missouri Southern State University – Joplin; Missouri Western State University – St. Joseph; Northwest Missouri State University – Maryville; Southeast Missouri State University – Cape Girardeau.)

Date of Previous E-Verify Documentation Submission: _____

Previous **Bid/Contract Number** for Which Previous E-Verify Documentation Submitted: _____
(if known)

Authorized Business Entity Representative's Name (Please Print)	Authorized Business Entity Representative's Signature
E-Verify MOU Company ID Number	E-Mail Address
Business Entity Name	Date

FOR STATE USE ONLY

Documentation Verification Completed By:

Buyer	Date

STATE OF MISSOURI
DEPARMENT OF HEALTH AND SENIOR SERVICES

TERMS AND CONDITIONS

This contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained herein. Any change must be accomplished by a formal signed amendment prior to the effective date of such change.

1. APPLICABLE LAWS AND REGULATIONS

a. The contract shall be construed according to the laws of the State of Missouri (state). The contractor shall comply with all local, state, and federal laws and regulations related to the performance of the contract to the extent that the same may be applicable.
b. To the extent that a provision of the contract is contrary to the Constitution or laws of the State of Missouri or of the United States, the provisions shall be void and unenforceable. However, the balance of the contract shall remain in force between the parties unless terminated by consent of both the contractor and the state.
c. The contractor must be registered and maintain good standing with the Secretary of State of the State of Missouri and other regulatory agencies, as may be required by law or regulations.
d. The contractor must timely file and pay all Missouri sales, withholding, corporate and any other required Missouri tax returns and taxes, including interest and additions to tax.
e. The exclusive venue for any legal proceeding relating to or arising out of the contract shall be in the Circuit Court of Cole County, Missouri.
f. The contractor shall only employ personnel authorized to work in the United States in accordance with applicable federal and state laws and Executive Order 07-13 for work performed in the United States.

2. INVOICING AND PAYMENT

a. The State of Missouri does not pay state or federal taxes unless otherwise required under law or regulation. Prices shall include all packing, handling and shipping charges FOB destination, freight prepaid and allowed unless otherwise specified herein.
b. The statewide financial management system has been designed to capture certain receipt and payment information. For each purchase order received, an invoice must be submitted that references the purchase order number and must be itemized in accordance with items listed on the purchase order. Failure to comply with this requirement may delay processing of invoices for payment.
c. The contractor shall not transfer any interest in the contract, whether by assignment or otherwise, without the prior written consent of the state.
d. Payment for all equipment, supplies, and/or services required herein shall be made in arrears unless otherwise indicated in the specific contract terms.
e. The State of Missouri assumes no obligation for equipment, supplies, and/or services shipped or provided in excess of the quantity ordered. Any unauthorized quantity is subject to the state's rejection and shall be returned at the contractor's expense.
f. All invoices for equipment, supplies, and/or services purchased by the State of Missouri shall be subject to late payment charges as provided in section 34.055, RSMo.
g. The State of Missouri reserves the right to purchase goods and services using the state purchasing card.

3. DELIVERY

Time is of the essence. Deliveries of equipment, supplies, and/or services must be made no later than the time stated in the contract or within a reasonable period of time, if a specific time is not stated.

4. INSPECTION AND ACCEPTANCE

a. No equipment, supplies, and/or services received by an agency of the state pursuant to a contract shall be deemed accepted until the agency has had reasonable opportunity to inspect said equipment, supplies, and/or services.
b. All equipment, supplies, and/or services which do not comply with the specifications and/or requirements or which are otherwise unacceptable or defective may be rejected. In addition, all equipment, supplies, and/or services which are discovered to be defective or which do not conform to any warranty of the contractor upon inspection (or at any later time if the defects contained were not reasonably ascertainable upon the initial inspection) may be rejected.
c. The State of Missouri reserves the right to return any such rejected shipment at the contractor's expense for full credit or replacement and to specify a reasonable date by which replacements must be received.
d. The State of Missouri's right to reject any unacceptable equipment, supplies, and/or services shall not exclude any other legal, equitable or contractual remedies the state may have.

5. CONFLICT OF INTEREST

Elected or appointed officials or employees of the State of Missouri or any political subdivision thereof, serving in an executive or administrative capacity, must comply with sections 105.452 and 105.454, RSMo, regarding conflict of interest.

6. WARRANTY

The contractor expressly warrants that all equipment, supplies, and/or services provided shall: (1) conform to each and every specification, drawing, sample or other description which was furnished to or adopted by the state, (2) be fit and sufficient for the purpose intended, (3) be merchantable, (4) be of good materials and workmanship, and (5) be free from defect. Such warranty shall survive delivery and shall not be deemed waived either by reason of the state's acceptance of or payment for said equipment, supplies, and/or services.

7. REMEDIES AND RIGHTS

a. No provision in the contract shall be construed, expressly or implied, as a waiver by the State of Missouri of any existing or future right and/or remedy available by law in the event of any claim by the State of Missouri of the contractor's default or breach of contract.
b. The contractor agrees and understands that the contract shall constitute an assignment by the contractor to the State of Missouri of all rights, title and interest in and to all causes of action that the contractor may have under the antitrust laws of the United States or the State of Missouri for which causes of action have accrued or will accrue as the result of or in relation to the particular equipment, supplies, and/or services purchased or procured by the contractor in the fulfillment of the contract with the State of Missouri.

8. CANCELLATION OF CONTRACT

a. In the event of material breach of the contractual obligations by the contractor, the state may cancel the contract. At its sole discretion, the state may give the contractor an opportunity to cure the breach or to explain how the breach will be cured. The actual cure must be completed within no more than 10 working days from notification, or at a minimum the contractor must provide the state within 10 working days from notification a written plan detailing how the contractor intends to cure the breach.
b. If the contractor fails to cure the breach or if circumstances demand immediate action, the state will issue a notice of cancellation terminating the contract immediately. If it is determined the state improperly cancelled the contract, such cancellation shall be deemed a termination for convenience in accordance with the contract.
c. If the state cancels the contract for breach, the state reserves the right to obtain the equipment, supplies, and/or services to be provided pursuant to the contract from other sources and upon such terms and in such manner as the state deems appropriate and charge the contractor for any additional costs incurred thereby.
d. The contractor understands and agrees that funds required to fund the contract must be appropriated by the General Assembly of the State of Missouri for each fiscal year included within the contract period. The contract shall not be binding upon the state for any period in which funds have not been appropriated, and the state shall not be liable for any costs associated with termination caused by lack of appropriations.

9. BANKRUPTCY OR INSOLVENCY

Upon filing for any bankruptcy or insolvency proceeding by or against the contractor, whether voluntary or involuntary, or upon the appointment of a receiver, trustee, or assignee for the benefit of creditors, the contractor must notify the state immediately. Upon learning of any such actions, the state reserves the right, at its sole discretion, to either cancel the contract or affirm the contract and hold the contractor responsible for damages.

10. INVENTIONS, PATENTS AND COPYRIGHTS

The contractor shall defend, protect, and hold harmless the State of Missouri, its officers, agents, and employees against all suits of law or in equity resulting from patent and copyright infringement concerning the contractor's performance or products produced under the terms of the contract.

11. NON-DISCRIMINATION AND AFFIRMATIVE ACTION

In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall agree not to discriminate against recipients of services or employees or applicants for employment on the basis of race, color, religion, national origin, sex, age, disability, or veteran status unless otherwise provided by law. If the contractor or subcontractor employs at least 50 persons, they shall have and maintain an affirmative action program which shall include:

a. A written policy statement committing the organization to affirmative action and assigning management responsibilities and procedures for evaluation and dissemination;
b. The identification of a person designated to handle affirmative action;
c. The establishment of non-discriminatory selection standards, objective measures to analyze recruitment, an upward mobility system, a wage and salary structure, and standards applicable to layoff, recall, discharge, demotion, and discipline;
d. The exclusion of discrimination from all collective bargaining agreements; and
e. Performance of an internal audit of the reporting system to monitor execution and to provide for future planning.

If discrimination by a contractor is found to exist, the state shall take appropriate enforcement action which may include, but not necessarily be limited to, cancellation of the contract, suspension, or debarment by the state until corrective action by the contractor is made and ensured, and referral to the Attorney General's Office, whichever enforcement action may be deemed most appropriate.

12. AMERICANS WITH DISABILITIES ACT

In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA).

13. FILING AND PAYMENT OF TAXES

The commissioner of administration and other agencies to which the state purchasing law applies shall not contract for goods or services with a vendor if the vendor or an affiliate of the vendor makes sales at retail of tangible personal property or for the purpose of storage, use, or consumption in this state but fails to collect and properly pay the tax as provided in chapter 144, RSMo. For the purposes of this section, "affiliate of the vendor" shall mean any person or entity that is controlled by or is under common control with the vendor, whether through stock ownership or otherwise.

14. COMMUNICATIONS AND NOTICES

Any notice to the contractor shall be deemed sufficient when deposited in the United States mail postage prepaid, transmitted by facsimile, transmitted by e-mail or hand-carried and presented to an authorized employee of the contractor.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

CONTRACT FUNDING SOURCE(S)

The Contract Funding Source(s) is supplemental information the Department is required to provide the Contractor when issuing a contract or amendment that will be funded by federal sources. The document identifies the total amount of funding and the federal funding source(s) expected to be used over the life of this contract. For the specific amount for a contract period, refer to the contract and/or applicable amendments. If the funding information is not available at the time the contract is issued or the information below changes, the Contractor will be notified in writing by the Department. Please retain this information with your official contract files for future reference.

Tracking # 41061 **State:** 0% $0.00 **Federal:** 100% $252,708.00

Contract Title: HIV PREVENTION

Contract Start: 1/1/2015 **Contract End:** 12/31/2016 **Amend#:** 02 **Contract #:** AOC15380158

Vendor Name: COLUMBIA/BOONE COUNTY HEALTH DEPARTMENT

CFDA: 93.940 **Research and Development:** N

CFDA Name: HIV PREVENTION ACTIVITIES_HEALTH DEPARTMENT BASED

Federal Agency: DEPARTMENT OF HEALTH AND HUMAN SERVICES / CENTERS FOR DISEASE CONTROL AND PREVENTION

Federal Award: 5U62PS003676-04

Federal Award Name: PS12-1201 COMPREHENSIVE HIV PREVENTION PROJECT FOR HEALTH DEPTS

Federal Award Year: 2015 **DHSS #:** PS003676-04A **Federal Obligation:** $127,805.00

CFDA: 93.940 **Research and Development:** N

CFDA Name: HIV PREVENTION ACTIVITIES_HEALTH DEPARTMENT BASED

Federal Agency: DEPARTMENT OF HEALTH AND HUMAN SERVICES / CENTERS FOR DISEASE CONTROL AND PREVENTION

Federal Award: *

Federal Award Name: *

Federal Award Year: 2016 **DHSS #:** CDC-RFA-PS12-120105C **Federal Obligation:** $124,903.00

*** The Department will provide this information when it becomes available.**

Project Description:

Comprehensive Human Immunodeficiency Virus (HIV) Prevention-HIV Planning, Health Education/Risk Reduction (HE/RR), HIV Testing Services, Partner Services, Evaluation, HIV Positives and Condom Distribution.