B.3 PERFORMANCE WORK STATEMENT

1. **GENERAL**:

1.1. SERVICES REQUIRED: The VA Salt Lake City Health Care System (VASLCHCS) Department of Veteran Affairs George E Wahlen Medical Center requires the following services to be provided in a private hospital, office or clinic environment to Veterans, primarily residing in Dagget, Duchesne, and Uintah counties.

1.1.1. Primary Care CBOC: offers both medical and mental health care (physically on site and by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. Primary Care CBOCs are required to provide both primary care and mental health services. Mental Health services will be provided by VA staff via telehealth.

1.2. PLACE OF PERFORMANCE: Within the city limits of Vernal, Utah.

1.3. AUTHORITY: In accordance with Title 38 United States Code (USC) 8153 to be furnished by the contractor on behalf of VA Salt Lake City Health Care System, 500 Foothill Dr. Salt Lake City, UT 84148. And also, in accordance with Federal Acquisition Regulations (FAR) PART 12 and 15.

1.4. POLICY AND REGULATIONS: The Contractor is required to meet VHA performance and quality criteria and standards including, but not limited to, access, customer satisfaction, prevention index, chronic disease index and clinical guidelines. Performance and quality standards may change during the contract. New or revised quality/performance criteria or standards will be provided to the Contractor before implementation date and throughout the life of the contract through unilateral or bi-lateral modifications, as applicable. Copies of current VA and VHA publications can be located at http://www.va.gov/vhapublications/ or at http://www.va.gov/vapubs/. Compliance with mandated performance is required as a condition of this contract. Contractor shall comply with all relevant VA policies and procedures, including those related to quality, access, patient safety and performance, including, but not limited to the policies listed on the Contracted Clinic Policy Document located at https://www.patientcare.va.gov/primarycare/docs/List_contracted_clinic_policy_documents_05_07_19.xlsx#.

1.5. DEFINITIONS/ACRONYMS**:**

1.5.1. ABMS: American Board of Medical Specialties
1.5.2. ACLS: Advanced Cardiac Life Support
1.5.3. ACGME: Accreditation Council for Graduate Medical Education
1.5.4. ACPE: American Council on Pharmaceutical Education
1.5.5. ACO: Administrative Contracting Officer
1.5.6. ADE: adverse drug events
1.5.7. AED: Automatic External Defibrillator
1.5.8. AIS: Automated Information Security
1.5.9. ANA: American Nurses Association
1.5.10. AOA: American Osteopathic Association
1.5.11. ARRT: American Registry of Radiologic Technology
1.5.12. ASC: Ambulatory Surgery Clinic

1.5.13. Assigned: A Veteran is "assigned" to an outpatient clinic via PCMM (i.e. CBOC) where the patient receives their primary care after the patient's eligibility is determined through registration and enrollment.
1.5.14. BAA: Business Associate Agreement
1.5.15. BI-RADS: Breast Imaging-Reporting and Data System; a quality assurance tool designed to standardize mammography reporting
1.5.16. BLS: Basic Life Support
1.5.17. BOS: Bureau of Osteopathic Specialists
1.5.18. CAHEA: Committee on Allied Health Education and Accreditation
1.5.19. CAP: College of American Pathologists
1.5.20. CARF: Commission on Accreditation of Rehabilitation Facilities
1.5.21. CBO: VA Central Billing Office.
1.5.22. CDC: Centers for Disease Control and Prevention
1.5.23. CEU: Certified Education Unit
1.5.24. CLIA: Clinical Laboratory Improvement Amendments
1.5.25. CME: Continuing Medical Education
1.5.26. CMS: Center for Medicare and Medicaid Services
1.5.27. CO: Contracting Officer
1.5.28. COPD: chronic obstructive pulmonary disease
1.5.29. COR: Contracting Officer's Representative
1.5.30. COS: Chief of Staff
1.5.31. CPA: Collaborative Practice Agreement
1.5.32. CPS: Clinical Pharmacy Specialist
1.5.33. CPT: Current Procedural Terminology
1.5.34. CRNP: Certified Registered Nurse Practitioners
1.5.35. CSWE: The Council on Social Work Education the CSWE website is http://www.cswe.org/ .
1.5.36. CPARS: Contractor Performance Assessment Reporting System
1.5.37. CVT: Clinical Video Telehealth
1.5.38. DICOM: Digital Image and Communication in Medicine
1.5.39. DIGMA: Drop in Group Medical Appointment
1.5.40. DRG: Diagnostic Related Group
1.5.41. DSS: Decision Support System
1.5.42. ECC Extended Care Center
1.5.43. Enrollment**:** The process of establishing eligibility for VA's "Medical Benefits Package." Most Veterans are required to "enroll" into the VA Health Care System to be eligible for VA health care and to be assigned to an outpatient clinic like a CBOC, however some can still receive care without enrolling. Applicants are only required to "enroll" once for VA health care unless they are determined ineligible for care at time of application or they have disenrolled.
1.5.44. EPRP: External Peer Review Program
1.5.45. FDA: Food and Drug Administration
1.5.46. FSMB: Federation of State Medical Boards
1.5.47. HCC: Health Care Center A HCC is a VA-owned, VA-leased, contract, or shared clinic operated at least 5 days per week that provides primary care, mental health care, on site specialty services, and performs ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.
1.5.48. HHS: Department of Health and Human Services
1.5.49. HCFA: HealthCare Financing Administration
1.5.50. HICPAC: Healthcare Infection Control Practices Advisory Committee- a federal advisory committee made up of 14 external infection control experts who provide advice and

guidance to the CDC and the Secretary of HHS regarding the practice of health care infection control, strategies for surveillance and prevention and control of health care associated infections in United States health care facilities.

1.5.51. HT: Home Telehealth

1.5.52. ICAVL: Intersocietal Commission for the Accreditation of Vascular Laboratories

1.5.53. ICD 10: International Classification of Diseases 10th edition

1.5.54. INR: International Normalized Ratio

1.5.55. ISO: Information Security Officer

1.5.56. LIP: licensed independent practitioner

1.5.57. MCCR: Medical Care Cost Recovery

1.5.58. Mental Health Services: per VHA Handbook 1160.01 is meant to include services for the evaluation, diagnosis, treatment, and rehabilitation of both substance use disorders and other mental disorders.

General mental health services include:

(a) Diagnostic and treatment planning evaluations for the full range of mental health problems;

(b) Treatment services using evidence-based pharmacotherapy, or primary evidence-based

psychotherapy for patients with mental health conditions and substance use disorders;

(c) Patient education;

(d) Family education when it is associated with benefits to the Veterans;

(e) Referrals as needed to inpatient and residential care programs; and

(f) Consultation about special emphasis problems including Post Traumatic Stress Disorder (PTSD) and Military Sexual Trauma (MST).

Specialty mental health services include:

(a) Consultation and treatment services for the full range of mental health conditions;

(b) Evidence-based psychotherapy;

(c) Mental Health Intensive Case Management (MHICM);

(d) Psychosocial Rehabilitation Services, including: PRRCs, family psycho-education,

family education, skills training, peer support, and Compensated Work Therapy (CWT) and supported employment;

(e) PTSD teams or specialists;

(f) MST special clinics;

(g) Homeless programs; and

(h) Specialty substance abuse treatment services.

1.5.59. MQSA: Mammography Quality Standards Act

1.5.60. MSN: Master of Science in Nursing

1.5.61. NCCPA: National Commission on Certification of Physician Assistants

1.5.62. NLN: National League for Nursing

1.5.63. NSQIP/CICSP: National Surgical Quality Improvement Program/Continuing Improvement in Cardiac Surgical Program

1.5.64. OTC: Over the Counter

1.5.65. PA: Physician Assistant

1.5.66. PACS: Picture Archiving and Communications System

1.5.67. PACT: Patient Aligned Care Team Background & Introduction: VA has implemented a PCMH model at all VA Primary Care sites which is referred to as PACT. This initiative supports VHA's Universal Health Care Services Plan to redesign VHA healthcare delivery through increasing access, coordination, communication, and continuity of care. PACT provides accessible, coordinated, comprehensive, patient-centered care, in team based environment including the active involvement of other clinical and non-clinical staff. PACT allows patients to have a more active role in their health care and is associated with increased quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions.

1.5.68. Parent Facility: VAMC responsible for performance monitoring and payment for contracted Outpatient Site of Care services.

1.5.69. PCMH: Patient-Centered Medical Home

1.5.70. PCMM: Primary Care Management Module- a software program used to track Primary Care Clinic Veteran rosters.

1.5.71. PCP: Primary Care Provider

1.5.72. Phar.D.: Doctor of Pharmacy

1.5.73. POC: Point of Care Testing

1.5.74. PRIMARY CARE VISIT: an episode of care furnished in a clinic that provides integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. The VHA site classification defines primary care as those encounters that occur within the primary care class of encounters.

1.5.75. PCMHI: Primary Care-Mental Health Integration

1.5.76. PWS: Performance Work Statement

1.5.77. QAPI: Quality Assessment and Performance Improvement

1.5.78. QASP: Quality Assurance Surveillance Plan

1.5.79. RME: reusable medical equipment

1.5.80. SOP (Clinical): Scope of Practice

1.5.81. SELF- REFERRAL: Referring patients to Contractor's facility for follow-up care. Self-referral for outpatient services at the Contractor's facility is prohibited.

1.5.82. SFT: Store and Forward Telehealth

1.5.83. SMA: Shared Medical Appointments

1.5.84. SPD: Sterile Processing Division

1.5.85. SPE: Senior Procurement Executive

1.5.86. SPECIALTY CARE VISIT: A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral." These services are generally divided into two sub-categories: medicine specialties and surgery specialties. The VHA site classification defines specialty care as those encounters that occur within the geriatric medicine; allergy; cardiology; dermatology; emergency; employee health; endocrinology; gastroenterology; general medicine; hematology or oncology; infectious disease; nephrology; neurology; outreach; pulmonary or respiratory disease; rheumatology; amputation follow-up; amputation; anesthesia; cardio-thoracic; ear, nose, and throat (ENT); eye; general surgery; gynecology (GYN); neurosurgery; orthopedics; plastic surgery; urology; or vascular clinic stops.

1.5.87. SUPPORT STAFF: staff present in the clinic area assisting providers in the actual delivery of care to patients. It consists of RNs, LPNs, Medical Assistants, Health Technicians, and Medical Clerks in the clinic.

1.5.88. TJC: The Joint Commission

1.5.89. TIU: Text Integration Utility
1.5.90. TCT: Telehealth Clinical Technicians
1.5.91. VA: Veterans Affairs
1.5.92. VA EHR: VA electronic health record
1.5.93. VAMC: Veterans Affairs Medical Center
1.5.94. VetPro: a federal web-based credentialing program for healthcare providers.
1.5.95. VHA: Veterans Health Administration

2. STAFFING AND QUALIFICATIONS:

2.1. MINIMUM PATIENT ALIGNED CARE TEAM (PACT) STAFFING REQUIREMENTS:

PACTs comprise the patients, the patients' personal support persons, teamlets (Primary Care Providers (PCPs), Registered Nurse Care Managers (RNCMs), Clinical Associates, Administrative Associates), and discipline specific team members (Clinical Pharmacy Specialists (CPSs), Licensed Clinical Social Workers (LCSWs), Registered Dietician/Nutritionists, and Primary Care-Mental Health Integration (PCMHI)staff). The Contractor shall provide PACT staffing in numbers and qualifications capable of fulfilling the standards outlined in the resultant contract. The Contractor shall provide a sufficient number of primary care providers so that each primary care provider has a caseload ratio to meet VA standards. Current standards are 1200 active patients per full time physician and 900 active patients per full time midlevel provider. Actual panel sizes can be determined by the VA in accordance with VHA Directive 1406 Patient Centered Management Module (PCMM) for Primary Care. The staffing standard for support staff shall be in ratios to Primary Care Providers of at least three full time equivalent (FTE) support staff (1 FTE RNCM, 1 FTE Clinical Associate, 1 FTE Administrative Associate) for each FTE Primary Care Provider. The Clinical Pharmacy Specialist (CPS) shall be provided the same support staffing given to other providers on the team when they are working in the capacity of a mid-level provider. The Contractor shall provide personnel in numbers and qualifications capable of fulfilling the standards outlined in the resultant contract. The Contractor must establish and implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events (e.g., extreme weather conditions, natural disasters). If the number of patients reaches 90% of maximum panel size assigned by the facility the Contractor shall communicate to the VA the Contractor's future staffing plan to ensure staffing ratio standards remain in accordance with PCMM staffing standards. Total Estimated Patients enrolled/assigned to site: 810.

2.2. PHYSICIAN DIRECTOR (MANDATORY FOR ALL SITES): FTE Ratio Performance Standard: 0.05 FTE (2 hours a week) per PACT Responsible Party: Shall be provided by Contractor. Qualifications: Contractor's Physicians (including subcontractors) providing physician director services under the resultant contract shall demonstrate evidence of education, training, and experience in Internal Medicine or Family Practice. Contactor's Physicians performing under this contract shall be board certified by the ABMS in Internal Medicine and/or Family Practice or the BOS in Internal Medicine and/or Family Practice. Physicians shall be licensed in the state where the Outpatient Site of Care (i.e. CBOC) is located. If proposed staff do not meet VA credentialing requirements, the Contractor shall propose substitute acceptable personnel within five (5) calendar days. May also be credentialed and privileged as a PCP. (If so, authorization for prescriptive authority is required). Position Responsibilities: Serves as medical director to oversee and be responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site.

2.3. PRIMARY CARE TEAMLET STAFFING (MANDATORY FOR ALL SITES): All primary care teamlet staffing shall be provided by Contractor

2.3.1. **TEAMLET MEMBER 1: Primary Care Provider (PCP):** FTE Ratio Performance Standard: Current standards are 1200 active patients per full time physician and 900 active patient per full time midlevel provider. Contractor shall propose quantity for FTE to meet Standard FTE ratio to panel size. Contractor to propose mix of PCP from the options below. At least one of the PCPs is required to be a physician.

OPTION 1: Physician (MD): Qualifications: Physicians shall demonstrate evidence of education, training, and experience in Internal Medicine or Family Practice. Physicians performing under this contract shall be board certified by the ABMS in Internal Medicine and/or Family Practice or the BOS in Internal Medicine and/or Family Practice. Authorization for prescriptive authority is required. Physicians shall be licensed in the state where the Outpatient Site of Care (i.e. CBOC) is located. If proposed staff do not meet VA credentialing requirements, the Contractor shall propose substitute acceptable personnel within five (5) calendar days. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care, providing health care commensurate to the PCP's licensure and clinical privileges or scope of practice, ensuring the patient's care plan contains medical recommendations for clinically indicated care, offering clinically indicated health care services to patients assigned to the PACT, and providing or arranging for care to which patients consent, providing leadership to the team including shared delegation of appropriate care and care processes to appropriate team members, reviewing available clinical and performance data with the team, and focusing on continuous improvement of critical team processes, ensuring the patient has same-day access for face-to-face and telephone care visits during regular clinic hours, and collaborating with PACT staff to develop personal health plans that incorporate care management and care coordination appropriate to the patient's needs.

OPTION 2: Certified Registered Nurse Practitioner (CRNP): Qualifications: CRNP's (including subcontractors) must have a MSN from a NLN accredited nursing program and have ANA Certification as a Nurse Practitioner in either Adult Health or Family Practice. Authorization for prescriptive authority is required. Three years of clinical nursing experience is required. A minimum of one (1) year clinical experience as a CRNP is required (three (3) years preferred). Experience in outpatient care in a Family Medicine or Internal Medicine environment is preferred. CRNP shall have current, full, active, and unrestricted license and registration as a graduate professional nurse in the state of the Outpatient Site of Care (i.e. CBOC); **Reference VA Handbook 5005, Appendix G6** http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=464&FType=2. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care, providing health care commensurate to the PCP's licensure and clinical privileges or scope of practice, ensuring the patient's care plan contains medical recommendations for clinically indicated care, offering clinically indicated health care services to patients assigned to the PACT, and providing or arranging for care to which patients consent, providing leadership to the team including shared delegation of appropriate care and care processes to appropriate team members, reviewing available clinical and performance data with the team, and focusing on continuous improvement of critical team processes, ensuring the patient has same-day access for face-to-face and telephone care visits during regular clinic hours, and collaborating with PACT staff to develop personal health plans that incorporate care management and care coordination appropriate to the patient's needs.

OPTION 3: Physician Assistant (PA):Qualifications: PA's (including subcontractors) must meet one of the three following educational criteria: a) A bachelor's degree from a PA training program which is certified by the CAHEA; or b) Graduation from a PA training program of at least twelve (12) months duration, which is certified by the CAHEA and a bachelor's degree in a health care occupation or health related science; or c) graduation from a PA training program of at least twelve (12) months duration which is certified by the CAHEA and a period of progressively responsible health care experience such as independent duty medical corpsman, licensed practical nurse, registered nurse, medical technologist, or medical technician. The duration of approved academic training and health care experience must total at least five (5) years. Authorization for prescriptive authority is required. PAs must be certified by the NCCPA. PA shall have current, full, active, and unrestricted license and registration in the state of the Outpatient Site of Care (i.e. CBOC); VA HANDBOOK 5005/78 PART II APPENDIX G8 PHYSICIAN ASSISTANT QUALIFICATION STANDARD http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=763&FType=2**. Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care, providing health care commensurate to the PCP's licensure and clinical privileges or scope of practice, ensuring the patient's care plan contains medical recommendations for clinically indicated care, offering clinically indicated health care services to patients assigned to the PACT, and providing or arranging for care to which patients consent, providing leadership to the team including shared delegation of appropriate care and care processes to appropriate team members, reviewing available clinical and performance data with the team, and focusing on continuous improvement of critical team processes, ensuring the patient has same-day access for face-to-face and telephone care visits during regular clinic hours, and collaborating with PACT staff to develop personal health plans that incorporate care management and care coordination appropriate to the patient's needs

2.3.2. **TEAMLET MEMBER 2: Registered Nurse (RN) Care Manager:** FTE Ratio Performance Standard: Current standard is 1.0 FTE RNCM per 1.0 FTE PCP. Reference VA Handbook 5005, Appendix G6 http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=464&FType=2
Qualifications: Graduate of a school of professional nursing approved by the appropriate State-accrediting agency **and** accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The accreditation Commission for Education in Nursing (ACEN) or The commission on Collegiate Nursing Education (CCNE). Current, full, active, and unrestricted registration as a graduate professional nurse in the state of the Outpatient Site of Care (i.e. CBOC). **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site, providing all aspects of professional nursing services consistent with licensure, certification, nursing professional standards of practice, and the clinician's Functional Statement with elements of practice, enhancing patient safety and quality of care by collaborating with PACT staff to develop, oversee, and manage care management plans and care coordination for patients assigned to PACTs, participating in modes of communication and care delivery including, but not limited to, secure messaging, telephone care, view alerts management, shared medical appointments, clinical video telehealth visits, face to face visits, etc., as part of care management, identifying patient needs for involvement of discipline-specific team members and discussing nursing recommendations with the PCP, engaging relevant PACT staff to support nursing care, according to locally established informal and formal communication processes, including entering consultation requests to discipline-specific

PACT members, if required for formal communications, assuming full accountability for the appropriateness of assignments made by the RNCM to clinical associates or administrative associates related to care management, care coordination, nursing services, and outcomes of care, entering orders in the VA EHR for tests per approved standardized RN care management protocols or PCP orders, ensuring the RNCM has same-day access for face-to-face and telephone care visits, using nursing expertise, evidence-based guidelines, standardized nursing protocols, and professionally accepted practice standards to promote patient engagement, self-care and wellness, and provide care to patients and determine care management requirements for individual patients or cohorts of patients. The RN collaborates for the improvement of patient care outcomes in the Patient Aligned Care Team. Promotes systems to improve access and continuity of care, uses advanced clinical knowledge and critical thinking skills to mentor staff in planning, implementing and evaluating interventions that improve patient outcomes, designs and provides age and population specific health promotion and risk reduction strategies, translates evidence-based research into practice to ensure that patients benefit from the latest innovations in nursing science, manages patients in transition between levels of care, serves as an expert resource to implement and teach skills, including motivational interviewing to promote patient self-management toward patient-driven holistic care plan for life.

2.3.3. **TEAMLET MEMBER 3: CLINICAL ASSOCIATE:** FTE Ratio Performance Standard: Current standard is 1.0 FTE clinical associate per 1.0 FTE PCP. Contractor to propose the mix of Clinical Associates from the options below.

OPTION 1: Licensed Practical Nurse (LPN): Qualifications: VA HANDBOOK 5005/3 PART II APPENDIX G13 LICENSED PRACTICAL OR VOCATIONAL NURSE QUALIFICATION STANDARD http://vaww.va.gov/OHRM/Directives-Handbooks/Documents/5005.pdf Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC). **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site, providing evaluation and care consistent with licensure, certification, and functional statement with elements of practice, to patients assigned PACTs, collaborating with PACT staff to develop comprehensive health care plans and care management plans for patients assigned to patient panels, managing clinic workflow, ensuring patients are placed in examination rooms in a timely manner, and providing direction to patients as they move through the clinic environment. Duties include but are not limited to the aability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas. The Clinical Associate shall receive training, and act as back-up for telehealth services

OPTION 2: Licensed Vocational Nurse (LVN):Qualifications: VA HANDBOOK 5005/3 PART II APPENDIX G13 LICENSED PRACTICAL OR VOCATIONAL NURSE QUALIFICATION STANDARD http://vaww.va.gov/OHRM/Directives-Handbooks/Documents/5005.pdf . Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site, providing evaluation and care consistent with licensure, certification, and functional statement with elements of practice, to patients assigned PACTs, collaborating

with PACT staff to develop comprehensive health care plans and care management plans for patients assigned to patient panels, managing clinic workflow, ensuring patients are placed in examination rooms in a timely manner, and providing direction to patients as they move through the clinic environment. Duties include but are not limited to the aability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas. The Clinical Associate shall receive training, and act as back-up for telehealth services.
OPTION 3: Medical Assistant (MA):Qualifications: Completion of an approved medical assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES), or by any accrediting agency recognized by the United States Department of Education or a current and active Certified Medical Assistant (CMA) or Registered Medical Assistant (RMA) from The American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT). Other credentials such as completion of a medical services training program of the Armed Forces of the United States may be accepted based on Chief of Staff determination.**Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site, providing evaluation and care consistent with licensure, certification, and functional statement with elements of practice, to patients assigned PACTs, collaborating with PACT staff to develop comprehensive health care plans and care management plans for patients assigned to patient panels, managing clinic workflow, ensuring patients are placed in examination rooms in a timely manner, and providing direction to patients as they move through the clinic environment. Duties include but are not limited to the aability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas. The Clinical Associate shall receive training, and act as back-up for telehealth services.

OPTION 4: Health Care Technician (HCT) (as part of PACT teamlet, not primary telehealth technician) : Qualifications: Completion of an approved medical assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES), or by any accrediting agency recognized by the United States Department of Education or a current and active Certified Medical Assistant (CMA) or Registered Medical Assistant (RMA) from The American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT). Other credentials such as completion of a medical services training program of the Armed Forces of the United States may be accepted based on Chief of Staff determination. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site, providing evaluation and care consistent with licensure, certification, and functional statement with elements of practice, to patients assigned PACTs, collaborating with PACT staff to develop comprehensive health care plans and care management plans for patients assigned to patient panels, managing clinic workflow,

ensuring patients are placed in examination rooms in a timely manner, and providing direction to patients as they move through the clinic environment. Duties include but are not limited to the aability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas. The Clinical Associate shall receive training, and act as back-up for telehealth services.

2.3.4. TEAMLET MEMBER 4: ADMINISTRATIVE ASSOCIATE: FTE Ratio Performance Standard: **Current standard is 1.0 FTE administrative associate per 1.0 FTE PCP**. **Qualifications:** Required education and experience demonstrating skills and abilities to perform duties ensuring smooth site operations .**Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care, providing clerical support and administrative functions to PACT staff, collaborating with PACT staff to incorporate the logistical elements of care coordination into comprehensive care management plans, providing guidance and direction to patients and personal support persons for navigating the VA health care system and administrative functions in VA, and coordinating care for patients assigned to the PACT.

2.4. DISCIPLINE SPECIFIC PACT TEAMLET MEMBERS (REQUIRED FOR ALL SITES): Discipline-specific team members are designated in PCMM for one or more PACT(s). Discipline-specific team members provide continuity of direct discipline-specific care to all patients assigned to PACT(s) for which the team member is designated.

2.4.1. **DISCIPLINE SPECIFIC 1: CLINICAL PHARMACY SPECIALIST (CPS) –**PACT:

2.4.1.1. This staffing will be provided by the VA parent facility through telehealth. Utilizing the Pharmacy Consult in the EHR

2.4.2. **DISCIPLINE SPECIFIC 2: CLINICAL PHARMACY SPECIALIST (CPS) ANTI-COAGULATION:** staffing will be provided by the VA parent facility through telehealth. Utilizing the Pharmacy Consult in the EHR.

2.4.3. **DISCIPLINE SPECIFIC 3: LICENSED CLINICAL SOCIAL WORKER (this position provides general/medical social work services):** staffing will be provided by the VA parent facility through telehealth. Utilizing the Social Work Consult in the EHR.

2.4.4.

2.4.5. **DISCIPLINE SPECIFIC 4: REGISTERED DIETITIAN/NUTRITIONIST**: FTE Ratio Performance Standard: staffing will be provided by the VA parent facility through telehealth. Utilizing the Nutrition Consult in the EHR

2.4.6. DISCIPLINE SPECIFIC 5: PRIMARY CARE MENTAL HEALTH INTEGRATION (PC-MHI):

staffing will be provided by the VA parent facility through telehealth. Utilizing the PCMHI Consult in the EHR.

2.5. SPECIALTY CARE STAFFING: The Contractor is not required to provide specialty care service(s). Veterans shall receive all specialty care services via telehealth, or through the VA Community Care Consult in the patients EHR.

2.5.1. **PODIATRIST:** The Contractor is not required to provide this service. The veterans shall receive podiatry services through VA podiatry consult in the patient's EHR.

2.6. ANCILLARY SUPPORT SERVICES STAFFING: The following specialty staffing shall be provided by the Contractor, except as noted below.

2.6.1 **PHLEBOTOMIST/LABORATORY TECHNICIAN**: Services will be a collateral assignment, duties will be provided by the contracted RN, or Clinical Health Associate. This clinic will utilize only Point of Care testing.

2.6.2 GENERAL AND SPECIALTY MENTAL HEALTH STAFFING: This staffing will be provided by the parent VA facility via telehealth, through the Mental Health Consult in the Electronic Health Record

2.6.3 **Suicide Prevention Coordinator (SPC)**: This staffing will be provided by the parent VA facility via telehealth, through the Mental Health Consult in the Electronic Health Record. The VA performance standard for sites with 10,000 patients or more is maintaining a Suicide Prevention Coordinator (SPC) with a full-time commitment to suicide prevention activities. In smaller sites serving less than 10,000, this may be a collateral assignment.

2.6.4 **Homeless Outreach Specialist:** This staffing will be provided by the parent VA facility via telehealth, through the Mental Health Consult in the Electronic Health Record. To ensure the availability of outreach and referral services to homeless Veterans, all sites with 10,000 patients or more must designate at least one outreach specialist, usually a clinical social worker, to provide services to homeless Veterans. NOTE: In smaller facilities, this may be a collateral assignment.

2.7 TELEHEALTH SERVICES CLINICAL STAFF: The contractor shall provide this staffing. Telehealth Clinical Technician (TCT) FTE Ratio performance standard 1.0 FTE Telehealth Clinical Technician (TCT) per estimated 5,000 patients at clinic, with a trained back-up (e.g., another TCT or a member of the PACT Teamlet (LIP, RNCM, or LPN), depending on size of clinic/clinic workload/clinic telehealth services). All staff providing telehealth related services (primary TCT(s) and back-ups) must be trained in teleretinal imaging, teledermatology, teleaudiology, tele-mental health, teleprimary care etc. by the parent VA facility. The qualifications, competencies, and position responsibilities noted below apply to primary TCT(s) and back-ups. The Telepresenter can be any clinically trained person assisting the provider in the presentation of the Veteran using video-conferencing. Depending on the skills needed for the encounter, the Telepresenter can be a licensed independent provider (LIP), Registered Nurse, LPN, or Telehealth Clinical Technician (TCT). Telepresenters can also serve as TCT back-ups. The number and discipline of Contractor's staff trained to function as a TCT back-up or Telepresenter will be based on the volume and type of telehealth services provided**.**

2.7.1. Qualifications: All staff providing telehealth related services into the clinic shall be appropriately credentialed and; where necessary, privileged. All contractor staff who support

and manage telehealth services must be working within permitted licensure and scope of practice. Where non-licensed staff is supporting telehealth services the Contractor's licensed staff must provide appropriate clinical supervision.

2.7.2. Competency – TCTs, Telepresenters, Store and Forward Imagers et al. and their back-ups, shall be expected to provide clinical care in compliance with established clinical protocol. Additional guidelines governing operations will be utilized and provided to Contractor by VA. TCTs, Telepresenters, Store and Forward Imagers and back-ups shall be expected to successfully complete training programs required for certification as a TCT, Telepresenter and/ or Store and Forward Imager and back-up including VA required training and any VA training mandated for TCT, Telepresenter, Teleretinal Imagers. TCTs, Telepresenters, and Store and Forward Imagers shall be responsible for maintaining imager and/or other required certification. TCTs, Telepresenters, and Store and Forward Imagers and back-ups shall be expected to demonstrate competency on the function and use of the telehealth equipment including digital retinal and dermatology imaging system, teleaudiology hardware and software. VA will provide training to TCTs, Telepresenters, Store and Forward Imagers and back-ups and document competency.

2.7.3. Training: Contractor's TCTs, RNs, LPNs, LIPs and support staff providing telehealth services shall be required to complete all Telehealth required training, both virtual and in-person. Contractor's Telehealth Staff shall be required to attend conference calls intended to support and maximize delivery of care as required by the VA.

2.7.4. TCT Position Responsibilities: TCT manages the Telehealth Services offered by the clinic (i.e., presenting, equipment management, training, imaging, audiology services, etc.) and is responsible for the provision of covered services to enrolled and unassigned patients presenting for care. The Contractor's telehealth services shall include but are not limited to: coordinating telehealth clinic set up, scheduling, equipment management, provision of data on request, attendance on VA or Network Telehealth Team calls, maintaining records required for quality control processes, and participating in performance improvement activities. The TCT shall be responsible for conveyance of clinically appropriate in-person interaction or on-site observations (e.g., assisting with hearing aid fittings, detection of alcohol use, etc.) with the Veteran patient to the telehealth provider. The TCT shall be responsible for gathering and transmitting telehealth images, sounds, data and all other supporting data to the assigned VA providers or reading centers within time lines established by policy. The TCT shall provide technology education to patients including but not limited to: review of acquired data or images for anatomic and general findings, review of photos, and provision of VA approved handouts. The TCT shall communicate regularly with the Facility Telehealth Coordinator (FTC) to work out any process issues, equipment needs/problems, data collection and any other logistical issues.

2.7.5. Telepresenter Position Responsibilities: Include but are not limited to the following: Assist the primary care or specialty care provider with the Veteran physical exam as needed, provide Veteran education, documentation and assistance with workload capture for the completion of the visit, per scope of practice and manage required screenings and complete clinical reminders, documentation, scheduling and opening and closing the encounter.

2.8 **LICENSE AND ACCREDITATION:** Contract physician(s) and all other contract licensed providers assigned by the Contractor to perform the services covered by this contract shall have a current license to practice in the state where the outpatient site is located. All licenses held by the personnel working on this contract shall be full and unrestricted licenses. Contract providers who have current, full and unrestricted licenses in one or more states, but who have, or ever had, a license restricted, suspended,

revoked, voluntarily revoked, voluntarily surrendered pending action or denied upon application will not be considered for the purposes of this contract.

2.8.1 Technical Proficiency/Board Certification: Personnel shall be technically proficient in the skills necessary to fulfill the government's requirements, including the ability to speak, understand, read and write English fluently.

2.8.2 The Contractor must ensure that all individuals who provide services and/or supervise services at the Contractor's Outpatient Site of Care, including individuals furnishing services under contract are qualified to provide or supervise such services.

2.8.3 Position specific competencies shall be completed for all staff annually.

2.8.4 Contractor staff qualifications, licenses, certifications and facility Joint Commission or equivalent accreditation must be maintained throughout the contract period of performance. If Contractor's staff is not directly employed by the treating facility, documentation must be provided to the COR to ensure adequate certification. All actions required for maintaining certification must be kept up to date always. Documentation verifying current licenses, certifications and facility accreditation must be provided by the Contractor on an annual basis.

2.8.5 The Contractor is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are properly licensed always under the applicable state law and/or regulations of the provider's license, and shall be subject to credentialing and privileging requirements by VA.

2.8.6 The Contractor shall not permit any employee to begin work at an Outpatient Site of Care prior to confirmation from the VA that the individual's background investigation has been reviewed and released to the Office of Personnel Management (OPM), by the Security and Investigations Center (SIC), and that credentialing and privileging requirements have been met. A copy of licenses must be provided with offer and will be updated annually. Any changes related to the providers' licensing or credentials will be reported immediately to the VA Credentialing Office. Failure to adhere to this provision may result in one or more of the following sanctions, which shall remain in effect until the deficiency is corrected:

2.8.7 The VA will not pay the capitation payment due on behalf of an enrolled patient if service is provided or authorized by unlicensed personnel, without regard to whether such services were medically necessary and appropriate.

2.8.8 The VA may refer the matter to the appropriate licensing authority for action, as well as notify the patient that he/she was seen by a provider outside the scope of the contract and may pursue further action.

2.8.9. The Contractor shall notify COR, Contracting Officer, and the VA Chief of Staff when any provider furnishing services under this contract is reported to the National Practitioner Data Bank. This notification shall include the name, title, and specialty of the provider.

2.9 **CREDENTIALING AND PRIVILEGING**: Credentialing and privileging will be done in accordance with the provisions of VHA Handbook 1100.19. This VHA Handbook provides updated VHA procedures regarding credentialing and privileging, to include incorporating: VHA policy concerning VetPro; the Expedited Medical Staff Appointment Process; credentialing during activation of the facility Disaster Plan; requirements for querying the FSMB; credentialing and

privileging requirements for Telemedicine and remote health care; clarifications for the Summary Suspension of Privileges process in order to ensure both patient safety and practitioner rights; and the credentialing requirements for other required providers.

2.9.1. Contractor shall ensure that all Physicians and any other discipline requiring licensure or accreditation under this contract participate in the Credentialing and Privileging process through VHA's electronic credentialing system, "VetPro" No services are to be provided by any contract provider requiring credentialing until the parent VA Medical Executive Board and Director have granted approval. The Contractor shall be provided copies of current requirements and updates as they are published.

2.9.2 Credentials and Privileges shall require renewal annually in accordance with VA and TJC requirements. Credentialed providers assigned by the Contractor to work at the site shall be required to report specific patient outcome information, such as complications, to the VA. Quality improvement data provided by the Contractor and/or collected by the VA will be used to analyze individual practice patterns. The Service Chief, Primary Care Service Line will utilize the data to formulate recommendations to the Medical Executive Board when clinical privileges are being considered for renewal.

2.9.3. Contractor shall ensure that all Nurse Practitioners, Clinical Pharmacy Specialists, and Physician Assistants to be employed under this contract also participate in the Credentialing process through VA's "VetPro," in accordance with VHA Handbook 1100.19. Since Contracted Nurse Practitioners, and Physician Assistants are not recognized by the VA as independent practitioners, they function under a VA Scope of Practice (not Clinical Privileges). The VA Scope of Practice must adhere to applicable practice acts within that state. The credentials and scope of practice for Nurse Practitioners, and Physician Assistants are reviewed at the time of the initial appointment and at least every two years thereafter by an appropriate VA discipline-specific Professional Standards Board

2.10 **CME/CEU**: Contractor staff registered or certified by national/medical associations shall continue to meet the minimum standards for CME to remain current. CME hours shall be reported to the credential's office for tracking. These documents are required for both privileging and re privileging. Failure to provide will result in loss of privileges.

2.11 **TRAINING (ACLS/BLS/VA MANDATORY):** Contractor staff shall complete VA mandatory training as requested and complete BLS training and keep BLS certifications current throughout the life of the contract. Copies of current certifications shall be provided to the COR. ACLS certification is only required for health care personnel that order, administer, monitor, or supervise moderate sedation, monitored anesthesia care, or general anesthesia, according to current VHA policy. Based on the size and complexity of this patient population, ACLS is not required. Providers do not use anesthesia, or sedation in the Primary Care setting. The contractor shall coordinate, and cover contract staff travel expenses in accordance with General Services Administration (GSA) rates. https://www.gsa.gov/portal/category/100000.

2.12 **ACCESS TO PATIENT INFORMATION:** In performance of official duties, Contractor's provider(s) have regular access to printed and electronic files containing sensitive data, which must be protected under the provisions of the Privacy Act of 1974 (5 U.S.C. 552a), and other applicable laws, Federal Regulations, Veterans Affairs statutes and policies. Contractor's provider(s) are responsible for (1) protecting that data from unauthorized release or from loss, alteration, or unauthorized deletion and (2) following all applicable regulations

and instructions regarding access to computerized files, release of access codes, etc., as set out in a computer access agreement which contract provider(s) signs.

2.12.1 Contractor staff shall complete required security training and sign a VA

Computer Access Agreement prior to having access to the VA computer system. Security Training will be accomplished **annually**. Contractor staff shall select training modules for Privacy Training and Information Security Training. Upon completion of the training, please email or fax training certificates to the Contracting Officer at Leigh Ann Nunn at (405)426-5113or Leigh.Nunn2@va.gov

2.12.2. In addition, if providing clinical services, Contractor staff will attend VA EHR training prior to providing any patient care services. Contractor staff shall document patient care in the VA EHR to comply with all VA and equivalent TJC standards.

2.12.3 All contract personnel requiring access to PHI / Encrypted information must obtain a PIV card to ensure secure communications to and from the VA (e.g. Clinical staff, contract billing staff requiring patient lists with PHI/PII and Contract management personnel requiring PHI/PII information).

2.13 **RULES OF BEHAVIOR FOR AUTOMATED INFORMATION SYSTEMS**: Contractor staff having access to VA Information Systems are required to read and sign a Rules of Behavior statement which outlines rules of behavior related to VA Automated Information Systems. The COR will provide, through the facility ISO, the Rules of Behavior to The Contractor for the respective facility. A copy of the Rules of Behavior may also be found in the attachments section of this solicitation.

2.14. STANDARD INFECTION CONTROL MEASURES (PPD, IMMUNIZATIONS, ETC.): Contractor shall provide statement that all required infection control testing and immunizations for their personnel are current and that the contractor is compliant with OSHA regulations concerning occupational exposure to blood borne pathogens. All clinic staff are required to receive annual influenza vaccination. Staff unable or unwilling to be vaccinated are required to wear a face mask throughout the influenza season. The Contractor shall also notify the VA of any significant communicable disease exposures and the VA will also notify the contractor of the same, as appropriate. Contractor shall adhere to current CDC/HICPAC Guideline for Infection Control in Health Care Personnel (as published in American Journal for Infection Control- AJIC 1998; 26:289-354 http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf) for infection control in their personnel. Contractor shall provide follow up documentation of clearance to return to the workplace prior to their return.

2.15. NATIONAL PROVIDER IDENTIFICATION (NPI): All Contractors who provide billable healthcare services to VA; VHA, shall obtain a NPI as required by the Health Insurance Portability and Accountability Act (HIPAA) National Provider Identifier Final Rule, administered by the CMS. This rule establishes assignment of a 10-digit numeric identifier for Contractor staff, intended to replace the many identifiers currently assigned by various health plans. Contractor staff needs only one NPI, valid for all employers and health plans. Contractor staff must also designate their Specialties/Subspecialties by means of Taxonomy Codes on the NPI application. The NPI may be obtained via a secure website at: https://nppes.cms.hhs.gov/NPPES

2.16. PRESCRIPTION DRUG MONITORING PROGRAM: Contractor's providers shall register with the state prescription drug monitoring program in accordance with VHA Directive 1306, Querying State Prescription Drug Monitoring Programs (PDMP).

2.17. CONFLICT OF INTEREST: The Contractor is responsible for identifying and communicating to the CO and COR conflicts of interest at the time of proposal and during the entirety of contract performance. At the time of proposal, the Contractor shall provide a statement which describes, in a concise manner, all relevant facts concerning any past, present, or currently planned interest (financial, contractual, organizational, or otherwise) or actual or potential organizational conflicts of interest relating to the services to be provided. The Contractor shall also provide statements containing the same information for any identified consultants or sub-Contractors who shall provide services. The Contractor must also provide relevant facts that show how its organizational and/or management system or other actions would avoid or mitigate any actual or potential organizational conflicts of interest in accordance with VA Directive1660.03. See attachment in Section D.

2.18. CITIZENSHIP RELATED REQUIRMENTS:

2.18.1 The Contractor certifies that the Contractor shall comply with all legal provisions contained in the Immigration and Nationality Act of 1952, As Amended; its related laws and regulations that are enforced by Homeland Security, Immigration and Customs Enforcement and the U.S Department of Labor as these may relate to non-immigrant foreign nationals working under contract or subcontract for the Contractor while providing services to Department of Veterans Affairs.

2.18.2 While performing services for the Department of Veterans Affairs, the Contractor shall not knowingly employ, contract or subcontract with an illegal alien; foreign national non-immigrant who is in violation their status, because of their failure to maintain or comply with the terms and conditions of their admission into the United States. Additionally, the Contractor is required to comply with all "E-Verify" requirements consistent with "Executive Order 12989" and any related pertinent Amendments, as well as applicable Federal Acquisition Regulations.

2.18.3 If the Contractor fails to comply with any requirements outlined in the preceding paragraphs or its Agency regulations, the Department of Veterans Affairs may, at its discretion, require that the foreign national who failed to maintain their legal status in the United States or otherwise failed to comply with the requirements of the laws administered by Homeland Security, Immigration and Customs Enforcement and the U.S Department of Labor, shall be prohibited from working at the Contractor's place of business that services Department of Veterans Affairs patient referrals; or other place where the Contractor provides services to Veterans who have been referred by the Department of Veterans Affairs; and shall form the basis for termination of this contract for breach.

2.18.4 This certification concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under 18 U.S.C. 1001.

2.18.5 The Contractor agrees to obtain a similar certification from its subcontractors. The certification shall be made as part of the offerors response to the RFP using the subject attachment in Section D of the solicitation document.

2.19 ANNUAL OFFICE OF INSPECTOR GENERAL (OIG) STATEMENT: In accordance with The Health Insurance Portability and Accountability Act (HIPAA) and the Balanced Budget Act (BBA) of 1977, the VA OIG has established a list of parties and entities excluded from Federal health care programs. Specifically, the listed parties and entities may not receive Federal Health Care program payments due to fraud and/or abuse of the Medicare and Medicaid programs.

2.19.1 Therefore, all Contractors shall review the OIG List of Excluded Individuals/Entities on the OIG web site at www.hhs.gov/oig to ensure that the proposed Contract staff and/or firm(s) are not listed. Contractors should note that any excluded individual or entity that submits a claim for reimbursement to a Federal health care program, or causes such a claim to be submitted, may be subject to a Civil Monetary Penalty (CMP) for each item or service furnished during a period that the person or entity was excluded and may also be subject to treble damages for the amount claimed for each item or service. CMP's may also be imposed against the Contract staff and entities that employ or enter contracts with excluded individuals or entities to provide items or services to Federal program beneficiaries.

2.19.2 By submitting their proposal, the Contractor certifies that the OIG List of Excluded Individuals/Entities has been reviewed and that the Contractor and/or firm is/are not listed as of the date the offer/bid was signed.

2.20 NON-PERSONAL SERVICES: The parties agree that The Contractor, contract staff, agents and sub-Contractors shall not be considered VA employees for any purpose. All individuals that provide services under this resultant contract and are not employees of the Contractor shall be regarded as subcontractors. The Contractor shall be responsible and accountable for the quality of care delivered by all its subcontractors. The Contractor shall be responsible for strict compliance of all contract terms and conditions without regard to who provides the service.

2.21 CONTRACT PERSONNEL: The Contractor shall be responsible for protecting all Contractor personnel furnishing services. To carry out this responsibility, The Contractor shall provide or certify that the following is provided for all contract staff providing services under the resultant contract:

Workers' compensation
Professional liability insurance
Health examinations
Income tax withholding, and
Social security payments

2.22 INHERENTLY GOVERNMENTAL FUNCTIONS PROHIBITED. This includes, but is not limited to, determination of agency policy, determination of Federal program priorities for budget requests, direction and control of government employees, selection or non-selection of individuals for Federal Government employment including the interviewing of individuals for employment, approval of position descriptions and performance standards for Federal employees, approving any contractual documents, approval of Federal licensing actions and inspections, and/or determination of budget policy, guidance, and strategy.

2.23 TORT: The Federal Tort Claims Act does not cover Contract staff. When a contract staff member has been identified as a provider in a tort claim, The Contractor's staff member shall notify the Contractor's legal counsel and/or insurance carrier. Any settlement or judgment arising from a Contractor's provider's action or non-action is the responsibility of The Contractor and/or insurance carrier.

2.24 RYAN HAIGHT ACT: In support of providing Veterans access to comprehensive Telehealth services, including the provision of controlled substances in compliance with the Ryan Haight Act, Contractor shall apply for DEA registration if this option is available under state law. If DEA registration is not available under state law or the contractor is unable to obtain DEA registration, Contractor shall ensure a DEA registered provider can be present in the room with the patient during discussions of controlled substances prescriptions, at telehealth visits in which controlled substances are prescribed, if the patient has not had at least one prior in-person medical assessment with the prescribing provider.

3 **HOURS OF OPERATION:** The following outlines the required hours of operation:

3.1 BUSINESS HOURS: The clinic and services should be available by the contractor Monday through Friday from 8:00 am – 4:30 pm for regularly scheduled appointments.

3.2 EVENING HOURS: With prior VA permission, the contractor may be open during non-business hours for backlog, and/or access issues.

3.3 WEEKEND HOURS: With prior VA permission, the contractor may be open during non-business hours for backlog, and/or access issues.

3.4 FEDERAL HOLIDAYS: The following holidays are observed by the Department of Veterans Affairs: New Year's Day, Washington's Birthday, Martin Luther King's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving, Christmas, any day specifically declared to be a national holiday. Should a holiday fall on a Saturday or Sunday (weekend), the holiday will occur on the Friday (if the holiday falls on a Saturday), or Monday (for holidays falling on a Sunday).

4 CONTRACTOR RESPONSIBILITIES:

4.1 **GENERAL:** Contractor performing services under this contract shall provide a continuum of care from prevention to diagnosis and treatment, to appropriate referral and follow-up. Contractor's outpatient site of care must have the necessary professional medical staff, diagnostic testing and treatment capability, and referral arrangements needed to ensure continuity of health care. The Contractor shall provide services solely dedicated to Veterans regardless of gender or age. Those patients needing specialty care shall be referred to VA.

4.1.1. NOTE: Patients referred for care outside the Contractor's clinic (e.g. to VA Community Care, VA facility, or similar) for care that the Contractor is required to provide under the terms of this contract will be removed from the applicable billing roster the month after the patient is referred for care.

4.2 REGISTRATION **AND FINANCIAL ASSESSMENTS:**

4.2.1. **REGISTRATION AND ENROLLMENT:** Enrollment is the acceptance of an eligible Veteran into the VA Health Care System and assignment to an enrollment priority group. Not all Veterans are required to enroll in the VA health care system to receive health care services. Veterans enroll once into VA's health care system and are continuously enrolled. Enrolled Veterans may seek care at any VA facility without being required or requested to reestablish eligibility for VA health care enrollment purposes. Veterans enrolled at one VA medical facility wishing to register for care at a VA medical facility where the patient has never before presented for care are not required to re-enroll.

All veterans applying for care at the CBOC will have an application processed in VA EHR by the Contractor to determine priority enrollment category for benefits. The Contractor will process all applications for veterans requesting to be followed at the CBOC. The Contractor will use a number of processes in making priority group determinations including discharge documentation, Hospital Inquiry (HINQ), and communications (written and telephonic) with the VA Regional Office and Records Management Center in St. Louis. The Contractor will contact the VA Supervisor, Patient Registration for any unusual or complicated enrollment issues/questions. The Contractor will adhere to the processes and guidelines established by the Supervisor, Patient Registration in regard to all issues concerning patient enrollment and registration. No veteran should receive clinical care by a CBOC without the Contractor confirming enrollment within the VA. Persons not verified eligible who present to a CBOC in need of urgent or emergent care will be treated on a Humanitarian basis until stable and discharged from CBOC or referred to the proper level of care in the community. If the patient is determined to have no authorization for services, and has received care at the Contractor's CBOC, the patient will be billed directly by the VA and will be informed by staff at the CBOC that he is not eligible to continue receiving services at this site. All applications will be registered and enrolled into VA EHR by the Contractor using the "Register a Patient" option in the VA EHR Registration package. All registrations will then be "Dispositioned" in VA EHR by using the "Disposition an Application" option before close of business each day. Any questions related to registrations, enrollment, and dispositions can be referred to the VA Supervisor, Patient Registration at 801-582-1565; ext. 5162

4.2.2. **FINANCIAL ASSESSMENTS**: Financial assessment is the process known as a Means Test (MT) used by VA to assess a Veteran's attributable income and assets. The MT determines a Veteran's copayment responsibilities, assists in determining enrollment priority group assignment, and assists in evaluating requirements for determining beneficiary travel benefits. Not all Veterans are required to make copayments.

The Contractor will provide a blank VA Form 10-10EZR (Renewal Application for Health Benefits) to the veteran; and the veteran will fill it out completely, including the financial information on side two of the form. The demographic and financial assessment information will be input into VA EHR and maintained by the Contractor. For some veterans, a financial assessment is not required (VA pensioners, service-connected veterans receiving VA compensation, etc.). VA will provide the Contractor with guidelines regarding Financial Assessments, and

questions can be addressed to the VA Means Test Clinic at 801-582-1565; ext. 6148.

Co-payment: A co-payment may be assessed for in-patient and outpatient services, as well as pharmaceuticals, to veterans. This co-payment is determined by priority group status and the law. All VA co-payments shall be billed and collected by the VA and are not the responsibility of the Contractor. The Contractor shall notify the patient that, depending on the priority group determination, there may be a co-payment. All disputes for VA co-payments shall be referred to the Customer Service Representative for Billing 1-866-393-1846.

4.3 EPISODIC CARE FOR UNASSIGNED/UNENROLLED PATIENTS.

4.3.1 Contractor shall provide at no additional cost approximately 7/month nurse-only visits and 5/month provider visits to Veterans who are not assigned for care at the Contractor's outpatient site of care. These visits occur when an unassigned Veteran eligible for VA health care comes to the clinic seeking limited episodic care that cannot be provided by the Veterans assigned primary care provider/team at their preferred facility. The clinic shall ensure that the Veteran is triaged by an appropriate clinical staff member and that any basic care that can be provided by the nurse and/or provider is provided. Contractor shall provide care for traveling Veterans in accordance with VHA Handbook 1101.11(2), "Coordinated Care for Traveling Veterans" http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=3099

4.3.2 Telehealth support for Patients Not Assigned at the Outpatient Site of Care— At no additional cost the contractor shall provide approximately 5/month telehealth visits with the VAMC parent for Veterans who are not assigned for care at the Contractor's outpatient site of care. These visits occur when an unassigned Veteran eligible for VA health care requires a telehealth visit with the parent VAMC (vs. requiring the patient traveling to the parent VAMC). The Contractor shall support the scheduling and visit management as per requirements and normal routine as defined in the PWS.

4.4. **PATIENT HANDBOOK:** The Contractor shall provide each patient with a copy of a patient handbook. A sample patient handbook which the Contractor can edit to apply specifically to the FILL-IN WITH NAME OF CLINIC will be provided by the parent VAMC. The handbook shall include: Address of Contractor's Outpatient Site of Care, names of providers, telephone number(s), and office hours; Description of services provided; Procedures for obtaining services; Procedures for obtaining emergency services; and notice to the patient that they have the right to grieve eligibility related decisions directly to the VA.

4.5 **STANDARDS OF PRACTICE**: Contractor shall be responsible for meeting or exceeding VA and TJC (or equivalent) standards.

4.6 DIRECT PATIENT CARE

4.6.1 PRIMARY CARE SERVICES:

4.6.1.1 PRIMARY CARE TASKS SUMMARY: VA employs the patient centered medical home model of primary care, which in VA is called the Patient Aligned Care Team. VHA HANDBOOK 1101.10 "Patient Aligned Care Team" outlines complete requirements for the PACT model. The PACT delivery model is predicated on a foundation of delivering care that is patient centered, team based and continuously striving for improvement. Important components of the model include Patient Centered Care, Access, Care Management and Coordination as well as redesigning the team and work. Contractor shall provide all services in accordance with Handbook 1101.10. Information provided below summarizes the PACT model and Contractor requirements. See Handbook 1101.10 for more comprehensive information and requirements.

4.6.1.1.1 ENHANCE PATIENT CENTERED CARE (PCC): Establishing a patient centered practice environment and philosophy as a core principle of PACT requires a knowledgeable staff and an engaged, activated patient and family. Contractor staff shall be required to complete the following tasks to begin to implement PCC:

4.6.1.1.1.1 Engage the patient/family in self-management and personal goal setting

4.6.1.1.1.2 Provide education pertinent to care needs and document the provision of that education.

4.6.1.1.1.3 Provide support on site to enroll patients in MyHealtheVet & Secure Messaging

4.6.1.1.1.4 Ensure staff is trained in self-management techniques, motivational interviewing, shared decision making as made available by VA.

4.6.1.1.1.5 Clinic patients will be notified of all test results requiring action within 7 days and all test results not requiring action within 14 days. For critical results that represent an imminent danger to the patient, the Contractor shall notify the patient immediately.

4.6.1.1.2 ENHANCE ACCESS TO CARE: PACT strives for superb access to care in all venues including face to face and virtual care. Contractor is expected to enhance access to care by offering care in the following modalities:

4.6.1.1.2.1 Face to Face Visit Access: Provide same day access for patients and increase (or establish) group visits and shared medical appointments

4.6.1.1.2.2 Virtual Access- the contractor shall provide the following virtual access:

4.6.1.1.2.2.1 Telephones: Phones should be answered by a "live" person with a focus on achieving first call resolution. First call resolution is taking care of the Veteran's issue/request during that call. This approach requires thoughtful planning and strategy

4.6.1.1.2.2.2 MyHealtheVet (MHV): Provide support to enroll Veterans into (MHV) to include full authentication for use of premium services (such as secure messaging).

4.6.1.1.2.2.3 Secure Messaging (SM): Encourage & educate patients to use SM as a non-synchronous mode of communication; establish SM as a communication method in clinic and increase Veteran participation in SM.

4.6.1.1.2.3. Telemedicine & Telehealth:

4.6.1.1.2.3.1 Improve access to scarce medical services via telemedicine

4.6.1.1.2.3.2 Increase Veteran enrollment in telehealth modalities

4.6.1.1.3 ENHANCE CARE MANAGEMENT & COORDINATION OF CARE: Improving systems and processes associated with critical patient transitions, managing populations of patients and patients at high risk has proven to have a positive impact on quality, patient satisfaction and utilization of high cost services such as acute inpatient admissions, skilled nursing facility stays, and emergency department visits. Clinic staff shall take the following actions to achieve improvements:

4.6.1.1.3.1 Improve Critical Transitions Processes: Inpatient to Outpatient: develop systems to identify admitted primary care patients; provide follow up care either by face to face visit or telephone visit within 2 days' post discharge and document the follow up care in the VA EHR and communicate among the team.

4.6.1.1.3.2 Enhance Primary Care to Specialty Care Interface:

4.6.1.1.3.3 Participate in electronic virtual consults & SCAN ECHO as available

4.6.1.1.3.4 Develop resource listing of specialty care points of contact for nursing and medical care

4.6.1.1.3.5 Participate in VAMC sponsored medical educational activities to enhance networking with specialty staff

4.6.1.1.3.6 Enhance VA & Community Interfaces in Caring for Veterans

4.6.1.1.3.7 Develop a list of community points of contact

4.6.1.1.3.8 Develop mutually agreeable interface systems with community facilities and providers

4.6.1.1.4 IMPROVE SYSTEMS FOR MANAGING THE CARE OF PATIENT POPULATIONS

4.6.1.1.4.1 Enhance Management of Patients with Chronic Illness

4.6.1.1.4.2 Identify patients with suboptimal chronic disease indices from VHA databases (registries)

4.6.1.1.4.2 Develop plans including staff roles and responsibilities in addressing care needs. Include all team members in delivering care as license allows. Use face to face and virtual care delivery methods such as pharmacy/nurse clinics, telephone clinic etc.

4.6.1.1.5 ENHANCE HEALTH PROMOTION & DISEASE PREVENTION FOCUS IN CARE DELIVERY

4.6.1.1.5.1 Identify patients with preventive care needs from VHA databases (registries)

4.6.1.1.5.2 Develop & implement plans including staff roles and responsibilities in addressing care needs. Include all team members in delivering care as license allows. Use face to face and virtual care delivery methods such as pharmacy/nurse clinics, telephone clinic etc.

4.6.1.1.6 ENHANCE MANAGEMENT OF HIGH-RISK VETERANS (such as Veterans with frequent emergency department visits, frequent inpatient admissions for ambulatory sensitive conditions, and severely injured/disabled, frail elderly).

4.6.1.1.6.1 Identify high risk patients from VHA databases (registries)

4.6.1.1.6.2 Develop plans including staff roles and responsibilities in addressing care needs. Include all team members in delivering care as license allows.

4.6.1.1.6.3 Use face to face and virtual care delivery methods such as pharmacy/nurse clinics, telephone clinic etc.

4.6.1.1.7 IMPROVE PRACTICE DESIGN & FLOW TO ENHANCE WORK EFFICIENCY & CARE DELIVERY

4.6.1.1.7.1 Maximize functioning of all team members through role and task clarification for work flow processes.

4.6.1.1.7.2 Ensure all team members work to their maximum ability/skill/license

4.6.1.1.7.3 Develop a plan to improve work flow process for visit or virtual care.

4.6.1.1.7.4 Conduct daily teamlet huddles to focus on operational needs for that day

4.6.1.1.7.5 Conduct weekly team meeting to focus on systems and process improvements, review and use data to monitor processes, etc.

4.6.1.2 PRIMARY CARE SERVICES SCOPE OF CARE: Contractor shall use the PACT model to provide primary care services supporting a continuum of care from prevention to diagnosis and treatment, to appropriate referral and follow-up. The Contractor shall be responsible for scheduling initial and/or follow-up appointments with primary care providers and other staff at the Contractor's outpatient site of care (or via virtual modalities) for simple to moderately complex workload that can be appropriately managed in a primary care outpatient environment to include (but not limited to) care for: hypertension, depression, ischemic heart disease, anxiety, alcohol use disorder, other mental health conditions, hypercholesterolemia, degenerative arthritis, congestive heart failure, respiratory infection, cerebral vascular disease, chronic obstructive pulmonary disease (COPD), peripheral vascular disease, urinary tract infection, diabetes mellitus, common dermatological conditions, acute and chronic pain, acute wound management, gastric disease, skin ulcers (stasis and dermal), anemia, genitourinary (GU) issues, stable chronic hepatic insufficiency,

constipation, osteoporosis, common optic and optic conditions, basic diagnostic, evaluation, and tests for infertility, preventive screening and procedures, cervical cancer screening, breast cancer screening, pharmacology in pregnancy & lactation, evaluation & treatment of vaginitis, amenorrhea/menstrual disorders, evaluation of abnormal uterine bleeding, menopause symptom management, diagnosis of pregnancy and initial screening tests, evaluation and management of acute and chronic pelvic pain, recognition and management of postpartum depression and postpartum blues, evaluation and management of breast symptoms, (mass, fibrocystic breast disease, mastalgia, nipple discharge, mastitis, galactorrhea, mastodynia), crisis intervention, evaluation of psychosocial, well-being and risks including issues regarding abuse, intimate partner violence screening, physical, emotional, verbal, and psychological abuse, preconception counseling and assessment of abnormal cervical pathology.

4.6.2 WOMEN VETERANS HEALTH CARE SERVICES:

See the following policy documents for more information on women Veterans health care requirements:

VHA Directive, "1330.01(2) Health Care Services for Women Veterans"
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5332

VHA Directive 1105.03, "Mammography Program Procedures and Standards"
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=6423

VHA Handbook 1330.03, Maternity Health Care and Coordination
www.va.gov/vhapublications/viewpublication.asp?pub_id=2803

VHA Directive 1330.02 Women Veterans Program Manager
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=7484

4.6.2.1 Breast Cancer Screening: The Contractor shall enter a Community Care consult to the parent facility after completing the Breast Cancer Screening template in the patients EHR. The Community Care team will contact the veteran to arrange scheduling of the appointment. This appointment will be paid for by the VA. The VA Women's Veteran Program Director will follow up and track the patient to ensure continuity of care. A process has been put in place to ensure that the VA receives report images, and/or diagnosis. The entry of outside exams into the electronic medical record should be reviewed and specified by the local VHA HIMS service and coordinated with the local VHA Radiology Service and VHA Mammography Program Standards. NOTE: Refer to 38 U.S.C. 7319(b) and VHA Directive1105.03, Mammography Program Procedures and Standards for full details. See FDA Mammography Standards Guidancewww.fda.gov\Radiation-EmittingProducts\MammographyQualityStandardsActandProgram\Guidance\PolicyGuidanceHelpSystem\ucm135583.htm.

4.6.2.1.1 Requests for screening, and diagnostic mammograms, breast ultrasound (US) and MRI must be initiated by the Contractor via an order placed into the VA Electronic Health Record Radiology package. The location will be determined by the VA. The veteran is referred to the community for a screening mammogram, there is an approved Standardized Episode of Care (SEOC) that authorizes a woman to have a screening, diagnostic, US, and biopsy if medically indicated. This order must be entered regardless of where the Veteran will obtain the mammogram. Orders through Community Care must be electronically entered in the Radiology Package and as a Community Care consult request.

4.6.2.1.2 Outsourced mammography reports received as hardcopy, must be scanned into VA Electronic Health Record Imaging. All reports must include the appropriate BI-RADS code including the FDA mandatory final assessment wording category. Mammogram results (BI-RADS codes) must be entered and associated to a radiology order in Computerized Patient Record System (VA ELECTRONIC HEALTH RECORD). Systems for tracking and management of mammography and breast cancer will not operate accurately without BI-RADS entered into VA ELECTRONIC HEALTH RECORD and associated to a radiology order. All outsourced mammogram written reports must be returned to the ordering provider within 30 days as per Mammography Quality Standards Act and Program (MSQA). Consistent with the requirements of 21 CFR Part 900.12(c), mammography facilities are required to establish a documented procedure to provide a lay summary of the written mammography report to the patient within 30 days from the date of the procedure.

4.6.2.1.3 Mammography facilities must notify patients and ordering providers of positive examinations (results of "Suspicious" or "Highly Suggestive of Malignancy" (BI-RADS codes 4 or 5, respectively) within 3 business days. The mammography facility must ensure the ordering provider is contacted by telephone with all critical results. The ordering provider must document in radiology report in VA ELECTRONIC HEALTH RECORD when and to whom they spoke. The ordering provider shall discuss the meaning of the findings with the patient and the alternatives for further study, treatment, or referral. Per VHA Directive 1088, Communicating Test Results to Providers and Patients, ordering provider or designee must communicate the results of normal mammograms to the patient within 14-calendar days of receiving the results. All mammogram

results requiring action must be communicated by the ordering provider or designee to patients no later than 7-calendar days from the date the results are available to the ordering provider. Communication must be documented in VA ELECTRONIC HEALTH RECORD. If indicated, the ordering provider is expected to also communicate and document a follow up diagnostic or treatment plan. The fact that an outside radiologist may discuss findings with the patient does not remove the obligation of the ordering provider to discuss the findings and a follow-up plan with the patient. Significant abnormalities may require review and communication in shorter timeframes and 7 calendar days represents the outer acceptable limit. For abnormalities that require immediate attention communication needs to occur in the timeframe that minimizes risk to the patient.

4.6.2.2 **Cervical Cancer Screening:** Cervical cancer screening must be performed in accordance with VHA guidelines. The results of normal (no evidence of malignancy (NEM)) cervical pathology must be reported to the ordering provider within 30-calendar days of the pathology report being completed. The interpreting pathologist must ensure the ordering provider is contacted with abnormal results within 5-business days. The cervical pathology report of normal NEM results must be communicated to the patient in terms easily understood by a layperson within 14-calendar days from the date of the pathology report and the Human Papilloma Virus (HPV) report becoming available to the ordering provider. Documentation of a letter and/or verbal communication with the patient must be entered into VA EHR. If using the United States Postal Service, confirmation of the receipt of these results is not required. For any abnormal cervical pathology report, the results must be communicated within 7-calendar days of the report (including both cytology and HPV) becoming available to the ordering provider.

4.6.2.3 **Tracking and Care Coordination:** Per VHA Directive 1330.01(2) Health Care Services for Women Veterans https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5332 Each facility must have a process in place to ensure tracking and timely follow-up of findings from breast and cervical cancer screening. All Administrative Parents (Health Care Systems) must have in place standard operating procedures that specify the tracking process and assign breast, maternity, and gynecological care coordination duties to specific individuals. These duties may be assigned to individuals such as a WH-PACT RN Care Coordinator, Oncology Care Coordinators Mammogram Coordinators or Maternity Care Coordinators (see VHA Handbook 1330.03). These duties should not be assigned to the WVPM who fills a leadership and management role for

the Women's Health Program. See local tracking and care coordination SOP in attachments section for more information. Contractor must designate a women's health clinical liaison to coordinate women's health services with the Women Veterans Program Manager at the main facility. The liaison is usually a nurse or social worker but may be a provider. The role of the liaison is to be the point of contact who communicates with the WVPM about issues related to women's health care, environment of care and policy, and to communicate these messages to other staff at the CBOC.

4.6.2.4 **Comprehensive primary care and specialty women's health services:** comprehensive primary care for women Veterans is defined as the availability of complete primary care from one primary care provider at one site. The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs, including acute and chronic illness, gender-specific, preventative and mental health care. The full range of primary care needs for women Veterans includes: Care for acute and chronic illness such as routine detection and management of disease such as acute upper respiratory illness, cardiovascular disorders, cancer of the breast, cervix, colon, and lung, diabetes mellitus, osteoporosis, thyroid disease, COPD, mental health conditions, etc. Gender-specific primary care, delivered by the same provider, encompasses preconception care, sexuality, contraception- including same day access to emergency contraception-, pharmacologic issues related to pregnancy and lactation, management of menopause-related concerns, and the initial evaluation and treatment of gender-specific conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, infertility, etc. Preventive care includes services such as age-appropriate cancer screening, weight management counseling, smoking cessation, immunizations, etc. The same primary care provider should screen and appropriately refer patients for military sexual trauma as well as evaluate and treat uncomplicated mental health disorders and substance use disorders.

4.6.2.4.1 When specialty care is necessary, the primary care provider will coordinate this care and communicate with the specialty provider regarding the evaluation and treatment plan to ensure continuity of care.

4.6.2.4.2 The Contractor must develop a plan to assign women to a proficient women Veteran health primary care provider (WH-PCP) who has a sufficient number of women in their primary care panel to maintain competency in caring for those Veterans.

4.6.2.4.3 The Contractor must develop a plan to assign women preferentially to the VA certified Women's Health PCPs at the contracted site. All CBOCSs must have at least two WH-PCPs. (Because of small populations of women at most

CBOCs, CBOC WH-PCPs will usually have mixed gender panels). It is necessary to have two WH-PCPs to provide full coverage for women during sick leave and vacation. All newly enrolling women should be assigned to a Women's Health PCP. Women in panels of non-women's health PCPs should be offered the opportunity to request transfer to a Women's Health PCP at the same site of care. It is recommended that women Veterans be clustered in teams where the provider and all team members have experience, knowledge and established systems of care to provide equitable, high-quality care to women Veterans. It is recommended that Women's Health PACT teamlets are assigned a panel size of at least 100 women Veterans, thus allowing all teamlet members to care for a volume of patients to support maintenance of expertise in the care of women.

4.6.2.4.3.1 To be initially designated as a Women's Health PCP (WH-PCP), a provider must have at least one of the following:

4.6.2.4.3.2 Documentation of attendance at a Women's Health Mini-Residency within the previous 3 years;

4.6.2.4.3.3. Documentation of at least 20 hours of women's health continuing medical education (CME) or continuing education unit (CEU) within the previous 3 years;

4.6.2.4.3.4 Documentation of at least 3 years in a practice with at least 50% women patients within the previous 5 years;

4.6.2.4.3.5 Evidence of completion of an internal medicine or family practice residency; women's health fellowship; or women's health, adult or family practice NP or PA training within the previous 3 years;

4.6.2.4.3.6 Documentation of a current preceptorship arrangement with an experienced WH-PCP such as weekly meetings (for at least 6 months); or

4.6.2.4.3.7 Evidence of being recognized as a known women's health leader and subject matter expert with experience practicing, teaching, and/or precepting women's health.

4.6.2.4.3.8 Renewal of status for Women's Health PCPs requires ten (10) hours of CME or CEU in women's health every 2 years and Skills Proficiency Check and Pap Sample adequacy review by the Womens Health Medical Director (WHMD) at the main facility.

4.6.2.4.3.9 The Contractor must provide ongoing education and training to the Women's Health Primary Care Providers to assure competency, proficiency and expertise in providing care to women Veterans.

4.6.2.4.4 Staffing must be adequate to provide gender-appropriate chaperones as well as clinical support with availability of same-gender providers on request.

4.6.2.4.5 VA is authorized to provide comprehensive pre-natal, intra-partum and post-partum care to eligible women Veterans. Maternity benefits begin with the confirmation of pregnancy, preferably in the first trimester, and continue through the final post-partum visit, usually at 6-8 weeks after the delivery, when the Veteran is medically released from obstetric care. Providers must initiate a Community Care Maternity Consult and notify the Women's Clinic Maternity Care Coordinator at (801)582-1565 ext. 2685.

4.6.2.4.6 Emergency contraception (e.g. Levonorgestrel (Plan B) etc.) must be available to all women Veteran patients in a timely manner (same day of their appointment) even if a provider has requested to opt out from providing emergency contraception to the patient because of a Rights of Conscience (ROC) Claim.

4.6.2.4.7 Contractor shall provide all equipment necessary to provide comprehensive women's health services. Examination rooms shall be set up in accordance with current VA standards to afford women with privacy (placement of examination tables in the room, privacy screens, etc. See Space Requirements section for more details). Equipment such as privacy curtains, exam tables with stirrups and lights, bathrooms adjacent to where pelvic exams are conducted, speculums, supplies, and equipment to perform Pap smears and pregnancy testing should be on hand in the clinic area. Each designated women's health provider shall have an appropriate exam table to conduct the annual women's health exam.

4.6.2.4.8 Women Veterans must have women-only or unisex toilet rooms and bathing/shower facilities. Appropriately locking door hardware with locking mechanisms providing for privacy, safety, security, and utility (allowing staff members to have key or code access in case of emergency) are required for all toilets, baths and showers. A female Veteran must not share a single bathroom between rooms with a male patient in the adjoining room (i.e.: Jack 'n Jill), even if the toilet room is locked. A female in both adjoining rooms sharing the bathroom is acceptable. Personal hygiene products (sanitary pads and tampons) shall be available in examination rooms, public female, unisex, and family toilet rooms at no charge. Diaper changing tables shall be available in designated public male, female, unisex, and family toilet rooms. Diaper changing tables shall be placed at least one per floor in male, female, and unisex toilet rooms, and no more than 300 feet

from areas accessible to a patient. Rooms with changing table must be identified, and toilet rooms without changing tables should include signage directing users to the nearest changing table.

4.6.2.4.9 Transgender Veterans: Patients will be addressed and referred to based on their self-identified gender. Room assignments and access to any facilities for which gender is normally a consideration will give preference to self-identified gender, or medical needs of the Veteran, irrespective of appearance and/or surgical history in a manner that respects the privacy needs of transgender and non-transgender patients.

4.6.3 PHARMACY SERVICES:

4.6.3.1 PRESCRIPTION FULFILLMENT: The VA will provide all medications, including any necessary vaccines that are to be administered to patients in the clinic. Routine prescriptions will be dispensed by the VA and mailed via VA Centralized Mail Out Pharmacy (CMOP) to the Veteran following appropriate Contractor's provider order entry in the VA EHR. The VA will review all submitted non-formulary restricted, and prior authorization medication consults in a timely manner in accordance with VHA Handbook 1108.08. VA Pharmacy Service will require Contractor clinic management or designee to conduct routine inspections of medication storage areas monthly and provide documentation per local VA Pharmacy policy to the Chief of Pharmacy. Urgent/Emergent medications needed will be filled via contracted local pharmacy for up to 10 days. The VA pharmacy at the parent facility will provide this contract. All other prescribed medications will be via the VA EHR, faxed, or mailed to VA pharmacy for filling. The Contractor must abide by all Joint Commission (or equivalent accreditation body) and VA policy on the storage, security, handling and disposal of all medications held in their clinic and comply with all monthly clinic inspections and the recommendations generated from those inspections.

4.6.3.1.1 The Contractor shall be responsible for prescribing medications as medically indicated. Prior to prescribing any medications, the Contractor shall review medication profiles in the VA EHR for duplicate therapy, drug-disease complications, drug-drug, drug-food, drug-lab interferences, appropriateness of dose, frequency and route of administration, drug allergy, clinical abuse/misuse, and documentation of medications obtained outside of the VA in the VA EHR "Non-VA" medications list, including over-the-counter and herbal agents and known allergies. The Contractor shall also query State Prescription Drug Monitoring Programs (PDMPs) before prescribing controlled substances per VHA Directive 1306 Querying State Prescription Drug Monitoring Programs (PDMP). IMED consents shall be obtained by clinic staff prior to prescribing

or dispensing medications requiring consent including prescriptions for controlled substances to Veterans.

4.6.3.1.2 Medication orders for all medications, including controlled substances prescriptions must be entered into the VA EHR (as per local policy) using the appropriate e-prescribing process (e.g., PIV card). In event of computer down-time, written prescriptions (on an authorized VA Form 10-2577F or other State or Federally approved controlled substance order form) must be used and shall be couriered, signature-confirmed, to the VA Pharmacy-designated point of contact at the end of each business day. The VA will dispense controlled substances in accordance with Federal Law CFR Title 21 1300-end. It is fully expected that all providers will maintain active PIV cards at all times to comply with required prescribing guidelines on controlled substances, as applicable. Vaccines shall be documented in the appropriate immunization record in the VA EHR.

4.6.3.1.3 The Contractor is required to utilize the VA National Formulary. The formulary is available electronically under Drug File Inquiry in the VA EHR physician package. Non-formulary, Restricted and prior authorization medications are marked "NF" or "Restricted" in the VA EHR drug file. Changes to the formulary affecting prescribing will be sent to the Contractor electronically through Outlook messages. Non-formulary or restricted medications may be reviewed for approval with appropriate clinical justification by utilization of the electronic non-formulary/restricted medication consult request process in the VA EHR. The Contractor is required to follow all national VA guidelines for the use of non-formulary, restricted, and prior authorization medications, and to support evidence-based VA cost savings initiatives undertaken by the local VA. The Contractor is also required to adhere to the VA Dual Care Policy. These guidelines may be accessed in the VA EHR, Web links, Pharmacy Benefits Management website or directly through the PBM website at VA National Formulary. The Contractor is required to adhere to the VA Dual Care Policy.

4.6.3.1.4 **NOTE: The Contractor's providers must enter documentation in the Non-VA medication section of the VA EHR for any medication(s) patients are taking that are not issued by VA**

4.6.3.1.5 A patient's new allergy information shall be entered into the patient's record via the VA EHR. The specifics of the patient's allergy or adverse drug reaction, if known, must be included in the documentation. VA Pharmacy is not permitted to dispense any prescriptions without documentation of a patient's allergies being listed in the

chart (or documentation that no known allergies exist as appropriate).

4.6.3.1.6 The Contractor shall be responsible for providing all necessary information for each provider with prescriptive authority to the VA Credentialing Office (or as designated by the parent facility

4.6.3.1.7 New drug orders: The contractor shall ensure that at least 95% of all new drug order requests follow all VA National Formulary prescribing guidelines

4.6.3.1.8 The Contractor shall refer the patient to the VA Clinical Pharmacy Specialist (CPS) assigned to your clinic to provide any necessary medication counseling to patients, family or caregivers in accordance with State and Federal laws and VHA requirements, including, but not limited to:

4.6.3.1.8.1 Medication instructions regarding drug, dose, route, storage, what to do if dose is missed, self-monitoring drug therapy, precautions, common side effects, drug-food interactions, and medication reconciliation, and importance of maintaining an accurate and up-to-date list of all medications (including herbals and over-the-counter medications), along with any verbal and/or written instruction provided. Confirmation and documentation of patient/caregiver instruction and the patient's/caregiver's understanding of the instructions including telephone contacts must be documented in the VA EHR Progress Notes.

4.6.3.1.8.2 Instructions for VA medications Refill process: There are four ways to refill VA medications (see Patient Handbook page 31 in the attachments section for more information)

4.6.3.1.8.2.1 If a veteran is out of refills or need to renew a prescription, they can contact (801) 584-2575 or 2-800-579-0540 ext. 2575. If the pharmacy is closed, the After Hours Help line is available 1-866-369-8020

4.6.3.1.8.2.2 Online at www.myhealth.va.gov

4.6.3.1.8.2.3 Call the automated refill system at (801)584-2525 or 1-800-579-0540. The veteran will need their Social Security number and prescription number(s). This number is also located on the prescription label or refill slip. This method requires a touch-tone phone.

4.6.3.1.8.2.4 Mail – Veterans may mail in their refill slip (or send a letter with their name, social security number and the name of the medication) to:

VA Salt Lake City Health Care System
Outpatient Pharmacy (119)
500 Foothill Dr.

Salt Lake City, UT 84148

4.6.3.1.8.3 Instructions to Veterans and/or caregiver on safe and appropriate use of medication-related equipment being supplied shall be documented in the Veteran's medical record.

4.6.3.1.8.4 Instructions on Coordinated Care for Traveling Veterans (or subsequent revisions thereto).

4.6.3.1.8.5 Instructions on VA National Dual Care Policy (or subsequent revisions thereto).

4.6.3.2 MEDICATION MANAGEMENT: All medications and supplies used in the treatment of outpatients on premises are required to be stored and secured to meet compliance with The Joint Commission (TJC) standards, VHA policy, OIG/CHIP and OSHA guidelines. Efforts should be made to limit the number of ward stock medications and supplies stored at the Outpatient Site of Care. The Contractor is responsible to ensure all medications are subject to routine inspection, as required by VA Pharmacy, proper storage (in a secure and locked location) and meet all VA policy and TJC standards for medication management.

4.6.3.2.1 In accordance with TJC standards, the Contractor shall actively participate in routine inspections in collaboration with the local VA Pharmacy on a VA-specified regular basis. All medication storage sites will be inspected to ensure that medications are being stored properly (e.g., under appropriate refrigeration, and USP800 compliant if required; externals separated from internals; expiration dates checked, etc.) and VA Medication Inspection Form (VA Form 10-0053) will be completed, signed by the inspecting Pharmacy personnel and the Clinic Nurse Manager. This information will be used in conjunction with the COR's quarterly evaluation of the Contractor's performance. Follow-up on all recommendations identified and resolution of all identified discrepancies on the Medication Inspection Form will be completed in a timely manner- by Clinic Personnel, as directed or requested by the VA Chief of Pharmacy.

4.6.3.2.2 Reports of Adverse Drug Events (ADEs) will be documented in the VA EHR, with the specifics of the event documented as outlined in local VA policy and enter the ADE into the VA ADERS MedSafe Portal located at: https://vaww.cmop.med.va.gov/MedSafe_Portal/. See attached Memorandum 119.02 Adverse Drug Reactions and Allergies.

4.6.3.2.3 All medication errors and medication-related incidents shall be reported immediately to the Chief, Pharmacy Service or designee and submitted to the local VA Patient Safety on the local VA-approved Incident Report form.

4.6.3.2.4 Customer complaints regarding pharmacy services must be addressed by the VA Pharmacy Service in collaboration with contract clinic management staff. Reports of such complaints must be recorded and forwarded to the VA Chief, Pharmacy Service on a routine and timely basis

4.6.3.2.5 The Contractor must work in collaboration with VA Pharmacy Service when there are identified unique medication management needs of the patients and submit appropriate Nonformulary/Restricted/Prior Authorization consults in the VA EHR where appropriate for further review and completed within 96 hours. Examples of this include notification and management of patients that are taking medications that pose a medication safety concern or patients that are taking medications that require therapeutic substitution based on formulary or medication safety concerns. Contractor requirements will be further identified by VA governing bodies and VA Pharmacy.

4.6.3.2.6 In accordance with TJC regulations, the Contractor shall provide the patient with an accurate, reconciled list of medication to include medications that the patient is receiving from the VA, medications that he takes from non-VA providers, and any OTC, herbal or alternative medications that he patient reports taking. The Contractor shall meet all requirements of Medication Reconciliation (or subsequent revisions thereto) as well as any VA policy related to medication reconciliation. See attached Memorandum 11.55 Medication Reconciliation in Section D.

4.6.3.2.7 The Contractor shall meet all requirements for anticoagulation management outlined in Anticoagulation Therapy Management (or subsequent revisions thereto) as well as local policy related to the management of patients on anticoagulation. Local policy is included in the attachments section.

4.6.3.2.8 The VA CPS shall provide Quarterly and annual anticoatulation quality assurance summaries as outlined by the local Pharmacy & Therapeutics Committee. For questions, please contact, Terri Evans, VA Anticoagulation Coordinator at terri.evans@va.gov.

4.6.3.2.9 The Contractor is required to enter all prescription orders using the VA EHR outpatient medication order entry option. The Contractor must include complete directions for the prescription ("PRN" alone is not acceptable), and must include the indication for medication use, the appropriate quantity, and subsequent refills for the medication.

4.6.3.3 Clinical Pharmacy Services -Staffing will be provided by the VA parent facility through telehealth. Utilizing the Pharmacy Consult in the EHR The Contracted provider is to perform comprehensive medication management to patients. The Parent facility is available for consult through the Pharmacy Consult in the HER. The Contracted provider is to perform comprehensive medication management to patients. The Parent facility is available for consult through the Pharmacy Consult in the EHR. The contracted provider must adhere

to pharmacy practice acts within that state and the VA Chief of Pharmacy, VA Chief of Staff, and Director must work collaboratively to provide oversight for professional practice of the contracted provider to include roles and responsibilities, VA Scope of Practice and its oversight in accordance with VHA and facility policy (VHA 1108.11 VHA Clinical Pharmacy Services.

4.6.3.3.1 The contractor shall provide space as detailed in space requirements, support staffing, and ancillary support to allow for the provision of clinical pharmacy services. The support services shall be consistent for scheduled telehealth clinic to include but not limited to intake vitals by LVN/LPN, Unlicensed Assistive Personnel (health tech or nursing assistant), or similar, downloading of blood sugar from meters, POC INR testing and downloading, teaching patients how to use BP monitors at home, calling patients for lab reminders, scheduling patient visits and contacting patients who no-show for rescheduling.

4.6.3.3.2 Direct patient care activities are essential impacting comprehensive medication management and optimal patient care outcomes in PACT. Direct patient care activities in PACT Pharmacy Clinics shall contain the 160-stop code in the primary or secondary position to ensure workload capture for clinical pharmacy services. As appropriate, telephone clinic shall contain appropriate stop codes as well to ensure billing and workload for clinical pharmacy services (160 in the secondary position).

4.6.3.3.3 Direct patient care refers to patient care functions which are carried out by a contracted provider. Some examples of direct patient care activities include: Face-to-face comprehensive medication management of complex patients and chronic diseases (such as, but not limited to, anticoagulation, hypertension, diabetes, hyperlipidemia, COPD, heart failure, hepatitis C, pain management);Urgent or same day face-to-face patient visits including but not limited to patient medication review for polypharmacy, recent hospital discharges, co-managed care patients; Virtual Care modality visits such as Veteran requests through secure messaging, telephone-based care, CVT,HT; SMA; and DIGMAs.

4.6.3.3.4 The Contractor providers will receive support from VA Pharmacy to address routine outpatient medication activities such as prescription verification, refill, renewal, and extension of medication, therapeutic substitutions and conversions, and other general pharmacy issues.

4.6.4 ANCILLARY SUPPORT SERVICES:

4.6.4.1 RADIOLOGY SERVICES: All radiology services are provided through the Radiology Consult Process. The Contractor is responsible for entering consult requests for radiology procedures into the VA EHR. All imaging orders shall be clinically appropriate. Radiology services shall be performed in through care in the community, or at the parent facility. The location will be determined by the VA. Images will be sent to the VA facility, these images will case edited in the Radiology section

of the VA EHR by the technologists and sent to the VA EHR Imaging and PACS as defined by local policy and VHA Directive RADIOLOGY PICTURE ARCHIVING AND COMMUNICATION SYSTEMS (PACS) 1104, within two (2) working business days of receipt. X-rays performed at VA or at the outpatient site of care can be viewed by the Contractor through the VA EHR Imaging and the PACS. All studies must be transferred to the VA EHR Imaging and must be available in the VA EHR Imaging for the ordering clinician and others to review so that patient care delays are avoided.

4.6.4.1.1 **Interpretation of x-rays performed at contractor's site of care:** X-rays, and radiology procedures will be interpreted by VA Radiologists at the parent VA facility. X-ray interpretation reports will be available in the VA EHR within two (2) working business days of receipt. The VA Radiology Program Service may be contacted at (801)582-1565. The Contractor shall follow VA policy and procedures and TJC standards for any critical results or urgent results. Timelines for delivery and interpretations should be specifically spelled out by the local facility. Local facility policy is in the attachments section.

4.6.4.2 ELECTROCARDIOGRAM SERVICES: Contractor is required to provide this service. MUSE-compatible EKGs shall be used which are interfaced with the VA EHR Imaging. (The name and model number of the EKG machine needed is GE 5500 with modem. This will be supplied by VA at cost to the contractor. EKGs are done by the Outpatient Site of Care and documentation will be sent electronically from the GE 5500 EKG machine directly into the VA EHR Imaging. When MUSE - compatible system is not available EKGs will be confirmed, interpreted and documented by the Contractor's licensed provider. The report will be scanned directly into the VA EHR Imaging by the Outpatient Site of Care. The EKGs will be confirmed and/or read by Contractor's providers.

4.6.4.3 LABORATORY SERVICES: Contractor is responsible for: 1) Entering orders for laboratory tests into the VA EHR. Information concerning the laboratory tests are provided as an attachment in Section D. 2) Sending specimens to the VA Core Laboratory once daily, prior to the close of business of the workday, *except* for those specified in this PWS. 3) Paying any costs of all lab work, except for lab work sent to the VA or emergency lab work sent to another site which has been authorized by the VA Communications Center and paying any costs associated with transportation of specimens to the VA and for arranging such transportation in a proper secure method and 4) ensuring that all courier service employees have completed VHA Privacy and HIPAA Focused Training 5) Ensuring the proper collection, specimen storage, collection supplies, and other preservation of specimens and providing appropriate specimen collection containers that are compatible with the instrumentation and methodology used by the VA laboratory.

4.6.4.3.1 Specimens must arrive at the VA in a condition that allows for safe specimen handling and not compromise the analyzers used for testing or specimen integrity. If

specimens are received in a container that does not satisfy those requirements, the VA reserves the right to specify the collection container to be used. A listing of specimen collection containers and laboratory test panels/profiles utilized by VA is included as an attachment to this requirement. The Contractor may not purchase the specimen collection containers from the VA since Federal Acquisition Regulations prohibit the purchase of supplies for resale. Specimens with a shipping manifest shall be delivered to the VA laboratory receiving area located in Building 14, First Floor of the parent facility. Instructions for specimen collection, specimen processing, shipping manifest, and packaging of specimens for transport as an attachment to this requirement. The VA will not be responsible for the quality of laboratory test results obtain from specimens improperly collected or labeled, processed (centrifuged and aliquoted) and/or transported by the Contractor. The Contractor shall be contacted to resolve any discrepancies identified on the shipping manifest. The Contractor shall be notified of any specimen or testing problems. All laboratory test results will be available through the VA EHR upon completion. The **Pathology and Laboratory Program Laboratory Information Manual** is provided in section D (attachments). Questions regarding VA laboratory services shall be addressed to the VA Chief Medical Technologist at (801)582-1565 ext. 1476.

4.6.4.3.2 The VA shall be responsible for transporting laboratory samples in a manner to ensure the integrity of the specimens and proper safeguarding of protected health information. The VA shall supply any special preservatives required for specimen preservation used in transportation. Frozen specimens shall be shipped on dry ice, if required. If laboratory services are performed at a site other than the VA, the Contractor is responsible for entering the laboratory results into the VA EHR. The results for laboratory tests performed at another site cannot be entered into the VA EHR using existing test files. The Contractor must contact the Pathology and Laboratory Medicine (801)582-1565 ext 1988 to create new test files prior to entering results.

4.6.4.4 ANCILLARY, POINT OF CARE, AND WAIVED TESTING SERVICES

4.6.4.4.1 Mandated POC testing includes: Urinalysis, Rapid Strep, Glucose (Glucometer finger stick), and Qualitative Urine Pregnancy testing. Outpatient Site of Care must have point of care or STAT pregnancy testing at the same site of care.

4.6.4.4.2 Anticoagulation services will be provided by the parent facility clinical laboratory. The Salt Lake City VA has not implemented a waived coagulation testing protocol or analysis in the CBOCs.

4.6.4.4.3 The laboratory tests designated as waived under the Clinical Laboratory Improvement Amendments of 1988 and all amendments (CLIA ’88, et al.), 42 CFR 493.15(b) and 493.15(c). In the CLIA regulations, waived tests were defined as simple laboratory examinations and procedures that are cleared by the FDA for home use; employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; or pose no reasonable risk of harm to the patient if the test is performed incorrectly. To perform these tests, the Contractor must apply for and maintain a current VA CLIA Certificate. The application for the VA CLIA Certificate, obtained from the Chief Medical Technologist, is sent to the National Enforcement Office who issues the CLIA Certificate.

4.6.4.4.4 In addition, the Contractor must apply for and maintain a Utah Department of Health Level II Clinical Laboratory Permit. In the performance of these tests, the Contractor must comply with the terms and requirements of the Ancillary Testing Policy, SOP 0951 Point of Care Authorization. The Ancillary Testing Policy is included in Section D.

4.6.4.4.5 The Contractor must also adhere to VA standards/requirements as detailed in VA Handbook 1106.1 when performing ancillary laboratory tests. The results of all testing must be entered into the medical record through the laboratory software package in the VA EHR. The Contractor must take immediate action on any critical test result, immediately inform the VA, and document the action taken through the VA EHR. It is the Contractor’s responsibility to maintain the test systems/instruments in proper working order. When necessary, the Contractor must send quality control records and test results to the Ancillary Testing staff for troubleshooting test system/instrument malfunction. The Contractor must address all questions concerning waived and point of care testing to the Ancillary Testing staff at (801)582-1565 ext. 1595.

4.6.4.4.6 The VA will provide the test systems/instruments and reagents for contractor waived testing except for fecal occult blood testing cards and developer. The Contractor must contact the VA Ancillary Testing staff prior to purchasing fecal occult blood test kits to ensure consistency of methodology/ manufacturer. If the VA changes fecal occult blood testing methodology/ manufacturer, the Contractor must comply with the change to maintain the same standard of care. These test systems/instruments are from manufacturers that have received 510(K) clearance from the FDA. The VA will provide test procedures and training materials, initial training, and annual competency assessment. The Ancillary Testing staff will make periodic

visits to the Contractor's site and monitor the quality control and test results to ensure accuracy and, consistency, and adherences to VA policies and requirements.

4.6.4.4.7 All ancillary testing at the Contractor's site will be under the oversight of the VA Ancillary Testing Program. The Contractor is required to use the same test systems/instruments; quality control and reagent lot numbers used for ancillary testing performed at the VA. See attachment in section D for waived testing test systems/instruments and reagents information. When the VA Ancillary Testing Program upgrades waived test systems/instruments, the VA will furnish the Contractor with the new test systems/instruments to maintain the same standard of care. The Ancillary Testing staff will arrange for repair/maintenance in the event of system/instrument failure. If required, the VA shall provide a courier to transport instruments and/or reagents to the Contractor or the VA Ancillary Testing staff for linearity/correlation studies and minor repairs. The VA will purchase proficiency testing materials for the Contractor, and the Contractor must comply with the Pathology and Laboratory Medicine, CAP and TJC requirements/regulations for testing proficiency materials and submitting results.

4.6.4.5 COMMUNICATING TEST RESULTS TO PROVIDERS AND PATIENTS: In accordance with VHA Directive 1088, Communicating Test Results to Providers and Patients, all test results requiring action must be communicated by the ordering provider, or designee, to patients no later than 7 calendar days from the date on which the results are available. For test results that require no action, results must be communicated by the ordering provider, or designee, to patients no later than 14 calendar days from the date on which the results are available. The Contractor shall provide the VA with the name, pager and telephone numbers of a LIP (physician, nurse practitioner, or physician assistant) at the Outpatient Site of Care to accept critical test results discovered on tests done by the VA. For critical results, the LIP must respond back to the VA within forty-five (45) minutes of the initial page or telephone call. The receiving LIP will document the results in the record and conduct a "read back" procedure to ensure accuracy of transmission and translation of all verbal results during business hours. After hours, or weekends, all critical lab test results will be delivered to the parent facility Emergency Department, the will document all communication in the veterans HER. The contractor shall determine a plan to fulfill critical test result procedures, per VA policy. VA will not be responsible for the failure of the Contractor to receive critically abnormal test results. Critical results must be reported to the clinician by the radiologist by telephone. Documentation of this notification, "who, when" must appear in the radiology report. For critical results that represent an imminent danger to the patient, the Contractor shall notify the patient

immediately. See policy Memorandum 113.07 Critical Result Reporting in section D (attachments) for additional requirements regarding communication of test results.

4.6.5 MENTAL HEALTH SERVICES:

4.6.5.1 ESTIMATED MENTAL HEALTH WORKLOAD:

It is estimated that 20% of enrolled Veterans will require Primary Care Mental Health Integration services.

It is estimated that 20% of enrolled Veterans will require General or Specialized Mental Health services.

4.6.5.2 SUMMARY OF INFORMATION FOR MENTAL HEALTH (MH) SERVICES:

4.6.5.2.1 MENTAL HEALTH AND SUBSTANCE USE SCREENING AND CARE As a part of standard primary care services, the Contractor's staff shall provide screening and care for common mental health and substance use conditions, consistent with team member's clinical privileges, skills, scope of practice, position description, or functional statement. The Contractor's staff shall:

4.6.5.2.1.1 During new patient encounters and at least annually, screen patients for depression, PTSD, alcohol use, and tobacco use

4.6.5.2.1.2. If primary screen for depression and/or PTSD is positive, a Columbia-Suicide Severity Rating Scale (C-SSRS) must be completed in the same calendar day. If the C-SSRS is positive, a comprehensive suicide risk evaluation (CSRE) must also be completed within the same calendar day

4.6.5.2.1.3 Provide counseling about smoking cessation. In addition to education and counseling about smoking cessation, evidence-based pharmacotherapy needs to be available for all adult patients using tobacco products. When provided, pharmacotherapy needs to be directly linked to education and counseling

4.6.5.2.1.4 Provide brief alcohol counseling for positive alcohol use screens

4.6.5.2.1.5 Because population screening is not evidence-based for substance use conditions other than alcohol misuse and tobacco use Contractor's staff will need to use targeted case-finding methods to identify patients who use illicit drugs or misuse prescription or over-the counter agents. These methods need to include evaluation of signs and symptoms of substance use in patients with other relevant conditions (e.g., other mental health disorders, hepatitis C, or HIV disease).

4.6.5.2.1.6 Provide care for patients with mild to moderate MH and SUD conditions, engaging Primary Care-Mental Health Integration (PC-MHI) providers, general and specialty MH providers, disease prevention specialists, substance use disorder (SUD) providers, or other providers as indicated.

4.6.5.2.1.7 For patients with SUD who decline referral to specialty SUD treatment, the Contractor's staff shall continue to monitor patients and their substance use conditions. They are to utilize their interactions with the patient to address the substance use problems and to work with them to accept referrals. NOTE: Strategies that may enhance motivation to seek SUD specialty care include: providing the patient easy-to-read information on the adverse consequences of drinking; having the patient identify problems that alcohol has caused; urging the patient to maintain a contemporaneous diary of alcohol use and the circumstances and consequences associated with it; and frequent appointments with the patient. Interventions with SUD treatment-reluctant patients are always to be characterized by a high-degree of provider empathy.

4.6.5.2.1.8 To ensure the availability of outreach and referral services to homeless Veterans, all contractor sites must designate at least one outreach specialist, usually a clinical social worker, to provide services to homeless Veterans. Contractor sites with 10,000 or more patients shall have a dedicated specialist. In smaller sites serving less than 10,000, this may be a collateral assignment.

4.6.5.2.1.9 Sites with 10,000 patients or more shall have a Suicide Prevention Coordinator (SPC) with a full-time commitment to suicide prevention activities. In smaller sites serving less than 10,000, this may be a collateral assignment.

4.6.5.2.1.10 In all MH services that the Contractor provides, the contractor shall comply with TJC and CARF and VAMC quality standards pertaining to patient treatment. Non-compliance with these requirements may result in the revocation of clinical privileges by the VA.

4.6.5.2.2 MENTAL HEALTH SAME DAY ACCESS REQUIREMENTS: The Contractor shall provide Same Day MH Access – Same Day MH Evaluation: Crisis/Suicidal Needs (on phone or in person): Any Veteran reporting or identified as being in crisis (including suicidality), will receive an immediate crisis response.

4.6.5.2.2.1 Veterans New to MH:

In Person: Any Veteran new to MH requesting or referred for care in person will be seen in person the same day by a Licensed Independent Provider (LIP) to screen for and address immediate care needs

By Phone: Any Veteran new to MH calling to initiate care will be scheduled for an initial evaluation. Schedulers answering the phone will ask if the Veteran needs to speak with a provider immediately. If an urgent request is made or suggested, an immediate crisis response will be initiated, and follow-up care will be provided, as needed. If an urgent response is not indicated, a LIP will call the Veteran back the same day or no later than the next calendar day

4.6.5.2.2.2 Veterans Established in MH Care:

In Person: Veterans established in mental health care self-identifying a need for attention will be seen in person the same day by a provider to address immediate care needs.

By Phone: Veterans established in mental health care may self-identify a need for urgent attention. Schedulers answering the phone will ask if the Veteran needs to speak with a provider immediately. If an urgent request is made or suggested, an immediate crisis response will be initiated, and follow-up care will be provided as needed. [If urgent response is not indicated, a provider will call the Veteran back the same day (or the next business day)].

4.6.5.2.2.3 Documentation should cover the requirements of the screening evaluation. This should include documentation of: determination of urgency of mental health care needed and initiation of immediate crisis response if needed, identification of the appropriate setting for subsequent evaluation and treatment, treatment follow-up plan, provision of emergency contact information for mental health services (this can include the VCL Hotline number or a local facility contact number), and follow-up on any specific concerns or questions by the Veteran

4.6.5.2.2.4 A Comprehensive MH diagnostic and treatment planning evaluation must be completed within 30 days of the same day evaluation.

4.6.5.2.3 **SUICIDE PREVENTION:** The Contractor shall follow established Medical Center policy for suicide prevention, to include coordinating with the Suicide Prevention Coordinator, contributing to a high risk for suicide list, and

establishing a Category II Patient Record Flag (PRF) as indicated. See current Medical Center policy provided in the attachments section for more detailed information

4.6.5.2.4 **MH URGENT/EMERGENT SERVICE:** If at any time a patient needs more intense services than those provided on site, the Contractor shall take steps to arrange transfer to VA; or if more urgent care is needed, to the nearest emergency room.

During normal business hours, and after hours, transfer to VA can be arranged by calling the Emergency Department at (801)582-1565 ext.1405 which is answered twenty-four (24) hours per day. The nurses or Administrative Officer of the Day will assist in arranging transfer to VA. If immediate consultation with a psychiatrist is needed, the staff can also call this number and request assistance. Patients with health-related questions may also be directed to call the Nurse Helpline at (801)582-1565 ext. 2575 and follow the menu options.

VA Mental Health also maintains same day services. Patients shall be given specific directions to the location; the contractor shall call the location on the VA Campus and alert the personnel to expect the same day need. The patient shall be advised that they will be seen in the Initial Evaluation clinic the same day. The Contractor shall follow up to document that patient successfully arrived or did not arrive at the location and document the file accordingly. If the patient did not arrive, the Contractor shall make phone contact with the patient to determine if the patient requires further direction or assistance

4.6.5.2.5 **PREVENTION AND MANAGEMENT OF VIOLENCE:** All Contractor Staff members must meet current VA training requirements on the prevention and management of disruptive behavior.

4.6.5.2.6 **MILITARY SEXUAL TRAUMA SCREENING:** VHA Directive 1115, Military Sexual Trauma (MST) Program (or subsequent revisions thereto) requires the expansion of the focus on sexual trauma beyond counseling and treatment, mandates that counseling and appropriate care and services be provided, and mandates that a formal mechanism be implemented to report on outreach activities. The VA has mandated screening of every Veteran, male and female, for sexual trauma while in the military. This includes asking the Veteran whether they have experienced sexual harassment, sexual or physical assault, or domestic violence while on active duty. All Veterans and potentially eligible individuals seen in Contractor’s site’s must be screened for experiences of MST. This must be done using the MST Clinical Reminder in the VA EHR (see subpar. 4c (5)). Screening is

to be conducted in appropriate clinical settings by providers with an appropriate level of clinical training; screenings are not to be conducted by clerks or health technicians. If a Veteran screen positive for such trauma and would like to receive evaluation or counseling services, a consult can be initiated to Behavioral Health outpatient services. The Veteran may decline such services, and this should be documented as well. Immediate assistance can be obtained by calling the VA Division at 801-582-1565 ext. 1255 and asking for the Military Sexual Trauma Coordinator. NOTE: Contactor sites with 5,000 or more patients must provide care for MST-related mental health conditions on-site. Contractor shall ensure that there are a sufficient number of clinicians able to provide specialized mental health care for conditions related to MST to adequately meet the demand for care.

4.6.5.2.7 DISASTER PREPAREDNESS: All Contractor sites must have a designated Mental Health Disaster POC, who can serve as a member of the VA parent facility's Disaster Response Team. Training for the Mental Health Disaster POC needs to be coordinated with training for other disaster response clinicians and emergency management teams at the parent facility and VISN levels

4.6.5.2.8 MENTAL HEALTH NO SHOW POLICY

Regardless of High-Risk Status, following a No Show appointment, there shall be at least 3 attempts to contact All Veterans, and these attempts must be documented in the electronic medical record (EHR).

- Staff shall make 3 attempts to follow up on all scheduled No Show appointments, including individual therapy, group therapy, or initial consult evaluation.
- In most cases follow up attempts for No Show appointment are telephone calls, but it is recognized other attempts may be appropriate to the specific situation, for example homeless outreach or certified mail when there is no telephone available
- The telephone attempts in most cases can be conducted by any staff member who has access to document in the VA EHR, including clerks, LPN, health tech, etc. However, if the patient has a VA EHR High Risk alert, a licensed independent provider (LIP) must make the attempts to contact the Veteran
- There must be a policy on No Show follow up, which includes a mechanism for supervisors to audit compliance by performing chart reviews

- If contact with the Veteran is unsuccessful, contacting local law enforcement for assistance is recommended when risk for harm is deemed to be imminent. Consideration for contacting local law enforcement should be based upon the documented clinical determination of imminent risk, which applies to all Veterans regardless of High-Risk status

4.6.5.6 MENTAL HEALTH SUPPORT SERVICES: The Contractor shall provide the following clerical support services for tele-mental health care.

- Schedule and reschedule patients for Mental Health Providers and the Quit Smart program.
- Check in patients for clinics
- Check out patients/encounters for clinics
- Utilize the Insurance Capture Buffer to record Veteran insurance information.
- Place reminder calls to patients no later than one day prior to their appointment
- Call patients to cancel and reschedule appointments when the provider is unable to see the patient.
- Receive and screen phone calls for the clinics and providers
- Process all consults for the above clinics
- Provide support for the tele mental health appointments including scheduling, set-up
- Participate in triaging secure messages

4.6.5.7 PRIMARY CARE-MENTAL HEALTH INTEGRATION (PC-MHI): Contractor supported Telemental health; referrals to the parent VA facility; or to nearby Vet Centers**:** All referrals are provided through the Mental Health Consult Process. The Contractor is responsible for entering consult requests for Mental Health into the VA EHR. The parent VA facility will determine if the Mental Health service will be provided to the veteran through Care in the Community to the extent if a Veteran is eligible, a sharing agreement, or at the parent VA facility (in person, or via Contractor supported telehealth at the contractor site)

4.6.5.8 GENERAL AND SPECIALTY MENTAL HEALTH SERVICES: Contractor supported Telemental health; referrals to the parent VA facility; or to nearby Vet Centers. All referrals are provided through the Mental Health Consult Process. The Contractor is responsible for entering consult requests for Mental Health into the VA EHR. The parent VA facility will determine if the Mental Health service will be provided to the veteran through Care in the Community to the extent if a Veteran is eligible, a sharing agreement, or at the parent VA facility (in person, or via contractor supported telehealth at the contractor site)

4.6.5.9 Evidence-based Psychotherapy for PTSD: All Veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy as designed and shown to be effective. Provides delivery of evidence-based psychotherapy when it is clinically indicated for patients

4.6.5.10 Evidence-based Psychotherapy for Depression and Anxiety Disorders: All Veterans with depression or anxiety disorders must have access to Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy. Delivery of evidence-based psychotherapy when it is clinically indicated for patients

4.6.5.11 Evidence-based Somatic Therapies: (1) Evidence-based pharmacotherapy shall be provided when indicated for mood disorders, anxiety disorders, PTSD, psychotic disorders, SUD, dementia, and other cognitive disorders. Such care must be consistent with current VA clinical practice guidelines and informed by current scientific literature. **NOTE:** Current VA clinical practice guidelines can be found at: http://www.healthquality.va.gov. (2) Care can be provided by a physician or appropriately credentialed and supervised advanced practice nurse or physician assistant and may be provided using telemental health when appropriate. (3) Because in many cases combined psychosocial and psychopharmacological treatment has been shown to be more effective than either intervention alone, Veterans must have access to combined treatment when indicated. Pharmacotherapy needs to be coordinated with other psychosocial or psychological interventions patients may be receiving, as well as primary and other specialty medical care

4.6.5.12 Veterans must have access to electroconvulsive therapy (ECT): in the VISN in which they receive care. ECT must be provided when it is clinically indicated consistent with VA clinical practice guidelines found at: http://www.healthquality.va.gov/guidelines/MH/mdd/ as well as those of the American Psychiatric Association. Staff needs to be knowledgeable about the current scientific literature and ECT needs to be coordinated with other psychosocial, psychological, psychopharmacological, and medical care that patients may be receiving.

4.6.5.13 Psychotherapy Groups: The mental health staff shall identify situations where group therapy may be beneficial to Veterans and their families. Groups should be time limited (10-12 sessions) and goal directed.

4.6.5.13.1 Psychotherapy groups can be closed or cohort-based, or they can continually be open to new members. There are several arguments in favor of closed groups. However, waiting for the formation of a new group can lead to delays in the initiation of treatment. Accordingly, closed or cohort-based groups are allowable in VHA facilities only when the facility's care system ensures that they do not lead to the denial of care for any Veteran, and that waiting for the start of a new psychotherapy group does not lead to delays in the implementation of care. Patients awaiting the start of a therapy group must be monitored

on an ongoing basis. Their care needs must be evaluated, and alternative treatments must be implemented when needed, for example: When patients are a danger to themselves or others, when they are experiencing increasing degrees of impairment, or When they are suffering from severe symptoms. Waiting periods need to be utilized to provide pre-group preparation to enhance the experience and benefits of group treatment. Whenever patients need to wait for the start of a group, they must be offered an appropriate form of interim treatment

4.6.5.14 Family Education and Involvement: Provide On-site Family Education, Family Consultation, Family Psychoeducation, and Marriage and Family Counseling for Veterans who need these services as part of their overall treatment. These services can be provided on-site through contractor supported Telemental health delivery, or at the parent VA facility.

4.6.5.14.1 Providers need to discuss family involvement in care with all patients with Serious Mental Illness (SMI) or as clinically indicated, at least annually and at the time of each discharge from an inpatient mental health unit. The treatment plan needs to identify at least one family contact, or the reason for the lack of a contact (e.g., absence of a family, Veteran preference, lack of consent). As part of this process, providers must seek consent from Veterans to contact families in the future, as necessary, if the Veteran experiences increased symptoms and families are needed to assist in care. If the Veteran's consent is unobtainable, this must be documented.

4.6.5.14.1.1 Family consultation, family education, or family psycho-education within existing statutory and regulatory counseling authority for Veterans with SMI or as clinically indicated must be provided for those who need them.

4.6.5.14.1.2 Opportunities for family consultation, family education, or psycho-education within existing statutory and regulatory counseling authority must be available to all Veterans with SMI or as clinically indicated

4.6.5.15 Social Skills Training: Social skills training is an evidence-based psychosocial intervention that must be provided when clinically indicated and must be available to all Veterans with SMI who would benefit from it

4.6.5.16 Peer Support Counseling: Contractor sites must make peer counseling available for Veterans with SMI when it is clinically indicated and included in the Veteran’s treatment plan. Peer counseling may be made available by telemental health, referral to VA facilities that are geographically accessible, or by referral to community-based providers

4.6.5.17 Compensated Work Therapy (CWT), Transitional Work, and Supported Employment: Provide information about the CWT Program and criteria for participation must be made available to Veterans.

Whether a particular patient's participation in the CWT program would be appropriate is a medical determination to be made by the responsible clinician, consistent with CWT Program criteria

4.6.5.17.1 Offer CWT with both Transitional Work and Supported Employment services for Veterans with occupational dysfunctions resulting from their mental health conditions, or who are unsuccessful at obtaining or maintaining stable employment patterns due to mental illnesses or physical impairments co-occurring with mental illnesses. Participation in the CWT program must be available to any Veteran receiving care through VA whom VA finds would benefit therapeutically from participation

4.6.5.18 Substance Use Disorders (SUD):

4.6.5.18.1 Provide appropriate services addressing the broad spectrum of substance use conditions including tobacco use disorders must be available for all Veterans who need them

4.6.5.18.2 Provide services for tobacco-related disorders need to be provided to those who need them in a manner that is consistent with the VA-DOD Clinical Practice Guideline for Management of Tobacco Use, which can be found at: http://www.oqp.med.va.gov/cpg/TUC3/TUC_Base.htm

4.6.5.18.3 During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for tobacco use.

4.6.5.18.4 In addition to education and counseling about smoking cessation, evidence-based pharmacotherapy needs to be available for all adult patients using tobacco products. When provided, pharmacotherapy needs to be directly linked to education and counseling

4.6.5.18.5 To the greatest extent practicable and consistent with clinical standards, interventions for substance use conditions must be provided when needed in a fashion that is sensitive to the needs of Veterans and of specific populations including, but not limited to: the homeless; ethnic minorities; women; geriatric patients; and patients with PTSD, other mental health conditions, and patients with infectious diseases (human immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and hepatitis C); TBI; and SCI

4.6.5.18.6 Services addressing substance use conditions can be provided in VA facilities in SUD specialty care, in primary care and other medical care settings (especially in programs that integrate mental health and primary care), through programs integrating treatment for co-occurring mental health disorders and SUD (dual diagnoses) in mental health settings, or in community settings through contracts, or Community Care to the extent that the Veteran is eligible. Regardless of the setting, the process of care must recognize the principle that SUDs are, in most cases,

chronic or episodic and recurrent conditions that require ongoing care

4.6.5.18.7 Consistent with the National Voluntary Consensus Standards for Treatment of Substance Use Conditions endorsed by the National Quality Forum (2007) and the VA-DOD Clinical Practice Guidelines for Management of Patients with SUD, the following services must be readily accessible to all Veterans when clinically indicated

4.6.5.18.8 During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for alcohol misuse

4.6.5.18.9 Because population screening is not evidence-based for substance use conditions other than alcohol misuse and tobacco use; primary care, medical specialty, and mental health services need to use targeted case-finding methods to identify patients who use illicit drugs or misuse prescription or over-the counter agents. These methods need to include evaluation of signs and symptoms of substance use in patients with other relevant conditions (e.g., other mental health disorders, hepatitis C, or HIV disease).

4.6.5.18.10 Patients who have a positive screen for, or an indication of, a substance use problem must receive further assessments to determine the level of misuse and to establish a diagnosis. Diagnostic assessment can be conducted by primary care or other medical providers, mental health providers, or specialists in substance use disorders. Patients diagnosed with a substance use illness must receive a multidimensional, bio-psychosocial assessment to guide patient centered treatment planning for substance use illness and any coexisting mental health or general medical conditions.

4.6.5.18.11 All patients identified with alcohol use more than National Institute on Alcohol Abuse and Alcoholism guidelines need to receive education and counseling regarding drinking limits and the adverse consequences of heavy drinking. When the excessive alcohol use is persistent, the patients are to receive brief motivational counseling by a health care worker with appropriate training in this area, referral to specialty providers, or other interventions depending upon the severity of the condition and the patient's preferences. For patients who are identified as dependent on alcohol, further treatment must be offered, with documentation of the offer and the care provided.

4.6.5.18.12 All health care providers caring for an individual Veteran must systematically promote the initiation of treatment and the ongoing engagement in care for patients with SUD.

4.6.5.18.13 For patients with SUD who decline referral to specialty SUD treatment, providers in primary care, mental health, or other

settings need to continue to monitor patients and their substance use conditions. They are to utilize their interactions with the patient to address the substance use problems and to work with them to accept referrals. NOTE: Strategies that may enhance motivation to seek SUD specialty care include: providing the patient easy-to-read information on the adverse consequences of drinking; having the patient identify problems that alcohol has caused; urging the patient to maintain a contemporaneous diary of alcohol use and the circumstances and consequences associated with it; and frequent appointments with the patient. Interventions with SUD treatment-reluctant patients are always to be characterized by a high-degree of provider empathy.

4.6.5.18.14 Motivational counseling needs to be available to patients in all settings who need it to support the initiation of treatment

4.6.5.18.15 When patients are evaluated as appropriate and are willing to be admitted to inpatient or residential treatment settings for substance use conditions, but admission to those settings is not immediately available, interim services must be provided as needed to ensure patient safety and promote treatment engagement

4.6.5.18.16 All contractor sites must make medically-supervised withdrawal management available by referral as needed, based on a systematic assessment of the symptoms and risks of serious adverse consequences related to the withdrawal process from alcohol, sedatives or hypnotics, or opioids

4.6.5.18.17 Although withdrawal management can often be accomplished on an ambulatory basis, contractor sites must make inpatient withdrawal management available by referral for those who require it.

4.6.5.18.18 Withdrawal management alone does not constitute treatment for dependence and must be linked with further treatment for SUD. Appointments for follow-up treatment must be provided within 1 week of completion of medically-supervised withdrawal management.

4.6.5.18.19 Coordinated and intensive substance use treatment programs must be available for all Veterans who require them to establish early remission from the SUD. These coordinated services can be provided through either or both following:

4.6.5.18.20 Intensive Outpatient services at least 3 hours per day at least 3 days per week in a designated program delivered by staff with documented training and competencies addressing SUD

4.6.5.18.21 An MH RRTP, either in a facility that specializes in SUD services or a SUD track in another MH RRTP that provides a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regimen

4.6.5.18.22 Multiple (at least two) empirically-validated psychosocial interventions must be available for all patients with substance use disorders who need them, whether psychosocial intervention is the primary treatment or as an adjunctive component of a coordinated program that includes pharmacotherapy

4.6.5.18.23 Empirically-validated interventions include motivational enhancement therapy, cognitive behavioral therapy for relapse prevention, 12-step facilitation counseling, contingency management, and SUD-focused behavioral couples counseling or family therapy

4.6.5.18.24 Pharmacotherapy with approved, appropriately- regulated opioid agonists (e.g. Buprenorphine or methadone) must be available to all patients diagnosed with opioid dependence for whom it is indicated and for whom there are no medical contraindications. It needs to be considered in developing treatment plans for all such patients. Pharmacotherapy, if prescribed, needs to be provided in addition to, and directly linked with, psychosocial treatment and support. When agonist treatment is contraindicated or not acceptable to the patient, antagonist medication (e.g., naltrexone) needs to be available and considered for use when needed. Opioid Agonist Treatment can be delivered in either or both following settings

4.6.5.18.25 Opioid Treatment Program (OTP). This setting of care involves a formally-approved and regulated opioid substitution clinic within which patients receive opioid agonist maintenance treatment using methadone or buprenorphine

4.6.5.18.26 Office-based Buprenorphine Treatment. Buprenorphine can be prescribed as office-based treatment in non-specialty settings (e.g., primary care), but only by a “waivered” physician. Buprenorphine is not subject to all the regulations required in officially-identified OTPs, but must be delivered consistent with treatment guidelines and Pharmacy Benefits Management criteria for use

4.6.5.18.27 Pharmacotherapy with an evidence-based treatment for alcohol dependence is to be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, must be provided in addition to, and directly linked with, psychosocial treatment and support

4.6.5.18.28 Patients with substance use illness need to be offered long-term management for substance use illness and any other coexisting mental health and general medical conditions. The patient's condition needs to be monitored in an ongoing manner, and care needs to be modified, as appropriate, in response to changes in their clinical status

4.6.5.18.29 When PTSD or other mental health conditions co-occur with substance use disorders, evidence-based pharmacotherapy and

psychosocial interventions for the other conditions need to be made available where there are no medical contraindications, with appropriate coordination of care

4.6.5.18.30 Substance use illness must never be a barrier for treatment of patients with other mental health conditions. Conversely, other mental disorders must never be a barrier to treating patients with substance use illnesses. When it is appropriate to delay any specific treatment, other care must be provided to address the clinical needs of the Veteran

4.6.5.18.31 Consultations from specialists in substance use disorders or dual diagnosis must be available when needed to establish diagnoses and plan treatment.

4.6.5.19SUICIDE PREVENTION: The Contractor shall follow established Medical Center policy for suicide prevention, to include coordinating with the Suicide Prevention Coordinator at the parent facility, contributing to a high risk for suicide list, and establishing a Category II Patient Record Flag (PRF) as indicated. See current Medical Center policy provided in the attachments section for more detailed information.

4.6.5.19.1 The parent facility Suicide Prevention Coordinator will perform tracking and reporting on Veterans determined to be at high risk for suicide and Veterans who attempt suicide

4.6.5.19.2 The parent facility Suicide Prevention Coordinator will respond to referrals from the National Suicide Prevention Hotline and other staff

4.6.5.19.3 The parent facility Suicide Prevention Coordinator will train staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with Veterans, so they know how to get immediate help when Veterans express any suicide plan or intent

4.6. 5.19.4 The parent facility Suicide Prevention Coordinator will provide general consultation to providers concerning resources for suicidal individuals, as well as expertise and direction in the areas of system design to prevent suicidal deaths within their local VA medical centers

4.6. 5.19.5 The parent facility Suicide Prevention Coordinator will work with providers to ensure that:(a) Monitoring and treatment is intensified for high risk patients; and(b) High-risk patients receive education and support about approaches to reduce risks

4.6. 5.19.6 The parent facility Suicide Prevention Coordinator will Report on a monthly basis to mental health leadership and the National Suicide Prevention Coordinator on the Veterans who attempted or completed suicide along with requested data that is used to determine characteristics and risks associated with these groups of Veterans. NOTE: This information is tracked and trended on a national level by the Center of Excellence at Canandaigua, NY

4.6. 5.19.7 Ensure patient safety and to initiate problem-solving about any tensions or difficulties in the patient's ongoing care. The Contractor, the SPC, and each patient's principal mental health providers must work together to monitor high-risk patients to ensure that both their suicidality and their mental health or medical conditions are addressed. Each VA medical center must establish a high risk for suicide list and a process for establishing a Category II Patient Record Flag (PRF) to help ensure that patients determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments (see current VHA policy for more detailed information).**NOTE:** Contractor site shall support and implement each component of VA's Suicide Prevention Program, and support the activities of the SPCs by ensuring they have the time and resources needed

4.6.5.20HOMELESS PROGRAMS: To ensure the availability of outreach and referral services to homeless Veterans, all contractor sites must designate at least one outreach specialist, usually a clinical social worker, to provide services to homeless Veterans. Based on the size of the CBOC this is collateral assignment for the PACT provider, with the help of the Administrative Associate.

4.6.5.20.1 All Veterans who are homeless, or at risk for homelessness, must be offered shelter through collaborative relationships with providers in the community. Contractor staff must ensure that homeless Veterans have a referral for emergency services and shelter or temporary housing. To the extent that it is possible under existing legal authority, facilities must facilitate the Veteran's transportation to the shelter or temporary housing

4.6. 5.20.2 Use of emergency shelter services should generally not exceed 3 days and is only to be used as a last resort. Within that period, homeless outreach staff or other qualified clinical staff must evaluate the Veteran's clinical needs and refer or place the Veteran for treatment and rehabilitation in therapeutic transitional housing, a MH RRTP, or another appropriate care setting. When longer stays in emergency shelters are unavoidable, this must be documented in the medical record; in these cases, ongoing Case Management, assessment and evaluation, and referral services must continue until more stable arrangements for transitional housing providing treatment or rehabilitation have been made

4.6. 5.20.3 VA will provide information to Contractor about collaborative formal, or informal, agreements with community providers for shelter, temporary housing, or basic emergency services and support them in working together to allow appropriate placement for Veterans together with their families when they are homeless or at risk of homelessness. VA will provide information to Contractor about placement opportunities in Grant and Per Diem Program, a VA Domiciliary, another VA MH RRTP, or other care settings that provide needed services.

NOTE: Eligibility criteria may differ between several types of programs

4.6. 5.20.4 Each VA medical center that has a designated Grant and Per Diem-funded program in its area is responsible for designating a Grant and Per Diem Liaison. Each liaison is to provide case management services for Grant and Per Diem patients, and oversight of the Grant and Per Diem funded program as outlined in VHA Handbook 1162.01. The Grant and Per Diem Liaison can be contacted by contacting the Health Care for Homeless Veterans (HCHV) Program at (801)582-1565 ext. 4706.

4.6. 5.20.5 Department of Housing and Urban Development (HUD)-VA Supported Housing (VASH) Programs have been established in areas that have a high concentration of homeless Veterans. Through a partnership agreement, HUD provides rental assistance vouchers to homeless Veterans referred by VA case management staff for permanent housing. VA provides case management and other clinical services to Veterans in this program. When appropriate, the housing vouchers can be provided to Veterans together with their families.

4.6.5.21 INTEGRATING MENTAL HEALTH SERVICES IN THE CARE OF OLDER VETERANS: Services shall be provided by professionals with specific experience in mental health and aging issues. Integrated mental health services are especially critical to ensuring access, quality, coordination, and continuity of care for older Veterans who are often otherwise much less likely to access mental health services. Accordingly, mental health specialists need to be included in teams serving the needs of older Veterans. The extent of staffing must be sufficient to ensure timely access to high quality, integrated care services: Psychological assessment; Cognitive evaluations; mental health treatment services, specifically including psychosocial, environmental, and behavioral management services; and Geriatric psychopharmacology treatment services

4.6.5.21.1 When families, or significant others, are involved in care giving, the management of Veterans with late life dementia needs to include education and support for them, when this is consistent with existing legal authority for including families in care processes. **NOTE:** There is a robust evidence-base demonstrating that these interventions benefit the patient.

4.6.5.22 SPECIALIZED PTSD SERVICES: Veterans with PTSD can be treated in Specialized PTSD Services, general Mental Health Services, or primary care. All contractor sites (i.e. CBOC) must:

4.6.5.22.1 Have the capacity to provide diagnostic evaluations and treatment planning for PTSD through full- or part-time staffing or by telemental health with parent VA medical centers

4.6. 5.22.2 Contractor sites seeing more than 1,500 unique Veterans each year must provide mental health treatment services for those who need them

4.6. 5.22.3 When Contractor's see less than 1,500 unique Veterans are within 1 hour of other VA facilities, they may make services for PTSD available to those who need them by referral to these other facilities

4.6. 5.22.4 When there are no nearby facilities, smaller contractor sites must provide needed services by telemental health, or by referral to the VA parent facility to the extent that the Veteran is eligible

4.6.5.22.5 Make PCTs available for consultation or care for Veterans who may have PTSD, either on site, by referral to nearby VA medical centers, or by telemental health.

4.6.5.22.6 All PTSD or Specialist programs must be able to address the care needs of Veterans with both PTSD and SUD. These needs can be addressed in two ways with:

4.6.5.22.7 Distinct PTSD dual diagnosis programs or tracks that include providers with specific expertise in both PTSD and SUD, or Structures, processes and formal mechanisms to support the coordination of care for PTSD with that provided in SUD programs. These may include specialized programs of care management for these patients. Care of the intensity available in a PTSD Day Hospital or MH RRTP needs to be available to all Veterans receiving care from VHA to the extent that it is clinically indicated

4.6.6 SPECIALTY CARE SERVICES:

4.6.6.1 PODIATRY SERVICES: The Contractor is not required to provide this service. The veterans shall receive podiatry services through VA podiatry consult in the patient's EHR.

4.6.7 **TELE HEALTH SUPPORT AND SERVICES:** Contractor shall implement VHA Telehealth Services using guidance provided within VHA Clinic Based Telehealth Operations Manual and VHA Home Telehealth Operations Manual provided in the attachments section. The Contractor shall support and provide telehealth services. It is the responsibility of the contractor to ensure that in the event of a patient emergency, e.g. acute medical event, violence or threat of self-harm that explicit processes are in place that ensures a distance provider can alert the clinic and institute the appropriate actions to protect patients and/or staff from harm. These processes must be regularly checked to ensure they are operational and meet specified response times. The contractor cannot assume that all clinical, technology, business, regulatory and legal aspects of telehealth that apply to VA and VA practitioners will automatically apply to contractor's staff. It is the responsibility of the contractor to ensure that all telehealth services provided by contractor's staff meet all such requirements. Staff, Space and Equipment requirements shall be as required by this document. TCTs and TelePresenters shall be qualified as specified in this document. The VA will maintain the VA-provided telehealth equipment. VA will also provide the networking capability to support the telehealth equipment. Sufficient band width is required for satisfactory communication.

4.6.7.1 This site has a requirement to support and provide telehealth services to VA patients. The veterans may visit with primary care VA providers,

mental health, specialty care providers and rehabilitative service· providers-over a proprietary VA Telehealth Network that initially includes Tele-mental health, Tele-retinal, and Tele-dermatology. Primary care providers may refer for other telehealth consultative services from specialty providers and rehabilitative service providers. The VA will provide all Tele-Video Conference Equipment, all associated Information Technology Equipment and T-1 access to the VA confidential data network. It is anticipated the VA will utilize Telehealth Primary Care at this site for up to 32 hours per week during Monday thru Friday from 8 a.m. to 4 p.m.

4.6.7.2 TELE-RETINAL SERVICES: The Contractor shall provide teleretinal imaging services for a target population of patients, to include those with Diabetes Mellitus who have not been evaluated for retinopathy within the past year. The contractor's Primary Care Providers (PCPs) will determine, based on the VA EHR eye clinic records or patient eye history documented in the VA EHR, which patients need to be imaged

4.6.7.3 TELE-DERMATOLOGY SERVICES: Contractor's PCPs and imagers (whether TCTs, nurses, mid-level provider or MDs) will complete all training required as specified by VA for Store and Forward Teledermatology (SFT), and will utilize standardized templates and coding guidance for SFT provided by VA. As requested by the Contractor's PCPs, the TCT will measure and photograph potential dermatologic concerns and transfer images to the VA Dermatology Department for consultative analysis. The Contractor's PCPs shall initiate treatment as recommended by the VA Dermatology Department's teledermatology readers. VA will provide all necessary equipment and supplies, to include: specialized camera with associated memory cards, tripod, storage case, battery pack and cleaning equipment; transmission software; cleaning supplies with instructions; and rulers. Contractor shall provide for storage of tele-derm equipment and supplies. The TCT will clean/maintain equipment and request maintenance/repair, beyond user-level, from VA Biomedical Repair.

4.6.7.4 TELE-MENTAL HEALTH SERVICES: The VA shall provide a qualified professional for tele-mental health services. The Contractor shall provide the support staff at the distal end who can arrange appropriate time and space for the veteran, and staff who can provide technical support as needed. Use of Telemental Health to support the delivery of services is allowed and encouraged as a mechanism for meeting requirements throughout this document. Nevertheless, it is important to recognize that there may be limits to the services that can be provided using this technology. These may include certain highly interactive and "high-touch" evaluations or interventions.

4.6.8 **TELEPHONE ACCESS TO CLINICAL CARE:** The Contractor must make provisions for toll free telephone care, twenty-four (24) hours a day, seven (7) days a week, including evenings, weekends and holidays, for all enrolled patients, in accordance with VHA Directive 2007-033, "Telephone Service for Clinical Care," dated 10/11/07 (or subsequent revisions thereto) located at http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1605. This directive establishes benchmarks for telephone service, which will be used by

VA to monitor Contractor performance (e.g., call volume, abandonment rate, and average speed to answer). Benchmarks include an average speed of answer by a live person within 30 seconds and a call abandonment rate of less than 5%.

4.6.8.1 After Hours Telephone Care: This requirement is met if the Contractor makes arrangements with the parent VA facility after hours WHEN call center to provide after-hours telephone access. It is recommended that the Contractor's telephone rolls over to the VA after-hours number if technology allows. If not, the after-hours telephone message should clearly provide instructions regarding access to WHEN telephone triage.

4.6.8.2 Business Hours Telephone Care: Contractor's shall 1) answer all incoming calls with a "live person" (vs. voice mail) and 2) resolve the patient's reason for calling while on the phone with the Veteran (known as First Call Resolution).

4.6.9 **REFERRAL FOR NON-EMERGENT VA INPATIENT SERVICES:** The Contractor shall be responsible to contact the Communications Center at the parent VA facility by calling (801)582-1565 ext. 1006 to schedule admission should non-emergent inpatient care deemed necessary by the Contractor. (NOTE: all inpatient care is outside the resultant contract-no costs should be charged to the resultant contract).

4.6.10 **EMERGENCY RESPONSE REQUIREMENTS:** The Contractor shall have a local policy or standard operating procedure defining how emergencies are handled, including mental health emergencies. This policy or SOP should include any state specific procedures such as special forms to complete for involuntary evaluations

4.6.10.1 Should emergency care be deemed necessary by the Contractor upon evaluation of the Veteran patient at the site, the Contractor shall first call 911 to arrange for emergency transportation to the closest facility that provides emergency care. After the emergency is resolved, the Contractor shall notify the Community Care at (801)582-1565 ext. 1259 or the Chief Nursing Officer (801)582-1565 ext. 1006, during normal working hours and the Emergency Department (801)582-1565 ext. 1405 or the Chief Nursing Officer (801)582-1565 ext. 1006, after normal working hours. Mental health emergencies must be considered with the same degree of urgency as other emergencies. Under no circumstances should emergent intervention be delayed pending administrative guidance from the VA. A Community Care consult is required to be entered by the provider, after the patient has been transported to the emergency facility. After notification, the VA will make a determination of eligibility for payment purposes.

4.6.10.2 Persons not verified eligible for VA care who present to the Contractor in need of urgent or emergent care shall be treated on a humanitarian basis until stable and discharged from the Contractor's Outpatient Site of Care or referred to the proper level of care in the community. If the patient is determined to have no authorization for services, and has received care by the Contractor, the patient will be billed directly by the VA and will be informed by the Contractor that he is not eligible to continue receiving services at this site.

4.6.10.3 Patients who self-refer to local emergency facilities and their associated charges for care are not the responsibility of the Contractor; and shall not be provided service under this contract, even if the designated Primary Care Provider under this contract is performing "on call" duties at the local facility. Patients who self-refer to emergency facilities should be referred to VA at Community Care at (801)582-1565 ext. 1259 as soon as possible to determine if emergency care will be paid for by VA

4.6.10.4 If an enrolled patient who is not actually receiving care in Contractor's facility contacts the Contractor, and the Contractor believes that the Veteran needs emergency care that the Contractor cannot provide, the Contractor shall advise the patient to go to the nearest emergency care facility or call 911. The Contractor shall also advise the patient to contact the VA at Community Care at (801)582-1565 ext. 1259 as soon as possible to determine if emergency care will be paid for by VA.

4.6.10.5 If any patient presents in need of urgent or emergent care Contractor shall provide practicable monitoring and intervention until patient is stabilized or transported to a higher level of care

4.6.10.6 **Under no circumstances shall emergency care be delayed pending administrative guidance from the VA**

4.6.10.7 The Contractor shall maintain appropriate emergency response capability. Outpatient Sites of Care are required to have AEDs. The Contractor is responsible for performing the device checks and supplying monthly reports to the COR verifying that the checks are being performed in accordance with the contract requirements. Smaller sites that do not have the appropriate staff mix to manage a code need to dial 911 in addition to retrieving and using the AED. At these facilities, the Physician Director, in consultation with the code team at the VA, must determine the best location for AEDs throughout the facility. The VA will provide the Contractor with an AED and train Contractor's staff in its use and checks of the device.

4.6.11 **NON-EMERGENCY TRANSPORT REQUESTS:** During regular business hours, the Contractor shall contact the Travel Assistants at (801)582-1565 ext. 1983 and the Patient Transportation Office will make arrangements for either in-house or contract transportation. The Contractor shall complete VA Memorandum Form 2105, *Request for Transportation*, and fax to the Travel Assistants at (801)584-1229 Calls regarding non-emergent transportation occurring after normal business hours should be made to the Administrative Officer of the Day (AOD) at (801)582-1565 ext. 1405.

4.6.12 **NON-EMERGENT SPECIALTY CONSULTATIONS, CARE, AND DIAGNOSTIC TESTS PERFORMED AT VA:** Non-emergent specialty consultations and diagnostic tests not performed at the Contractor's site will be performed at the VA. Contractor shall request specialty consultations electronically through the VA EHR and include consult service requested, urgency, diagnosis (when required), and reason for request. All additional information required by some Specialty Sections must be entered by the referring Contractor's Primary Care Provider via the consult template.

4.6.12.1 The Contractor is responsible for the coordination of the patient's primary care including referral to specialties as indicated. The VA serves as the referral center for any care or service outside the scope of this contract unless pre-authorized by the VA. The VA is responsible for communicating with the Contractor results of any treatment provided by the VA for the patient. The primary communication link will be the VA EHR. Consult services available at VA via electronic request include the following:

Medicine, Surgery, Other, Allergy, Anesthesia, Anticoagulation Therapy, Autopsy Request, Bariatric Surgery, Audiology, Speech, Cardiology, Cardiac Surgery, Mental Health, Dermatology, Colorectal Cancer, Clinical Pharmacy, Emergency Dept. Referral Care, Community Based Care, Endocrine/Diabetes, ENT, Communication, General Medicine, General Surgery, Dental, Gastro Intestinal (GI),Gynecology, Laboratory, Hematology/Oncology, Neurosurgery, Geriatric, Hospice (Palliative Care), Ophth/Optometry, Miscellaneous Team, Orthopedic, Nutrition & Weight, Infectious Disease, Plastic, Pain Management, Neurology, Podiatry, Pastoral Care, Pulmonary, Pressure, Primary Care, Renal, Ulcer/Wounds, Prosthetics, Rheumatology, Thoracic Surgery, Radiation Therapy, Therapeutic Phlebotomy, Transplant, Recreation, Vascular, (Liver/Renal), Rehab Medicine, Urology, Social Work, Urogynecology, Speech Pathology.

4.6.13 **NON- EMERGENT SPECIALTY CONSULTATIONS, CARE, AND DIAGNOSTIC TESTS NOT PROVIDED AT VA OR CONTRACTOR'S SITE:** The charges incurred from non-emergent specialty evaluations, diagnostic testing, and care provided at sites other than the VA will be the responsibility of the Contractor, unless prior authorization is obtained from the Community Care Office at (801)582-1565 ext 1259. A request for Authorization for Community Care Services is requested by the ordering Provider by completing the VA EHR Community Care consult with full vendor information including name, address, fax, phone and date of appointment, if the date of appointment is known. Subsequent approval may be granted upon review by the Community Care Approving Physician or Nurse. These authorizations, however, will be granted only in rare instances, as non-emergent referrals should be made to the VA.

4.6.14 **THE GOVERNMENT RESERVES THE RIGHT TO REFUSE ACCEPTANCE** of Contractor, if personal or professional conduct jeopardizes patient care or interferes with the regular and ordinary operation of the facility. Breaches of conduct include intoxication or debilitation resulting from drug use, theft, patient abuse, dereliction or negligence in performing directed tasks, or other conduct resulting in formal complaints by patient or other staff members to designated Government representatives. Standards for conduct shall mirror those prescribed by current federal personnel regulations. The CO and COR shall deal with issues raised concerning contract personnel's conduct. The final arbiter on questions of acceptability is the CO.

4.7 ADMINSTRATIVE:

4.7.1 MEETINGS: Contractor's Personnel shall attend service staff meetings as required by the VA COS or designee. Contractor to communicate with COR on this requirement and report any conflicts that may interfere with compliance with this requirement.

4.7.2 SCHEDULING OF SERVICES AND CANCELLATIONS: It is VHA policy that Veterans' appointments are scheduled timely, accurately, and consistently with the goal of scheduling primary care, mental health, and non-institutional extended care services appointments no more than 20 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider (Clinically Indicated Date (CID)), or, in the absence of a CID, 20 calendar days from the date the Veteran requests outpatient health care service (Preferred Date (PD)). Specialty care services appointments are to be scheduled no more than 28 days from date an appointment is deemed clinically appropriate (CID) by a VA health care provider or, in the absence of a CID, 28 days from the date the Veteran requests the appointment (PD). The scheduling of all appointment requests originating from fully processed VA Form 10-10EZs must be initiated within 7 calendar days. The Contractor shall meet the Veterans Health Administration's (VHA's) scheduling standards as outlined in

VHA Directive 1230 "VHA Outpatient Scheduling Processes and Procedures" located at
www.va.gov/vhapublications/viewpublication.asp?pub_id=3218 ,

VHA Directive 1232(1) "Consult Processes and Procedures" located at
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3230, and

VHA Notice 2019-09(1) Minimum Scheduling Effort Required for Outpatient Appointments: Update to VHA Directive 1230 and VHA Directive 1232(1) located at
https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=8306.

4.7.2.1 The Contractor shall also follow the criteria for Community Care established in the MISSION Act of 2018. Veterans shall be offered the option of care in the community when:

4.7.2.1.1 Services are unavailable at the VA

4.7.2.1.2 The Veteran resides in a state without a full-service VA medical facility

4.7.2.1.3 It's in the Veterans best interest

4.7.2.1.4 The Veteran needs care from a VA medical service line that the VA determines is not providing care that complies with VA's standards for quality

4.7.2.1.5 There is a wait-time of more than 20 days for Primary Care, Mental Health Care, and no-institutional extended care services.

4.7.2.1.6 There is wait-time of more than 28 days for specialty care

4.7.2.1.7 For Primary Care, Mental Health, and non-institutional extended care services a Veteran has more than a 30-minute average drive time.

4.7.2.1.8 For specialty care, a Veteran has more than a 60-minute average drive time.

4.7.2.2 When the criteria above is met Veterans may elect to receive care in the community or care at a VA medical facility. Contractor shall follow this process when the above criteria is met and the Veteran requests care in the community: The Contractor shall contact the VA parent facility Community Care Office at (801)582-1565 ext. 1259 with any questions regarding care in the community. Note: Patients referred for care outside the Contractor's clinic (e.g. VA Community Care, VA facility, or similar) for care that the Contractor is required to provide under the terms of this contract will be removed from the applicable billing roster the month after the patient is referred for care.

4.7.2.3 The Contractor shall be responsible for scheduling office, telephone and telehealth visits with other health care providers including nurses, mid-level providers, CPSs, or dietitians for the purposes of monitoring or preventing disease and providing patients with information and/or skills so they can participate in decision-making and self-care.

4.7.2.4 The Contractor shall be responsible for ensuring all Veterans assigned to Contractor's site of care in PCMM have at least one qualifying encounter with Contractor's PCP at least every 12 months (See Appendix J of VHA Directive 1406 Patient Centered Management Module or the Billable Roster section of this PWS for a list of qualifying encounters and clinic stop codes).

4.7.2.5 The Contractor shall be responsible for ensuring phone contacts with patients and primary care providers or their designee

4.7.2.6 The Contractor clinic is not designated as an emergency or urgent care center, and as such is by "appointment only." Nonetheless, the Contractor shall maintain a triage system for walk-in patients. Walk-in patients are to be triaged by a qualified medical practitioner and provided care or connected to appropriate services if the level of care required exceeds that of the level of care provided at the contractor's site of care. Traveling Veterans shall be cared for in accordance with VHA Handbook 1101.11(2), "Coordinated Care for Traveling Veterans" http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=3099

4.7.2.7 Open Access is an important concept for VHA primary care. Contractor is expected to provide same day appointments as needed. This is in part measured by the Same Day Access metric (see Performance Section).

4.7.2.8 Critical patients (those with true emergent needs) shall not be served by the Contractor and shall be referred to the nearest "safe harbor" medical facility capable of providing critical emergent services. (See Emergency Response Requirements section). Immediate notification of the Communications Center at (801)582-1565 ext 1006 is mandatory.

4.7.2.9 In most instances, patients shall be seen within a reasonable time of scheduled appointments in accordance with VHA standards and is included in patient satisfaction surveys.

4.7.2.10 Cancellations: Contractor shall not unnecessarily cancel patient appointments and will reschedule cancelled appointments in a timely manner. Cancelled appointments will be rescheduled with patient input and use the original CID or PD in the desired date (DD) field. Wait time will be measured from the original CID/PD

4.7.2.11 No Shows: See Appendix I of VHA Directive 1230 "VHA Outpatient Scheduling Processes and Procedures" at www.va.gov/vhapublications/viewpublication.asp?pub_id=3218. for no-show process business rules. For MH Services no shows, see MH Services summary section.

4.7.3 MY HEALTHEVET PROMOTION: Veterans interested in the My HealtheVet initiative will be directed to the web site www.myhealth.va.gov where they can register as a Veteran seen at the VAHCS. Once registered, the Veteran can present to the Contractor's Outpatient Site of Care to be authenticated.

4.7.4 MEDICAL RECORDS/COMPUTERIZED RECORD SYSTEMS/ DISCLOSURE/ RECORD RETENTION

4.7.4.1 MEDICAL RECORDS REQUIREMENTS: Authorities: Contractor providing treatment and healthcare services to VHA patients shall comply with the U.S.C.552 (Privacy Act), 38 U.S.C. 5701 (Confidentiality nature of claims), 5 U.S.C. 552 (FOIA), 38 U.S.C. 5705 (Confidentiality of medical quality assurance records) 38 U.S.C. 7332 (Confidentiality of certain medical records) and 45 C.F.R. Parts 160, 162, and 164 (Health Insurance Portability and Accountability Act's Privacy Rule)

4.7.4.2 The resultant contract and its requirements meet exception in 45 CFR 164.502(e), and do not require a Business Associate Agreement (BAA) for a covered entity such as VHA to disclose protected health information to another health care provider for treatment. Based on this exception, a BAA is not required for this contract. Treatment and administrative patient records generated by this contract or provided to the Contractor by the VA are covered by VHA system of records entitled 'Patient Medical Records-VA' 24VA10P2 at https://www.oprm.va.gov/privacy/privacy_SOR.aspx. Contractor generated VHA patient records are the property of VHA and shall not be accessed, released, transferred, or destroyed except in accordance with applicable laws and regulations. Contractor shall ensure that all records pertaining to medical care and services are available for immediate transmission when requested by VHA. Records identified for review, audit, or evaluation by VHA representatives and authorized federal and state officials, shall be accessed on-site during normal business hours or mailed by the Contractor's provider at his expense. Contractor shall deliver all final patient records, correspondence, and notes to VHA within twenty-one (21) calendar days after the contract expiration date.

4.7.4.3 Neither the VA nor the Contractor has the legal authority to require that a patient provide his/her Social Security Number to the VHA as a condition for receiving medical care under Title 38, United States Code.

If the patient does not provide a Social Security Number, the VA will assign a unique identification number to the patient.

4.7.4.5 VA utilizes both a scanned and electronic health record (EHR). The scanned component of the medical record will consist only of those items not already in the VA EHR (such as health records from a non-VA provider). The VA requires that all medical entries be entered into the VA EHR, including, but not limited to, prescriptions, labs, radiology requests, progress notes, vital signs, problem lists, and consults.

4.7.4.6 VHA will provide the necessary training to Contractor personnel on the proper use and operation of the VA EHR.

4.7.5 Clinical Reminders: Proper documentation and completion of all clinical reminders as they appear during a patient's visit. Standard is 90% completion of all clinical reminders monthly. The VA EHR will automatically remind providers to complete clinical reminders during patients visits.

4.7.6 Professional standards for documenting care: Medical record entries shall be maintained in detail consistent with good medical and professional practices to facilitate internal and external peer reviews, medical audits, and follow-up care.

4.7.6.1 The quality of medical practice shall meet or exceed reasonable standards of professional practice for the required services in health care as determined by the same authority that governs VAMC medical professionals and will be audited by the Medical Center, Service Line or other processes established for that purpose

4.7.6.2 The Contractor shall maintain up-to-date electronic medical records at the site where medical services are provided for each member enrolled under this contract. Records accessible by the Contractor during the performance of this contract are the property of the VA and shall not be accessed, released, transferred or destroyed except in accordance with applicable federal law and regulations. The treatment and administrative patient records created by, or disclosed to the Contractor under this agreement are maintained in VA's Privacy Act system of records entitled "Patient Medical Records-VA" 24VA10P2 at https://www.oprm.va.gov/privacy/privacy_SOR.aspx. VA shall have unrestricted access to patient medical records received or created by the Contractor

4.7.6.3 The Contractor shall maintain electronic medical records using the VA EHR making sure they are up-to-date and shall include the enrolled patients' medical records to all subcontractor providers. The electronic record shall include, at a minimum, medical information, prescription orders, diagnoses for which medications were administered or prescribed, documentation of orders for laboratory, radiological, EKG, hearing, vision, and other tests and the results of such tests and other documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services performed or ordered under this contract. Each member's record must be electronic, which includes scanned images, and will be maintained in detail consistent with good medical and professional practice and VA policy. No documents from the electronic medical record will print and no shadow or duplicate

records are authorized. Effective internal and external peer review and/or medical audits facilitate an adequate system of follow-up treatment. Hard copies of external source documents may be scanned into the electronic medical record by the Contractor or a summary progress note written by an appropriate clinician after a review of the external source documents may be used in lieu of scanning any external source documents. After these documents, have been scanned, an audit of the scanned records must be conducted by the contractor to assure they are scanned properly, and then the original documents are to be sent via a secure delivery service that tracks mail from pick-up to delivery at the Contractor's expense to VA Medical Records file room at Salt Lake City VA Health Care System, Attention: Release of Information, 500 Foothill Dr., Salt Lake City, UT 84148 to be stored for 9 months and then destroyed. Scanning and audit reports will be sent via PKI encrypted e-mail to the VA File Room/Scanning Supervisor and File Room/Scanning Lead by the end of the first week of every month. No paper record shall be maintained. If there are no errors found, the Contractor shall report via email that there were no errors to be reported for the previous month.

4.7.6.4 Documentation and Clinical Records: Documentation and clinical records shall be complete, timely, and compliant with VA policies, and current Joint Commission Standards. The Contractor shall not allow its inability to access the VA EHR to prevent any patient from being seen by a provider. In the event, and for any reason, that the Contractor is not able to access the VA EHR system, the Contractor shall record all data manually including the completion of the Encounter Form. Upon recovery of the Contractor's ability to access the VA EHR, the Contractor shall input all data recorded manually into the VA EHR within forty-eight (48) hours of the system becoming operational. See local documentation and clinical records policy in section D

4.7.6.4.1 The Contractor shall report workload (check-in, check-out) within two (2) working days

4.7.6.4.2 The Contractor shall provide patient encounters (visits) workload in accordance with established VA reporting procedures. All Progress Notes, medication orders, and test results, applicable to services which the Contractor is responsible to provide and perform at its site or subcontractor's site, shall be entered into the VA EHR by the Contractor

4.7.6.4.3 VA Radiologist's professional interpretation of diagnostic radiology and diagnostic imaging performed by the Contractor shall be entered into the VA EHR by VA. Contractor shall be responsible for entering all information and requests for laboratory and radiology test requests into the VA EHR

4.7.6.4.4 Progress Notes shall be entered into the VA EHR the same day as the visit/encounter and must meet CMS guidelines for documentation which include the 3 key components to determine the level of evaluation and management (E/M). These key components include: (1) History; (2) Exam; and (3) Medical

decision making. Progress Notes associated with each visit/encounter will include pertinent medical treatment, test results, a treatment plan, teaching that was provided to the patient and/or the patient's family, the date of appointment, and the electronic signature of the treating clinician

4.7.6.4.5 All progress notes must be linked to the correct visit/encounter and location. A patient problem list must be present on the patient's record by the third clinic visit and will be entered via the VA EHR on the Problem List tab. This list will include all diagnoses, medications and procedures and will be updated as the patient's condition changes. Laboratory reports and results will be entered into the Laboratory Package. The process for entry of data may include manual entry or an automated procedure; however, it must adhere to applicable VA Automated Information Security (AIS) system regulations. Questions may be directed to the VA Information Security Officer at (801)582-1565 extension(s) 5442 or 5443

4.7.6.4.6 Patient Care Encounter (PCE) module: The Contractor shall electronically complete encounter form data within two (2) working days of visit. Completed Encounter Forms will include, but are not limited to, the Problem list, appropriate CPT code(s), a primary ICD-10 Diagnosis Code(s), designation of a primary provider, and whether the treatment or care rendered was for a service connected condition or as a result of exposure to agent orange, environmental contaminates, or ionizing radiation. The Contractor is responsible for resolving all Action Required and Encounter Errors daily

4.7.6.5 Event Capture System: Contractor shall ensure that Dietitians electronically complete an Event Capture System form for all direct patient care, whether individual visits, group visits or team meetings that discuss individual patients

4.7.6.6 Forms: The Contractor shall utilize the standardized, VHA templates, available in the VA EHR. Requests for revisions to the standardized templates or new templates are to be submitted to the Primary Care Administrative Officer at (801)582-1565 ext. 2476 for approval.

4.7.6.7 Access to VA Records: Subject to applicable federal confidentiality laws, the Contractor or its designated representatives may have access to VHA records at VHA's place of business on request during normal business hours where necessary to perform the duties under this resultant contract.

4.7.6.8 Reports: The Contractor is responsible for complying with all related VA reporting requirements requested by the VHA.

4.7.6.9 Availability of Records: The Contractor shall make all records available at the Contractor's expense for review, audit, or evaluation by authorized federal, state, and Comptroller or VHA personnel. Access will be during normal business hours and will be either through on-site review of records or through the mail. All records to be sent by mail will

be sent via a secure delivery service that tracks mail from pick-up to delivery at contractor's expense to the VA within one (1) business day of request

4.7.6.10 External Peer Review Program: The Contractor shall document in the medical record preventive health case management measures and the chronic disease indicators of the enrolled patient. The medical treatment records generated by the contractor during performing services under this contract shall be made available for audit by the VHA's External Peer Review Program (EPRP). Medical record data must be available in the VA EHR and any additional records required for EPRP audit will be promptly forwarded to the VA upon request. This data will be sent via a secure delivery service that tracks mail from pick-up to delivery at contractor's expense if necessary to meet the due date requested by the VHA. EPRP is provided to the VHA by other contractors. Contract providers who are seeing VA patients are the VHA providers and as such are provided access to confidential patient information as contained in the medical record.

4.7.6.11 Release of Information: The VHA's Release of Information Section shall provide the Contractor with assistance in completing forms. Additionally, the Contractor shall use VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, when releasing protected health information or any records protected by 38 U.S.C. § 7332. Treatment and release records shall include the patient's consent form. Completed Release of Information requests will be forwarded to the VHA Privacy Officer at the following address: Salt Lake City VA Health Care System, Attention: Release of Information, 500 Foothill Dr., Salt Lake City, UT 84148

4.7.6.12 Disclosure: Contractor may have access to patient medical records, however, Contractor must obtain permission from VHA before disclosing any patient information. Subject to applicable federal confidentiality or privacy laws, the Contractor, or their designated representatives, and designated representatives of federal regulatory agencies having jurisdiction over Contractor, may have access to VHA 's records, at VHA's place of business on request during normal business hours, to inspect and review and make copies of such records. VHA will provide the Contractor with a copy of VHA Handbook 1907.01, Health Information management and Health Records and VHA Directive 1605.01, Privacy and Release of Information. The penalties and liabilities for the unauthorized disclosure of VHA patient information mandated by the statutes and regulations mentioned above, apply to the Contractor, Contractor and/or sub-Contractors.

4.7.6.12.1 The Contractor must provide copies of medical records, at no charge, when requested by the VHA to support billing and/or VA mandated programs if these records are not available in the VA EHR. The Contractor shall use VA Form 10-5345a, Individuals' Request for a Copy of Their Own Health Information when releasing a Veteran's health information to the Veteran. The Contractor shall release information in accordance with the Privacy Act of 1974, and the Health Insurance

Portability and Accountability Act's Privacy Rule, 38 U.S.C. §§ 7332, 5701 and 5705. Release of Information software will be used to print and release record information thus accounting for all disclosures of record information. The contractor shall use the provided software package DSS ROI Manager to record and account for all release of information request processed by the contractor. When releasing medical records to the Veteran themselves, the 10-5345a form will clearly indicate: The Veteran full name and full SSN; The information that was released as authorized by the Veteran; The date the information was released (inferred that date signed is date released); Block will be checked that the information was released in person to the Veteran. When releasing the information to an outside third party, the10- 5345 form will clearly indicate: Full name of Veteran and full SSN; Complete address of third party to who the records were released to; The exact information that was released as authorized by the Veteran; The purpose for third party receiving the records; The expiration date for authorization; Whether any or all §7332 – protected information may be disclosed

4.7.6.13 Records Retention: The Contractor must retain records generated during services provided under this contract for the time periods required by VHA Record Control Schedule 10-1 and VA regulations (24 VA 136, *Patient Medical Records - VA*, par. *Retention and Disposal*). No hard copies of medical records or logbooks of any type may be maintained. If this agreement is terminated for any reason, the contractor shall promptly provide the VA with any individually-identified VA patient treatment records or information in its possession, as well as the database created pursuant to this agreement, within two (2) weeks of termination date

4.7.7 WORK RELATED INCIDENT TREATMENT: When treating the Veteran for injuries sustained because of a work-related incident or an accident, the Contractor must complete the appropriate forms to allow the VA to assert a Federal Medical Care Recovery Act (FMCRA) or a Workers Compensation Claim.

4.7.8 PATIENT RIGHTS, SAFETY, COMPLAINTS, GRIEVANCE SYSTEM PROCESSES

4.7.8.1 Patient Rights and Responsibilities: Contractor shall conform to all patients' rights issues addressed in VA Medical Center Memorandum 11.02 which is provided in the attachments section.

4.7.8.2 Safety: Adverse events at the Contractor's site shall be reported to the VA Quality & Patient Safety Office to the Patient Safety Manager or Patient Safety Coordinator and entered into the Patient Safety Reporting System, as outlined in the National Center for Patient Safety Handbook (https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2389 adverse events will be scored utilizing the Safety Assessment Code for determination of the need for conducting a Root Cause Analysis (RCA). Report adverse events to Lead Patient Safety Manager at (801) 582-1565

ext. 2611 or if unavailable, contact Patient Safety Coordinator at (801) 582-1565 ext. 2611. Adverse drug reactions, allergies, and adverse drug events should be appropriately and promptly entered into the VA EHR

4.7.8.3 Patient Complaints: The VA Patient Advocacy Program was established to ensure that all Veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner in accordance with VHA Directive 1003.4, "VHA Patient Advocacy," available at the following hyperlink: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5970

4.7.8.3.1 All patient complaints are to be reported immediately (within 24 hours) to the CO and COR. The CO shall resolve complaints received from the COR concerning Contractor relations with the Government employees or patients. Providers and staff are familiarized with the process outlined in contractor's grievance procedures as well as patient rights. The CO is final authority on validating complaints. If the Contractor is involved and named in a validated patient complaint, the Government reserves the right to refuse acceptance of the services of such personnel. This does not preclude refusal in the event of incidents involving physical or verbal abuse.

4.7.8.3.1.1 Response to complaints will occur as soon as possible, but no longer than seven (7) days after the complaint is made. All patient complaints will be entered in the National Patient Complaint database. Information concerning the Patient Advocacy Program must be prominent and available to patients seen at the Outpatient Site of Care. The VA will provide the Contractor with informational handouts describing the program and how to contact the VA Patient Advocate.

4.7.8.3.1.2 THE GOVERNMENT RESERVES THE RIGHT TO REFUSE ACCEPTANCE of Contractor, if personal or professional conduct jeopardizes patient care or interferes with the regular and ordinary operation of the facility. Breaches of conduct include intoxication or debilitation resulting from drug use, theft, patient abuse, dereliction or negligence in performing directed tasks, or other conduct resulting in formal complaints by patient or other staff members to designated Government representatives. Standards for conduct shall mirror those prescribed by current federal personnel regulations. The CO and COR shall deal with issues raised concerning contract personnel's conduct. The final arbiter on questions of acceptability is the CO.

4.8 **GREIVANCE SYSTEM REQUIREMENTS:** The enrolled patients have the right to grieve actions taken by the Contractor, including disenrollment recommendations, directly to the Contractor. The Contractor shall provide readable materials reviewed and approved by VA, informing enrolled patients of their grievance rights. The Contractor shall develop internal grievance procedures and obtain VA approval of the procedures prior to implementation. The grievance procedures shall be governed by the guidelines in VHA Directive 1003.4, "VHA Patient Advocacy," available at the following hyperlink: https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5970

4.9 **SPACE REQUIREMENTS:** PACT space standards are found in the PACT Space Module Design Guide at http://www.cfm.va.gov/til/dGuide/dgPACT.pdf. Accessibility design standards are defined in the VA Barrier Free Design Standard at: http://www.cfm.va.gov/til/etc/dsBarrFree.pdf These documents are to be used by VA as a reference in defining space requirements for this solicitation. Contractor's design of space will be evaluated on how it best supports accessibility and the PACT model of care.

4.9.1 Contractors shall provide space that meets the standards outlined in the PACT Space Module Design Guide (see link above) and for the purposes of this solicitation the following minimum space requirements are:

- 1 Offstage Team work space to accommodate all PACT team members
- 3 Exam rooms – one of which needs to have an adjacent restroom per the Women Veterans guidelines
- 2 Dedicated Tele-health room (1 for Mental Health, and the other for tele-derm, and any other special telehealth needs)
- Tele-Retinal room
- 1 Shared Group Space with Telehealth capabilities
- 1 blood draw/specimen processing room
- 1 dedicated space for the proper storage of clean linen, and medical supplies
- 1 dedicated space for the proper storage of soiled linen and/or hazardous waste
- 1 secure space to meet the Data closet needs for IT equipment

4.9.2 The codes, standards, and references listed below indicate minimum performance requirements. Compliance is required with applicable codes and standards throughout the process of design, construction, acceptance, and on-going maintenance of the CBOC facility. Design and documentation of the CBOC shall be in compliance with the requirements of the codes, standards, and references listed below. This also covers construction materials and standards not fully addressed by the codes, standards, and references below

4.9.3 **Codes**: All Contracted CBOC facilities are to conform to all applicable codes, which includes but is not limited to following:

4.9.3.1 National Fire Pro Protection Association (NFPA) 101 Life Safety Code, NFPA 99

4.9.3.2 Health Care Facilities Code and all standard references therein, current edition

4.9.3.3 Occupancy classification to be Chapter 38 New Business Occupancy

4.9.3.4 NFPA 75 Standard for the Fire Protection of Information Technology, current edition, applicable where the CBOC contains a Data Center

4.9.3.5 Architectural Barriers Act Accessibility Standards (ABAAS), current edition

4.9.3.6 International Building Codes (IBC): New buildings shall comply with IBC 2015 or later edition (within 2 years of release).

4.9.3.7 International Energy Code

4.9.3.8 International Mechanical Code

4.9.3.9 International Plumbing Code

4.9.3.10 State and local International Building Codes (IBC) amendments as required by the local Authority Having Jurisdiction (AHJ).

4.9.3.11 United States Pharamcopeial Convention (USP) Chapters <795>, <797>, and <800>

4.9.4 **Standards:** All contracted CBOC facilities are to conform to the following standards:

4.9.4.1 FGI Guidelines for the Design and Construction of Outpatient Facilities, current edition (referred to as FGI Guidelines herein

4.9.4.2 The Joint Commission (TJC) accreditation standards for outpatient clinics in a Business occupancy. TJC requirements apply to the facility under the affiliated VA medical center license. Building construction and on-going maintenance procedures shall meet TJC Environment of Care and Life Safety standards. Contractor shall provide and submit all documentation that is required for TJC requirements

4.9.4.3 GSA Facility Security Level (FSL) shall be Level 2 Security.

4.9.4.4 Sustainability standards shall be Green Leaf Standards.

4.9.4.5 American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standard 170, Ventilation of Health Care Facilities, current edition (referred to as ASHRAE 170 herein)

4.9.4.6 ASHRAE Standard 188, Legionellosis: Risk Management for Building Water Systems, current edition

4.9.4.7 ASHRAE Standard 62.1, Ventilation for Acceptable Indoor Air Quality, current edition (referred to as ASHRAE 62.1 herein)

4.9.4.8 Sheet Metal and Air Conditioning Contractors National Association (SMACNA) Standard, HVAC Duct Construction Standards - Metal and Flexible.

4.9.4.9 USP General Chapter 797 Pharmaceutical Compounding – Sterile Preparations.

4.9.4.10 USP General Chapter 800 Hazardous Drugs - Handling in Healthcare Settings

4.9.5 **References**: Following are guides, manuals, and other references developed by VA applicable to contracted CBOC facilities:

4.9.5.1 VA Signage Design Manual PG 18-12

4.9.5.2 VA Enterprise Facility IT Support Infrastructure Standard, V2.1

4.9.5.2.1 Building Prototypes, Community Based Outpatient Clinic
https://www.cfm.va.gov/til/prototypes.asp#CBOC

4.9.5.2.2 PACT Space Module Design Guide
https://www.cfm.va.gov/til/dGuide/dgPACT.pdf

4.9.5.2.3 Space Planning Criteria PG 18-9
https://www.cfm.va.gov/til/space/spChapter265.pdf

4.9.5.2.4 Room Templates, Leased Community Based Outpatient Clinics
https://www.cfm.va.gov/til/leasing.asp

4.9.6 The Contractor shall provide a floor plan of their proposed space as part of their proposal and indicate how it meets the design standards in the PACT Space Module Design Guide.

4.9.7 The Contractor's facility must be in compliance with National Fire Protection Association (NFPA) Life/Safety requirements and the Americans with Disabilities Act. VA shall inspect the Contractor's facility before contract start date and retains a rite of inspection throughout the period of performance during normal business hours of 8:00 AM – 4:30 PM, Monday through Friday. Contractor must be in compliance with these requirements prior to contract start date. A list of any deficiencies identified during an inspection will be provided to the Contractor along with a required date for correction of the deficiencies. Any planned changes in the physical environment at the Outpatient Site of Care must be reviewed and approved by the VA to ensure that all life safety codes are met. Parking should be adequate to accommodate Veteran patients and shall include at least two (2) handicapped parking spaces.

4.9.8 Automatic Fire Sprinkler System

4.9.8.1 In VA occupied buildings, fire sprinkler protection shall be required to protect patients, visitors, and staff; also, for maintaining the continuity of important clinical and administrative activities; and protecting VA property. This is for compliance with the Federal Fire Safety Act PL-102-522. This applies to all categories of VA construction and renovation projects, station level projects, and acquisition of all VA property (including contracted CBOC space).

4.9.8.2 The entire Building shall be protected throughout by an automatic fire sprinkler system. Automatic fire sprinkler system(s) shall be installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems that was in effect on the actual date of installation

4.9.8.3 Automatic fire sprinkler system(s) shall be maintained in accordance with the requirements of NFPA 25, Standard for the Inspection, Testing,

and Maintenance of Water-based Fire Protection Systems (current as of the Lease Award Date

4.9.8.4 “Equivalent level of safety" means an alternative design or system (which may include automatic fire sprinkler systems), based upon fire protection engineering analysis, which achieves a level of safety equal to or greater than that provided by automatic fire sprinkler systems

4.9.8.5 VA requires a fire alarm system regardless of floor.

4.9.9 Fire Alarm System:

4.9.9.1 A Building-wide fire alarm system shall be installed in the entire building

4.9.9.2 The fire alarm system shall be installed in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code, that was in effect on the actual date of installation

4.9.9.3 The fire alarm system shall be maintained in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code (current as of the Contract Award Date).

4.9.9.4 The fire alarm system shall transmit all fire alarm signals to the local fire department via any of the following means: directly to the local fire department, to the (911) public communications center, to a central station, to a remote supervising station, or to a proprietary supervising station

4.9.9.5 If the Building’s fire alarm control unit is over 25 years old as of the date of award of this Lease, Lessor shall install a new fire alarm system in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code (current as of the Contract Award Date), prior to Government acceptance and occupancy of the Space.

4.9.9.6 Access by the government: The Government shall have the right to access any space within the Building during construction or build out for the purposes of performing inspections or installing Government furnished equipment. The Government shall coordinate the activity of Government contractors with the Contractor to minimize conflicts with and disruption to other contractors on site. Access shall not be unreasonably denied to authorized Government officials including, but not limited to, Government contractors, subcontractors, or consultants acting on behalf of the Government on this project.

4.9.9.7 Maintenance and Testing of Systems: The Contractor is responsible for the total maintenance and repair of the contracted premises. Such maintenance and repairs include the site and private access roads. All equipment and systems shall be maintained to provide reliable, energy efficient service without unusual interruption, disturbing noises, exposure to fire or safety hazards, uncomfortable drafts, excessive air

velocities, or unusual emissions of dirt. The Contractor's maintenance responsibility includes initial supply and replacement of all supplies, materials, and equipment necessary for such maintenance. Maintenance, testing, and inspection of appropriate equipment and systems shall be done in accordance with current applicable codes, and inspection certificates shall be displayed as appropriate. Copies of all records in this regard shall be forwarded to the Government's designated representative

4.9.9.8 At the Contractor's expense, the Government reserves the right to require documentation of proper operations, inspection, testing, and maintenance of fire protection systems, such as, but not limited to, fire alarm, fire sprinkler, standpipes, fire pump, emergency lighting, illuminated exit signs, emergency generator, prior to occupancy to ensure proper operation. These tests shall be witnessed by the Government's designated representative

4.9.9.9 Acceptance of Space and Certificate of Occupancy. The Contractor shall issue written notice to the Government to schedule inspection of the space for acceptance. The Government shall only accept the space if the construction or build-out is conforming to the requirements of the solicitation. The space shall be considered complete only if the space may be used for its intended purpose and completion of any remaining work will not interfere unreasonably with the intended use of the space as defined under the contract. Acceptance is final with the exception of items identified on a punch list generated as a result of the inspection, concealed conditions, latent defects or fraud but shall not relieve the Contractor of any other contract requirements

4.9.9.10 The VA shall inspect the Contractor's facility before contract start date and retains a rite of inspection throughout the period of performance during normal business hours of 8:00 AM – 4:30 PM, Monday through Friday. Contractor must be in compliance with these requirements prior to contract start date. A list of any deficiencies identified during an inspection will be provided to the Contractor along with a required date for correction of the deficiencies. Any planned changes in the physical environment at the Outpatient Site of Care must be reviewed and approved by the VA to ensure that all life safety codes are met.

4.9.9.11 The Contractor shall provide a valid Certificate of Occupancy, issued by the local jurisdiction, for the intended use as outlined in the contract. If the local jurisdiction does not issue C of O's or if the C of O is not available, the Contractor may satisfy this condition by providing a report prepared by a licensed fire protection engineer that indicates the Space and Building are compliant with all applicable local codes and ordinances and all fire protection and life safety-related requirements of this contract

4.9.9.12 Other equipment required by Occupational Safety and Health Administration (OSHA) and TJC List.

4.9.10 **Privacy Standards:** Veterans must be provided adequate visual and auditory privacy at check-in. Patient names are not posted or called out loudly in hallways or clinic areas. Veterans must be provided adequate visual and auditory privacy in the interview area. Patient-identified information must not be visible in the hall including charts where names are visible. Every effort should be made to restrict unnecessary access to hallways by patients and staff who do not work in that clinic area. Patient dignity and privacy must be maintained at all times during the course of a physical examination. Examination rooms must be located in a space where they do not open into a public waiting room or a public corridor. Appropriate locks which allow staff members to have emergency key or code access are required for all examination room doors. Locks must be installed in all examination rooms in all clinics and outpatient testing or procedure areas, not only those clinical areas primarily serving women. All locks must be designed to always allow a safe exit from locked rooms without a key or code. Privacy curtains/screens must be present and functional in examination rooms. Curtains/screens are to ensure privacy from incidental door openings, or from view of others in the room that are not taking part in the examination. Curtains/screens must fully shield the patient while dressing/undressing, during examination, and offer sufficient work space for the provider to perform the examination. Rooms where a patient would not be expected to disrobe within a private room are exempted from this requirement. All examination tables must be placed in such a way that the genital area is not visible from the doorway. Toilet rooms should be located in close proximity to the examination room. Patients who are undressed or wearing examination gowns must have access without going through public hallways or waiting rooms. Personal hygiene products shall be available in public female, unisex, and family toilet rooms at no charge. Diaper changing tables shall be available in designated public male, female, unisex, and family toilet rooms. Diaper changing tables shall be placed at least one per floor in male, female, and unisex toilet rooms, and no more than 300 feet from areas accessible to a patient. Rooms with changing table must be identified, and toilet rooms without changing tables should include signage directing users to the nearest changing table. Cameras (telehealth, computer, teaching) must be shielded/ covered/in locked cabinet/room when not in use.

4.9.11 **Physical Security:** The contract clinic site for the VA clinic shall comply with VA Physical Security requirements which may be found in the Physical Design Manual for Life-Safety Protected Facilities located at the following link: https://www.cfm.va.gov/til/PhysicalSecurity/dmPhySecLS.pdf and with Appendix B of VA Handbook 0730 which defines specifications for physical barrier security, lock set hardware, alarms, and storage containers for high value items and dangerous drugs. In order to comply with Executive Orders, Federal laws, and VA policy, space contracted by VA must meet certain physical security requirements. VA has adopted the protection of the Interagency Security Committee (ISC) Security Design Criteria for all facilities as the minimum requirement.

4.9.11.1 The Contractor shall provide a written certification from a licensed professional engineer that the Building conforms to a minimum of:

4.9.11.1.2 Window glazing and façade protection level, with a performance condition as prescribed by WINGARD 4.1 or later or WINLAC 4.3 software

4.9.11.1.3 Setback distance from the face of the Building's exterior to the protected/defended perimeter (i.e., any potential point of explosion). This means the distance from the Building to the curb or other boundary protected by bollards, planters or other street furniture. Such potential points of explosion may be, but are not limited to, such areas that could be accessible by any motorized vehicle (i.e., street, alley, sidewalk, driveway, parking lot).

4.9.11.1.2 Lobbies, mailrooms, and loading docks shall not share a return-air system with the remaining areas of the Building. The Contractor shall provide lobby, mailroom, and loading dock ventilation systems' outside air intakes and exhausts with low leakage, fast acting, isolation dampers that can be closed to isolate their systems. Dedicated HVAC shall be required for mailrooms only when the Government specifically requires a centrally operated mailroom. On Buildings of more than four stories, air intakes shall be located on the fourth floor or higher. On Buildings of three stories or less, air intakes shall be located on the roof or as high as practical. Locating intakes high on a wall is preferred over a roof location

4.9.12 **Panic Alarms:** The Contractor shall provide a panic alarm system per VA Handbook 0730/4, “Security and Law Enforcement”. This system must provide coverage of entire facility to protect staff in all rooms. This system shall be used to provide rapid notification to on site staff at the CBOC who will ascertain the need for notification of local law enforcement. The alarm may be activated by a covertly placed switch or button and enough switches/buttons must be available to personnel receiving patients. The alarm annunciator will be monitored by local staff (and paid for if necessary) by the Contractor. The exact location of panic/duress alarm switches shall be determined by a VA Police physical security survey of the protected area. VA Police will provide annual physical security surveys. Compliance with items marked as “Findings” must be corrected at the contractor’s expense. A written response for any “Findings” must be sent to VA Police within 30 days of receiving the letter. All alarm switches or buttons will be tested once per month by the contract clinic company to ensure operational effectiveness with results provided monthly to the VA Police located at the VA Salt Lake City Health Care System.

4.9.13 **Intrusion Detection System (IDS):** At a minimum, there must be motion detection provided near all entry doors to the clinic from an outside area. Door switch type alarms can also be used in conjunction with the motion detection equipment. It is highly recommended that all IDS be monitored by an outside contracted agency to summon local law enforcement to the CBOC

4.9.14 **Closed Circuit Television (CCTV):** Shall be provided by the Contractor to monitor building entrances, restricted areas, mission critical asset areas, and

alarm conditions. CCTV system shall be used for surveillance and observations of defined exterior areas, such as site and roadway access points, parking lots, and building perimeter, and interior areas such as hallways, common areas and waiting areas, CCTV system will be viewed from a VA location determined by the VA Physical Security Officer. The design, installation, and use of CCTV cameras shall support the visual identification and surveillance of persons, vehicles, assets, incidents, and defined locations. The Contractor shall contact the VA Physical Security Officer at (801)582-1565 ext. 4444 prior to installation of CCTV system to ensure proper placement.

4.10 **ENVIRONMENT OF CARE (EOC):** Contractor must meet Joint Commission and VHA standards regarding EOC and shall provide the following Safety and Health EOC documents, as required by Joint Commission, with the submission within 15 calendar days after contract award. EOC Management Plans addressing Safety, Security, Hazardous Materials, Hazardous Waste, Emergency Preparedness, Life Safety, Medical Equipment and Utility Systems. The VA Safety Officer shall approve the EOC documents prior to commencement of patient care activities at the clinic. The EOC Management Plans shall be updated annually, along with a summary of performance and opportunities for improvement. Environment of Care (EOC) Rounds will be conducted at least once per fiscal year (FY) in nonpatient care areas and twice per FY in patient care areas in accordance with The Joint Commission (TJC) Standard EC.04.01.01. These rounds will be conducted by VA in accordance with VHA Directive 1608 Comprehensive Environment of Care (CEOC) Program using the Environment of Care Assessment and Compliance Rounding Process Guide found at http://vaww.ceosh.med.va.gov/10N/10NA7EPS/documents/EOC%20Assessment%20%20Compliance%20Guide%20v07%208-03-2014.pdf and included as an attachment in section D. Contractor shall address deficiencies identified during EOC rounds and ensure they are closed within 14-business days or have a documented Plan for Action (PFA) for deficiencies that take longer than 14 business days to correct.

4.11 **EQUIPMENT, OFFICE SUPPLIES AND TECHNICAL SUPPORT:** In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA. No other equipment will be connected to this network. The use of the equipment will be for the benefit of the Government in providing care to our Veterans. The equipment will only be used by those expressly authorized in support of the VA Salt Lake City Health Care System. All users must comply with and adhere to VA Directives and VA Cyber Security policies.

4.11.1 The Contractor shall be responsible for:

4.11.1.1 The installation and maintenance of the network infrastructure within the facility including, but not limited to, cabling located inside the walls of the structure and a secure communications closet space to house the patch panels and networking equipment

4.11.1.2 The backup, contingency and continuity of operations, the Contractor shall provide connectivity to the Internet via cable modem, DSL or T1 circuits to the communications closet space

4.11.1.3 The maintenance and on-going technical support for all data and voice wiring within the walls and ceilings from the data closet to the endpoints of the network

4.11.1.4 All charges related to the backup, contingency, and COOP connectivity.

4.11.1.5 The procurement, installation and maintenance of all printers, copiers, scanners, fax machines*, shredders, or other peripheral office equipment and all related and ongoing supplies (paper, toner, ink cartridges) required to operate the equipment in support of the facility under the

specifications of this contract.* VA Handbook 6500 that requires the following statement on all fax cover sheets be included: “This fax is intended only for the use of the person or office to which it is addressed and may contain information that is privileged, confidential, or protected by law. All others are hereby notified that the receipt of this fax does not waive any applicable privilege or exemption for disclosure and that any dissemination, distribution, or copying of this communication is prohibited. if you have received this fax in error, please notify this office immediately at the telephone number listed above.”

4.11.1.6 All office supplies (pens, paper, pencils, folders, paper clips) and other supplies to facilitate operation of the clinic.

4.11.1.7 All clinical supplies to accomplish all required work in this contract, other than those provided by the VA specifically mentioned in this document

4.11.1.8 Ensuring hardware/software compatibility with VA approved list: the following printers have passed compatibility testing with the VA EHR Encounter Form: Lexmark T642n, Lexmark T644n and Lexmark E342n or compatible; The following scanner has passed compatibility testing with the VA EHR Imaging System: Fujitsu fiI-4340C Sheet Feed Scanner (Any other model used will require approval and certification for VA EHR Imaging)

4.11.1.9 One small desktop color printer for printing patient education information.

4.11.1.10 Having a contingency plan for computer downtime that defines the processes to ensure continuity of patient care and maintenance of the integrity of the patient’s medical record during periods of loss of computer functions. The contingency plan must be reviewed and approved by the Contracting Officer prior to award. In addition, a contingency plan template that designates criticality of application/system, estimate of impact, locations of equipment, and contact persons will be provided to the Contractor for completion after award.

4.11.2 The Contractor Shall provide the following requirements for Network/Data Rooms: No co-location with other tenants is permissible, Room size: min 10’ x 10’. Adequate lighting to work. All equipment will be mounted or stored off the floor. Floor will be tile or painted concrete. Physical and environmental protection shall be in accordance with VA Handbook 6500 Risk Management Framework for VA Information Systems - Tier 3: VA Information Security Program, to include physical and environmental protection policy and procedures, physical access authorizations, physical access control, access control for transmission medium, access control for output devices, monitoring physical access, visitor control, visitor access records, power equipment and cabling, emergency shutoff, emergency power, emergency lighting, fire protection, temperature and humidity controls, water damage protection, delivery and removal, alternate worksite, location of information system components, information leakage, and asset monitoring and tracking.

4.11.2.1 Door:

4.11.2.1.1 Only access will be through the main door.

4.11.2.1.2 ¾ hour fire rating

4.11.2.1.3 Steel frame and door, minimum 36” width

4.11.2.1.4 Primary lock, and a deadbolt (this can be one combined unit). If separate the locks will be keyed the same

4.11.2.1.5 Hinges on the inside of the room, or if on the outside the pins will be spot welded for security

4.11.2.1.6 No signage for the room other than a room number if required.

4.11.2.2 Fire Suppression:

4.11.2.2.1 Contractor supplied 10 LB Dry Chemical ABC fire extinguisher mounted on the inside wall of the IT Room

4.11.2.2.2 If room does not have sprinklers, it must have a gaseous clean extinguishing system

4.11.2.3 Walls/Ceiling:

4.11.2.3.1 Provide a one-hour fire rating on all four sides, top, and bottom

4.11.2.3.2 Inside walls will be sheetrock; must extend from floor to ceiling

4.11.2.3.3 Ceiling may be sheetrock; no drop ceilings

4.11.2.3.4 Painted flat white

4.11.2.3.5 All data communication lines will be terminated in this room on the back wall

4.11.2.3.5 this wall will be ¾" plywood

4.11.2.3.6 fire retardant rating or painted for fire resistance

4.11.2.4 Air Exchange:

4.11.2.4.1 sufficient air exchanges or another acceptable means to cool space

4.11.2.4.2 independent air conditioner

4.11.2.4.3 maintain the room at 70 degrees

4.11.2.5 Power Requirements:

4.11.2.5.1 Four (4) L6-20 receptacles

4.11.2.5.2 One (1) L6-30 receptacle in the closet

4.11.2.5.3. Each receptacle should be on a separate circuit

4.11.2.5.4 Receptacles should be located in close proximity to the top or side of the rack, not to impede the walkway or cable management

4.11.2.6 Racks

4.11.2.6.1 Standard 19" wide data/relay racks; one to support network equipment, one to support PC/Servers, similar to the one displayed below

4.11.2.6.2 Height from 40-48 RU and a depth no less than 21"

4.11.2.6.3 Secured and grounded to the floor

4.11.2.6.4 Placed such that at there is a least 3 feet in the front and behind the rack

4.11.2.6.5 Either aluminum or steel construction and the holes should be standard 10-32 tapped

4.11.2.6.6 Both racks will have 2 shelves on the bottom installed to hold IT computers

4.11.2.6.7 Infrastructure installer should install Leviton CAT6 patch panels and connectors in the rack

4.11.2.7 Cable Management:

4.11.2.7.1 Cables should be installed to the patch panel at the hinged end so that the articulation of the panel doesn't stress the terminations

4.11.2.7.2 vertical cable trough on both sides of rack

4.11.2.7.3 horizontal cable troughs between patch panels

4.11.2.7.4 cable ladder assembly above rack for cable into closet to patch panels

4.11.2.7.5 "B" connection terminated at each end (wall jack & communications closet, where applicable) IAW TIA/EIA standards

4.11.3 The VA will be responsible for:

4.11.3.1 providing PC workstations, software, primary telecommunications lines and networking equipment required to access the VA EHR

4.11.3.2 providing antivirus software for PC workstations and ensure that data definition files are current. In addition, the VA will ensure that all Microsoft critical updates and patches are current

4.11.3.3 the connection and management from that Contractor's connectivity to the Internet via cable modem, DSL or T1 circuits to the VA owned networking equipment in the closet

4.11.3.4 the backup, contingency, COOP connectivity to the VA and will be established through a VA provided Site-to-Site VPN connection utilizing Contractor provided Internet Service Provider (ISP)

4.11.3.5 providing advisory technical support to the Contractor's technical support person for the initial site set-up relative to the VA EHR and VPN connectivity. The VA will provide on-going technical support for the VA EHR software and any other VA software applications. Technical support will be through an escalation process. The Contractor's employee technical representative will submit a "Help Desk" request by calling (801)582-1565 ext 1293. Initial technical support will be provided by the VA via telephone, which will consist of a VA technical representative speaking to a Contractor employed representative to identify the problem, trouble-shoot and attempt to resolve the problem with the Contractor's end-user. If the problem cannot be resolved the VA will provide on-site support for VA owned equipment, VA EHR software and other VA software applications, if necessary within two business days or less depending on the nature and severity of the problem

4.12 **PERFORMANCE STANDARDS, QUALITY ASSURANCE AND QUALITYIMPROVEMENT:** Services and documentation of care provided under the resultant contract shall be subject to quality management and safety standards as established by VA, consistent with the standards published by TJC or equivalent. The contractor shall develop and maintain Quality Improvement/ Quality Assurance Programs ad provision of care equal to or exceeding VA Standards. The results of all Quality improvement activities performed by the contractor involving VA patients will be shared with VA Quality Management Office. Documentation by the Contractor provided to the VA includes, but is not be limited to the following:

4.12.1 Quality improvement plans: Staff meetings minutes (or summary minutes) where quality improvement has been discussed and which include practitioner-specific findings, conclusions, recommendations and written plans for actions taken in

response to such conclusion and recommendations, and evaluation of those actions taken

4.12.2 Contractor must be accredited by TJC or maintain a level of service that is in compliance with all current TJC standards. If the Contractor is TJC accredited, he/she will be required to furnish a copy of the accreditation letter(s) upon request by the Contracting Officer prior to award

4.12.3 The Contractor shall notify the Chief of Staff in writing whenever a malpractice claim involving a VA patient has been filed against the Contractor. The Contractor shall forward a copy of the malpractice claim within three (3) workdays after receiving notification that a claim has been filed. The Contractor shall also notify the VA Special Assistant to the Chief of Staff when any provider furnishing services under this contract is reported to the National Practitioner Data Bank. This notification will include the name, title, and specialty of the provider. All written notifications shall be sent to the Chief of Staff at the following address: VA Salt Lake City Health Care System, Chief of Staff Office, 500 Foothill Dr. Salt Lake City, UT 84148. The Chief of Staff or Contracting Officer Representative will notify the CO of any notifications received from the Contractor

4.12.4 The Contractor shall permit on-site visits by VA personnel and TJC surveyors accompanied by VA personnel and/or other accrediting agencies to assess contracted services, e.g., adequacy, compliance with contract requirements, record-keeping, etc.

4.12.4 The Contractor is responsible for the quality management plan for monthly clinical pertinence review of ambulatory care records. The results shall be forwarded to Chief of Primary Care Service, or the Assistant Chief of Community Clinics. If in the course of VA business, a concern is identified, the issues must be addressed by the Contractor and a performance improvement plan initiated. Recommendations and implementation of performance improvement activities will be the responsibility of the Medical Director of the clinic. The Contractor shall conduct audits of JTC standards that require performance measures. Those audit results shall be sent to the HIMS Program VA Salt Lake City Health Care System, HIMS Office, 500 Foothill Dr. Salt Lake City, UT 84148 on a quarterly basis

4.12.5 The VA is committed to providing high quality primary care. The VA measures quality in primary care through its performance measurement system. Several "process" and "outcome" measures are extracted by external reviewers from random samples of records of Veterans who visited VA primary care providers at the Contractor's Outpatient Site of Care. These measures change from year to year. The current performance measures and method of extraction are available at https://vaww.car.rtp.med.va.gov/default.aspx. This is an internal VA site so this information is provided in the attachments section. The Contractor is responsible for achieving levels of performance on these measures that meet or exceed the annual expectations for performance of the VA Salt Lake City Health Care System as outlined in the Network Performance Plan and Network Technical Manual. Revisions/updates to the Network Performance Plan and Network Technical Manual may be obtained from the above website. The Contractor is required to utilize the VA EHR clinical reminder system as a means of both ensuring high performance on these measures and to facilitate monitoring of performance at the site independent of external reviewers. Levels of performance on the quality measures in primary care will be used as a factor in decisions about renewal of the contract.

4.12.6 The Contractor shall document in writing on appropriate orientation programs for all employees involved in the delivery of patient care, e.g., infection control procedures, patient confidentiality, handling emergencies, patient safety, etc., and provide a copy to the VA COR. Contractor shall be required to furnish method/guidelines by which he/she intends to meet above requirement

4.12.7 The Contractor shall have a quality monitoring/performance improvement program. This program shall be available to VA staff and JC. The VA will provide regular feedback on clinic performance measures, including but not limited to the following: licensure verification, workload, consults, drug and lab utilization, formulary compliance, prescription writing patterns, Prevention and Performance measures, patient satisfaction, and medical record completeness. The Contractor shall conduct audits pertaining to access, quality improvement, documentation, safety and performance measures. These reports shall be submitted to the COR monthly and sent via secured email using PKI or utilizing a secure delivery service that tracks mail from pick-up to delivery

4.12.8 The Contractor shall comply with all PBM formulary guidance regarding medication use, monitoring and safety

4.12.9 Contractor shall collaborate with VA Pharmacy when patients are identified that require intervention

4.12.10 The Contractor shall meet all Federal, State, and Local fire and Life Safety Codes

4.12.11 The Contractor shall be responsible for meeting national quality standards and shall comply with mandated policies established by VA Central Office (VACO) Patient Care Services (PCS). Each fiscal year new quality standards are developed by PCS and forwarded to each VISN for implementing at each primary care site. Those standards are found at the VA website and provided by the COR for implementing

4.13 **PERFORMANCE STANDARDS AND SURVEILLANCE-** To be paid the full capitated rate on the schedule, the contractor must provide services as required in the entire contract and to meet or exceed the acceptable quality level outlined in this section/sub-sections. If any portion of the requirement is not met and/or the acceptable quality level in any of the elements in this section/subsection are not maintained, the contractor will be notified by the contracting officer. The contracting officer may take administrative action to notify the contractor of such performance issues and may request a response from the contractor outlining the contractors proposed remedy.

DOMAIN: ACCESS

4.13.1 MEASURE: NEW PC APPOINTMENTS COMPLETED WITHIN 20 DAYS OF CREATE DATE (PC18)

Performance Requirement: Contractor shall provide completed appointments f or new PC patients <=20 days from the create date
Standard: Contractor shall provide completed appointments for new PC patients <=20 days from the create date no less than 76% of the time
Acceptable Quality Level: Contractor shall provide completed appointments for new PC patients <=20 days from the create date no less than 77% of the
Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the PACT Profile report and Performance Measures Report. COR will send reports to the Contractor and to the CO quarterly to notify them of performance

4.13.2 MEASURE: ESTABLISHED PC PATIENT AVERAGE WAIT TIME IN DAYS (PC17)

Performance Requirement: Contractor shall provide completed appointments for established PC patients <=20 days from the patient indicated date.

Standard: Contractor shall provide completed appointments for established PC patients <=20 days from the patient indicated date no less than 97% of the time.

Acceptable Quality Level: Contractor shall provide completed appointments for established PC patients <=20 days from the patient indicated date no less than 95% of the time

Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the PACT Profile report and Performance Measures Report. COR will send reports to the Contractor and to the CO quarterly to notify them of performance

4.13.3 MEASURE: PCMHI Penetration (PACT15) SHEP Access Composite:

Performance Requirement: Contractor shall involve PCMHI staff in the care of patients with mental health needs.

Standard: Contractor's PCMHI penetration rate shall meet or exceed 8%

Acceptable Quality Level: Contractor's PCMHI penetration rate shall meet or exceed 5%

Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the SHEP and Performance Measures report. COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.4 MEASURE: PCMH SHEP ACCESS COMPOSITE:

Performance Requirement: Contractor shall provide: 1) urgent care appointments as soon as needed, 2) routine care appointments as soon as needed, and 3) same day answers to patients' medical questions

Standard: Contractor's SHEP access composite score shall meet or exceed 51%

Acceptable Quality Level: Contractor's SHEP access composite score shall meet or exceed 45%

Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the SHEP and Performance Measures report. COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.5 MEASURE: SHEP QUESTION 7

Performance Requirement: Contractor shall provide timely appointments when patients need care right away

Standard: Contractor's SHEP question 7 score shall meet or exceed 41%

Acceptable Quality Level: Contractor's SHEP question 7 score shall meet or exceed 53%

Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the SHEP and Performance Measures report. COR will send reports to the Contractor and CO quarterly to notify them of current performance.

4.13.6 MEASURE: SAME-DAY APPTS W/ PCP

Performance Requirement: Contractor shall provide same day appointments with primary care provider
Standard: Contractor's same day appointments with PCP rate shall meet or exceed 60%
Acceptable Quality Level: Contractor's same day appointments with PCP rate shall meet or exceed 75%
Surveillance Method and Frequency: VA will monitor progress quarterly using data from the PACT Compass. COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.7 MEASURE: APPOINTMENT CANCELLATIONS:

Performance Requirement: Contractor shall not unnecessarily cancel patient appointments
Standard: Contractor's rate of appointments cancelled by clinic shall not exceed 9%
Acceptable Quality Level: Contractor's rate of appointments cancelled by clinic shall not exceed 7%
Surveillance Method and Frequency: VA will monitor progress quarterly using data from the Performance Measure Report and the PACT Compass. COR will send reports to the Contractor and CO quarterly to notify them of current performance

DOMAIN: QUALITY OF CARE:

4.13.8 MEASURE: COMPOSITE - BEHAVIORAL HEALTH SCREENING:

Performance Requirement: Contractor shall complete all behavioral health screening and follow-up evaluations
Standard: Contractor shall maintain a behavioral health composite score of at least 95%
Acceptable Quality Level: Contractor shall maintain a behavioral health composite score of at 90%
Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the CBOC Report. The COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.9 MEASURE: COMPOSITE – DIABETES

Performance Requirement: Contractor shall manage patients with diabetes in accordance with VA standards
Standard: Contractor shall maintain a diabetes composite score of at least 79%
Acceptable Quality Level: Contractor shall maintain a diabetes composite score of at least 81%
Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the CBOC Report. The COR will send

reports to the Contractor and CO quarterly to notify them of current performance

4.13.10 MEASURE: COMPOSITE - ISCHEMIC HEART

Performance Requirement: Contractor shall manage patients with ischemic heart disease in accordance with VA standards
Standard: Contractor shall maintain an ischemic heart composite score of at least 78%
Acceptable Quality Level: Contractor shall maintain an ischemic heart composite score of at least 80%
Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the CBOC Report. The COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.11 MEASURE: COMPOSITE – PREVENTION

Performance Requirement: Contractor shall provide preventive health care in accordance with VA standards
Standard: Contractor shall maintain a prevention composite score of at least 80%
Acceptable Quality Level: Contractor shall maintain a prevention composite score of at least 75%
Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the CBOC Report. The COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.12 MEASURE: COMPOSITE – TOBACCO

Performance Requirement: Contractor shall provide tobacco counseling and care in accordance with VA standards
Standard: Contractor shall maintain a tobacco composite score of at least 94%
Acceptable Quality Level: Contractor shall maintain a tobacco composite score of at least 95%
Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the CBOC Report. The COR will send reports to the Contractor and CO quarterly to notify them of current performance

4.13.13 MEASURE: CLINICAL REMINDERS

Performance Requirement: Contractor shall complete all clinical reminders as indicated in VA EHR
Standard: Contractor shall complete no less than 90% of all clinical reminders as indicated in VA EHR
Acceptable Quality Level: Contractor shall complete no less than 87% of all clinical reminders as indicated in VA EHR
Surveillance Method and Frequency: VA will monitor progress weekly using VA EHR reports. COR will send reports weekly to the Contractor, and notify the CO of any issues of non-compliance, otherwise they will notify the CO quarterly

4.13.14 MEASURE: PROGRESS NOTES AND PATIENT CARE ENCOUNTER (PCE) MODULE DOCUMENTATION

Performance Requirement: Contractor shall complete workload and encounter documentation as defined in the PWS within 2 business days. Progress notes must be connected to the correct visit/encounter and location, entered into VA EHR/VA EHR on the same day as the visit/encounter, meet CMS guidelines, and include content as defined in PWS.

Standard: Contractor shall properly complete documentation for each patient encounter 100% of the time

Acceptable Quality Level: Contractor shall properly complete documentation for each patient encounter 100% of the time

Surveillance Method and Frequency: VA will monitor progress weekly using VA EHR reports. COR will send reports weekly to the Contractor, and notify the CO of any issues of non-compliance, otherwise they will notify the CO quarterly

DOMAIN: PANEL MANAGEMENT:

4.13.15 MEASURE: PERCENT OF TEAMS WITH CORE TEAMLET STAFFING RATIO >=3:

Performance Requirement: Contractor shall provide core teamlet staffing at a ratio of >=3 FTE core teamlet members (RN care manager, clinical associate, administrative associate) for each PCP FTE

Standard: 100% of Contractor's primary care teams shall have a core teamlet staffing ratio of >=3

Acceptable Quality Level: 100% of Contractor's primary care teams shall have a core teamlet staffing ratio of >=3

Surveillance Method and Frequency: VA will monitor progress monthly using data from the mPACT Dashboard, and PCMM Panel Report. COR will send reports monthly to the Contractor and notify the CO of any issues of non-compliance, otherwise the COR will notify CO quarterly.

4.13.16 MEASURE: PERCENT OF WOMEN ASSIGNED TO WOMEN'S HEALTH PACT OR DESIGNATED WOMEN'S HEALTH PROVIDER (WH1)

Performance Requirement: Contractor shall ensure that an appropriate number of WH-PACTs or WH-PCPs are available at site of care to ensure that all VHA access goals are met for women Veterans who choose to be seen by a designated women's health provider.

Standard: Contractor's percent of women assigned to Women's Health PACT or Designated Women's Health Provider shall meet or exceed 77%

Acceptable Quality Level: Contractor's percent of women assigned to Women's Health PACT or Designated Women's Health Provider shall meet or exceed 85%

Surveillance Method and Frequency: VA will monitor progress quarterly using data from the PACT Compass. COR will send reports to the Contractor and CO quarterly to notify them of current performance.

4.13.17 MEASURE: PERCENT PRIMARY CARE PATIENTS ENROLLED IN HOME TELEHEALTH

Performance Requirement: Contractor shall offer and refer patients to home telehealth

Standard: Contractor shall exceed 1.6% of PC patients enrolled in Home Telehealth (HT)

Acceptable Quality Level: Contractor shall exceed 1.7% of patients enrolled in Home Telehealth (HT)

Surveillance Method and Frequency: VA will monitor progress quarterly using data from the PACT Compass. COR will send reports to the Contractor and CO quarterly to notify them of current performance.

4.13.18 MEASURE: RATIO OF NON-TRADITIONAL ENCOUNTERS

Performance Requirement: Contractor shall provide telephone encounters, group encounters, and secure messaging

Standard: Contractor shall exceed 25% ratio of non-traditional encounters

Acceptable Quality Level: Contractor shall exceed 28% ratio of non-traditional encounters

Surveillance Method and Frequency: VA will monitor progress quarterly using data from the PACT Compass. COR will send reports to the Contractor and CO quarterly to notify them of current performance

DOMAIN: VETERAN SATISFACTION

4.13.19 MEASURE: VETERAN SATISFACTION

Performance Requirement: The Contractor's PCPs shall provide care that Veterans rate as a 9 or 10 on question 32 of the SHEP/PCMH survey

Standard: Contractor's SHEP question 32 score shall meet or exceed 69%

Acceptable Quality Level: Contractor's SHEP question 32 score shall meet or exceed 65%

Surveillance Method and Frequency: VA will monitor progress quarterly by using data from the SHEP report and Performance Measures Report. COR will send reports to the Contractor and to the CO quarterly to notify them of performance

DOMAIN: COORDINATION OF CARE

4.13.20 MEASURE: POST DISCHARGE CONTACT BY PACT TEAMLET

Performance Requirement: The Contractor's PACT teamlets shall contact their assigned patients within 2 business days of discharge from any VA facility

Standard: Contractor's rate of post discharge contact by PACT teamlet shall meet or exceed 60%

Acceptable Quality Level: Contractor's rate of post discharge contact by PACT teamlet shall meet or exceed 65%

Surveillance Method and Frequency: VA will monitor progress quarterly using data from the PACT Compass. COR will send reports to the Contractor and CO quarterly to notify them of current performance

DOMAIN: ENVIRONMENT OF CARE (EOC)

4.13.21 MEASURE: PERCENTAGE OF DEFICIENCIES IDENTIFIED DURING EOC ROUNDS THAT ARE CLOSED TIMELY (e5eoc1)

Performance Requirement: Contractor shall address deficiencies identified in EOC rounds within 14 business days or have a documented Plan for Action (PFA)

Standard: Contractor's rate of EOC deficiencies that are closed within 14 business days or have a PFA shall meet or exceed 85%

Acceptable Quality Level: Contractor's rate of EOC deficiencies that are closed within 14 days or have a PFA shall meet or exceed 89%

Surveillance Method and Frequency: VA will monitor progress quarterly using data from the Performance Measure Report. COR will send reports to the Contractor and CO quarterly to notify them of current performance.

DOMAIN: PHARMACY

4.13.22 MEASURE: NON-FORMULARY AND RESTRICTED DRUG REQUESTS

Performance Requirement: Contractor shall submit non-formulary and restricted drug requests in VA EHR/VA EHR using the PBM consult option

Standard: Contractor shall submit non-formulary and restricted drug requests in VA EHR/VA EHR using the PBM consult option 100% of the time. (Zero disapproval ratings for non-formulary and restricted drug requests quarterly).

Acceptable Quality Level: Contractor shall submit non-formulary and restricted drug requests in VA EHR/VA EHR using the PBM consult option 100% of the time. (No more than 10% disapproval ratings for non-formulary and restricted drug requests quarterly).

Surveillance Method and Frequency: COR will monitor performance monthly via electronic reports pulled from VA EHR/VA EHR. COR will send monthly status reports to the CO and Contractor to notify them of current performance

4.13.23 MEASURE: PHARMACY NEW DRUG ORDER REQUESTS

Performance Requirement: Contractor shall submit new drug orders through VA EHR/VA EHR

Standard: The contractor shall ensure that 95% all new drug order requests follow all prescribing guidelines. This is including but not limited to ensuring all appropriate labs have been previously ordered and that the order is not a non-formulary drug.

Acceptable Quality Level: The contractor shall ensure that 100% all new drug order requests follow all prescribing guidelines. This is including but not limited to ensuring all appropriate labs have been previously ordered and that the order is not a non-formulary drug.

Surveillance Method and Frequency: COR will monitor performance monthly via electronic reports pulled from VA EHR/VA EHR. COR will send monthly status reports to the CO and Contractor to notify them of current performance.

4.14 REQUIRED REGISTRATION WITH CONTRACTOR PERFORMANCE ASSESSMENT REPORTING SYSTEM (CPARS)

4.14.1 As prescribed in Federal Acquisition Regulation (FAR) Part 42.15, the Department of Veterans Affairs (VA) evaluates Contractor past performance on all contracts that exceed the Simplified Acquisition Threshold and shares those evaluations with other Federal Government contract specialists and procurement officials. The FAR requires that the Contractor be provided an opportunity to comment on past performance evaluations prior to each report closing. To fulfill this requirement VA uses an online database, CPARS, which is maintained by the Naval Seal Logistics Center in Portsmouth, New Hampshire. CPARS has connectivity with the Past Performance Information Retrieval System (PPIRS) database, which is available to all Federal agencies. PPIRS is the system used to collect and retrieve performance assessment reports used in source selection determinations and completed CPARS report cards transferred to PPIRS. CPARS also includes access to the federal awardee performance and integrity information system (FAPIIS). FAPIIS is a web-enabled application accessed via CPARS for Contractor responsibility determination information

4.14.2 Each Contractor whose contract award is estimated to exceed the simplified acquisition threshold (SAT) $250,000.00 (This a mount may change during the life of the contract) is required to register with CPARS database at the following web address: www.cpars.csd.disa.mil. Help in registering can be obtained by contacting Customer Support Desk @ DSN: 684-1690 or COMM: 207-438-1690. Registration should occur no later than thirty days after contract award and must be kept current should there be any change to the Contractor's registered representative.

4.14.3 For contracts with a period of one year or less, the contracting officer will perform a single evaluation when the contract is complete. For contracts exceeding one year, the contracting officer will evaluate the Contractor's performance annually. Interim reports will be filed each year until the last year of the contract, when the final report will be completed. The report shall be assigned in CPARS to the Contractor's designated representative for comment. The Contractor representative will have thirty days to submit any comments and re-assign the report to the VA contracting officer.

4.14.4 Failure to have a current registration with the CPARS database, or to re-assign the report to the VA contracting officer within those thirty days, will result in the Government's evaluation being placed on file in the database with a statement that the Contractor failed to respond

5. GOVERNMENT RESPONSIBILITIES. Special Contract Requirements

5.1. Oversight of Service/Performance Monitoring:

5.1.1. **CO Responsibilities:** The CO is the only person authorized to approve changes or modify any of the requirements of this contract. The Contractor shall communicate with the CO on all matters pertaining to contract administration. Only the CO is authorized to make commitments or issue any modification to include (but not limited to) terms affecting price, quantity or quality of performance of this contract. The CO shall resolve complaints concerning Contractor's provider relations with the Government employees or patients. The CO is final authority on validating complaints. In the event the Contractor effects any

such change at the direction of any person other than the CO without authority, no adjustment shall be made in the contract price to cover an increase in costs incurred as a result thereof. If contracted services do not meet quality and/or safety expectations, the best remedy will be implemented, to include but not limited to a targeted and time limited performance improvement plan; increased monitoring of the contracted services; consultation or training for the contract staff to be provided by the VA; replacement of the contract staff and/or renegotiation of the contract terms or termination of the contract. The Contractor's start-up requirements must be completed prior to the commencement of the Contractor's treatment of VA enrolled patients. Upon approval by the VA of the Contractor's completion of the start-up requirements, the VA will issue a written Notice to Proceed to the Contractor.

5.1.2. **The COR:** The COR shall be the VA official responsible for verifying contract compliance. After contract award, any incidents of Contractor or Contractor's provider noncompliance as evidenced by the monitoring procedures shall be forwarded immediately to the Contracting Officer. The COR will be responsible for monitoring the Contractor staff performance to ensure all specifications and requirements are fulfilled. Quality Improvement data that will be collected for ongoing monitoring is outlined in the QASP. The COR will maintain a record-keeping system of services by reviewing the QASP and invoices submitted by the Contractor. The COR will review this data monthly when invoices are received and certify all invoices for payment. Any evidence of the Contractor's non-compliance shall be forwarded immediately to the Contracting Officer. The COR will review and certify monthly invoices for payment. If in the event the Contractor fails to provide the services in this contract, payments will be adjusted to compensate the Government for the difference.

5.1.3. Contract Administration: All contract administration functions will be retained by the VA. After award of contract, all inquiries and correspondence relative to the administration of the contract shall be addressed to:

Contracting Officer (CO)
Leigh Ann Nunn
750 NE 13th Street 2nd Floor
Oklahoma City, OK 73104
Leigh.Nunn2@va.gov
(405)456-5113

Contracting Officer's Representative (COR) for this contract is:
Rebecca Kemp
500 Foothill Dr. (110)
Salt Lake City, UT 84148
Rebecca.Kemp@va.gov
(801)582-1565 ext. 2476

Liaison Persons: While the liaison persons identified, and other VA staff may be contacted for questions/information and/or may visit the Contractor's sites to oversee policy compliance, **only the CO is authorized to make commitments or issue changes which will affect the price, quantity, quality, or delivery terms of this contract.** Any guidance provided, which the Contractor feels is beyond the scope of this contract, must be communicated to the CO, via the COR, for possible contract modification.

The VA has designated the following liaison personnel for this resultant contract –

Title	Role	Phone Number
Primary Care Service Line	Clinical Contact	801-582-1565 ext. 2278
VA Manager	COR and Admin Contact	801-582-1565 ext. 2476
VA Coordinator	Admin Contact	801-582-1565 ext. 1400
Administrative Officer of the Day	Contact for any administrative and clinical problems that arise after normal working hours of 8:00 AM-4:30 P.M., Monday - Friday, weekends and holidays	801-582-1565 ext. 1035 or 1173
IRM "Help Desk"	Assistance with VA EHR	801-582-1565 ext. 1293
HIMS ADPAC	Assistance with Patient Information Management System (PIMS)	801-582-1565 ext. 1035 or 1173
Patient Registration Office	Assistance with Patient Eligibility	801-582-1565 ext. 5126
Medical Care Cost Recovery	Assistance with Financial Assessments	801-582-1565 ext. 2457
Outpatient Pharmacy	Outpatient Pharmacy Supervisor	801-582-1565 ext. 2193
Health Information Management Service	Assistance with VA EHR and Medical Records	801-582-1565 ext. 1654
VA Patient Advocate	Assistance with patient complaints, etc.	801-582-1565 ext. 1900
Community Care	Assist in questions involving community care consults, timeliness of care provided in the community, and Mission Act concerns,	801-582-1565 ext 1259
Ancillary Testing	Questions involving lab work, and other ancillary testing	801-582-1565 ext. 1595 or 1261
Pathology and Laboratory Medicine	Chief Medical Technologist for pathology and laboratory medicine	801-582-1565 ext. 1988
Women Veterans Health Services	Program Manager for women veteran’s health issues	801-582-1565 ext. 5423

Radiology Service	Chief Technologist for radiology imaging related questions	801-582-1565 ext. 2352

6. Special Contract Requirements

6.1 CONTRACT START-UP REQUIREMENTS:

6.1.1. The Contractor's start-up requirements must be completed prior to the commencement of the Contractor's treatment of VA enrolled patients. Upon approval by the VA of the Contractor's completion of the start-up requirements, the VA will issue a written Notice to Proceed to the Contractor.

6.1.2. The Contractor shall have 120 days from contract award to commencement of the provision of medical care to local Veterans. However, the Contractor must have all start-up requirements in place and ready to commence operation NLT 113 calendar days from contract award. The final seven (7) days will be used for training and resolution of any last minute or unexpected technical or personnel related challenges. The Contractor shall comply with the following contract requirements prior to commencement of clinical operations:

6.1.2.1. The Contractor shall hire, train, and ensure licensure of all necessary personnel.

6.1.2.2. The Contractor shall furnish evidence of insurability of the offeror and/or of all health-care providers, who will perform under this contract (see VAAR 852.237-7, Indemnification and Medical Liability Insurance).

6.1.2.3. All Contractor-provided health care services shall be available.

6.1.2.4. The Contractor's case management program with primary care providers as case managers for all health care services provided to enrolled patients shall be operational.

6.1.2.5. The Contractor's VA approved performance improvement program shall be operational.

6.1.2.6. The Contractor's facility shall be in compliance with the requirements of this contract.

6.1.3. The VA will provide training to the Contractor at the VA relative to data reporting needs, the VA EHR, eligibility issues, billing procedures and medical referral procedures within 89 calendar days of contract award. The Contractor is responsible to provide future training to his/her personnel after the initial 90 calendar days of the contract award. The Contractor must provide documentation of training prior to Pathology and Laboratory Medicine providing access to the VA EHR laboratory software options. The Contractor shall be responsible for attendance and performance regarding training sessions. Training will be coordinated by the COR and the Contractor's designee. After contract performance begins, VA staff is readily available by telephone and e-mail to answer questions and provide guidance.

6.1.4. Upon receipt of Notice of Award, Contractor shall immediately commence the credentialing and privileging process for all clinical staff through the VA. A minimum of 6

calendar weeks is required for VA credentialing after the package has been completed and received from the provider.

6.1.5. Patient Transportation: Each patient will be responsible for his/her own transportation to appointments.

6.1.6. Signage: The Contractor shall furnish and install clearly visible signage on the exterior of the building, in the front window, or on the door which displays the VA logo and reads: VA Salt Lake City Health Care System Primary Care Clinic

6.1.7. The Contractor shall provide the Contracting Officer with a diagram of the proposed sign which specifies dimensions and identifies the installation location for approval by the Contracting Officer prior to fabrication of the sign. The VA has renamed Community Based Outpatient Clinics, when necessary, to reflect the county in which they are located. At start up, this clinic will be called Roosevelt CBOC.

6.2. **BILLING CODES:** The Contractor shall adhere to the most current American Medical Association Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services' International Classification of Diseases (ICD) coding standards for all services provided. The Contractor shall submit accurate and complete CPT and ICD codes for each patient care encounter.

6.2.1. BILLABLE ROSTER:

6.2.1.1. Additions to Billable Roster

6.2.1.1.1. All enrollees are estimated in the quantity for the PC CLIN. Approximately 1/3 of the PC CLIN will be estimated for the MH CLIN (if there is a MH CLIN).

6.2.1.1.2. The ONLY time the contractor may bill against the MH CLIN is when Primary Care-Mental Health Integration (PC-MHI), and/or general/specialty MH services are provided by the contractor's professional MH staff under the 500 series (MH) stop coded clinics with separate CPT coded encounters. MH screening and services provided as part of primary care in a 300 series stop coded clinic are NOT billed against the MH CLIN.

6.2.1.1.3. "Professional MH Staff" eligible to provide services that will result in billing against the MH CLIN are: Psychologist, Psychiatrist, Licensed Clinical Social Worker (LCSW), MH Nurse Practitioner (NP), Mental Health Physician Assistant (PA), Licensed Professional Mental Health Counselor (LPMHC) and Marriage and Family Therapist.

6.2.1.1.4. The billable roster for the PC CLIN will include all patients assigned to the Contractor's site of care in the Patient Centered Management Module (PCMM) with at least one qualifying encounter by the Contractor's Primary Care Provider(s) (PCP) within the previous 12 months. For the purposes of this contract, a qualifying encounter is a completed encounter by a PCP and must have one of the following primary stop codes and **ANYTHING** in secondary credit code:

- 323 (Primary Care Medicine)

- 338 (Telephone Primary Care) [E0001]
- 348 (Primary Care Shared Appointment)

OR ANYTHING in primary stop code that is not on the list above and credit stop is:

- 179 (Real Time Clinical Video Telehealth to Home Provider Site)
- 322 (Comprehensive Women's Primary Care Clinic)
- 323 (Primary Care Medicine)

6.2.1.1.5. The billable roster for the MH CLIN (if there is a MH CLIN) will include all patients provided at least one Primary Care-Mental Health Integration and/or General/Specialty MH service by the Contractor's professional MH staff within the previous 12 months under a 500 series stop coded clinic with a separate CPT coded encounter.

6.2.1.1.6. VA has the sole authority to assign Veterans who are treated by the Contractor into the PCMM software program. Eligibility determination and enrollment of Veterans into VHA health care shall be the responsibility of the VA. The Contractor is responsible for notifying the VA of newly seen Veterans at the Contractor's site that are not already assigned in the PCMM software program. The VA will then verify that the Veteran was seen through the VA EHR documentation, and enter the Veteran into the PCMM software as credited to the Contractor's site and associated clinic roster upon verification with the Veteran of their intent to establish care at the Contractor's site.

6.2.1.1.7. If the Contractor seeks to request placement on the billable roster a Veteran at the Contractor's site who is already assigned to another primary care team or provider in the VHA, the VA will have final authority to assign the primary care site for the Veteran. The main basis for this decision will be Veteran preference. Veterans shall not be allowed to be assigned to more than one VA Outpatient Site of Care. In addition, Veterans will not be allowed to be assigned simultaneously at the Contractor's site and in any of the primary care teams at the VA. If the Veteran has an active PCMM assignment at another location, care provided will fall under the requirements in the Episodic Care for Unassigned/Unenrolled Patients section of this solicitation. If the Veteran is requesting transfer of care to the Contractor's site, VA will review the request in accordance with the VHA Directive 1406 Patient Centered Management Module (PCMM).

6.2.1.1.8. For Veterans newly assigned in PCMM, the Contractor shall be paid the monthly capitation rate for the full month in which the first Contractor's PCP qualifying encounter occurs. (See first paragraph in this section for more information on qualifying encounters). All payments shall be monthly in arrears.

6.2.1.2. Removal from Billable Roster

6.2.1.2.1. The Contractor is responsible for informing and confirming with the VA Veterans who no longer should be included on the billable roster at the Contractor's site. This includes Veterans who have died, moved to other areas, have decided to receive their primary care elsewhere or whom have not had at least one

Contractor's PCP qualifying encounter in the previous 12 months. Delayed notification that a Veteran should be removed from the billable roster for these reasons will result in offsets being taken against subsequent invoices. The Contractor shall notify VA of these circumstances in a timely manner. Delayed notification includes circumstances in which the Contractor or VA, through no fault of their own, do not receive such information until after the fact.

6.2.1.2.2. If a Veteran has a legitimate complaint and demands disenrollment for cause, payment shall be discontinued the month after the patient is reassigned in PCMM and Contractor is notified. If arbitration is necessary, clinical issues will be referred to the Executive Director of the contracted facility and the Chief, Primary Care Service of the VA. If a decision cannot be reached at the clinical level, referral shall be made to the CO for final determination. This decision shall be binding.

6.2.1.2.3. The Contractor shall contact the COR, or his designated representative, to discuss any issues, including possible removal from the billable roster, due to disruptive Veteran behavior. The COR, or the designated representative, will engage the VA Disruptive Behavior Committee to recommend the appropriate location for the Veteran to receive care.

6.2.1.2.4. The Contractor shall also notify VA of any of the following:

- Death of the Veteran.
- When a Veteran moves to another area.
- When a Veteran receives his/her primary care elsewhere.
- When a Veteran assigned to the Contractor's site of care in the Patient Centered Management Module (PCMM) does not receive at least one qualifying encounter by the Contractor's Primary Care Provider(s) (PCP) within the previous 12 months.
  NOTE: These circumstances may become known after the fact. Upon discovery of these situations, the Contractor shall credit or reimburse the VA back to the original date of the removal criteria being met for reasons above.

6.2.1.2.5. The VA has ultimate authority to remove a Veteran from the billable roster and from the responsibility of the Contractor at any time. The VA will notify the Veteran and the Contractor of the effective date of removal from the billable roster. Removal of Veterans from the Contractor's responsibility may occur, but not be limited to, the following reasons:

- The Veteran loses eligibility for VA care.
- The VA decides that removal from the billable roster is in the best interest of the Veteran.
- The Veteran was found to have falsified the application for VA services, and approval was based on false information.
- When it is determined that a Veteran has abused the VA system by allowing an ineligible person to utilize the Veteran's identification card to obtain services.

- When it is determined that the Veteran has willfully and repeatedly refused to comply with the Contractor's requirements or VA requirements, subject to federal laws and regulations.
- When it is determined that the Veteran has abused the VA program by using VA identification card to seek or obtain drugs or supplies illegally or for resale, subject to state and federal laws and regulations.
- When it is determined by VA's Disruptive Behavior Committee that it is not safe for the Veteran to receive care at Contractor's site.

6.2.1.2.6. The Contractor gives written notification to the VA that the Contractor cannot provide the necessary services to the Veteran or establish an appropriate provider Veteran relationship.

6.2.1.2.7. For Veterans removed from the billable roster under the "per Veteran[patient] per month (PPPM)" capitation payment method, the Contractor shall be paid the monthly capitation rate for the full month in which the date of removal occurred.

6.2.1.2.8. If the Contractor disagrees with a removal from the billable roster, the issue will be referred to the VA Contracting Officer for resolution. If such resolution is consistent with the other terms of the contract, the final decision of the CO is binding.

6.2.1.3. **Monthly Billable Roster and Invoice Reconciliation:** Monthly billable roster and invoice reconciliation shall take place as follows:

6.2.1.3.1. The VA shall present to the Contractor the VA billable roster for the applicable month to be invoiced.

6.2.1.3.2. The Contractor shall reconcile the VA billable roster with its records, negotiate any differences between its records and the VA billable roster, and invoice the VA.

6.2.1.3.3. The VA shall certify the Contractor's invoice.

6.2.1.3.4. No later than the seventh (7th) workday of each month, the VA Coordinator or the COR (or their designee) will submit to the contractor a list of Veteran names who properly meet the billing criteria. This list is the VA "billable roster" for the applicable month to be invoiced. This list will represent the Veterans for whom the VA is willing to provide payment for the previous month. This list will include the names of all Veterans who are assigned to the Contractor's site of care in PCMM and have had at least one qualifying encounter with Contractor's PCP within the previous 12 months. (Example: A list sent to the Contractor on October 7, 2009 will cover the time frame of October 1, 2008 through September 30, 2009.) This billable roster represents all Veterans assigned to Contractor's site of care in PCMM and have had at least one qualifying encounter with the Contractor's PCP within the previous 12 months minus any Veterans who may have been seen in that timeframe but have, in the meantime, died, moved to another location and do not plan to receive care at the particular site, or have transferred their care to either another

site, a VA Medical Center, or to a private medical practitioner, or who meet any of the remaining disenrollment categories.

6.2.1.3.5. The VA will also provide the Contractor with an alphabetically arranged lists of names of Veterans who were removed that month from the billable roster due to death, relocation, transfer of care, failure to have at least one qualifying encounter with the Contractor's PCP within the previous 12 months and/or any one of the reasons listed above. The list shall also include which disenrollment reason is applicable to the disenrolled Veteran.

6.2.1.3.6. Veteran names that come to either the VA' or the Contractor's attention "after the fact" will not only be removed from the current list of invoiced names, but the Contractor shall also credit or reimburse the VA for any previous months that may have passed during which time the VA and/or the Contractor were unaware of the Veteran's demise, relocation, receipt of health care at a different location or any other reason listed in above, for which the VA was paying the Contractor for perceived care.

6.2.1.3.7. The Contractor shall reconcile the VA billable roster with its records. Any perceived discrepancies identified by the Contractor, regarding the VA provided billable roster, will be required to be negotiated between the Contractor and the VA Coordinator/COR or the CO or their designee. The final Arbitrator to any disagreements between the Contactor and the VA regarding this billable roster is CO. CO decisions in this regard are final, if such decision is consistent with the other terms of the contract.

6.2.1.3.8. Upon receipt of an electronic invoice from the Contractor, based on the billable roster agreed upon and including supporting data, the VA will certify the invoice for payment. The Contractor shall have 30 calendar days from the date of invoice to justify any additions to the billable roster for the applicable month of invoice. After 30 calendar days, no further changes will be authorized for the applicable month's invoice.

6.2.2. **INVOICING AND PAYMENT**:

6.2.2.1. **Department of Labor Wage Determination** -The Service Contract Act of 1965 and the Department of Labor Wage Determination applies to the resultant contract(s) and is attached in Section D

6.2.2.2. **Payment in Full.** Costs are responsibility of parent VA contracting this service. The contractor shall accept payment for services rendered under this contract as payment in full. VA beneficiaries shall not under any circumstances be charged nor their insurance companies charged for services rendered by the Contractor, even if VA does not pay for those services. This provision shall survive the termination or ending of the contract. To the extent that the Veteran desires services which are not a VA benefit or covered under the terms of this contract, the Contractor must notify the Veteran that there will be a charge for such service and that the VA will not be responsible for payment. The contractor shall not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, any person or entity other than VA for services provided pursuant to this contract. It shall be considered fraudulent for the

Contractor to bill other third-party insurance sources (including Medicare) for services rendered to Veteran enrollees under this contract.

6.2.2.3. **Electronic Invoice Submission:** Invoices will be electronically submitted to the Tungsten website at https://www.tungsten-network.com/customer-campaigns/veterans-affairs/ Tungsten direct vendor support number is 877-489-6135 for VA contracts. The VA-FSC pays all associated transaction fees for VA orders. During Implementation (technical set-up) Tungsten will confirm your Tax Payer ID Number with the VA-FSC. This process can take up to 5 business days to complete to ensure your invoice is automatically routed to your Certifying Official for approval and payment. To successfully submit an invoice to VA-FSC please review "How to Create an Invoice" within the how to guides. All invoices submitted through Tungsten to the VA-FSC should mirror the current submission of Invoice, with the following items required. Clarification of additional requirements should be confirmed with your Certifying Official (your CO or buyer). Payments will only be made for actual services rendered. Payments shall be made monthly, in arrears. The Contractor shall be reimbursed at the capitation rate specified in the Supplies or Services and Prices/Costs Section. The VA-FSC requires specific information in compliance with the Prompt Pay Act and Business Requirements. The Contractor shall be reimbursed upon receipt of a proper invoice. Invoices must contain the following information:

6.2.2.3.1. Total number of listed Veterans from the previous month's invoice.

6.2.2.3.2. New Veterans added to the billable roster since the previous month's invoice.

6.2.2.3.3. Veterans removed from the billable roster since the previous month's invoice.

6.2.2.3.4. Number of Veterans (if any) whose dis-enrollments generate a credit, the amount of the credit, and the calculation(s) used to arrive at the credit.

6.2.2.3.5. Firm's Tax Payer ID Number (TIN)

6.2.2.3.6. Firm's "Remit Address" information

6.2.2.3.7. The VA Purchase Order (PO) number

6.2.2.3.8. Firm's contact information: (Personal Name, Email, and Phone)

6.2.2.3.9. VA point of contact information: (Personal Name, Email, and Phone)

6.2.2.3.10. The Period of Performance dates (Beginning and Ending)

6.2.2.3.11. All discount information if applicable (Percent and Date Terms)

6.2.2.3.12. For additional information, please contact:

6.2.2.3.12.1. **Tungsten Support Phone**: 1-877-489-6135 Website: https://www.tungsten-network.com/customer-campaigns/veterans-affairs/ **Department of Veterans Affairs Financial Service Center** Phone: 1-877-353-9791 Email: vafscched@va.gov

6.2.2.4. Veteran Patients determined to be ineligible for VA medical care will be billed by VA for the care rendered in accordance with VA regulations. VA shall reimburse the Contractor for one visit for patient or Veteran subsequently deemed ineligible by VA. Reimbursement will be at the Medicare rate in effect on date of service for the state of Utah for the CPT codes utilized during the initial visit. In accordance with the Description/Specifications/Work Statement Section, the VA is required to verify Veteran eligibility within twenty-four (24) hours from the time the Contractor requests an eligibility determination for each applicant.

6.2.2.5. The VA may deny payment for emergency medical services performed locally outside the Contractor's facility if the VA physician reviewing the Veteran's medical record determines that no emergency existed. The Contractor can appeal this determination in writing to the Contracting Officer by submitting supporting documentation. If a dispute still exists after Contractor's documentation is reviewed, the Contractor may file a claim under the Disputes clause of the contract, FAR 52.212-4(d).

6.2.3. PROCEDURE REGARDING THIRD PARTY RESOURCES:

6.2.3.1. The VA shall be entitled to and shall exercise full subrogation rights and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrolled Veterans under this contract and recover any such liability from the third party. If the Contractor has determined that third party liability exists for part or all the services provided directly by the Contractor to an enrolled patient, the Contractor shall make reasonable efforts to notify VA for recovery from third party liable sources the value of services rendered. All such cases will be referred to the MCCR Section at VA.

6.2.3.2. VA has the authority to bill insurance carriers for treatment provided to Veterans for non-service related conditions. Veterans presenting for care will be asked by the Contractor's staff to provide their insurance and/or Medicare card(s). Per the national mandate, the Contractor's staff will then scan the insurance cards (front and back) into the DSS program for processing. In the event the card is not able to be scanned, a photocopy of the front and back should be made and faxed to the MCCR Section at the VA Salt Lake City Health Care System. The copy of the card must be faxed no later than the end of the second business day the Veteran is seen. The system automatically requires update of this data every six months (180 days) unless the Veteran identifies a change in his insurance status. Contractor is not liable for data older than 6 months if Veteran has not visited. The Contractor shall review the health insurance information at the time of each clinic visit. The Contractor shall provide the VA with Veteran treatment information daily to facilitate third party billing. The Contractor shall also provide copies of medical records, at no charge, when requested by the VA to support billing.

6.3. CONTRACTOR SECURITY REQUIREMENTS (HANDBOOK 6500.6):

The contractor, their personnel, and their subcontractors shall be subject to the Federal laws, regulations, standards, and VA Directives and Handbooks regarding information and information system security as delineated in this contract. See attachment.