TO: SOUTHERN NEVADA DISTRICT BOARD OF HEALTH **DATE: March 23, 2017**

RE: *Approve Interlocal Contract with Clark County Social Services*

PETITION #08-17

That the Southern Nevada District Board of Health *approve an Interlocal Contract between the Southern Nevada Health District (SNHD) and the Clark County Social Services (CCSS) to provide Medical Core and Support Services to people living with and affected by HIV/AIDS residing in the Las Vegas Ryan White Transitional Grant Area (TGA).*

PETITIONERS:

Fermin Leguen, MD, MPH, *Director of Clinical Services*
Andrew J. Glass, FACHE, MS, *Director of Administration*
Joseph P. Iser, MD, DrPH, MSc, *Chief Health Officer*

DISCUSSION:

This Interlocal Contract covers the Ryan White Part A grant award received from HRSA through CCSS for the period of March 1, 2017 to February 28, 2018, with the option to renew for four (4), one-year periods subject to contract provisions. SNHD will provide a range of core and support services including Outpatient/Ambulatory Health Services, Early Intervention Services, Medical Case Management, Substance Abuse Outpatient Care, and Emergency Financial Assistance.

FUNDING:

The one year funding will be issued by CCSS to SNHD in the form of a purchase order, not to exceed amount based upon the allocated amount per service category by the Las Vegas TGA Ryan White Planning Council.

CLARK COUNTY, NEVADA

CONTRACT FOR MEDICAL CORE & SUPPORT SERVICES FOR HIV/AIDS INFECTED & AFFECTED CLIENTS IN LAS VEGAS, RYAN WHITE, TRANSITIONAL GRANT AREA RFP NO. 604274-16

SOUTHERN NEVADA HEALTH DISTRICT
NAME OF FIRM
Lourdes, Yapjoco
DESIGNATED CONTACT, NAME AND TITLE (Please type or print)
PO Box 3902 Las Vegas, Nevada 89127
ADDRESS OF FIRM INCLUDING CITY, STATE AND ZIP CODE
(702) 759-0799
(AREA CODE) AND TELEPHONE NUMBER
N/A
(AREA CODE) AND FAX NUMBER
yapjoco@snhdmail.org
E-MAIL ADDRESS

CONTRACT FOR MEDICAL CORE & SUPPORT SERVICES FOR HIV/AIDS INFECTED & AFFECTED CLIENTS IN LAS VEGAS, RYAN WHITE, TRANSITIONAL GRANT AREA

This Contract is made and entered into this ____ day of ________ 20__, by and between CLARK COUNTY, NEVADA (hereinafter referred to as COUNTY), and SOUTHERN NEVADA HEALTH DISTRICT (hereinafter referred to as PROVIDER), for Medical Core & Support Services for HIV/AIDS Infected & Affected Clients in Las Vegas, Ryan White, Transitional Grant Area (hereinafter referred to as PROJECT).

W I T N E S S E T H:

WHEREAS, the PROVIDER has the required licenses and/or authorizations pursuant to all federal, State of Nevada and local laws in order to conduct business relative to this Contract.

WHEREAS, the PROVIDER has the personnel and resources necessary to accomplish the SERVICES as described in **Exhibit A,** Scope of Work, Outpatient/Ambulatory Health Services, Early Intervention Services, Medical Case Management, Substance Abuse Outpatient Care and Emergency Financial Assistance and Standard(s) of Care.

WHEREAS, the PROVIDER and OWNER stipulate that total payment for services performed under this contract by PROVIDER cannot exceed the amount of funds appropriated annually;

WHEREAS, all funds are dependent upon the Health Resources and Services Administration of the U.S. Department of Health and Human Services (hereinafter referred to as "HRSA") as a Transitional Grant Area (TGA) for TREATMENT EXTENSION ACT funding;

WHEREAS, pursuant to the authority granted by NRS 277.180, COUNTY and AGENCY may enter into agreements for the performance of governmental services; and (GOVERNMENT AGENCY ONLY)

WHEREAS, PROVIDER has the required licenses and/or authorizations pursuant to all federal, State of Nevada and local laws in order to conduct business relative to this Contract.

NOW, THEREFORE, COUNTY and PROVIDER agree as follows:

SECTION I: TERM OF CONTRACT

COUNTY agrees to retain PROVIDER for the period from date of award through February 28, 2018, with the option to renew for four (4), one -year period subject to the provisions of Sections II and VIII herein. During this period, PROVIDER agrees to provide services as required by COUNTY within the scope of this Contract.

SECTION II: COMPENSATION AND TERMS OF PAYMENT

A. Compensation

COUNTY agrees to pay PROVIDER for the performance of services described in the Scope of Work (Exhibit A, Outpatient/Ambulatory Health Services, Early Intervention Services, Medical Case Management, Substance Abuse Outpatient Care, Emergency Financial Assistance Standards of Care and Exhibit E Request for Reimbursement), for the not-to-exceed amount issued in accordance with appropriated funds issued via purchase order. COUNTY will issue an award letter for the annual not-to-exceed amount based upon the allocated amount per service category by the Las Vegas TGA Ryan White Part A Planning Council. Non-profit PROVIDER may draw down advance program money once at the commencement of the yearly PROJECT for each year of the CONTRACT. Such advance shall not exceed an amount equal to two months of the yearly PROJECT budget dependent on COUNTY determination of need and types of expenses. Requests for any advance must be submitted in writing on the letterhead of the requesting organization and bear the original signature of an authorized representative. COUNTY reserves the right to require any and all expenditures of advance funds to be fully documented prior to approving any reimbursements.

It is expressly understood that the entire work defined in Exhibit A must be completed by the PROVIDER and it shall be the PROVIDER'S responsibility to ensure that hours and tasks are properly budgeted so the entire PROJECT is completed for the said fee.

B. Progress Payments

PROVIDER will be entitled to periodic payments for work completed in accordance with the completion of tasks indicated in the Scope of Work (Exhibit A).

C. Terms of Payments

1. Each invoice received by COUNTY must include a Progress Report based on actual work performed to date in accordance with the completion of tasks indicated in Exhibit A, Scope of Work.
2. Payment of invoices will be made within thirty (30) calendar days after receipt of an accurate invoice that has been reviewed and approved COUNTY.
3. COUNTY, at its discretion, may not approve or issue payment on invoices if PROVIDER fails to provide the following information required on each invoice:
   a. The title of the PROJECT as stated in Exhibit A, Scope of Work, COUNTY'S Contract Number, Project Number, Purchase Order Number, Invoice Date, Invoice Period, Invoice Number, and the Payment Remittance Address.
   b. Expenses not defined in Exhibit A, Scope of Work, or expenses greater than the per diem rates will not be paid without prior written authorization by COUNTY.
   c. COUNTY'S representative shall notify PROVIDER in writing within fourteen (14) calendar days of any disputed amount included on the invoice. PROVIDER must submit a new invoice for the undisputed amount which will be paid in accordance with paragraph C.2 above. Upon mutual resolution of the disputed amount PROVIDER will submit a new invoice for the agreed to amount and payment will be made in accordance with paragraph C.2 above.
4. No penalty will be imposed on COUNTY if COUNTY fails to pay PROVIDER within thirty (30) calendar days after receipt of a properly documented invoice, and COUNTY will receive no discount for payment within that period.
5. In the event that legal action is taken by COUNTY or PROVIDER based on a disputed payment, the prevailing party shall be entitled to reasonable attorneys' fees and costs subject to COUNTY'S available unencumbered budgeted appropriations for the PROJECT.
6. COUNTY shall subtract from any payment made to PROVIDER all damages, costs and expenses caused by PROVIDER'S negligence, resulting from or arising out of errors or omissions in PROVIDER'S work products, which have not been previously paid to PROVIDER.
7. COUNTY shall not provide payment on any invoice PROVIDER submits after six (6) months from the date PROVIDER performs services, provides deliverables, and/or meets milestones, as agreed upon in Exhibit A, Scope of Work.
8. Invoices shall be submitted to: Ryan White Part A Program, 1600 Pinto Lane, Las Vegas, NV 89106.
9. COUNTY offers electronic payments to all suppliers. Payments will be deposited directly into your bank account via the Automated Clearing House (ACH) network. PROVIDER will be provided information on how to enroll at time of award.

D. County's Fiscal Limitations

1. The content of this section shall apply to the entire Contract and shall take precedence over any conflicting terms and conditions, and shall limit COUNTY'S financial responsibility as indicated in Sections 2 and 3 below.
2. Notwithstanding any other provisions of this Contract, this Contract shall terminate and COUNTY'S obligations under it shall be extinguished at the end of the fiscal year in which COUNTY fails to appropriate monies for the ensuing fiscal year sufficient for the payment of all amounts which will then become due.
3. COUNTY'S total liability for all charges for services which may become due under this Contract is limited to the total maximum expenditure(s) authorized in COUNTY'S purchase order(s) to PROVIDER.

SECTION III: SCOPE OF WORK

Services to be performed by PROVIDER for the PROJECT shall consist of the work described in the Scope of Work as set forth in Exhibit A of this Contract, attached hereto.

SECTION IV: CHANGES TO SCOPE OF WORK

A. COUNTY may at any time, by written order, make changes within the general scope of this Contract and in the services or work to be performed. If such changes cause an increase or decrease in PROVIDER'S cost or time required for performance of any services under this Contract, an equitable adjustment limited to an amount within current unencumbered budgeted appropriations for the PROJECT shall be made and this Contract shall be modified in writing accordingly. Any claim of PROVIDER for the adjustment under this clause must be submitted in writing within thirty (30) calendar days from the date of receipt by PROVIDER of notification of change unless COUNTY grants a further period of time before the date of final payment under this Contract.

B. No services for which an additional compensation will be charged by PROVIDER shall be furnished without the written authorization of COUNTY.

SECTION V: RESPONSIBILITY OF PROVIDER

A. It is understood that in the performance of the services herein provided for, PROVIDER shall be, and is, an independent contractor, and is not an agent, representative or employee of COUNTY and shall furnish such services in its own manner and method except as required by this Contract. Further, PROVIDER has and shall retain the right to exercise full control over the employment, direction, compensation and discharge of all persons employed by PROVIDER in the performance of the services hereunder. PROVIDER shall be solely responsible for, and shall indemnify, defend and hold COUNTY harmless from all matters relating to the payment of its employees, including compliance with social security, withholding and all other wages, salaries, benefits, taxes, demands, and regulations of any nature whatsoever.

B. PROVIDER shall appoint a Manager, upon written acceptance by COUNTY, who will manage the performance of services. All of the services specified by this Contract shall be performed by the Manager, or by PROVIDER'S associates and employees under the personal supervision of the Manager. Should the Manager, or any employee of PROVIDER be unable to complete his or her responsibility for any reason, PROVIDER must obtain written approval by COUNTY prior to replacing him or her with another equally qualified person. If PROVIDER fails to make a required replacement within thirty (30) calendar days, COUNTY may terminate this Contract for default.

C. PROVIDER has, or will, retain such employees as it may need to perform the services required by this Contract. Such employees shall not be employed by COUNTY.

D. PROVIDER agrees that its officers and employees will cooperate with COUNTY in the performance of services under this Contract and will be available for consultation with COUNTY at such reasonable times with advance notice as to not conflict with their other responsibilities.

E. PROVIDER will follow COUNTY'S standard procedures as followed by COUNTY'S staff in regard to programming changes; testing; change control; and other similar activities.

F. PROVIDER shall be responsible for the professional quality, technical accuracy, timely completion, and coordination of all services furnished by PROVIDER, its subcontractors and its and their principals, officers, employees and agents under this Contract. In performing the specified services, PROVIDER shall follow practices consistent with generally accepted professional and technical standards.

G. It shall be the duty of PROVIDER to assure that all products of its effort are technically sound and in conformance with all pertinent Federal, State and Local statutes, codes, ordinances, resolutions and other regulations. PROVIDER will not produce a work product which violates or infringes on any copyright or patent rights. PROVIDER shall, without additional compensation, correct or revise any errors or omissions in its work products.

   1. Permitted or required approval by COUNTY of any products or services furnished by PROVIDER shall not in any way relieve PROVIDER of responsibility for the professional and technical accuracy and adequacy of its work.

2. COUNTY's review, approval, acceptance, or payment for any of PROVIDER'S services herein shall not be construed to operate as a waiver of any rights under this Contract or of any cause of action arising out of the performance of this Contract, and PROVIDER shall be and remain liable in accordance with the terms of this Contract and applicable law for all damages to COUNTY caused by PROVIDER'S performance or failures to perform under this Contract.

H. All materials, information, and documents, whether finished, unfinished, drafted, developed, prepared, completed, or acquired by PROVIDER for COUNTY relating to the services to be performed hereunder and not otherwise used or useful in connection with services previously rendered, or services to be rendered, by PROVIDER to parties other than COUNTY shall become the property of COUNTY and shall be delivered to COUNTY'S representative upon completion or termination of this Contract, whichever comes first. PROVIDER shall not be liable for damages, claims, and losses arising out of any reuse of any work products on any other project conducted by COUNTY. COUNTY shall have the right to reproduce all documentation supplied pursuant to this Contract.

I. The rights and remedies of COUNTY provided for under this section are in addition to any other rights and remedies provided by law or under other sections of this Contract.

J. PROVIDER shall comply with Federal Requirements in Exhibit F.

SECTION VI: SUBCONTRACTS

A. Services specified by this Contract shall not be subcontracted by PROVIDER, without prior written approval of COUNTY.

B. Approval by COUNTY of PROVIDER'S request to subcontract, or acceptance of, or payment for, subcontracted work by COUNTY shall not in any way relieve PROVIDER of responsibility for the professional and technical accuracy and adequacy of the work. PROVIDER shall be and remain liable for all damages to COUNTY caused by negligent performance or non-performance of work under this Contract by PROVIDER'S subcontractor or its sub-subcontractor.

C. The compensation due under Section II shall not be affected by COUNTY'S approval of PROVIDER'S request to subcontract.

SECTION VII: RESPONSIBILITY OF COUNTY

A. COUNTY agrees that its officers and employees will cooperate with PROVIDER in the performance of services under this Contract and will be available for consultation with PROVIDER at such reasonable times with advance notice as to not conflict with their other responsibilities.

B. The services performed by PROVIDER under this Contract shall be subject to review for compliance with the terms of this Contract by COUNTY'S representative, Alisha Barrett, Grant Administrator, Social Services, telephone number (702) 455-1071 or their designee. COUNTY'S representative may delegate any or all of his responsibilities under this Contract to appropriate staff members, and shall so inform PROVIDER by written notice before the effective date of each such delegation.

C. The review comments of COUNTY'S representative may be reported in writing as needed to PROVIDER. It is understood that COUNTY'S representative's review comments do not relieve PROVIDER from the responsibility for the professional and technical accuracy of all work delivered under this Contract.

D. COUNTY shall assist PROVIDER in obtaining data on documents from public officers or agencies, and from private citizens and/or business firms, whenever such material is necessary for the completion of the services specified by this Contract.

E. PROVIDER will not be responsible for accuracy of information or data supplied by COUNTY or other sources to the extent such information or data would be relied upon by a reasonably prudent PROVIDER.

SECTION VIII: TIME SCHEDULE

A. Time is of the essence of this Contract.

B. If PROVIDER'S performance of services is delayed or if PROVIDER'S sequence of tasks is changed, PROVIDER shall notify COUNTY'S representative in writing of the reasons for the delay and prepare a revised schedule for performance of services. The revised schedule is subject to COUNTY'S written approval.

SECTION IX: SUSPENSION AND TERMINATION

A. Suspension

COUNTY may suspend performance by PROVIDER under this Contract for such period of time as COUNTY, at its sole discretion, may prescribe by providing written notice to PROVIDER at least 10 working days prior to the date on which COUNTY wishes to suspend. Upon such suspension, COUNTY shall pay PROVIDER its compensation, based on the percentage of the PROJECT completed and earned until the effective date of suspension, less all previous payments. PROVIDER shall not perform further work under this Contract after the effective date of suspension until receipt of written notice from COUNTY to resume performance. In the event COUNTY suspends performance by PROVIDER for any cause other than the error or omission of the PROVIDER, for an aggregate period in excess of thirty (30) days, PROVIDER shall be entitled to an equitable adjustment of the compensation payable to PROVIDER under this Contract to reimburse PROVIDER for additional costs occasioned as a result of such suspension of performance by COUNTY based on appropriated funds and approval by COUNTY.

B. Termination

1. This Contract may be terminated in whole or in part by either party in the event of substantial failure or default of the other party to fulfill its obligations under this Contract through no fault of the terminating party; but only after the other party is given:
   a. not less than ten (10) calendar days written notice of intent to terminate; and
   b. an opportunity for consultation with the terminating party prior to termination.
2. Termination for Convenience
   a. This Contract may be terminated in whole or in part by COUNTY for its convenience; but only after PROVIDER is given:
      i. not less than ten (10) calendar days written notice of intent to terminate; and
      ii. an opportunity for consultation with COUNTY prior to termination.
   b. If termination is for COUNTY'S convenience, COUNTY shall pay PROVIDER that portion of the compensation which has been earned as of the effective date of termination but no amount shall be allowed for anticipated profit on performed or unperformed services or other work.
3. Termination for Default
   a. If termination for substantial failure or default is effected by COUNTY, COUNTY will pay PROVIDER that portion of the compensation which has been earned as of the effective date of termination but:
      i. No amount shall be allowed for anticipated profit on performed or unperformed services or other work; and
      ii. Any payment due to PROVIDER at the time of termination may be adjusted to the extent of any additional costs occasioned to COUNTY by reason of PROVIDER'S default.
   b. Upon receipt or delivery by PROVIDER of a termination notice, PROVIDER shall promptly discontinue all services affected (unless the notice directs otherwise) and deliver or otherwise make available to COUNTY'S representative, copies of all deliverables as provided in Section V, paragraph H.
   c. If after termination for failure of PROVIDER to fulfill contractual obligations it is determined that PROVIDER has not so failed, the termination shall be deemed to have been effected for the convenience of COUNTY.
4. Upon termination, COUNTY may take over the work and execute the same to completion by agreement with another party or otherwise. In the event PROVIDER shall cease conducting business, COUNTY shall have the right to make an unsolicited offer of employment to any employees of PROVIDER assigned to the performance of this Contract.
5. The rights and remedies of COUNTY and PROVIDER provided in this section are in addition to any other rights and remedies provided by law or under this Contract.

6. Neither party shall be considered in default in the performance of its obligations hereunder, nor any of them, to the extent that performance of such obligations, nor any of them, is prevented or delayed by any cause, existing or future, which is beyond the reasonable control of such party. Delays arising from the actions or inactions of one or more of PROVIDER'S principals, officers, employees, agents, subcontractors, vendors or suppliers are expressly recognized to be within PROVIDER'S control.

SECTION X: NOTICES

Any notice required to be given hereunder shall be deemed to have been given when received by the party to whom it is directed by personal service, hand delivery, certified U.S. mail, return receipt requested or facsimile, at the following addresses:

TO COUNTY:
Department of Social Service
Attn: Ryan White Program Part A
1600 Pinto Lane
Las Vegas Nevada 89106

TO PROVIDER:
Southern Nevada Health District
Attn: Lourdes Yapjoco
PO Box 3902
Las Vegas, Nevada 89127

SECTION XI: MISCELLANEOUS

A. Independent Contractor

PROVIDER acknowledges that PROVIDER and any subcontractors, agents or employees employed by PROVIDER shall not, under any circumstances, be considered employees of COUNTY, and that they shall not be entitled to any of the benefits or rights afforded employees of COUNTY, including, but not limited to, sick leave, vacation leave, holiday pay, Public Employees Retirement System benefits, or health, life, dental, long-term disability or workers' compensation insurance benefits. COUNTY will not provide or pay for any liability or medical insurance, retirement contributions or any other benefits for or on behalf of PROVIDER or any of its officers, employees or other agents.

B. Immigration Reform and Control Act

In accordance with the Immigration Reform and Control Act of 1986, PROVIDER agrees that it will not employ unauthorized aliens in the performance of this Contract.

C. Non-Discrimination/Public Funds

The BCC is committed to promoting full and equal business opportunity for all persons doing business in Clark County. PROVIDER acknowledges that COUNTY has an obligation to ensure that public funds are not used to subsidize private discrimination. PROVIDER recognizes that if they or their subcontractors are found guilty by an appropriate authority of refusing to hire or do business with an individual or company due to reasons of race, color, religion, sex, sexual orientation, gender identity or gender expression, age, disability, national origin, or any other protected status, COUNTY may declare PROVIDER in breach of the Contract, terminate the Contract, and designate PROVIDER as non-responsible.

D. Assignment

Any attempt by PROVIDER to assign or otherwise transfer any interest in this Contract without the prior written consent of COUNTY shall be void.

E. Indemnity

PROVIDER does hereby agree to defend, indemnify, and hold harmless COUNTY and the employees, officers and agents of COUNTY from any liabilities, damages, losses, claims, actions or proceedings, including, without limitation, reasonable attorneys' fees, that are caused by the negligence, errors, omissions, recklessness or intentional misconduct of PROVIDER or the employees or agents of PROVIDER in the performance of this Contract.

F. Governing Law

Nevada law shall govern the interpretation of this Contract.

G. Gratuities

1. COUNTY may, by written notice to PROVIDER, terminate this Contract if it is found after notice and hearing by COUNTY that gratuities (in the form of entertainment, gifts, or otherwise) were offered or given by PROVIDER or any agent or representative of PROVIDER to any officer or employee of COUNTY with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending or making of any determinations with respect to the performance of this Contract.

2. In the event this Contract is terminated as provided in paragraph 1 hereof, COUNTY shall be entitled:

   a. to pursue the same remedies against PROVIDER as it could pursue in the event of a breach of this Contract by PROVIDER; and

   b. as a penalty in addition to any other damages to which it may be entitled by law, to exemplary damages in an amount (as determined by COUNTY) which shall be not less than three (3) nor more than ten (10) times the costs incurred by PROVIDER in providing any such gratuities to any such officer or employee.

3. The rights and remedies of COUNTY provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

H. Audits

The performance of this Contract by PROVIDER is subject to review by COUNTY to insure contract compliance. PROVIDER agrees to provide COUNTY any and all information requested that relates to the performance of this Contract. All requests for information will be in writing to PROVIDER. Time is of the essence during the audit process. Failure to provide the information requested within the timeline provided in the written information request may be considered a material breach of Contract and be cause for suspension and/or termination of the Contract.

I. Covenant

PROVIDER covenants that it presently has no interest and that it will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Contract. PROVIDER further covenants, to its knowledge and ability, that in the performance of said services no person having any such interest shall be employed.

J. Confidential Treatment of Information

PROVIDER shall preserve in strict confidence any information obtained, assembled or prepared in connection with the performance of this Contract.

K. ADA Requirements

All work performed or services rendered by PROVIDER shall comply with the Americans with Disabilities Act standards adopted by Clark County. All facilities built prior to January 26, 1992 must comply with the Uniform Federal Accessibility Standards; and all facilities completed after January 26, 1992 must comply with the Americans with Disabilities Act Accessibility Guidelines.

L. Subcontractor Information

PROVIDER shall provide a list of the Minority-Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Physically-Challenged Business Enterprise (PBE), Small Business Enterprise (SBE), Veteran Business Enterprise (VET), Disabled Veteran Business Enterprise (DVET), and Emerging Small Business Enterprise (ESB) subcontractors for this Contract utilizing the attached format (Exhibit C). The information provided in Exhibit C by PROVIDER is for COUNTY'S information only.

M. Authority

COUNTY is bound only by COUNTY agents acting within the actual scope of their authority. COUNTY is not bound by actions of one who has apparent authority to act for COUNTY. The acts of COUNTY agents which exceed their contracting authority do not bind COUNTY.

N. Force Majeure

PROVIDER shall be excused from performance hereunder during the time and to the extent that it is prevented from obtaining, delivering, or performing, by acts of God, fire, war, loss or shortage of transportation facilities, lockout or commandeering of raw materials, products, plants or facilities by the government. PROVIDER shall provide COUNTY satisfactory evidence that nonperformance is due to cause other than fault or negligence on its part.

O. Severability

If any terms or provisions of CONTRACT shall be found to be illegal or unenforceable, then such term or provision shall be deemed stricken and the remaining portions of CONTRACT shall remain in full force and effect.

P. HIPAA - CONFIDENTIALITY REGARDING PARTICIPANTS

PROVIDER shall maintain the confidentiality of any information relating to participants, COUNTY Employees, or third parties,(added) in accordance with any applicable laws and regulations, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Attached hereto as **Exhibit G**, and incorporated by reference herein, is a HIPAA Business Associate Agreement, executed by the parties in accordance with the requirements of this sub-section. PROVIDER agrees to sign the attached HIPAA Business Associate Agreement" prior to award of Contract.

Q. Non-Endorsement

As a result of the selection of PROVIDER to supply goods or services, COUNTY is neither endorsing nor suggesting that PROVIDER'S service is the best or only solution. PROVIDER agrees to make no reference to COUNTY in any literature, promotional material, brochures, sales presentations, or the like, without the express written consent of COUNTY.

R. Public Records

COUNTY is a public agency as defined by state law, and as such, is subject to the Nevada Public Records Law (Chapter 239 of the Nevada Revised Statutes). Under the law, all of COUNTY'S records are public records (unless otherwise declared by law to be confidential) and are subject to inspection and copying by any person. All bid documents are available for review following the bid opening.

IN WITNESS WHEREOF, the parties have caused this Contract to be executed the day and year first above written.

SOUTHERN NEVADA HEALTH DISTRICT

By: ______________________________

ANDREW J. GLASS, FACHE, MS
Director of Administration

Date: ______________________________

APPROVED AS TO FORM:

By: ______________________________

ANNETTE L. BRADLEY, ESQ.
Attorney for Southern Nevada Health District

Date: 3/16/2017

CLARK COUNTY, NEVADA

By: ______________________________

STEVE SISOLAK, Chairman
Board of County Commissioners

Date: ______________________________

ATTEST:

By: ______________________________

LYNN GOYA,
COUNTY Clerk

Date: ______________________________

APPROVED AS TO FORM:
Steven B. Wolfson, District Attorney

By: ______________________________

ELIZABETH VIBERT
Deputy District Attorney

Date: ______________________________

EXHIBIT A
MEDICAL CORE & SUPPORT SERVICES FOR HIV/AIDS INFECTED & AFFECTED CLIENTS IN LAS VEGAS, RYAN WHITE, TRANSITIONAL GRANT AREA
SCOPE OF WORK

Scope of Project

Funds are provided by U.S. Department of Health and Human Services, Health Resources and Services Administration, Ryan White HIV/AIDS Treatment Extension Act of 2009 known as the Ryan White HIV/AIDS Program (RWHAP). The HIV Emergency Relief Grant Program Part A: Eligible Metropolitan Areas/Transitional Grant Areas HRSA Announcement No: HRSA-17-030 Catalog of Federal Domestic Assistance (CFDA) No. 93.914. Las Vegas Ryan White Transitional Grant Area (TGA) includes Mohave County, Arizona, Clark County and Nye County, Nevada.

Funds for Grant Year March 1, 2017-February 28, 2018 are contingent upon receipt of Grant Award funds from Health Resources and Services Administration to the Las Vegas Ryan White TGA.

The purpose of this section is to provide a description of how your agency plans to utilize the allocated funding to provide the highest quality of service based on the HHS Treatment Guidelines, the Health Resources and Services Administration (HRSA) mandated core and support service categories, the Las Vegas TGA Planning Council approved Standards of Care and the HSRA required National Monitoring Standards to meet the client's need(s). The timeframe for the contract is March 1, 2017 – February 28, 2018.

PROPOSER(S) may submit a proposal for one and up to all service categories listed.

Listed below are the Grant service categories approved and deemed fundable by the Health Resources and Services Administration (HRSA). Please note that the service categories have been separated by HRSA as "Core and Support Services." All PROPOSERS may apply for one or multiple service categories (i.e., medical case management and medical nutritional therapy). Refer to the Las Vegas TGA Planning Council approved Standard of Care for each service category for a description of the required level of service and service category requirement(s). (SEE EXHIBIT A – ATTACHMENT 1)

The Conceptual Treatment of Project and Work Plan template is required for each core and support service category applied for.

Core Service Categories:

1. Outpatient/Ambulatory Health Services

Description:

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

2. Oral Health Care

Description:

Oral Health Care services provide outpatient diagnostic, preventive, and therapeutic services by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants.

3. Early Intervention Services (EIS)

Description:

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

RWHAP Parts A and B EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
  - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - **<u>HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources</u>**
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

4. Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals

Description:

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program.

The service provision consists of either or both of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services and pharmacy benefits that provide a full range of HIV medications for eligible clients, not currently covered by Part B
- Paying cost-sharing (copay, co-insurance, deductible) on behalf of the client for Physician appointments and labs.

5. Medical Nutrition Therapy

Description:

Medical Nutrition Therapy includes:

- Nutrition assessment and screening
- Dietary/nutritional evaluation
- Food and/or nutritional supplements per medical provider's recommendation
- Nutrition education and/or counseling

These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Program Guidance:

All services performed under this service category must be pursuant to a medical provider's referral and based on a nutritional plan developed by the registered dietitian or other licensed nutrition professional.

6. Mental Health Services

Description:

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers.

Program Guidance:

Mental Health Services are allowable only for HIV-infected clients.

7. Substance Abuse Outpatient Care

Description:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

8. Medical Case Management, including Treatment Adherence Services

Description:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:

Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

Support Service Categories

1. Emergency Financial Assistance

Description:

Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:

Direct cash payments to clients are not permitted.
It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

2. Food Bank/Home Delivered Meals

Description:

Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. This also includes the provision of essential non-food items that are limited to the following:

- Personal hygiene products
- Household cleaning supplies
- Water filtration/purification systems in communities where issues of water safety exist

Program Guidance:

Unallowable costs include household appliances, pet foods, and other non-essential products. Nutritional services and nutritional supplements provided by a registered dietitian are considered a core medical service provided under Medical Nutrition Therapy service category.

3. Health Education/Risk Reduction

Description:

Health Education/Risk Reduction is the provision of education to clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes sharing information about medical and psychosocial support services and counseling with clients to improve their health status. Topics covered may include:

- Education on risk reduction strategies to reduce transmission such as pre-exposure prophylaxis (PrEP) for clients' partners and treatment as prevention
- Education on health care coverage options (e.g., qualified health plans through the Marketplace, Medicaid coverage, Medicare coverage)
- Health literacy
- Treatment adherence education

Program Guidance:

Health Education/Risk Reduction services cannot be delivered anonymously.

4. Housing

Description:

Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance. Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:

- Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
- Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Sub-recipients must have mechanisms in place to allow newly identified clients access to housing services. Sub-recipients must assess every client's housing needs at least annually to determine the need for new or additional services. In addition, sub-recipients must develop an individualized housing plan for each client receiving housing services and update it annually. Sub-recipients must provide the Recipient a copy of the individualized written housing plan upon request. Housing services cannot be in the form of direct cash payments to clients and cannot be used for mortgage payments.

5. Medical Transportation

Description:

Medical Transportation is the provision of nonemergency transportation services that enables an eligible client to access or be retained in core medical and support services.

Program Guidance:

Medical transportation may be provided through:

- o Contracts with providers of transportation services
- o Mileage reimbursement (through a non-cash system) that enables clients to travel to needed medical or other support services, but should not in any case exceed the established rates for federal Programs
- o Purchase or lease of organizational vehicles for client transportation programs, <u>provided the recipient receives prior approval for the purchase of a vehicle</u>
- o Voucher or token systems

Unallowable costs include:

- o Direct cash payments or cash reimbursements to clients
- o Direct maintenance expenses (tires, repairs, etc.) of a privately-owned vehicle
- o Any other costs associated with a privately-owned vehicle such as lease, loan payments, insurance, license, or registration fees

6. Psychosocial Support Services

Description:

Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:

- o Bereavement counseling
- o Child abuse and neglect counseling
- o HIV support groups
- o Nutrition counseling provided by a non-registered dietitian (*see* Medical Nutrition Therapy Services)
- o Pastoral care/counseling services

Program Guidance:

Funds under this service category may not be used to provide nutritional supplements (*See* Food Bank/Home Delivered Meals and Medical Nutrition Therapy).

RWHAP-funded pastoral counseling must be available to all eligible clients regardless of their religious denominational affiliation.

Funds may not be used for social/recreational activities or to pay for a client's gym membership.

Additional Information related to use of Gift Cards under any Applicable Service Category:

Where direct provision of the service is not possible or effective, store gift cards (Store gift cards that can be redeemed at one merchant or an affiliated group of merchants for specific goods or services that further the goals and objectives of the Ryan White HIV/AIDS Program are allowable as incentives for eligible program participants), vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used.

Sub-recipients must include in the Conceptual Treatment of Project and Work Plan if applicable the method which the administration of the voucher and/or store gift card programs will assure that vouchers and store gift cards cannot be exchanged for cash or used for anything other than the allowable goods or services, and that systems are in place to account for disbursed vouchers and store gift cards. General-use prepaid cards are considered "cash equivalent" and are therefore unallowable. Such cards generally bear the logo of a payment network, such as Visa, MasterCard, or American

Express, and are accepted by any merchant that accepts those credit or debit cards as payment. Gift cards that are cobranded with the logo of a payment network and the logo of a merchant or affiliated group of merchants are general-use prepaid cards, not store gift cards, and therefore are unallowable.

Unallowable Costs under all service categories:

Ryan White HIV/AIDS Program (RWHAP) funds may not be used to make cash payments to intended clients of RWHAP-funded services. This prohibition includes cash incentives and cash intended as payment for RWHAP core medical and support services.

Other unallowable costs include:

- Clothing
- Employment and Employment-Readiness Services
- Funeral and Burial Expenses
- Property Taxes

Las Vegas Transitional Grant Area Planning Council

EMERGENCY FINANCIAL ASSISTANCE

STANDARDS OF CARE

LAS VEGAS TGA
PART A HIV/AIDS PROGRAM
CLARK | MOHAVE | NYE COUNTIES

Originated	Ratified	Revised
March 2011	November 2012	May 2016

1. HRSA Service Definition

Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program. Ryan White HIV/AIDS Program funds may be used to provide Emergency Financial Assistance (EFA) as an allowable support service.

- The decision-makers deliberately and clearly must set priorities and delineate and monitor what part of the overall allocation for emergency assistance is obligated for transportation, food, essential utilities, and/or prescription assistance. Careful monitoring of expenditures within a category of "emergency assistance" is necessary to assure that planned amounts for specific services are being implemented, and to indicate when reallocations may be necessary.
- In addition, Grantees and planning councils/consortia must develop standard limitations on the provision of Ryan White HIV/AIDS Program funded emergency assistance to eligible individuals/households and mandate their consistent application by all contractors. It is expected that all other sources of funding in the community for emergency assistance will be effectively utilized and that any allocation of Ryan White HIV/AIDS Program funds to these purposes will be the payer-of-last-resort, and for limited amounts, limited use and limited periods of time.

Allowable: Vision Care: To pay the cost of corrective prescription eye wear for eligible clients through a Ryan White HIV/AIDS Program supported Emergency Financial Assistance Program

Funds awarded under the Ryan White HIV/AIDS Program may NOT be used for direct maintenance expense (tires, repairs, etc.) of a privately owned vehicle or any other costs associated with a vehicle, such as lease or loan payments, insurance, or license and registration fees. This restriction does not apply to vehicles operated by organizations for program purposes.

Clothing Ryan White HIV/AIDS Program funds may NOT be used to purchase clothing.

Property Taxes: Funds awarded under the Ryan White HIV/AIDS Program may NOT be used to pay local or State personal property taxes (for residential property, private automobiles, or any other personal property against which taxes may be levied).

1.2 Key Definitions

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the staff providing these services.

As used herein, the term:

Grantee: Ryan White Part A Las Vegas TGA-Clark County Social Services. Client: includes the terms "patient" and "consumer".

Provider: includes the terms "service provider"; "agency"; "organization" and "subgrantee".

2. Service Goals and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Emergency Financial Assistance Service Goal:

To provide emergency financial service to clients in crisis to maintain adherence to primary medical care

2.2 LAS VEGAS TRANSITIONAL GRANT AREA (TGA) EMERGENCY FINANCIAL ASSISTANCE SERVICE OBJECTIVES:

1. Continue to provide access to and retention in HIV medical services by providing assistance with safe and affordable housing options.
2. Increase access to housing assistance by 10% by targeting clients currently out of care.
3. Continue to provide access to and retention in HIV medical services by providing food vouchers for nutritious and culturally appropriate food supplies.
4. Increase access to food vouchers for nutritious and culturally appropriate food supplies by 10% by targeting clients currently out of care

3. Key Services

Provide Emergency Financial Assistance for:

- Food
- Housing (Rental and Mortgage)
- Utilities
- Emergency Medication(s)
- Emergency Transportation

4. Eligibility

4.1 PART A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re- assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re- assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household
5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

4.2 EMERGENCY FINANCIAL ASSISTANCE (EFA)

The following eligibility is for any client determined eligible for Part A services but must also meet the criteria specific for this service category.

Clients are to be referred to Emergency Financial Assistance program from another Ryan White funded program after Part A eligibility is determined.

Eligible utilization of service

EFA is to be utilized as a last resort of payment for clients in crisis and in need of emergency assistance. Eligible uses include:

- Essential utilities
- Short term housing rental assistance
- Short term mortgage assistance
- Emergency food assistance, including food vouchers
- Emergency medication assistance
- Emergency Transportation

Clients must present the bill and demonstrate the inability to pay in order to receive EFA for housing or utilities. A request is considered approved when documentation that at least two (2) prior resources have been exhausted is present and confirmation is received from the supervisor that funding is available. In addition, agencies should make a reasonable effort to assess proof of sustainability, including how item will be paid in the future.

For utility assistance, the eligible person must have an account in their name with a utility company or proof of responsibility to make utility payments, such as receipts in their name from a utility company. Utility assistance payments are limited to power, gas, water/sewer, and trash bills.

For EFA housing assistance the eligible person or a member of the resident household must present evidence that he/she is a named tenant under a valid lease or he/she is a legal resident of the premise. To receive a mortgage payment, the eligible person must demonstrate that he/she is the resident owner of the mortgaged real property.

EFA assistance for food, medication, and transportation will be considered on a case by case basis by the provider and are subject to the availability of funding.

5. Clients Rights and Confidentiality

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.
2. The provider will provide assurances and a method for protection of client rights in the process of care provision.
3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.

4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.
5. Respect, confidentiality and equal access to all clients will be assured.

6. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.
2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.
3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

7. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

8. Access, Care Coordination and Provider Continuity

- ❖ All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.
- ❖ Providers will document the following regarding access to and continuity of care:
  - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).
  - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.
  - Procedures for providing feedback to referring providers when a client is referred from another provider.
  - For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

9. Fees:

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease

in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.

10. Licensing, Knowledge, Skills and Experience

Minimum HS Diploma; college graduate preferred. Should have HIV related experience. If qualified individuals do not have HIV related experience they must receive HIV specific training within six months of hire.

11. Program Data and Reporting

Program data for each Ryan White Part A funded program will be collected and reported through CAREWare, the Ryan White client level data collection system. This data will be used to monitor program progress as well as clinical outcomes. This data should also be reflected in each of the client's individual client charts.

12. Quality Assurance and Service Measures

12.1 QUALITY MANAGEMENT AND ASSURANCE

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.
2. The provider organization will provide for methods to monitor services areas in need of improvement.
3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

12.2 SERVICE INDICATORS AND MEASURES

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. All measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. The intent is that agency compliance with standards of care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Emergency Financial Assistance services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

13. Clinical Standards

The Client Level Outcome Measures are a reflection of a client's progress as they access Emergency Financial Assistance. The following Client Level Outcome Measures and percentage goals will be assessed annually:

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4 T-cell Count

- 75% of clients will stabilize or increase their CD4 T-cell count from initial count within the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200)

Undetectable Viral Load

- 75% of clients that maintained an undetectable viral load or achieved an undetectable viral load from initial count within the measurement period.

Most Recent Viral Load Undetectable

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

14. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Emergency Financial Assistance services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

15. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

16. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

17. Appendices

Not Applicable.

Las Vegas Transitional Grant Area
Planning Council

Early Intervention Services Standards of Care

Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Early intervention services for Parts A and B include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, and tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and provision of therapeutic measures.

1.2 Key Definitions:

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the staff providing these services.

As used herein, the term:

Grantee: Ryan White Part A Las Vegas TGA-Clark County Social Services.

Client: includes the terms "patient" and "consumer".

Provider: includes the terms "service provider"; "agency"; "organization" and "subgrantee".

2. Service Goals and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Early Intervention Services Service Goal:

Increase access to high quality HIV services for clients not in care and clients who have fallen out of the continuum of care.

2.2 Las Vegas Transitional Grant Area (TGA) Early Intervention Services Service Objectives:

1. Find and enroll clients infected with HIV but unaware of their status in the EIS program.
2. Find, educate and enroll into the EIS program no less than 5% of the out of care population, with an emphasis on individuals representing the MSM, IDU and Hispanic populations.

3. Key Services

1. One encounter with EIS staff for newly enrolled individuals in the current grant year.

4. Eligibility

4.1 Early Intervention Services

Presumptive eligibility is determined only by Early Intervention Services. Due to the nature and mission of the EIS program and the clients it services, EIS clients are to be determined to be presumptively eligible for Part A services, until which time the standard eligibility requirements can be fulfilled not to exceed a period of six months. Upon official determination of eligibility for Part A services the EIS client will either be referred to Part A service providers or other community service providers.

4.2 Part A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re-assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re-assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household
5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

5. Baseline Evaluation

5.1 Client Intake and Initial Assessment

Intake is required for all clients who request or who are referred for HIV/AIDS EIS services. Client intake should be completed in the first contact with the potential client. EIS services should also extend to at-risk partners and family members of clients, regardless of their HIV status to include, but not limited to; confirmatory testing, health education, HIV transmission risk reduction and prevention, short-term family or couples counseling and linkages to pediatric services for the children of clients.

5.2. Short Term Intensive Case Management

EIS programs should provide short term intensive client-centered case management services to help link people living with HIV to health care and psychosocial services (see Medical Case Management standard of care for a description of Intensive Medical Case Management Medical-Nursing).

5.3 Medical Evaluation, Monitoring and Treatment

Medical evaluation, monitoring and treatment are important components of the integrated multi-service model that constitute Early Intervention Services. EIS programs may confirm the presence of HIV infection and provide tests to diagnose the extent of immunologic deficiency in the immune system. Additionally, programs will ensure that referrals are made to medical providers who provide diagnostic and therapeutic measures for preventing and treating the deterioration of the immune system and related conditions that conform to the most recent clinical protocols. At a minimum these services include regular medical evaluations; appropriate treatment of HIV infection; and prophylactic and treatment interventions for complications of HIV infection, including opportunistic infections, opportunistic malignancies and other AIDS defining conditions. Medical services must be provided on-site or through referral to another facility offering the required service(s). Approved health care professionals for these services include Physicians, Nurse Practitioners (NPs) and/or Physician Assistants (PAs), Registered Nurses (RNs) will provide primary HIV nursing care. Practitioners must utilize established practice guidelines when providing these services (see Outpatient/Ambulatory Medical Care standard of care).

5.4 Referrals

EIS programs must develop policies and procedures for referral to all health and social service providers in the HIV/AIDS continuum of care. All internal referrals must be tracked in CAREWare and external referrals documented in the client chart.

5.5 Case Closure

EIS programs will develop criteria and procedures for case closure. Whenever possible, all clients whose cases are being closed must be notified of such action. All attempts to contact the client and notifications about case closure will be documented in the client file

or CAREWare, along with the reason for case closure.

Cases may be closed when the client:

- Has met the established milestones and is being transferred another service provider for Outpatient/Ambulatory Medical Care
- Is deceased
- Has relocated out of the service area
- No longer requires the services
- Decides to discontinue the service
- Is improperly utilizing EIS

6. Clients Rights; Confidentiality and Program Specific Forms

6.1 Clients Rights and Confidentiality

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.
2. The provider will provide assurances and a method for protection of client rights in the process of care provision.
3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.
4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.
5. Respect, confidentiality and equal access to all clients will be assured.

6.2 Program Specific Forms

1. A Statement of Consumer Rights
2. Sanction policy and/or Zero Tolerance Information
3. Notice of Privacy Practices for each individual agency

4. Booklet of information regarding community resources (compiled by the Part A Grantee or another reputable source)

7. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.

2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.

3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

8. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

9. Access, Care Coordination and Provider Continuity

- EIS programs should make available mental health and psychosocial service provided by Master's level social workers and/or appropriate licensed healthcare providers or counselors to include; counseling and crisis intervention services offered as needed and provided in accordance with PHS Guidelines, comprehensive psychosocial assessment of all new clients.
- All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.
- Providers will document the following regarding access to and continuity of care:
  - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).
  - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.

- Procedures for providing feedback to referring providers when a client is referred from another provider.
- For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

10. Fees

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.

11. Licensing, Knowledge, Skills and Experience
Staff providing Early Intervention Services must either be a licensed RN; Disease Investigator; or a college graduate with a four year degree or higher in either Behavioral/Bioscience or other health care related field plus field experience.

12. Program Data and Reporting

Program data for each Ryan White Part A funded program will be collected and reported through CAREWare, the Ryan White client level data collection system. This data will be used to monitor program progress as well as clinical outcomes. This data should also be reflected in each of the client's individual client charts.

13. Quality Assurance and Service Measures

13.1 Quality Management and Assurance

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.
2. The provider organization will provide for methods to monitor services areas in need of improvement.
3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging

national standards.

13.2 Service Indicators and Measures

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. All measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. The intent is that agency compliance with standards of care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Early Intervention Services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

14. Clinical Standards

The Client Level Outcome Measures are a reflection of our client's progress as they access Early Intervention Services. The following Client Level Outcome Measure and percentage goal will be assessed annually:

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Most Recent CD4 Stable

- 50% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Most Recent Viral Load Undetectable

- 25% of clients with at least one viral load within the measurement year will be considered undetectable (<50). (Please note that clients in care through EIS services are not receiving any HIV/AIDS medication and therefore will

generally not have an undetectable viral load.)

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Early Intervention Services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

16. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

17. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

18. Appendices

Not Applicable.

Las Vegas Transitional Grant Area
Planning Council

Medical Case Management (including treatment adherence) Standards of Care

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Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic reevaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through an ongoing assessment/reassessment of the client and other key family members' needs and personal support systems. Medical case management may also include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: (1) initial assessment of service needs; (2) development of a comprehensive, individualized care plan; (3) coordination of services required to implement the care plan; (4) continuous client monitoring to assess the efficacy of the care plan; and (5) periodic reevaluation and adaptation of the care plan, at least every 6 months, as necessary during the enrollment of the client.

Benefits and Entitlement Counseling

Funds awarded under the Ryan White HIV/AIDS Program may be used to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g. Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, and other State or local health care and supportive services. Such benefits/entitlement counseling and referral activities may be provided as a component of three allowable Ryan White HIV/AIDS Program support service categories: "Medical Case Management," "Case Management (Non Medical)" and/or "Referral for Health Care/Supportive Services."

1.2 Key Definitions

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the staff providing these services.

As used herein, the term:

Grantee: Ryan White Part A Las Vegas TGA-Clark County Social Services.

Client: includes the terms "patient" and "consumer".

Provider: includes the terms "service provider"; "agency"; "organization" and "subgrantee".

2. Service Goals and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Medical Case Management (including treatment adherence) Service Goal:

To provide coordinated HIV services that improves the quality of health for clients in the Las Vegas TGA

2.2 Las Vegas Transitional Grant Area (TGA) Medical Case Management (including treatment adherence) Service Objectives:

1. Continue to provide to clients, currently in medical case management, an assessment of the client's individual HIV specific and non-specific needs, a comprehensive client-centered service plan including referrals to outpatient/ambulatory medical care, supportive services, any other referrals required to meet the clients HIV health needs, and management and review of comprehensive service plan.
2. Increase MSM, IDU and MSM/IDU enrollment in medical case management by 5% by targeting identified population through out of care program and needs assessments.

3. Key Services

1. One appointment with a medical case manager (face to face or phone)
2. Ryan White funded clients will have a medical case management visit every 6 months.
3. Ryan White funded clients will work with their case manager to create or update their care plan at a minimum of every 6 months.

4. Eligibility

4.1 Part A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re-assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re-assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household
5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

4.2 Medical Case Management (including treatment adherence)

The following eligibility is for any client determined eligible for Part A services but must also meet the criteria specific for this service category.

Clients are to be referred to Medical Case Management (including treatment adherence) program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline evaluation

5.1 Client Intake and Initial Assessment

Intake is a time to gather registration information, assess the clients overall health status and unmet needs, provide necessary referrals for care, and provide basic information about case management and other HIV services. It is also a pivotal moment for establishment of trust and

confidence in the care system. Each client will receive an initial comprehensive assessment utilizing the standardized Ryan White Part A assessment forms. Part A eligible clients referred from another agency must receive contact from the receiving agency within 5 business days and an appointment within thirty days of referral.

5.2 Case Management Reassessment

Case management is to be an ongoing management process, not simply an initial or occasional assessment and referral. The purpose of the reassessment process is to ensure continued progress in meeting consumer needs while identifying any new emerging needs or problems.

5.3 Follow-up and Monitoring

Follow-up and monitoring contacts need not all be face-to-face, telephone contacts are adequate. However, the client must be seen face-to-face at a minimum of every six months for a full reassessment and a redetermination of eligibility. Each follow-up contact should include, at a minimum, discussion of the client's progress on their ISP and goals outlined therein, current needs and necessary referrals, and the clients overall health and wellbeing.

5.4 Discharge Planning

Unplanned discharge from case management services may affect the client's ability to receive and stay compliant with medical care. Therefore it is mandatory that at least three attempts be made over no more than a three month period to contact the clients who appear to be lost to follow-up (those who haven't had an appointment with the agency for a period of twelve months or more in moderate services or three months or more in intensive services). Clients who cannot be located after three attempts shall receive a formal letter by mail explaining their reason for discharge. A client may be discharged from case management services for any of the following conditions:

- The client is deceased.
- The client has become ineligible for services (e.g., due to relocation outside the TGA or fails to meet other eligibility criteria).
- The client no longer demonstrates need for case management due to their own ability to effectively advocate for their needs.
- The client chooses to terminate services.
- The client's needs would be better served by another agency.
- The client is being discharged from the correctional facility at which they are receiving jail case management services.
- The client demonstrates pervasive unacceptable behavior that violates client rights and responsibilities.
- The client cannot be located after documented three attempts for a period of no less than three months.

- The client is transitioning into another level of case management services within the Part A system. In this case to ensure a smooth transition, relevant intake documents maybe forwarded to the new service provider and case managers from both agencies should work together to provide a smooth transition for the client and ensure that all critical services are maintained.

6. Clients Rights and Confidentiality:

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.

2. The provider will provide assurances and a method for protection of client rights in the process of care provision.

3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.

4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.

5. Respect, confidentiality and equal access to all clients will be assured.

7. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.

2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.

3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

8. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

9. Access, Care Coordination and Provider Continuity

- All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.
- Providers will document the following regarding access to and continuity of care:
  - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).
  - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.
  - Procedures for providing feedback to referring providers when a client is referred from another provider.
  - For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

10. Fees

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.

11. Licensing, Knowledge, Skills and Experience

Medical case management services must be provided by trained professionals, including both medically credentialed and other health care staff who provide a range of client-centered

services that result in a coordinated care plan which links clients to medical care, psychosocial, and other services.

Any staff that is considered "other health care staff" positions will need prior approval by the grantee regarding the qualifications of these positions to ensure compliance with the approved program model as well as within the scope of allowable credentials approved by HRSA.

12. Program Data and Reporting

Program data for each Ryan White Part A funded program will be collected and reported through CAREWare, the Ryan White client level data collection system. This data will be used to monitor program progress as well as clinical outcomes. This data should also be reflected in each of the client's individual client charts.

13. Quality Assurance and Service Measures

13.1 Quality Management and Assurance

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.
2. The provider organization will provide for methods to monitor services areas in need of improvement.
3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

13.2 Service Indicators and Measures

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. Through our Quality Management Program, all measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. Agency Compliance Measures and Client Level Outcomes will be tracked and reported by agency and TGA wide, the Overall Program Performance Measures will be tracked and reported as TGA wide only. The intent is that agency compliance with Standards of Care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each

agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Medical Case Management services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

14. Clinical Standards

The Client Level Outcome Measures are a reflection of a client's progress as they access Medical Case management. The following Client Level Outcome Measure and percentage goal will be assessed annually for each of the three primary levels of medical case management:

14.1 Intensive Medical Case Management-Medical

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care (HRSA HAB Measure)

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Undetectable Viral Load

- 50% of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs during the measurement period to final labs during the measurement period. (Please note that clients in Intensive Medical Case Management-Medical services are generally entering the care system and therefore not receiving any HIV/AIDS medication, consequently they will most likely not have an undetectable viral load.)

Most Recent Viral Load Undetectable

- 50% of clients with at least one viral load within the measurement year will be considered undetectable (<50). (Please note that clients in Intensive Medical Case Management-Medical services are generally entering the care system and therefore not receiving any HIV/AIDS medication, consequently they will most likely not have any improvements in their viral load.)

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

14.2 Intensive Medical Case Management-Social

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care (HRSA HAB Measure)

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Undetectable Viral Load

- 50% of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs during the measurement period to final labs during the measurement period.

Most Recent Viral Load Undetectable

- 50% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

Medication Adherence

- 80% of clients will indicate missing less than 2 doses of their prescribed HIV/AIDS medication within the last 30 days of their most recent Medical Case Management appointment.

14.3 Medical Case Management

In Medical Care

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care (HRSA HAB Measure)

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Stabilized CD4

- 75% of clients will have stabilized (≥200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200).

Undetectable Viral Load

- 75% of clients will have a viral load that remained undetectable or decreased to ≤50 from initial labs during the measurement period to final labs during the measurement period.

Most Recent Viral Load Undetectable

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

Decreased Client Acuity

- 90% of clients will have a decreased client acuity score from initial score on intake to final score at discharge or final score within the measurement period.

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Medical Case Management (including treatment adherence) services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

16. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

17. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

18. Appendices

Not Applicable.

Las Vegas Transitional Grant Area
Planning Council

Outpatient Ambulatory Medical Services Standards of Care

Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Outpatient/ambulatory medical care includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's (PHS) guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Note: Regarding vision care-Ryan White HIV/AIDS Program funds may be used for Outpatient/Ambulatory Medical Care (health services), which is a core medical service, that includes specialty ophthalmic and optometric services rendered by licensed providers.

1.2 Key Definitions

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the staff providing these services.

As used herein, the term:

Grantee: Ryan White Part A Las Vegas TGA-Clark County Social Services.

Client: includes the terms "patient" and "consumer".

Provider: includes the terms "service provider"; "agency"; "organization" and "subgrantee".

2. Service Goals and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Outpatient Ambulatory Medical Services Service Goal:

To provide comprehensive medical care to people living with HIV/AIDS in the Las Vegas TGA.

2.2 Las Vegas Transitional Grant Area (TGA) Outpatient Ambulatory Medical Services Service Objectives:

1. Continue to provide quality HIV care, which meets PHS Guidelines, to all new and returning clients requiring a routine health screening every six months. Screening will include CD4 count, Viral Load, PAP Test, TB Testing, Syphilis serology screening, Gonorrhea testing, Chlamydia testing, Toxoplasmosis screening and Hepatitis testing; and continue to provide HIV specialty medical care as needed.
2. Increase the capacity to provide HIV medical care, based on PHS Guidelines at each of the outpatient/ambulatory clinics in the TGA, while reducing wait times for medical service appointments.

3. Key Services

1. Ryan White funded clients will have a medical visit with an HIV specialist every 6 months.
2. Ryan White funded female clients will receive a pap screening annually.
3. Ryan White funded clients will receive routine labs every 6 months including CD4 and viral load testing.
4. Ryan White funded clients with an AIDS diagnosis will be prescribed HAART.

4. Eligibility

4.1 Part A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re-assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re-

assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household
5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

4.2 Outpatient Ambulatory Medical Services

The following eligibility is for any client determined eligible for Part A services but must also meet the criteria specific for this service category.

Clients are to be referred to Outpatient Ambulatory Medical Services program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline Evaluation

5.1 Initial Assessment

All HIV infected clients receiving medical care must receive an initial comprehensive assessment that should include at a minimum; a general medical history, a comprehensive HIV related history and a comprehensive physical examination.
The comprehensive HIV related history shall include:

- Psychosocial history
- HIV treatment history and staging
- Most recent CD4 counts and Viral Load test results
- Medication adherence history
- History of HIV related illness and infections
- History of Tuberculosis
- History of Hepatitis and vaccines
- Psychiatric history
- Transfusion/blood products history
- Past medical care
- Sexual history
- Substance abuse hi story
- Review of systems

This must be completed by an MD, NP or PA in accordance with professional and established HIV Public Health Service (PHS) Guidelines within thirty days of initial contact with the client.

5.2. Annual Reassessment

A comprehensive reassessment shall be completed on an annual basis or when clinically indicated. The reassessment shall include at a minimum; a general medical history update, a comprehensive HIV related history and a comprehensive physical examination

5.3 Follow-up Visits

All clients shall have follow-up visits at least every four to six months or more frequently if clinically indicated for treatment and monitoring and also to detect any changes in the client's HIV status.
At each clinical visit the provider will at a minimum:

- Measure vital signs including height and weight
- Perform physical examination and update client history
- Document current therapies on all clients receiving treatment or assess and reinforce adherence with the treatment plan
- Update problem list
- Incorporate HIV prevention strategies into medical care for persons living with HIV
- Screening for risk behaviors
- Refer for other clinical and social services as needed

5.4 Yearly Surveillance Monitoring and Vaccinations

To ensure prevention and early detection clients must receive the following screenings and vaccinations. It is the responsibility of each agency providing Outpatient/Ambulatory Medical Care to have a mechanism in place to identify clients who are in need of health screenings, vaccinations, and/or follow-ups.

5.5 Preconception Care for HIV Infected Women of Child Bearing Age

Preconception care shall be woven into routine primary care for HIV infected women of child bearing age and should include preconception counseling.
At a minimum, the preconception counseling should include:

- Use of appropriate contraceptive method to prevent unintended pregnancy
- Safe sexual practices
- Elimination of illicit drugs and smoking
- Education and counseling on risk factors for perinatal HIV transmission and prevention and potential effects of HIV and treatment on pregnancy and outcomes.

- Available reproductive options

5.6 Obstetrical Care for HIV Infected Pregnant Women

Obstetrical care for HIV infected pregnant women shall be provided by board certified obstetrician experienced in the management of high risk pregnancy and has at least two years' experience in the care of HIV infected pregnant women. Antiretroviral therapy during ante partum, perinatal and postpartum should be based on current PHS Guidelines.

5.7. HIV Exposed and HIV Infected Infants, Children, and Adolescents

Treatment of HIV infected infants and children should be managed by a specialist in pediatric and adolescent HIV infection. Where it is not possible, primary care providers must consult with such specialists. Providers must utilize current PHS Guidelines for the use of antiretroviral agents in pediatric HIV infection providing and monitoring antiretroviral therapy in infants, children and adolescents. These clients should also be monitored for growth and development, drug toxicities, neurodevelopment, nutrition and symptoms management.

5.8 8. Medication Education

All clients must receive comprehensive documented education regarding their most current prescribed medication regimen. Medication education must include the following topics, which should be discussed then documented in the patient record:

- The name, action and purposes of all medications in the patients regimen
- The dosage schedule
- Food requirements, if any
- Side effects
- Drug interactions
- Adherence

Patients must also be informed of the following:

- How to pick up medications
- How to get refills
- What to do and who to call when having problems taking medications as prescribed

Note: The agency must utilize an RN, LVN, PA, NP, MD or Pharmacist licensed in the State of Nevada or Arizona to provide educational services.

6. Clients Rights; Confidentiality

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this

documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.
2. The provider will provide assurances and a method for protection of client rights in the process of care provision.
3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.
4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.
5. Respect, confidentiality and equal access to all clients will be assured.

7. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.
2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.
3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

8. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

9. Access, Care Coordination and Provider Continuity

- All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.

- Providers will document the following regarding access to and continuity of care:

    - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).

    - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.

    - Procedures for providing feedback to referring providers when a client is referred from another provider.

    - For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

10. Fees

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease in fees must also be reported so that expansion to serve more clients can be reviewed and implemented if applicable.

11. Licensing, Knowledge, Skills and Experience

Medical care for HIV infected persons must be provided by an MD, NP, or PA licensed in the State of Nevada or Arizona and has at least six months paid experience in HIV/AIDS care. The provider must keep professional licensure of all staff providing clinical services including physicians, nurses, social workers, etc. If for any reason eligible candidates who do not possess the six month experience in the HIV field then within 12 months of hire the qualified individual must complete HIV specific training.

The agency must utilize an RN, LVN, PA, NP, MD or Pharmacist licensed in the State of Nevada or Arizona to provide educational services.

12. Program Data and Reporting

Program data for each Ryan White Part A funded program will be collected and reported through

CAREWare, the Ryan White client level data collection system. This data will be used to monitor program progress as well as clinical outcomes. This data should also be reflected in each of the client's individual client charts.

13. Quality Assurance and Service Measures

13.1 Quality Management and Assurance

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.

2. The provider organization will provide for methods to monitor services areas in need of improvement.

3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

13.2 Service Indicators and Measures

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. All measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. The intent is that agency compliance with standards of care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at each agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Outpatient/Ambulatory Medical Care services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date

indicators, measures and outcomes.

14. Clinical Standards

The Client Level Outcome Measures are a reflection of our client's progress as they access Outpatient/Ambulatory Medical Care. The following Client Level Outcome Measures and percentage goals will be assessed annually:

Disease Status at Time of Entry Into Care (HRSA HAB Measure -Systems Level)

- 20% or fewer individuals will have an AIDS diagnosis (CD4 T-cell count of <200) at time of initial outpatient/ambulatory medical care visit in the measurement year.

Stabilized CD4

- 75% of clients will have stabilized (≥ 200) or increased their CD4 T-cell count from initial labs during the measurement period to final labs during the measurement period.

Most Recent CD4 Stable

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥ 200).

Undetectable Viral Load

- 75% of clients will have a viral load that remained undetectable or decreased to ≤ 50 from initial labs during the measurement period to final labs during the measurement period.

Most Recent Viral Load Undetectable

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Outpatient Ambulatory Medical Services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

16. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

17. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

18. Appendices

Not Applicable.

Las Vegas Transitional Grant Area
Planning Council

Substance Abuse-Outpatient Standards of Care

Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Substance abuse services (outpatient) is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a physician or under the supervision of a physician, or by other qualified personnel.

Substance Abuse Treatment Services-Outpatient is an allowable core medical service. Funds used for outpatient drug or alcohol substance abuse treatment, including expanded HIV-specific capacity of programs if timely access to treatment and counseling is not available, must be rendered by a physician or provided under the supervision of a physician or other qualified/licensed personnel.

Such services should be limited to the following:

- Pre-treatment/recovery readiness programs
- Harm reduction
- Mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse
- Outpatient drug-free treatment and counseling
- Opiate Assisted Therapy
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention.

b. Syringe Exchange: Will be addressed in future HAB policy issuances.

1.2 Key Definitions

The Las Vegas Transitional Grant Area (TGA) has designated the following definitions in an effort to standardize language across all programs for both the community being served and the staff

providing these services.

As used herein, the term:

<u>Grantee</u>: Ryan White Part A Las Vegas TGA-Clark County Social Services.

<u>Client</u>: includes the terms "patient" and "consumer".

<u>Provider</u>: includes the terms "service provider"; "agency"; "organization" and "subgrantee".

2. Service Goals and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Substance Abuse Service Goal:

Provide Substance Abuse Outpatient services to PLWH/A in the TGA to increase adherence to medical care while eliminating barriers to access.

2.1 Las Vegas Transitional Grant Area (TGA) Substance Abuse Service Objectives:

1. To address and stabilize current client's substance abuse issues in order to promote and maintain access to the TGA system of care.

2. To address and stabilize new client's substance abuse issues in order to promote and maintain access to the TGA system of care.

3. Key Services

1. One substance abuse outpatient visit individual or group encounter.

4. Eligibility

4.1 Part A

The following eligibility criteria is to be used for determining if a client is eligible for Part A services. This documentation must be verified during each eligibility assessment and re-assessment period. Every potential Part A client must have an initial eligibility assessment to ensure that they are eligible to receive a Part A service and will undergo an eligibility re-assessment every six months to ensure that the client's status has not changed. All Part A clients must meet the following criteria regardless of their service needs to be eligible for Part A services.

1. Proof of HIV Infection
2. Proof of Nevada or Arizona Residency
3. Proof of Identification
4. Proof of Household

5. Proof of Income Level
6. Asset Test (Regarding Income Determination)
7. Miscellaneous Provisions

4.2 Substance Abuse

The following eligibility is for any client determined eligible for Part A services but must also meet the criteria specific for this service category.

Clients are to be referred to Substance Abuse program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline Evaluation

5.1 Screening and Intake

Clients receiving individual session should receive a comprehensive Mental Health Screening to be completed within the first three appointments with the Substance Abuse provider. At a minimum this screening should include the following:

- Demographic information
- Employment status Current living arrangement
- HIV status
- Presenting symptoms
- Alcohol and drug history and current usage
- History of treatment Medical history
- Family history
- Mental status exam Bio psychosocial
- Current Global Assessment of Functioning (GAF) Score Development of treatment plan
- Signed consent and treatment forms

5.2 Global Assessment of Functioning (GAF)

All eligible clients should have a GAF assessment as part of their initial assessment. The rating shall be determined upon intake but no later than within the first three appointments with the substance abuse provider. GAF is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults, e.g., how well or adaptively one is meeting various problems-in-living. The GAF Scale considers psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. It doesn't include impairment in functioning due to physical (or environmental) limitations.

5.3 Treatment Plan-Individual Sessions Only

Treatment plans should be created for all clients attending individual sessions. The Substance Abuse provider should develop a treatment plan based on the comprehensive assessment. This should be completed on intake but no later than within the first three appointments with the Substance Abuse provider. Treatment plans should be detailed including dates for measurable goal completion and continued treatment progress on the plan documented in the progress notes. All treatment plans will be reviewed every 90 days

5.4 Ongoing Support and Reassessment

Clients receiving Substance Abuse services should be continually monitored and assessed for progress throughout treatment.

Clients attending individual sessions should have follow-up visits at least every thirty to sixty days or more frequently if clinically indicated. These should include an updated GAF score at a minimum of every 180 days, a review and update if necessary on the clients treatment plan at a minimum of every 180 days and a detailed progress notes at each appointment

6. Clients Rights and Confidentiality

All providers' staff should be able to document the following in terms of clients' rights and confidentiality for each Part A funded client that are receiving services. In addition, this documentation shall be available for program monitoring compliance by the grantee designated staff:

1. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.

2. The provider will provide assurances and a method for protection of client rights in the process of care provision.

3. The provider will provide assurances and a method for protection of client confidentiality (in accordance with Nevada State law as well as with HIPAA) with regard to medical information transmission, maintenance and security.

4. The provider will provide assurances regarding the provision of culturally appropriate care to its clients. Specifically, the providers' staff must have appropriate training, supervision and/or experience with caring for those groups most affected by the epidemic. This training may be provided within the providers' organization as well as any other grantee recommended trainings.

5. Respect, confidentiality and equal access to all clients will be assured.

7. Grievance Procedures-Part A

All providers will ensure that:

1. Each client will receive a copy of a Ryan White Part A grievance procedure upon eligibility and acceptance as a Part A client. The grievance procedure will clearly indicate the process of a grievance regarding Ryan White Part A service(s) only with final appeal directly to the Part A grantee office.

2. Grievance procedures will be signed by each client with a signed copy included in the clients Part A files.

3. The grievance procedure will be reviewed with each client no less than one time annually and no more than two times per year.

8. Client Satisfaction

Client satisfaction surveys as well as other provider methods will be monitored at minimum on an annual basis for each provider site. The program indicator is as follows:

- 75% of clients will report being satisfied or very satisfied with the Ryan White Part A services they have received for their HIV status over the past 12 months.

9. Access, Care Coordination and Provider Continuity

- All providers, regardless of type of service that they are funded to provide (core or support) will ensure that (medical) case coordination and collaboration between providers will occur in order to ensure that all of the client's needs are being met, identify any potential for needs to go unmet and measure the progress of the clients care.
- Providers will document the following regarding access to and continuity of care:
  - Care/action plans that will include timeframes for delivery of services (this should be documented in the client's chart).
  - Procedures for making, receiving and tracking referrals to/from other providers must be developed and implemented and will include follow-up procedures.
  - Procedures for providing feedback to referring providers when a client is referred from another provider.
  - For all those providers that are providing Part A services, with the exception of outpatient ambulatory medical services, verification that a client is currently receiving primary medical care should be documented in the client's chart.

10. Fees

All providers must adhere to the negotiated fees as stated in the contract between the provider and the Part A grantee. Any changes to fees, specifically for an increase, must receive prior approval by the grantee in order to assure that the grant can substantiate the increase in costs as well as maintain access for eligible clients. Decrease in fees must also be reported so that

expansion to serve more clients can be reviewed and implemented if applicable.

11. Licensing, Knowledge, Skills and Experience

Substance Abuse services may be provided by a Psychiatrist: licensed M.D.; licensed psychologist; licensed psychiatric nurses; licensed clinician: M.F.T., L.C.S.W., PhD or PsyD; registered student interns with appropriate supervision; or certified Alcohol and Drug Abuse counselors.

12. Program Data and Reporting

Program data for each Ryan White Part A funded program will be collected and reported through CAREWare, the Ryan White client level data collection system. This data will be used to monitor program progress as well as clinical outcomes. This data should also be reflected in each of the client's individual client charts.

13. Quality Assurance and Service Measures

13.1 Quality Management and Assurance:

1. All providers will have written quality-assurance activities and methods that can identify any areas that may require improvement and action steps required to strategically improve these areas.

2. The provider organization will provide for methods to monitor services areas in need of improvement.

3. Regular utilization review of the clinical measures and data for individual clients will be conducted to ensure client's progress is being monitored. Utilization review decisions will be clinically based on best practices and consistent with emerging national standards.

13.2 Service Indicators and Measures

Indicators are used to measure and determine, over time, performance of a particular element of care. Outcomes are benefits or other results (positive or negative) for clients that may occur during or after their participation in a program. The Las Vegas TGA has developed three categories of measures to accurately track compliance vs. client progress vs. overall program performance. All measures will be tracked on an annual basis by grant year in their respective categories, which are; Agency Compliance Indicators, Client Level Outcome Measures, and Overall Program Performance Measures. The intent is that agency compliance with standards of care will improve the overall health and well-being of the clients and improve access to care. The primary method of data collection is CAREWare, in addition to an annual chart review at

each agency receiving Part A funding and client satisfaction surveys. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

Agency Compliance Measures for Substance Abuse services and their percentage goals are listed next to their respective standards in the Service Standards section. All agencies are expected to uphold the outlined standards to a minimum of the designated percentage goal and annually their compliance will be assessed. Additional standards and guidelines pertinent to each agency regardless of the service categories they provide are outlined in the Universal Monitoring Standards document which will also be assessed annually. Providers should refer to the Las Vegas TGA Quality Management Plan for the most up to date indicators, measures and outcomes.

14. Clinical Standards

The Client Level Outcome Measures are a reflection of a client's progress as they access Substance abuse Care. The following Client Level Outcome Measure and percentage goal will be assessed annually:

In Medical Care-Individual Sessions

- 75% of clients that are in medical care (at least one medical visit per measurement period).

Maintained Adherence to Medical Care-Individual Sessions

- 75% of clients that maintain adherence to Medical Care visits within the measurement year (at least two medical visits with a provider with prescribing privileges at least three months apart in the measurement year).

Improved Functional Status-Individual Sessions

- 55% of clients will have an increased GAF rating from initial GAF to GAF at discharge or final GAF rating within the measurement period if client is still accessing services.

Stabilized CD4 T-cell Count-Individual Sessions

- 75% of clients will stabilize or increase their CD4 T-cell count from initial count within the measurement period.

Most Recent CD4 Stable-Individual Sessions

- 75% of clients with at least one CD4 T-cell count within the measurement year and those that are considered medically stable (CD4 ≥200)

Undetectable Viral Load-Individual Sessions

- 75% of clients that maintained an undetectable viral load or achieved an undetectable viral load from initial count within the measurement period.

Most Recent Viral Load Undetectable-Individual Sessions

- 75% of clients with at least one viral load within the measurement year will be considered undetectable (<50).

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Substance Abuse services. It is expected that all providers follow these standards as well as the universal programmatic and administrative standards of care. Provider organizations and staff may exceed any of these standards as part of the program delivery.

16. Recommendations

All Part A funded providers are to adhere to these service category specific standards, program standards, the primary program standards and ensure that they are familiar with their individual Part A contracts to meet the expectations of their deliverables.

17. References and further reading

All Part A funded providers should read their individual Part A contracts as well as but not limited to the Quality Management Plan and all local policies and guidelines set forth by the Part A office regarding the Part A program in the Las Vegas Transitional Grant Area. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

18. Appendices

Not Applicable.

EXHIBIT A - ATTACHMENT 2

Service Category:

Item	Detail	Annual Part A Total
1. Personnel:		
Position Title, Name ***Description of Part A duties that relate to the standard of care service description including where services are provided, state any personnel standard qualifications, licensure, etc. and the quality management expectations (ie. Case management expected case load). If title does not correlate with duties explain why.*** *RWPA Percentage, Other Percentage*	FTE for RWPA Annual Salary x RWPA %	
Total Personnel		$
2. Fringe Benefits:		
a. ***List fringe benefits included (ie. Social security, health benefits etc.)***	Total Salary x Fringe Benefit %	
Total Fringe:		$
3. Travel:		
a. List travel location and number of staff attending		$
Airfare: Amount x # of people		
Lodging: Amount x # of nights x # of people		
Per Diem Meals: amount x # of days x # of people		
Airport Parking: amount x # of days x # of people		
Ground Transportation:		
Other (list):		
b. Mileage: Purpose: Amount per mile x # of months (Home visits: $0.50 per mile x 12 months)		$
c.		$
d.		$
Total Travel:		$

EXHIBIT A - ATTACHMENT 2

Item	Detail	Annual Part A Total
4. Equipment: a. List equipment costs and provide justification for the need of the equipment to support the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (i.e, a unit cost of a minimum of $5,000 and a useful life of one or more years).		
a.		$
b.		$
Total Equipment:		$
5. Supplies: a. List supplies related to service category, provide narrative related to use per the service category. List the items that the program will use. In this category, separate different types of supplies. Medical supplies (service category: outpatient/ambulatory) are syringes, blood tubes, plastic gloves, etc., and educational supplies (service category: health education/risk reduction) may be pamphlets and educational videotapes. Remember, they must be listed separately. (Office supplies listed in Administrative budget)		
a.		$
b.		$
Total Supplies:		$
6. Contractual: a. Providers are responsible for ensuring that their organization and or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the		

purpose of each contract, how the costs were estimated, and the specific contract deliverables.		
a.		$
b.		$
Total Contractual		**$**
7. Other: a. Put all costs that do not fit into any other budget category in this budget category and provide an explanation of each cost in this budget category and how it relates to this service category.		
a.		$
b.		$
Total Other		**$**
Service Category Grand Total		**$**
*** This form may be updated per HRSA or County approval.**		

EXHIBIT A
Southern Nevada Health District-Outpatient Ambulatory Health Services
PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK
Attachment 3

Service Category and Requirements and Performance Measures

A. **PROVIDER shall provide Outpatient Ambulatory Health Services,** defined by HRSA as follows:

Outpatient/Ambulatory Health Services are diagnostic and therapeutic services provided directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings include clinics, medical offices, and mobile vans where clients do not stay overnight. Emergency room or urgent care services are not considered outpatient settings. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing, including laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription, and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis

B. **PROVIDER** shall render services in accordance with the following requirements:

1. A minimum of **50** unduplicated clients shall receive **Outpatient Ambulatory Medical Care** services during the award period.
2. A minimum of **10** service units shall be provided each month during the award period in **Outpatient Ambulatory Medical Care.**
3. **PROVIDER** shall serve women, infants, children and youth (WICY) and document client numbers and funds spent for the mandated WICY report. **PROVIDER** shall report to **COUNTY** the WICY population served upon request.
4. **PROVIDER** shall submit a quarterly report detailing services provided and narrative of program. Report shall be submitted on an approved CCSS form.

C. **PROVIDER** shall comply with the Program Goals and Measures as defined below:

Program Goals – Outpatient Ambulatory Medical Care	Performance Measure	Target Percentage	Source
Initial Comprehensive Assessment	Percentage of new clients will have documentation in the client chart of an initial comprehensive assessment including a general medical history, a comprehensive HIV related history and a comprehensive physical examination within thirty days of initial appointment.	100%	CAREWare/Chart Review
Annual Reassessment	Percentage of existing clients will have documentation in the client chart of an annual comprehensive assessment including a detailed medical history and physical examination.	100%	CAREWare/Chart Review

Medical Visits	Percentage of clients with HIV infection will have two or more medical visits in an HIV care setting within a twelve month period.	75%	CAREWare/Chart Review
CD4 T-cell Count	Percentage of clients with HIV infection will have two or more CD4 T-cell counts performed within a twelve month period.	75%	CAREWare/Chart Review
AIDS Clients on HAART	Percentage of clients who have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm or other AIDS defining condition) should be prescribed HAART.	95%	CAREWare/Chart Review
CD4 < 200 with PCP Prophylaxis	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm should be prescribed PCP Prophylaxis.	80%	CAREWare/Chart Review
MAC Prophylaxis	Percentage of clients with HIV infection and a CD4 T-cell count <50 cells/mm will be prescribed Mycobacterium Acium Complex (MAC) Prophylaxis within a 12 month period.	85%	CAREWare/Chart Review
HIV Risk Counseling	Percentage of clients with HIV infection will receive HIV risk counseling within a 12 month period.	80%	CAREWare/Chart Review
Syphilis Screening	Percentage of clients who are ≥ 18 years old or had a history of sexual activity at < 18 years will have a Syphilis screening documented at least once within the last 12 months.	80%	CAREWare/Chart Review
Chlamydia Screening	Percentage of clients who were either a) newly enrolled in care; b) sexually active; or c) had an STI within the last 12 months will have a Chlamydia screening documented at least once within the last 12 months.	70%	CAREWare/Chart Review
Gonorrhea Testing	Percentage of clients who were either a) newly enrolled in care; b) sexually active; or c) had an STI within the last 12 months will have a Gonorrhea test documented at least once within the last 12 months.	70%	CAREWare/Chart Review
Influenza Vaccination	Percentage of clients with HIV infection will have a Influenza vaccination documented within the last 12 months.	50%	CAREWare/Chart Review
Mental Health Screening	Percentage of clients with HIV infection will have a mental health screening documented at least once within the last 12 months.	45%	CAREWare/Chart Review
Substance Use Screening	Percentage of clients with HIV infection will have a substance use screening at least once within the last 12 months.	45%	CAREWare/Chart Review
Lipid Screening	Percentage of clients with HIV infection on HAART will have a fasting lipid panel (cholesterol and triglycerides panel) within the last 12 months.	75%	CAREWare/Chart Review
Tobacco Cessation Counseling	Percentage of clients that admit to using tobacco will receive tobacco cessation counseling within the last 12 months.	70%	CAREWare/Chart Review
Hepatitis/HIV Alcohol Counseling	Percentage of clients diagnosed with Hepatitis B or Hepatitis C will receive alcohol counseling within the last 12 months.	70%	CAREWare/Chart Review

Oral Exam	Percentage of clients will report having received an oral exam by a dentist at least once within the last 12 months.	70%	CAREWare/Chart Review
Cervical Cancer Screening	Percentage of women with HIV infection will have a pap screening at least once within the measurement year.	70%	CAREWare/Chart Review
Hepatitis B Vaccination	Percentage of clients with HIV infection will have documentation of a completed vaccine series for Hepatitis B.	45%	CAREWare/Chart Review
Hepatitis B Screening	Percentage of clients with HIV infection will be screened for Hepatitis B virus infection status.	80%	CAREWare/Chart Review
Hepatitis C Screening	Percentage of clients with HIV infection will have a Hepatitis C (HCV) screening performed at least once since diagnosis.	75%	CAREWare/Chart Review
TB Screening	Percentage of clients with HIV infection who do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA will have documentation of testing for LTBI (latent TB infection) at least once since HIV diagnosis.	75%	CAREWare/Chart Review
Pneumococcal Vaccination	Percentage of clients with HIV infection will have a pneumococcal vaccine documented at least once in their lifetime.	75%	CAREWare/Chart Review
Toxoplasma Screening	Percentage of clients with HIV infection will have a Toxoplasma screening performed at least once since diagnosis.	80%	CAREWare/Chart Review
Pregnant Women Prescribed ART	Percentage of pregnant women with HIV infection will be prescribed antiretroviral therapy.	100%	CAREWare/Chart Review
Medication Education	Percentage of clients with HIV infection who were prescribed new medication will receive medication education concurrently documented in the client chart.	80%	CAREWare/Chart Review
Adherence Assessment and Counseling	Percentage of clients with HIV infection on ARV's will be assessed and counseled for adherence two or more times within a 12 month period as part of their primary care.	75%	CAREWare/Chart Review

PROVIDER shall submit deliverables in accordance with **Exhibit A**, Reporting Deliverables Schedule

EXHIBIT A
Southern Nevada Health District-Early Intervention Services
PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK
Attachment 3

Service Category and Requirements and Performance Measures

A. **PROVIDER shall provide Early Intervention Services,** defined by HRSA as follows:

The elements of EIS often overlap with other service category descriptions; however, EIS is the combination of such services rather than a stand-alone service. RWHAP Part recipients should be aware of programmatic expectations that stipulate the allocation of funds into specific service categories.

RWHAP Parts A and B EIS services must include the following four components:

- Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care and treatment services if found to be HIV-infected
  - Recipients must coordinate these testing services with other HIV prevention and testing programs to avoid duplication of efforts
  - **HIV testing paid for by EIS cannot supplant testing efforts paid for by other sources**
- Referral services to improve HIV care and treatment services at key points of entry
- Access and linkage to HIV care and treatment services such as HIV Outpatient/Ambulatory Health Services, Medical Case Management, and Substance Abuse Care
- Outreach Services and Health Education/Risk Reduction related to HIV diagnosis

B. **PROVIDER** shall render services in accordance with the following requirements:

1. A minimum of **60** unduplicated clients shall receive **Early Intervention** services during the award period.
2. A minimum of **15** service units shall be provided each month during the award period in **Early Intervention** services.
3. **PROVIDER** shall serve women, infants, children and youth (WICY) and document client numbers and funds spent for the mandated WICY report. **PROVIDER** shall report to **COUNTY** the WICY population served upon request.
4. **PROVIDER** shall submit a quarterly report detailing services provided and narrative of program. Report shall be submitted on an approved CCSS form.

C. **PROVIDER** shall comply with the Program Goals and Measures as defined below:

Program Goals –Early Intervention Services	Performance Measure	Target Percentage	Source
Initial CD4 and Viral Load Results Documented	Percentage of clients entering the system through EIS services will have an initial CD4 T-cell count and Viral Load documented in the client chart.	85%	CAREWare/Chart Review

PROVIDER shall submit deliverables in accordance with **Exhibit A**, Reporting Deliverables Schedule

EXHIBIT A
Southern Nevada Health District-Medical Case Management
PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK
Attachment 3

Service Category and Requirements and Performance Measures

A. **PROVIDER shall provide Medical Case Management** defined by HRSA as follows:

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Program Guidance:
Medical Case Management services have as their objective improving health care outcomes whereas Non-Medical Case Management Services have as their objective providing guidance and assistance in improving access to needed services. Visits to ensure readiness for, and adherence to, complex HIV treatments shall be considered Medical Case Management or Outpatient/Ambulatory Health Services. Treatment Adherence Services provided during a Medical Case Management visit should be reported in the Medical Case Management service category whereas Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit should be reported under the Outpatient/Ambulatory Health Services category.

B. **PROVIDER** shall render services in accordance with the following requirements:

1. A minimum of **200** unduplicated clients shall receive **Medical Case Management** services during the award period.
2. A minimum of **50** service units shall be provided each month during the award period in **Medical Case Management**.
3. **PROVIDER** shall serve women, infants, children and youth (WICY) and document client numbers and funds spent for the mandated WICY report. **PROVIDER** shall report to **COUNTY** the WICY population served upon request.
4. **PROVIDER** shall submit a quarterly report detailing services provided and narrative of program. Report shall be submitted on an approved CCSS form.

C. **PROVIDER** shall comply with the Program Goals and Measures as defined below:

Program Goals – Medical Case Management	Performance Measure	Target Percentage	Source
Assigned to Case Manager	Percentage of clients will be assigned to a Case Manager upon intake.	100%	CAREWare/Chart Review
Initial Acuity	Percentage of clients entering Intensive Medical Case Management-Medical will have a client acuity performed and documented on intake or within their first three appointments.	95%	CAREWare/Chart Review
Nursing Assessment	Percentage of clients entering Intensive Medical Case Management-Medical will have a nursing assessment performed and documented on intake or within their first three appointments.	95%	CAREWare/Chart Review
Client Care Plan or Individual Service Plan	Percentage of clients entering Intensive Medical Case Management-Medical will have a client care plan or individual service plan performed and documented on intake or within their first three appointments.	95%	CAREWare/Chart Review
Updated Case Management Care Plan (HRSA HAB Measure)	Percentage of clients will have an updated care plan or individual service plan (ISP) documented at least twice each at least three months apart within the measurement period.	85%	CAREWare/Chart Review
Updated Labs	Percentage of clients (still in Intensive Medical Case Management services at the six month mark) will have updated labs documented in the client chart.	85%	CAREWare/Chart Review
Transitioned Within Six Months of Initial Contact	Percentage of clients in Intensive Medical Case Management-Medical will be transitioned into another level of care or program within six months of initial contact (excluding those 18 years old or younger or those that are pregnant).	85%	CAREWare/Chart Review
Justification of Continued Intensive Medical Case Management Services	Percentage of clients found to be in need of Intensive Medical Case Management services beyond the six month mark (and don't fall within the allotted exceptions), an acceptable explanation and verification of Part A eligibility must be provided in the CAREWare custom tab no more than two business days from the determination.	100%	CAREWare/Chart Review
Follow-up Every Month	Percentage of clients will have a follow-up documented by a client encounter form or in CAREWare at least once per month while the client is in Medical Case Management-Medical services.	85%	CAREWare/Chart Review
Discharge Summary	Percentage of clients discharged from case management will have a discharge summary documented in the client chart or in CAREWare.	90%	CAREWare/Chart Review
Final Acuity Score at Discharge	Percentage of clients will have an updated acuity score documented in their chart at the time of discharge.	90%	CAREWare/Chart Review

PROVIDER shall submit deliverables in accordance with **Exhibit A**, Reporting Deliverables Schedule

EXHIBIT A
Southern Nevada Health District-Substance Abuse Outpatient Care
PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK
Attachment 3

Service Category and Requirements and Performance Measures

A. **PROVIDER shall provide Substance Abuse Outpatient Care,** defined by HRSA as follows:

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. Services include:

- Screening
- Assessment
- Diagnosis, and/or
- Treatment of substance use disorder, including:
    - Pretreatment/recovery readiness programs
    - Harm reduction
    - Behavioral health counseling associated with substance use disorder
    - Outpatient drug-free treatment and counseling
    - Medication assisted therapy
    - Neuro-psychiatric pharmaceuticals
    - Relapse prevention

Program Guidance:

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the RWHAP, it is included in a documented plan.

B. **PROVIDER** shall render services in accordance with the following requirements:

1. A minimum of **20** unduplicated clients shall receive **Substance Abuse** services during the award period.
2. A minimum of **10** service units shall be provided each month during the award period in **Substance Abuse** services.
3. **PROVIDER** shall serve women, infants, children and youth (WICY) and document client numbers and funds spent for the mandated WICY report. **PROVIDER** shall report to **COUNTY** the WICY population served upon request.
4. **PROVIDER** shall submit a quarterly report detailing services provided and narrative of program. Report shall be submitted on an approved CCSS form.

C. **PROVIDER** shall comply with the Program Goals and Measures as defined below:

Program Goals – Substance Abuse	Performance Measure	Target Percentage	Source

PROVIDER shall submit deliverables in accordance with **Exhibit A**, Reporting Deliverables Schedule

Southern Nevada Health District-Emergency Financial Assistance
PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK
Attachment 3

Service Category and Requirements and Performance Measures

D. **PROVIDER shall provide Emergency Financial Assistance,** defined by HRSA as follows:

Emergency Financial Assistance provides limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. Emergency financial assistance can occur as a direct payment to an agency or through a voucher program.

Program Guidance:
Direct cash payments to clients are not permitted.
It is expected that all other sources of funding in the community for emergency financial assistance will be effectively used and that any allocation of RWHAP funds for these purposes will be as the payer of last resort, and for limited amounts, uses, and periods of time. Continuous provision of an allowable service to a client should not be funded through emergency financial assistance.

E. **PROVIDER** shall render services in accordance with the following requirements:

5. A minimum of **([UDC])** unduplicated clients shall receive [Service Category] services during the award period.
6. A minimum of (NUMBER) service units shall be provided each month during the award period in [Service Category].
7. **PROVIDER** shall serve women, infants, children and youth (WICY) and document client numbers and funds spent for the mandated WICY report. **PROVIDER** shall report to **COUNTY** the WICY population served upon request.
8. **PROVIDER** shall submit a quarterly report detailing services provided and narrative of program. Report shall be submitted on an approved CCSS form.
9. [Requirements specific to service category].

F. **PROVIDER** shall comply with the Program Goals and Measures as defined below:

Program Goals – [Service Category]	Performance Measure	Target Percentage	Source

PROVIDER shall submit deliverables in accordance with **Exhibit A**, Reporting Deliverables Schedule

EXHIBIT D

GRIEVANCE REPORTING STRUCTURE

Grievance means an oral or written communication, submitted by a client or by their representative, which addresses issues with any aspect of the PROVIDER's operations, activities, or behavior that pertains to 1) the availability, delivery, or Quality of Care, including utilization review decisions, that are believed to be adverse by the client. The expression may be in whatever form or communication or language that is used by the client or their representative, but must state the reason for the dissatisfaction and the client's desired resolution.

No retaliatory actions will be taken against any client, client representative or provider filing a grievance. The client shall be assured that information pertaining to the grievance issue is kept confidential except to the extent that sharing of such information between CCSS and the provider agency and other persons authorized by the client, is necessary to resolve the issue.

PROVIDER shall have a grievance form available in all areas that are accessed by clients. The PROVIDER is the first point of access for all grievances for the clients PROVIDER serves. PROVIDER is responsible for responding, investigating and resolving the client's grievance before the client or PROVDER refers the grievance to CCSS staff. PROVIDER shall supply client with the following, upon client's request:

- An agency grievance form in triplicate.
- A pre-addressed and pre-stamped envelope addressed to the agency's Executive Director.
- A pre-addressed and pre-stamped envelope addressed to the Las Vegas Part A Grants Administrator.

PROVIDER shall submit quarterly grievance logs to CCSS staff for monitoring. The grievance log from each PROVIDER will be tracked and trended by CCSS for quality improvement purposes.

Grievances are a source of information that is one of the ways to evaluate the quality of access, Provider service, or clinical care. PROVIDER shall have written policies and procedures for the thorough, appropriate and timely resolution of a client's. Grievances, which include:

A. Documentation of the nature of the Grievance which shall include, at minimum:
   a. A log of formal Grievances;
   b. A file of written formal Grievances, and
   c. Records of their resolution
B. Analysis and investigation of the Grievance; and
C. Written notification to the client of the disposition of the Grievance and the way to appeal the outcome of the Grievance or handling of a Grievance to CCSS staff.

Provider shall complete and submit the Grievance Log on a quarterly basis within 15 calendar days of the end of each calendar quarter. Contractor shall record each Grievance once on the Grievance Log. If the Grievance covers more than one category, PROVIER shall record the Grievance in the predominant category. The Grievance Log shall be submitted electronically, either by email or CD. Contact CCSS staff to have form sent electronically.

PROVIDER shall send the Grievance Log to:

Clark County Social Service, Ryan White Part A Program
1600 Pinto Lane
Las Vegas, NV 89106.

EXHIBIT D

Las Vegas Transitional Grant Area

Effective May 1, 2007

TGA Provider Grievance Log

Provider name:______________________ Year:____________

Report period (circle): Mar-May June-Aug Sept-Nov Dec-Feb

Grievance: An oral or written communication, submitted by a client or their representative, which addresses issues with any aspect of Provider's operations, activities, or behavior that pertains to the availability, delivery, or quality of the service including utilization review decisions that are believed to be adverse to the client. The communication may be in whatever form of communication or language that is used by the client or their representative, but must state the reason for the client's dissatisfaction and the desired resolution.

Client Identifier	Date Received	Grievance Type	Disposition: Select One Resolved/Appeal Requested	Disposition Date	# Days to Disposition

The count of calendar days begins with the receipt date and does not include the final date of disposition. (For example, if a grievance received Thursday, January 4, 2007 and disposed of Tuesday, January 9,2007, the number of calendar days would be five (5) days.)

EXHIBIT D

ACCESS		Interaction with Provider - COUNTY Staff	
A1	Difficulty contacting Provider	I1	Client feels not treated with dignity or respect
A2	Timely appointment not available	I2	Client disagrees with staff or clinician response
A3	Convenient appointment not available	I3	Lack of courteous service
A4	No choice of clinicians or clinician not available	I4	Lack of cultural sensitivity
A5	Transportation or distance barrier	I5	Other (describe)
A6	Physical barrier to Provider's office	**Quality of Service**	
A7	Language barrier or lack of interpreter services	Q2	Provider office unsafe
A8	Wait time during visit too long	Q2	Provider office uncomfortable
A9	Other (describe)	Q3	Client did not receive information about available services
Denial of Service, Authorization, or Payment		Q4	Excessive wait times on phone
D1	Desired service not available	Q5	Phone call not returned
D2	Client wanted more service than offered/authorized	Q6	Client doesn't like pre-authorization requirements
D3	Request for service not covered by Ryan White TGA	Q7	Other (describe)
D4	Request for medically unnecessary service	**Client Rights**	
D5	Payment to non-participating provider denied	CR1	Not informed of client rights
D6	Service authorization denied	CR2	Grievance and appeal procedure not explained
D7	Other (describe)	CR3	Access to own records denied
Clinical Care		CR4	Concern over confidentiality
C1	Client not involved in treatment planning	CR5	Allegation of abuse
C2	Client's choice of service not respected	CR6	Treatment discontinued without proper notification
C3	Disagreement with treatment plan	CR7	Other (describe)
C4	Concern about prescriber or medication issues		
C5	Lack of response or follow-up		
C6	Lack of coordination among providers		
C7	Care not culturally appropriate		
C8	Client believed quality of care inadequate		
C9	Other (describe)		

EXHIBIT E

REQUEST FOR REIMBURSEMENT

EIN:

Grant Period:

Sub-Grantee:

Period Covered:

Address:

PO:

REQUEST FOR REIMBURSEMENT

Service Category	Budget	Current Period Invoice	Expenditure to Date	Unexpended Balance	Unexpended %
Core Services					
Outpatient & ambulatory	$0.00	$0.00	$0.00	$0.00	
AIDS Pharmaceutical Assistance	$0.00	$0.00	$0.00	$0.00	
Oral Health	$0.00	$0.00	$0.00	$0.00	
Early Intervention Services	$0.00	$0.00	$0.00	$0.00	
Health Insurance Program HIC	$0.00	$0.00	$0.00	$0.00	
Mental Health Services	$0.00	$0.00	$0.00	$0.00	
Medical Nutrition Therapy	$0.00	$0.00	$0.00	$0.00	
Medical Case Management	$0.00	$0.00	$0.00	$0.00	
Substance Abuse Outpatient	$0.00	$0.00	$0.00	$0.00	
Support Services	$0.00				
EFA - Housing /Utilities/Food	$0.00	$0.00	$0.00	$0.00	
Food Bank/Home Delivered Meals	$0.00	$0.00	$0.00	$0.00	
Housing Services	$0.00	$0.00	$0.00	$0.00	
Medical Transportation	$0.00	$0.00	$0.00	$0.00	
Health Ed/Risk Red Prev	$0.00	$0.00	$0.00	$0.00	

EXHIBIT E

REQUEST FOR REIMBURSEMENT

Service Category	Budget	Current Period Invoice	Expenditure to Date	Unexpended Balance	Unexpended %
Administration	$0.00	$0.00	$0.00	$0.00	
TOTALS	$0.00	$0.00	$0.00	$0.00	

Total Award:	$0.00
Less: Prior Reimbursement Payments:	$0.00
Funds Available:	$0.00
Total Reimbursement Requested:	$0.00
Balance of Funds Remaining:	$0.00

Provider Signature:	Title:	Date:
Fiscal Review/Approval:		Date:
Grant Admin/Director Approval:		Date:

TOTAL REQUEST FORM – PER SERVICE CATEGORY

Line Item	Salary	% FTE	Current Budget	Current Invoice	Expenditure to Date	Unexpended Balance
Personnel						
Subtotal Salaries				$0.00		
Fringe Benefits						
TOTAL PERSONNEL				$0.00		
Travel						
TOTAL TRAVEL				$0.00		

EXHIBIT E

REQUEST FOR REIMBURSEMENT

Line Item	Salary	% FTE	Current Budget	Current Invoice	Expenditure to Date	Unexpended Balance
Supplies						
TOTAL SUPPLIES				$0.00		
Contractual/Subcontracts						
TOTAL CONTRACTUAL/SUBCONTRACTS				$0.00		
Others - direct cost						
TOTAL DIRECT COST				$0.00		
Total Requested Grant Funds				**$0.00**		
PROGRAM INCOME						

EXHIBIT F
FEDERAL REQUIREMENTS

1. COUNTY is the recipient of Part A funds pursuant to the CFDA title: HIV Emergency Relief Project CFDA Number 93.914; Ryan White HIV/AIDS Treatment Extension Act of 2009 Grant Number H89HA06900, (hereinafter referred to as the "TREATMENT EXTENSION ACT") and COUNTY is responsible for the administration of said funds within the Las Vegas, Nevada, standard metropolitan statistical area as defined by the U.S. Census Bureau, which metropolitan area has been designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services (hereinafter referred to as "HRSA") as a Transitional Grant Area (TGA) for TREATMENT EXTENSION ACT funding.

2. PROVIDER understands that TREATMENT EXTENSION ACT funds are to be used as dollars of last resort for each client. PROVIDER understands and further agrees that it shall account for the use of TREATMENT EXTENSION ACT funding by ensuring all expenditures are reasonable and necessary, and are subject to the following:

    a. PROVIDER may allocate no more than 10% of the contract amount for "administrative" costs, as defined by COUNTY, HRSA and applicable federal Office of Management and Budget (OMB) Circulars. Funds are to be provided on a reimbursement basis.
    b. Approval of the award budget by COUNTY constitutes prior approval for the expenditure of funds for specified purposes included in this budget. The transfer of funds between providers at any level requires approval from the Board of County Commissioners. Requests to revise approved budgeted amounts must be made in writing and provide sufficient narrative detail to determine justification.
    c. COUNTY reserves the right to hold reimbursement under this award until any delinquent forms or requirements of grant award are filed.
    d. Reimbursement requests shall be submitted no later than sixty (60) days from the end of the month in which the costs were incurred.
    e. Within forty-five (45) days of the CLOSE OF THE AWARD PERIOD, a complete financial accounting of all expenditures shall be submitted to COUNTY.
    f. COUNTY reserves the right to reallocate funding based on utilization of services furnished by PROVIDER during the term of this Agreement, so that services to be provided and the corresponding maximum payment amount may be decreased or increased at the discretion of COUNTY for services remaining to be provided. COUNTY reserves the right to reduce PROVIDER's funding and to reallocate such funding to other Ryan White providers if it appears the full funding shall not be used by PROVIDER.
    g. The Agreement may also be immediately terminated by COUNTY in the event federal funding is reduced or eliminated and for cause as set forth herein. Upon the effective date of any termination, any and all rights and obligations of each party hereto shall be deemed at an end and canceled, except as previously accrued or vested.

3. Restrictions on Grant Expenditures

    a. TREATMENT EXTENSION ACT funds shall not be used to purchase or improve land, or to purchase, construct, or make permanent improvements to any building, except for minor remodeling, if authorized.
    b. TREATMENT EXTENSION ACT funds shall not be used to make direct payments to recipients of services.

c. TREATMENT EXTENSION ACT funds shall not be used to supplant or replace current state, local, or private HIV-related funding. PROVIDER shall maintain documentation on file assuring that services rendered under this Agreement will use TREATMENT EXTENSION ACT funding as "dollars of last resort" and that the client has no other source of funding to provide such services.

d. TREATMENT EXTENSION ACT funds are to be used for HIV/AIDS-related services only. Use of these funds for research, epidemiological surveys, clinical trials, and capital projects is prohibited.

e. TREATMENT EXTENSION ACT funds shall not be used to provide items or services for which payment already had been made or reasonably can be expected to be made by third party payers, including Medicaid, Medicare, and/or other federal, state, or local entitlement programs, prepaid health plans, or private insurance. PROVIDER shall provide its Medicare/Medicaid certification number or evidence of the status of becoming Medicare/Medicaid certified.

f. COUNTY shall not honor any request for payment for services provided by volunteers at no cost to PROVIDER. COUNTY shall not honor any request for payment for services provided outside of Clark and Nye Counties, Nevada, and Mohave County, Arizona, unless prior written authorization has been obtained from COUNTY.

4. PROVIDER understands and further agrees to the eligibility criteria for the Ryan White Part A Program. Delivery of services is contingent on verification of medical and financial eligibility.

a. General Scope of Work for All Providers

(1) See Exhibit A for specific services and Scope of Work.

(2) PROVIDER shall provide Care and Support Services to HIV/AIDS infected persons regardless of age, race, ethnicity, religion or gender, and sexual orientation which services are culturally sensitive, linguistically appropriate and appropriate to patients' functional acuity level.

(3) Comply with *National Standards for Culturally and Linguistically Appropriate Services in Health Care* as defined by the US Department of Health and Human Services, Office of Minority Health. These Standards are available on the Office of Minority Health's website at http://www.thinkculturalhealth.hhs.gov/clas/standards

(4) Participate in the Las Vegas TGA Continuum of Care where services are organized to respond to the individual or family's changing needs in a holistic, coordinated, timely and uninterrupted manner, thereby reducing fragmentation of care. PROVIDER shall submit to COUNTY copies of current Memoranda of Understanding with all other providers within the Continuum of Care.

(5) PROVIDER must establish a system of written procedures through which a client or their representative may present grievances about the operation of PROVIDER's services. PROVIDER shall provide these written procedures to COUNTY upon request and shall make them readily accessible to clients, such as through the posting or distribution of the procedures in areas frequented by clients. PROVIDER shall, upon request, provide advice to such persons as to the grievance procedure. Refer to Exhibit D for Grievance Reporting Structure. PROVIDER shall submit resolved grievances to the Ryan White Part A Grantee staff quarterly by the 15th of the following month (see Exhibit D).

(6) PROVIDER shall maintain on file and adhere to its current internal and Ryan White Part A grievance and/or sanction procedures made available in English and in Spanish for clients not satisfied with services received from PROVIDER.

(7) PROVIDER must submit to COUNTY, prior to permanent banning or restriction to services by mail only, all data related to eligible client for a final determination by COUNTY.

(8) PROVIDER shall obtain written approval from COUNTY prior to making programmatic changes in the scope of the project.

(9) PROVIDER shall inform COUNTY, in writing, of changes in Board composition specified in this Agreement within thirty (30) business days of any such change.

(10) Utilize COUNTY furnished COUNTY approved management information system software to manage eligible client data. Data must be entered within three (3) business days of delivery of service to client. Specialty services encounter data must be entered within three (3) business days of receipt by PROVIDER.

(11) PROVIDER shall ensure that client confidentiality is maintained when accessing the client services management information systems database.

(12) PROVIDER shall ensure that 100% of clients are registered in the client services management information systems database approved by COUNTY prior to the receipt of services.

(13) PROVIDER shall check eligibility status on 100% of clients prior to the delivery of services and refer 100% of clients not registered for an eligibility assessment.

(14) PROVIDER shall openly and honestly disclose business practices, written records and client files pertaining to the provision of Ryan White Part A funded services to COUNTY representatives during scheduled site review visits by COUNTY staff.

(15) PROVIDER shall comply with corrective action recommendations as a result of the site review visit.

(16) PROVIDER shall actively assist in quality improvement effort(s) by COUNTY and/or the Ryan White Part A Planning Council by encouraging their clients to participate in various client opinion sampling opportunities which may include ongoing written client satisfaction surveys, personal onsite interviews or focus groups and/or needs assessment for the purpose of ongoing or periodic assessment of client needs to improve the quality of care.

(17) PROVIDER shall submit documentation/proof of completing any corrective actions identified in the programmatic site visits by due dates specified in the site visit reports.

(18) PROVIDER shall collaborate with COUNTY by allowing staff to participate in meetings and trainings as attendees and/or as presenters, as needed.

(19) At least one PROVIDER representative shall attend mandatory TREATMENT EXTENSION ACT Provider Meetings with dates, times, and locations to be determined by COUNTY.

(20) PROVIDER will send qualified participants(s) to attend Medical Case Management related meetings as directed by COUNTY. Times and dates will be determined by COUNTY.

(21) PROVIDER will send qualified participant(s) to attend Clinical Quality Management related meetings as directed by COUNTY. Times and dates will be determined by COUNTY.

(22) PROVIDER required to attend at minimum a quarterly one-on-one meeting with COUNTY to discuss budgets, service provision, client concerns and any other pertinent events related to grant funding or programming. Times and dates will be determined by COUNTY.

(23) PROVIDER shall participate in Technical Assistance training as needed and as identified by COUNTY and PROVIDER staff.

(24) The following written documents shall be visibly posted within thirty (30) business days of execution of this Agreement.

1. The Statement of Consumer Rights
2. Disability Act
3. Labor laws
4. Sanction policy and/or zero tolerance information
5. Grievance policy or posted information informing clients that there is a grievance policy.

(25) PROVIDER shall supply COUNTY with a copy of any Direct Service subcontract Agreements within thirty (30) days of execution of that Agreement.

(26) PROVIDER shall notify COUNTY, in writing, of staff changes that occur during the award period to staff that are employed using TREATEMENT EXTENSION ACT funds within one (1) business day of such occurrences.

(27) PROVIDER shall supply COUNTY with a list of active Board of Directors' members and meetings scheduled to occur seven (7) days after the execution date of this Agreement, PROVIDER shall supply COUNTY with a list of the Board of Directors members.

(28) PROVIDER shall make meeting minutes available, upon request, within five (5) business days of request.

(29) PROVIDER shall supply COUNTY with a summary of all current fiscal year funding sources with dollar amounts or estimates of amounts no later than ninety (90) days after the execution of this Agreement.

(30) PROVIDER agrees, pursuant to HRSA/HAB and the COUNTY Quality Management requirements, to maintain and annually update a written Quality Improvement Work Plan. The plan shall integrate culturally relevant, client-centered services as defined and outlined in the HRSA Quality Management Technical Assistance Manual. The work plan shall have a planned, systematic process for monitoring, evaluating, improving and measurement methodology for the following domains: accessibility of care, appropriateness of care, continuity of care, effectiveness of care, and efficacy of care. PROVIDER shall demonstrate that findings are used to improve access and remove barriers to services; improve capacity to provide services in a timely manner; improve the quality of care provided and the coordination of benefits; and strengthen and expand prevention, early intervention and education services. The Quality Improvement Work Plan will identify the population served, objectives, indicators, performance goals and measurement method for each of the domains listed above. PROVIDER shall supply COUNTY with an annual Quality Improvement Plan within sixty (60) days of the executed contract.

(31) PROVIDER shall complete and submit to HRSA all federally mandated Program Data no later than the due dates specified by HRSA.

(32) PROVIDER shall supply COUNTY with a copy of the most recent Office of Management and Budget (OMB) A – 133 audit within six (6) months of completion of PROVIDER Fiscal Year.

(33) PROVIDER shall adhere to the HRSA Part A Program Monitoring Standards, Fiscal Monitoring Standards and Universal Monitoring Standards.

5. PROVIDER understands and further agrees that this Agreement is valid and enforceable only if sufficient TREATMENT EXTENSION ACT funds are made available to COUNTY by HRSA. Payment for all services provided under this Agreement is expressly contingent upon the availability of such TREATMENT EXTENSION ACT funds. This Agreement may be amended, suspended or terminated effective immediately by COUNTY at any time in the event of a change in, a suspension of or discontinuation of the availability of these funds.

6. PROVIDER shall comply with all applicable state, federal and county laws and regulations relating to its performance under this Agreement as they now exist and as hereafter amended or otherwise modified. PROVIDER shall perform all services under this Agreement in compliance with the U.S. Office of Management and Budget (OMB) cost principles and uniform administrative requirements as promulgated in its published circulars as well as U.S. Department of Health and Human Services Public Health Service Grants Policy Statements, all HRSA TREATMENT EXTENSION ACT program guidelines, policies and practices and comply with the Universal Health Records Standards issued by HRSA and the Title 45 CFR Part 75 – Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards found here http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75

7. PROVIDER agrees that grant funds may only be used for the awarded purpose and are approved expenditures under the guidelines of U.S. Department of Health and Human Services and Health Resources and Services Administration.

In the event PROVIDER expenditures do not comply with this condition, that portion not in compliance must be refunded to the COUNTY.

8. PROVIDER agrees that the expenditure of award funds in excess of approved budgeted amount, without prior written approval by the COUNTY, may result in the PROVIDER refunding to the COUNTY that amount expended in excess of the approved budget.

9. PROVIDER agrees to comply with the requirements of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and any relevant program-specific regulations, and shall not discriminate against any employee or offer for employment because of race, national origin, ethnicity, color, gender, sexual orientation, religion, age, or disability (including AIDS and AIDS-related conditions). PROVIDER shall include this non-discrimination clause in all subcontracts/agreements in connection with any service or other activity under this Agreement.

10. PROVIDER shall also be in compliance with the Equal Employment Opportunity Act, Anti-Kickback Act, the Davis-Bacon Act and OSHA regulations.

11. In accordance with the Immigration Reform and Control Act of 1986, PROVIDER shall not knowingly employ unauthorized or illegal aliens in the performance of this Agreement.

12. PROVIDER agrees to comply with the Americans with Disabilities Act of 1990 (P.L. 101-136), 42 U.S.C. 12101, as amended, and regulations adopted there under contained in 28 CFR 26.101-36.999 inclusive, and any relevant program-specific regulations.

13. PROVIDER certifies, by signing this Agreement, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pt. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal Register (pp.19150-19211). This certification shall be required by PROVIDER of every subcontractor receiving any payment in whole or in part from monies paid pursuant to this Agreement.

14. PROVIDER agrees, whether expressly prohibited by federal, state, or local law, or otherwise, that no funding associated with this award shall be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose the following:

    a. any federal, state, county or local agency, legislature, commission, council, or board;
    b. any federal, state, county or local legislator, commission member, council member, board member, or other elected official; or
    c. any officer or employee of any federal, state, county or local agency, legislature, commission, council, or board.

15. PROVIDER shall also account for and report funds expended and/or services provided from other funding sources, specifically for the HIV/AIDS programs including but not limited to in-kind contributions, volunteer services, cash match, other grants and all monetary contributions and donations.

16. PROVIDER agrees to disclose any existing or potential conflicts of interest relative to the performance of services resulting from this award. The COUNTY reserves the right to disqualify PROVIDER on the grounds of actual or apparent conflict of interest. Any concealment or obfuscation of a conflict of interest, whether intentional or unintentional, shall automatically result in the disqualification of funding.

17. PROVIDER shall ensure the confidentiality of medical information that contains patient identifiers including name, date of birth, Social Security number, telephone number, medical record number and ZIP code. PROVIDER shall

comply with all state confidentiality laws and federal Health Insurance Portability and Accountability Act (HIPAA) regulations that protect all individually identifiable health information in any form (electronic, paper-based, oral) that is stored or transmitted by a HIPAA covered entity.

18. PROVIDER must have on file updated yearly certification of HIPAA training completed by members of staff.

19. All client data listed in the COUNTY approved data management system or included in client files must only be used in course of regular business. Any data from COUNTY approved data management system or client files intended for any other use must have written approval from COUNTY.

20. PROVIDER shall submit copies to COUNTY of all forms of written correspondence and/or documents pertaining to Ryan White TREATMENT EXTENSION ACT Part A services including, but not limited to, press releases and notices to the general public issued or released by PROVIDER.

21. All statements, press releases, flyers, posters, brochures, and other documents promoting programs and services funded in whole or in part with TREATMENT EXTENSION ACT funds shall specifically reference that funding has been made available through a grant from the U.S. Department of Health and Human Services, HRSA, and Clark County under the TREATMENT EXTENSION ACT.

22. Title to any and all equipment procured through the expenditure of TREATMENT EXTENSION ACT funds will vest upon acquisition with COUNTY. Upon termination of this Agreement, COUNTY shall solely determine the disposition of all such equipment.

23. Property records shall be maintained by PROVIDER, including a description of the property, serial or ID number, source of property, title holder, acquisition date and cost of property, percentage of TREATMENT EXTENSION ACT funds used to procure property, location, use and condition of the property.

24. COUNTY shall monitor PROVIDER's performance during the term of this Agreement. This shall include, but not be limited to, site visits, PROVIDER's participation in COUNTY's sponsored training and contractor meetings, timeliness of deliverables and grantee sponsored projects through the Ryan White Part A Planning Council. Results of this review may be considered when evaluating PROVIDER's performance for continued funding in future grant year. This section shall survive the termination of this Agreement.

25. If PROVIDER fails to substantially comply with any material provisions of this Agreement, COUNTY reserves the right to withhold payment in an amount that corresponds to the harm caused by PROVIDER, and/or to immediately suspend, modify or terminate this Agreement. Events that may also lead to withholding of funds, and/or suspension, modification or termination include, but are not limited to:

    a. PROVIDER materially breaches this Agreement or is in material violation of any applicable county ordinance or state or federal law in conducting activities under this Agreement.
    b. PROVIDER fails to maintain any license, registration, or permit required to provide the services specified in this Agreement or fails to utilize licensed personnel, where required by law;
    c. PROVIDER, either knowingly or unknowingly, misrepresents, in any way, information or data furnished to COUNTY, or submits reports that are materially incorrect, incomplete or delinquent;
    d. PROVIDER makes improper use of funds;
    e. PROVIDER fails to resolve, to the reasonable satisfaction of COUNTY, any disallowed or questionable costs and/or operating practices identified in any current or prior fiscal year program monitoring, site visit or audit report;
    f. PROVIDER engages in unlawful discrimination;
    g. PROVIDER fails to take timely corrective action in response to written notification by COUNTY;
    h. PROVIDER is indebted to the United States Government;

i. PROVIDER fails to collaborate and cooperate with other TREATMENT EXTENSION ACT funded or non-funded agencies when deemed necessary to provide efficient and effective services to the HIV infected/affected population. This includes failing to attend or send an appropriate representative to HIV/AIDS related meetings scheduled by COUNTY and other agencies;

j. PROVIDER fails to accomplish the Scope of Work or fails to meet deliverable due dates specified in this Agreement.

k. PROVIDER uses TREATMENT EXTENSION ACT funds for lobbying purposes or fails to submit to COUNTY "Disclosure of Lobbying Activities with Non-Federal Funds" Statement if PROVIDER engages in lobbying activities.

l. COUNTY reasonably deems PROVIDER's performance unsatisfactory.

26. All participating client information furnished by COUNTY to PROVIDER shall be provided via COUNTY approved management information system. PROVIDER is entitled to rely on information provided in COUNTY approved management information system to the extent such information or data would be relied upon by a reasonably prudent PROVIDER.

27. This Contract may be immediately terminated by COUNTY in the event federal funding is reduced or eliminated and for cause as set forth herein. Upon the effective date of any termination, any and all rights and obligations of each party hereto shall be deemed at an end and canceled, except as previously accrued or vested.

28. PROVIDER shall schedule an annual financial audit with a qualified certified public accounting firm. A copy of the auditor's report, financial statements and management letter, if any, for the prior fiscal year shall be submitted to COUNTY for review along with any required corrective action plan. A copy of the Financial Audit Report must be sent to Clark County Social Service, Attn: Ryan White Grant Administrator, 1600 Pinto Lane, Las Vegas, Nevada 89106. Failure to meet this requirement may result in loss of current funding and disqualification from consideration for further COUNTY administered funding. This audit shall be made by an independent auditor in accordance with generally accepted accounting principles and title 45 Code of Federal Regulation Part 75 – Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards. This requirement applies equally to any and all subcontractors of PROVIDER that receive TREATMENT EXTENSION ACT funds. Any subcontracts shall be furnished to COUNTY to ensure conformance with all TREATMENT EXTENSION ACT requirements.

29. PROVIDER shall make appropriate corrections within two (2) months after receipt of an audit report to remedy any problems identified in the audit report. COUNTY may withhold payment for non-correction of material weaknesses identified by the audit report in addition to its right to terminate this Agreement for such non-correction.

30. If PROVIDER is unable to furnish the audit reports required above, PROVIDER shall submit to COUNTY a written request with an explanation for an extension prior to the six (6) month deadline. The request shall include a letter from the Certified Public Accounting firm engaged to perform the audit that states, at a minimum, that the firm has been engaged to perform the audit and the anticipated completion date.

31. COUNTY shall monitor the entire program under this Agreement on an ongoing basis. COUNTY shall advise PROVIDER in advance of the monitoring procedure which shall be used. All information obtained by monitors shall be kept confidential within COUNTY, except as otherwise required by federal or state statutes or regulations.

32. This Agreement may be terminated without cause by COUNTY giving written notice by personal service or Certified Mail to the PROVIDER at least thirty (30) days prior to the effective date of such termination.

33. Accounting records are considered to be all records relating to the expenditure and reimbursement of funds awarded under this Agreement. Records required for retention include all accounting records, including related original and

supporting documents that substantiate costs charged to the award activity. Recipients of awards are required to maintain accounting records, identifiable by award number. Such records shall be maintained in accordance with the following:

a. Records must be retained for at least five (5) calendar years (unless otherwise stipulated) from the date that the final reports have been submitted to COUNTY.

b. In all cases, an overriding requirement exists to retain records until resolution of any audit questions relating to individual awards.

c. Current job descriptions as well as curriculum vitae, resumes, copies of certificates, licenses, and other pertinent credentials of all employees serving in positions funded under this Agreement need to be retained for a minimum of five (5) years subsequent to the expiration date of this agreement, making them available to COUNTY upon request.

EXHIBIT C
SUBCONTRACTOR INFORMATION

DEFINITIONS:

MINORITY OWNED BUSINESS ENTERPRISE (MBE): An independent and continuing **Nevada** business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.

WOMEN OWNED BUSINESS ENTERPRISE (WBE): An independent and continuing **Nevada** business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.

PHYSICALLY-CHALLENGED BUSINESS ENTERPRISE (PBE): An independent and continuing **Nevada** business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.

SMALL BUSINESS ENTERPRISE (SBE): An independent and continuing **Nevada** business for profit which performs a commercially useful function, is **not** owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed $2,000,000.

VETERAN OWNED ENTERPRISE (VET): A Nevada business at least 51% owned/controlled by a veteran.

DISABLED VETERAN OWNED ENTERPRISE (DVET): A Nevada business at least 51% owned/controlled by a disabled veteran.

EMERGING SMALL BUSINESS (ESB): Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

It is our intent to utilize the following MBE, WBE, PBE, SBE, VET, DVET and ESB subcontractors in association with this Contract:

1. Subcontractor Name:______________________________
   Contact Person:__________________ Telephone Number:__________________
   Description of Work:______________________________
   ____
   Estimated Percentage of Total Dollars:______________________________
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

2. Subcontractor Name:______________________________
   Contact Person:__________________ Telephone Number:__________________
   Description of Work:______________________________
   ____
   Estimated Percentage of Total Dollars:______________________________
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

3. Subcontractor Name:______________________________
   Contact Person:__________________ Telephone Number:__________________
   Description of Work:______________________________
   ____
   Estimated Percentage of Total Dollars:______________________________
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

4. Subcontractor Name:______________________________
   Contact Person:__________________ Telephone Number:__________________
   Description of Work:______________________________
   ____
   Estimated Percentage of Total Dollars:______________________________
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

☐ No MBE, WBE, PBE, SBE, VET, DVET or ESB subcontractors will be used.

EXHIBIT G
RFP NO. 604274-16
Business Associate Agreement

This Agreement is made effective the _____of ________________, 201__, by and between **Clark County, Nevada** (hereinafter referred to as "Covered Entity"), with its principal place of business at 500 S. Grand Central Parkway, Las Vegas, Nevada, 89155, and _______________________, hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Rules"); and

WHEREAS, the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), pursuant to Title XIII of Division A and Title IV of Division B, called the "Health Information Technology for Economic and Clinical Health" ("HITECH") Act, as well as the Genetic Information Nondiscrimination Act of 2008 ("GINA," Pub. L. 110-233), provide for modifications to the HIPAA Rules; and

WHEREAS, the Secretary, U.S. Department of Health and Human Services, published modifications to 45 CFR Parts 160 and 164 under HITECH and GINA, and other modifications on January 25, 2013, the "Final Rule," and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "Business Associate" of Covered Entity as defined in the HIPAA Rules (the agreement evidencing such arrangement is entitled "Underlying Agreement"); and

WHEREAS, Business Associate will have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

THEREFORE, in consideration of the Parties' continuing obligations under the Underlying Agreement, compliance with the HIPAA Rules, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Rules and to protect the interests of both Parties.

I. <u>DEFINITIONS</u>

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

"Protected Health Information" means individually identifiable health information created, received, maintained, or transmitted in any medium, including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the

provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. "Protected Health Information" includes without limitation "Electronic Protected Health Information" as defined below.

"Electronic Protected Health Information" means Protected Health Information which is transmitted by Electronic Media (as defined in the HIPAA Rules) or maintained in Electronic Media.

The following terms used in this Agreement shall have the same meaning as defined in the HIPAA Rules: Administrative Safeguards, Breach, Business Associate, Business Associate Agreement, Covered Entity, Individually Identifiable Health Information, Minimum Necessary, Physical Safeguards, Security Incident, and Technical Safeguards.

II. ACKNOWLEDGMENTS

Business Associate and Covered Entity acknowledge and agree that in the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Rules, the HIPAA Rules shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement shall control.

Business Associate acknowledges and agrees that all Protected Health Information that is disclosed or made available in any form (including paper, oral, audio recording or electronic media) by Covered Entity to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.

Business Associate has read, acknowledges, and agrees that the Secretary, U.S. Department of Health and Human Services, published modifications to 45 CFR Parts 160 and 164 under HITECH and GINA, and other modifications on January 25, 2013, the "Final Rule," and the Final Rule significantly impacted and expanded Business Associates' requirements to adhere to the HIPAA Rules.

III. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(a) Business Associate agrees that all uses and disclosures of Protected Health information shall be subject to the limits set forth in 45 CFR 164.514 regarding Minimum Necessary requirements and limited data sets.

(b) Business Associate agrees to use or disclose Protected Health Information solely:

(i) For meeting its business obligations as set forth in any agreements between the Parties evidencing their business relationship; or

(ii) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement or the Underlying Agreement (if consistent with this Agreement and the HIPAA Rules).

(c) Where Business Associate is permitted to use Subcontractors that create, receive, maintain, or transmit Protected Health Information; Business Associate agrees to execute a "Business Associate Agreement" with Subcontractor as defined in the HIPAA Rules that includes the same covenants for using and disclosing, safeguarding, auditing, and otherwise administering Protected Health Information as outlined in Sections I through VII of this Agreement (45 CFR 164.314).

(d) Business Associate will acquire written authorization in the form of an update or amendment to this Agreement and Underlying Agreement prior to:

(i) Directly or indirectly receiving any remuneration for the sale or exchange of any Protected Health Information; or

(ii) Utilizing Protected Health Information for any activity that might be deemed "Marketing" under the HIPAA rules.

IV. SAFEGUARDING PROTECTED HEALTH INFORMATION

(a) Business Associate agrees:

(i) To implement appropriate safeguards and internal controls to prevent the use or disclosure of Protected Health Information other than as permitted in this Agreement or by the HIPAA Rules.

(ii) To implement "Administrative Safeguards," "Physical Safeguards," and "Technical Safeguards" as defined in the HIPAA Rules to protect and secure the confidentiality, integrity, and availability of Electronic Protected Health Information (45 CFR 164.308, 164.310, 164.312). Business Associate shall document policies and procedures for safeguarding Electronic Protected Health Information in accordance with 45 CFR 164.316.

(iii) To notify Covered Entity of any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system ("Security Incident") upon discovery of the Security Incident.

(b) When an impermissible acquisition, access, use, or disclosure of Protected Health Information ("Breach") occurs, Business Associate agrees:

(i) To notify the Covered Entity HIPAA Program Management Office immediately upon discovery of the Breach, and

(ii) Within 15 business days of the discovery of the Breach, provide Covered Entity with all required content of notification in accordance with 45 CFR 164.410 and 45 CFR 164.404, and

(iii) To fully cooperate with Covered Entity's analysis and final determination on whether to notify affected individuals, media, or Secretary of the U.S. Department of Health and Human Services, and

(iv) To pay all costs associated with the notification of affected individuals and costs associated with mitigating potential harmful effects to affected individuals.

V. RIGHT TO AUDIT

(a) Business Associate agrees:

(i) To provide Covered Entity with timely and appropriate access to records, electronic records, personnel, or facilities sufficient for Covered Entity to gain

reasonable assurance that Business Associate is in compliance with the HIPAA Rules and the provisions of this Agreement.

(ii) That in accordance with the HIPAA Rules, the Secretary of the U.S. Department of Health and Human Services has the right to review, audit, or investigate Business Associate's records, electronic records, facilities, systems, and practices related to safeguarding, use, and disclosure of Protected Health Information to ensure Covered Entity's or Business Associate's compliance with the HIPAA Rules.

VI. <u>COVERED ENTITY REQUESTS AND ACCOUNTING FOR DISCLOSURES</u>

(a) At the Covered Entity's Request, Business Associate agrees:

(i) To comply with any requests for restrictions on certain disclosures of Protected Health Information pursuant to Section 164.522 of the HIPAA Rules to which Covered Entity has agreed and of which Business Associate is notified by Covered Entity.

(ii) To make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Rules. If Business Associate maintains Protected Health Information electronically, it agrees to make such Protected Health Information electronically available to the Covered Entity.

(iii) To make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Rules.

(iv) To account for disclosures of Protected Health Information and make an accounting of such disclosures available to Covered Entity as required by Section 164.528 of the HIPAA Rules. Business Associate shall provide any accounting required within 15 business days of request from Covered Entity.

VII. <u>TERMINATION</u>

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Underlying Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate of such belief within a reasonable time after forming such belief, and Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Underlying Agreement immediately.

At termination of this Agreement, the Underlying Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit

further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

VIII. MISCELLANEOUS

Except as expressly stated herein or the HIPAA Rules, the Parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Underlying Agreement and/or the business relationship of the Parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of Nevada. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a Party believes in good faith that any provision of this Agreement fails to comply with the HIPAA Rules, such Party shall notify the other Party in writing. For a period of up to thirty days, the Parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Rules, then either Party has the right to terminate upon written notice to the other Party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:	BUSINESS ASSOCIATE:
By:____________________________	By:___________________________
JESSICA COLVIN	
CHIEF FINANCIAL OFFICER	Title:_________________________
Date:___________________________	Date:__________________________