TO: SOUTHERN NEVADA DISTRICT BOARD OF HEALTH

Date: March 28, 2013

RE: *Ryan White CARE Act – Part A / Approval for Interlocal Contract with Clark County for Medical, Core and Support Services for HIV/AIDS Infected and Affected Clients in the Las Vegas Transitional Grant Area (TGA).*

PETITION # 08-13

That the Southern Nevada District Board of Health *approve the attached Interlocal Contract with Clark County for the provision of services in accordance with Health Resources Services Administration (HRSA) HIV/AIDS Programs, Ryan White Part A HIV Emergency Relief Grant for the period of March 1, 2013 – February 28, 2014.*

PETITIONERS:

Rick Reich, *Communicable Disease Manager*
Bonnie Sorenson, R.N., *Director of Clinics/Nursing Services*
Elaine Glaser, *Director of Administration*
John Middaugh, MD, *Interim Chief Health Officer*

DISCUSSION:

Continuation of the Interlocal Contract for Ryan White Part A Services for period March 1, 2013 – February 28, 2014.

FUNDING:

All funds are pre-awarded based on the Ryan White HIV/AIDS Treatment extension Act of 2009 HIV Emergency Relief Grant No. 93.914 for Grant Year March 1, 2013 – February 28, 2014 for the Las Vegas Ryan White TGA. Prior year allocation **estimated** for CORE medical services under this continuation are as follows:

Service Category	Allocation
Outpatient/Ambulatory Health Services	$ 300,000.00
Early Intervention Services	$ 589,627.00
Medical Case Management	$ 483,217.00
Outpatient Substance Abuse Services	$ 21,842.20

Funds for grant period noted above are contingent upon Clark County's receipt of Awarded funds from HRSA to the Las Vegas TGA.

CLARK COUNTY, NEVADA

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

RFQ NO. 602819-12

SOUTHERN NEVADA HEALTH DISTRICT
NAME OF FIRM
Rick R. Reich, Communicable Disease Manager
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) 759-0711
(AREA CODE) AND TELEPHONE NUMBER
(702) 868-2825
(AREA CODE) AND FAX NUMBER
reich@snhdmail.org
E-MAIL ADDRESS

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

This Contract is made and entered into this _____ day of _____ 2013, by and between CLARK COUNTY, NEVADA (hereinafter referred to as COUNTY), and SOUTHERN NEVADA HEALTH DISTRICT (hereinafter referred to as PROVIDER , for CONTRACT FOR MEDICAL, CORE ANDSUPPORT SERVICES FOR HIV/AIDS INFECTED AND AFFECTED CLIENTS IN THE LAS VEGAS, RYAN WHITE,TRANSITIONAL GRANT AREA (hereinafter referred to as PROJECT).

WITNESSETH:

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 and Outpatient/Ambulatory Medical Care, Early Intervention Services, Medical Case Management, Substance Abuse Services-Outpatient 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 contracts for the performance of governmental services;

NOW, THEREFORE, COUNTY and PROVIDER agree as follows:

SECTION I: TERM OF CONTRACT

COUNTY agrees to retain PROVIDER for the period from March 1, 2013 through February 28, 2014, with the option to renew for three (3), one (1) -year periods 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. COUNTY reserves the right to extend the CONTRACT for up to an additional three (3) months for its convenience.

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, and Outpatient/Ambulatory Medical Care, Early Intervention Services, Medical Case Management, Substance Abuse Services-Outpatient standards of care), 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. Any modification to the annual amount awarded, prior to the renewal term, requires a written amendment to the contract. 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.

The 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).

B. 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. For time and materials contracts, time is to be defined as an hourly rate prorated to the 1/4 hour for invoicing purposes. If applicable, copies of all receipts, bills, statements, and/or invoices pertaining to reimbursable expenses such as; airline itineraries, car rental receipts, cab and shuttle receipts, and statement of per diem rate being requested must accompany any invoices containing travel expenses. Maximum reimbursable travel expenses under this contract shall be defined and set at the current U.S. GSA's CONUS rates at the time of travel. CONUS rates may be found at the following website: http://www.gsa.gov/portal/category/21287 .

   c. 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.

   d. A "BUDGET SUMMARY COMPARISON" which outlines the total amount PROVIDER was awarded, the amount expended to date, the current invoice amount, the total expenditures, and the remaining award balance must accompany all invoices.

   e. COUNTY's representative shall notify the PROVIDER in writing within 14 calendar days of any disputed amount included on the invoice. The 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 the 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 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 the 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.

C. 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 the PROVIDER.

SECTION III: SCOPE OF WORK

Services to be performed by the 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 the 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 the PROVIDER for the adjustment under this clause must be submitted in writing within 30 calendar days from the date of receipt by the 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 the 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, the 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 30 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 the COUNTY.

D. The 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. The 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. The PROVIDER shall be responsible for the professional quality, technical accuracy, timely completion, and coordination of all services furnished by the 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 the 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. The 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 the 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.

SECTION VI: SUBCONTRACTS

A. Services specified by this Contract shall not be subcontracted by the 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 the PROVIDER'S performance of services is delayed or if the 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 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 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 the PROVIDER is given:
      i. not less than 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 the 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 the PROVIDER at the time of termination may be adjusted to the extent of any additional costs occasioned to COUNTY by reason of the PROVIDER 's default.
   b. Upon receipt or delivery by PROVIDER of a termination notice, the 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 the PROVIDER to fulfill contractual obligations it is determined that the 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 prosecute the same to completion by agreement with another party or otherwise. In the event the PROVIDER shall cease conducting business, COUNTY shall have the right to make an unsolicited offer of employment to any employees of the PROVIDER assigned to the performance of this Contract.
5. The rights and remedies of COUNTY and the 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: INSURANCE

The PROVIDER shall obtain and maintain the insurance coverage required in **Exhibit E** incorporated herein by this reference. The PROVIDER shall comply with the terms and conditions set forth in **Exhibit E** and shall include the cost of the insurance coverage in their prices.

SECTION XI: 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: Alisha Barrett, Grant Administrator
1600 Pinto Lane
Las Vegas, NV 89106

TO PROVIDER: Southern Nevada Health District
Rick R. Reich, Communicable Disease Supervisor
400 Shadow Lane
Las Vegas NV 89106

SECTION XII: 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 the 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, the PROVIDER agrees that it will not employ unauthorized aliens in the performance of this Contract.

C. Public Funds

PROVIDER acknowledges that the 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, the COUNTY may declare the PROVIDER in breach of the Contract, terminate the Contract, and designate the 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

The 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 the PROVIDER or the employees or agents of the PROVIDER in the performance of this Contract.

F. Governing Law

Nevada law shall govern the interpretation of this Contract.

G. Covenant Against Contingent Fees The PROVIDER warrants that no person or selling agency has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide permanent employees. For breach or violation of this warranty, COUNTY shall have the right to annul this Contract without liability or in its discretion to deduct from the Contract price or consideration or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee.

H. Gratuities

1. COUNTY may, by written notice to the 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 the PROVIDER or any agent or representative of the 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 the PROVIDER as it could pursue in the event of a breach of this Contract by the 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 10 times the costs incurred by the 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.

I. Audits

The performance of this contract by the PROVIDER is subject to review by COUNTY to insure contract compliance. The PROVIDER agrees to provide COUNTY any and all information requested that relates to the performance of this contract. All request for information will be in writing to the 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.

J. Covenant

The 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.

K. Confidential Treatment of Information

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

L. 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.

M. Subcontractor Information

The 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), and Nevada Business Enterprise (NBE) subcontractors for this Contract utilizing the attached format **(Exhibit F)**. The information provided in **Exhibit F** by the PROVIDER is for the COUNTY's information only.

N. Entire Contract

This Contract, including any exhibits and documents referred to in this Contract which are attached hereto, each of which is incorporated herein, constitutes the entire and exclusive statement of the Contract between the parties with respect to its subject matter and there are no oral or written representations, understandings, or agreements relating to this Contract which are not fully expressed herein. The parties agree that any other terms or conditions included in any forms utilized or exchanges by the parties shall not be incorporated or be binding upon the parties unless expressly referred to in this Contract.

O. Severability

The invalidity or unenforceability of any term or provision of this Contract shall in no way affect the validity or enforceability of any other term or provision of the Contract.

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

SOUTHERN NEVADA HEALTH DISTRICT

By: [redacted]
~~TIM JONES, Chair~~
Southern Nevada Health District
Board of Health

Date: _____

CLARK COUNTY, NEVADA

By: [redacted]
STEVE SISOLAK, Chairman
Board of County Commissioners

Date: 2/19/13

ATTEST:

By: [redacted]
~~LAWRENCE K. SANDS, DO MPH~~
Interim Chief Health Officer

Date: _____

ATTEST:

By: [redacted]
DIANA ALBA,
COUNTY Clerk

Date: 2/19/13

APPROVED AS TO FORM:

By: _____
ANNETTE L BRADLEY Esq.
Attorney for Southern Nevada Health District

Date: _____

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

By: [redacted]
ELIZABETH VIBERT
Deputy District Attorney

Date: 2/4/2013

EXHIBT A
SCOPE OF PROJECT

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. The HIV Emergency Relief Grant Program Part A: Eligible Metropolitan Areas/Transitional Grant Areas HRSA Announcement No: HRSA-13-155 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.

All funds are pre-awarded based on the Ryan White HIV/AIDS Treatment Extension Act of 2009 HIV Emergency Relief Grant No. 93.914 for Grant Year Mar 1, 2013 – Feb 28, 2014 for the Las Vegas Ryan White TGA. Funds for Grant Year Mar 1, 2013-Feb 28, 2014 are contingent upon receipt of Grant Award funds from Health Resources and Services Administration to the Las Vegas Ryan White TGA.

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 broken out 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)

An implementation plan and its required components as described above are required for each core and support service category.

Core Service Categories

A. **Outpatient/Ambulatory Medical Care**

Medical care is 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 outpatient settings. Services include:

1. Diagnostic testing
2. Early intervention and risk assessment
3. Preventive care and screening
4. Practitioner examination
5. Medical history taking
6. Diagnosis and treatment of common physical and mental conditions
7. Prescribing and managing medication therapy
8. Education and counseling on health issues
9. Well-baby care
10. Continuing care and management of chronic conditions
11. 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 guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

C. **Early Intervention Services**

Include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, 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 providing therapeutic measures.

G. **Medical Case Management**

Range of client-centered services that link clients with health care, psychosocial, and other services, including Treatment Adherence. 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 must include:

(1) Initial assessment of service needs
(2) Development of a comprehensive, individualized service plan
(3) Coordination of services required to implement the plan, including internal and external referrals
(4) Client monitoring to assess the efficacy of the plan
(5) Periodic re-evaluation and adaptation of the plan as necessary over the life of the client

Medical Case Management 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. **When applying for this category please list how your agency will meet the required key activities of medical case management (items one through five). Description should also include formalized communication plan with medical team to ensure client's adherence to medical care or alerting medical team when client is not adhering to medical care or medication regimen.**

H. **Substance Abuse Services: Outpatient**

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, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

EXHIBIT A – ATTACHEMENT 1
STANDARDS OF CARE

Las Vegas Transitional Grant Area
Planning Council

All categories must follow *Universal Programmatic and Administrative Standards of Care* in additional to the specific standard of care listed below

Originated	Ratified
October 2012	

1. Overview/Purpose

The Federal Ryan White Program is funded through the Health Services Resources Administration (HRSA) HIV/AIDS Bureau (HAB) and works with cities, states, and local community-based organization to provide HIV-related services to more than half a million people each year. The Ryan White program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills gaps in care not covered by these other sources.

Ryan White Part A program *provides emergency assistance* to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.

The Las Vegas Transitional Grant Area (TGA) is committed to ensuring that appropriate and adequate services funded under Ryan White Part A meet the needs of those eligible persons living with HIV/AIDS; access is available to care and Part A services; and that all funded programs provide a standard system of delivery of care to all of its clients. These standards align with current Public Health Services (PHS) Guidelines and the Health Resources and Services Administration's (HRSA) standards and performance measures for service delivery to ensure the highest quality of services.

The following standards apply to all programs regardless of the type of service activity provided. These are the basic standards that all clients should expect when applying for/or receiving a Ryan White Part A funded service in the Las Vegas Transitional Grant Area. Additional standards may apply based on specific service category requirements and will be *in addition* to these standards. The standards set forth describe the provider's minimum programmatic and clinical requirements. Providers and individuals may exceed these standards.

While the following standards have been identified as basic standards of care they are not limited to these specific standards and each provider is still expected to carry out all terms as specified in the Part A contracts; follow all directives as outlined in the Ryan White Part A Manual and institute any modifications that may be required through updated HRSA/HAB policies or changes in the Ryan White legislation under the direction of the grantee.

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".

3. Eligibility- 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 client must meet the following criteria regardless of their service needs to be eligible for Part A services.

Although a client may be eligible for Part A services based on these general eligibility criteria, the specific service need that the client may be seeking may require additional eligibility criteria to be reviewed for service eligibility.

For complete guidelines and data entry procedures and definitions please refer to the "Ryan White Part A Eligibility Guidelines and Data Entry Procedures".

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. 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. All providers who distribute checks on the clients behalf will ensure that the agency name on the check will not indicate HIV and/or AIDS services.

5. All correspondence to a client, which includes but is not limited to, mail and faxes will not include HIV and/or AIDS in its titles.

6. 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.

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

5. 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.

6. 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.

7. 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.

- ❖ All providers that provide financial assistance on behalf of eligible clients and services (i.e., utilities, rent, medications, health insurance assistance, etc.) must have procedures in place that ensure that under no circumstances the financial assistance will be made directly to a client. In any event that the original or part of the financial payment assistance is directly reimbursed by the third party is forwarded to the client; a process to recover these funds must be enacted and collected immediately.

  As per HRSA Policy Notice 10-02, Federal funds are not to be directly provided to and/or used by the client.

  - ➢ *In no case may Ryan White HIV/AIDS Program funds be used to make direct payments of cash to recipients of services. Where direct provision of the service is not possible or effective, vouchers, coupons, or tickets that can be exchanged for a specific service or commodity (e.g., food or transportation) must be used. Grantees are advised to administer voucher programs in a manner which assures that vouchers cannot be used for anything other than the allowable service, and that systems are in place to account for disbursed vouchers.*

8. 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.

9. Licensing, Knowledge, Skills and Experience

All staff providing Ryan White Part A funded services will have appropriate licensing, certification and/or experience in the HIV field as prescribed by the individual service category that the provider receives funding for.

10. 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.

11. Quality Assurance and Service Measures

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.

4. 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.

5. Agency Compliance Measures for all 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.

12. Clinical Standards

Each service category may have specific clinical standards developed and outlined to properly measure the client's progress as it relates to the care the client is receiving and requiring. Program wide standards have been developed and are to be followed by all service categories. These indicators are expected to be tracked and monitored annually by all providers.

Clinical measures and standards are to be collected and reported to the grantee for monitoring. Where applicable these standards both clinical and administrative will be reported and monitored through the CAREWare electronic data collection system required for use by all of the Part A providers.

Program wide standard indicators

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).

13 Summary

The universal and administrative standards listed in this document represents the foundation of standards for the Ryan White Part A program for the Las Vegas Transitional Grant Area. They outline the expectations to be followed by every funded Ryan White Part A program, provider, and service. Specific details and definitions are subject to change by HRSA or the grantee depending on language in the legislation that could impact or alter care on the local level; available funding and available resources. Coordination of care should occur on each of the provider level as well as on the grantee level with other Ryan White Parts to ensure access to care, availability of services and that Part A is payor of last resort.

14. Recommendations

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

15. 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 .

References used for these Standards as well as service category specific:

- Part A Eligibility Guidelines Policy: Ryan White Part A Eligibility Guidelines and Data Entry Procedures. Las Vegas TGA, March 2012
- Ryan White HIV/AIDS TREATMENT EXTENSION ACT of 2006: Definitions for Eligible Services, August 2009
- HIV/AIDS Bureau's (HAB) updated Policy Notice 10-02: *Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services,* April 2010
- Implementing the National HIV/AIDS Strategy: Overview of Agency Operational Plans; Office of National AIDS Policy: The White House, February 2011
- HIV/AIDS Bureau, Division of Service Systems Monitoring Expectations for Ryan White Part A: Part A Program, Fiscal and Universal Monitoring Standards, April 2012
- Comprehensive HIV/AIDS Services Care Plan, Ryan White Part A HIV/AIDS Program: Las Vegas TGA, 2013-2016

16 Appendices

Not Applicable.

Las Vegas Transitional Grant Area
Planning Council

(A.) *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 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

(C.) *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

(G.) *Medical Case Management (including treatment adherence) Standards of Care*

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

(H.) *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
- Oplate 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:

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) 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.

2.2 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
[redacted]		
a.		$
b.		$
Total Equipment:		**$**
[redacted]		
a.		$
b.		$
Total Supplies:		**$**
[redacted]		
a.		$
b.		$
Total Contractual		**$**
[redacted]		
a.		$
b.		$
Total Other		**$**
Service Category Grand Total		**$**

*** This form may be updated per HRSA or County approval.**

EXHIBIT A
PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK
Attachment 3

Service Category and Requirements and Performance Measures

A. **PROVIDER shall provide [Service Category],** defined by HRSA as follows: *"[HRSA Definition for Service Category]".*

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

1. A minimum of **([UDC])** unduplicated clients shall receive [Service Category] services during the award period.
2. A minimum of (NUMBER) service units shall be provided each month during the award period in [Service Category].
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.
5. [Requirements specific to service category].

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

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

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

EXHIBIT B

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 B

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 B

ACCESS	
A1	Difficulty contacting Provider
A2	Timely appointment not available
A3	Convenient appointment not available
A4	No choice of clinicians or clinician not available
A5	Transportation or distance barrier
A6	Physical barrier to Provider's office
A7	Language barrier or lack of interpreter services
A8	Wait time during visit too long
A9	Other (describe)
Denial of Service, Authorization, or Payment	
D1	Desired service not available
D2	Client wanted more service than offered/authorized
D3	Request for service not covered by Ryan White TGA
D4	Request for medically unnecessary service
D5	Payment to non-participating provider denied
D6	Service authorization denied
D7	Other (describe)
Clinical Care	
C1	Client not involved in treatment planning
C2	Client's choice of service not respected
C3	Disagreement with treatment plan
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)

Interaction with Provider - COUNTY Staff	
I1	Client feels not treated with dignity or respect
I2	Client disagrees with staff or clinician response
I3	Lack of courteous service
I4	Lack of cultural sensitivity
I5	Other (describe)
Quality of Service	
Q2	Provider office unsafe
Q2	Provider office uncomfortable
Q3	Client did not receive information about available services
Q4	Excessive wait times on phone
Q5	Phone call not returned
Q6	Client doesn't like pre-authorization requirements
Q7	Other (describe)
Client Rights	
CR1	Not informed of client rights
CR2	Grievance and appeal procedure not explained
CR3	Access to own records denied
CR4	Concern over confidentiality
CR5	Allegation of abuse
CR6	Treatment discontinued without proper notification
CR7	Other (describe)

EXHIBIT D
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 D
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 D
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
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.

NEVADA BUSINESS ENTERPRISE (NBE): Any Nevada business which has the resources necessary to sufficiently perform identified County projects, and is owned or controlled by individuals that are not designated as socially or economically disadvantaged.

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.

It is our intent to utilize the following MBE, WBE, PBE, SBE, and NBE 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 ___ NBE

2. Subcontractor Name:_____
   Contact Person:_____ Telephone Number:_____
   Description of Work:_____
   _____
   Estimated Percentage of Total Dollars:_____
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ NBE

3. Subcontractor Name:_____
   Contact Person:_____ Telephone Number:_____
   Description of Work:_____
   _____
   Estimated Percentage of Total Dollars:_____
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ NBE

4. Subcontractor Name:_____
   Contact Person:_____ Telephone Number:_____
   Description of Work:_____
   _____
   Estimated Percentage of Total Dollars:_____
   Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ NBE

☐ No MBE, WBE, PBE, SBE, or NBE subcontractors will be used.

EXHIBIT H
FEDERAL REQUIREMENTS

1. COUNTY is the recipient of Part A funds pursuant to the CFDA title: HIV Emergency Relief Project Grants Number CFDA Number 93.914; Ryan White HIV/AIDS Treatment Extension Act of 2009 Award Number 2 H89HA06900-07-00, (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 Contract, 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. All payments made to PROVIDER from the date of execution of this Contract, for services provided, shall be reimbursed through a cost-based reimbursement system.

   h. The Contract 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 Contract 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) Utilize the Las Vegas Standards of Care developed by the Ryan White Part A Planning Council for providing appropriate care to clients in the TGA once they become available. These Standards are available on the Las Vegas TGA website at http://www.lasvegasema.org .

(3) 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.

(4) 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.omhrc.gov/assets/pdf/checked/executive.pdf.

(5) 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.

(6) 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 B 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 B).

(7) 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.

(8) 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.

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

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

(11) Utilize COUNTY furnished COUNTY approved management information system software to manage eligible client data. Data must be entered within one (1) business day of delivery of service to client. Specialty services encounter data must be entered within one (1) business day of receipt by PROVIDER.

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

(13) 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.

(14) 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.

(15) 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.

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

(17) 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.

(18) 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.

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

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

(21) 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.

(22) 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.

(23) 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.

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

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

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.

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

(27) 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.

(28) 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 Contract, PROVIDER shall supply COUNTY with a list of the Board of Directors members.

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

(30) 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 Contract.

(31) 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.

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

(33) 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.

(34) 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 Contract 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 Contract is expressly contingent upon the availability of such TREATMENT EXTENSION ACT funds. This Contract 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 Contract as they now exist and as hereafter amended or otherwise modified. PROVIDER shall perform all services under this Contract 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.

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 Contract.

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 Contract.

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 Contract, 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 Contract.

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, and oral) that is stored or transmitted by a HIPAA covered entity.

18. PROVIDER must attend annual HIPAA training developed by Clark County Privacy Officer.

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

20. 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.

21. 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.

22. 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.

23. 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 Contract, COUNTY shall solely determine the disposition of all such equipment.

24. 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.

25. COUNTY shall monitor PROVIDER's performance during the term of this Contract. 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 Contract.

26. PROVIDER shall adhere to U.S. Department of Health and Human Services Grant Policy Statement.

27. If PROVIDER fails to substantially comply with any material provisions of this Contract, 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 Contract. 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 Contract or is in material violation of any applicable county ordinance or state or federal law in conducting activities under this Contract.
    b. PROVIDER fails to maintain any license, registration, or permit required to provide the services specified in this Contract 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 Contract.

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.

28. 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.

29. 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.

30. 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. 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.

31. 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 Contract for such non-correction.

32. If PROVIDER receives a combined total of $500,000 or more annually from all contracts funded under the TREATMENT EXTENSION ACT, and/or receives $500,000 or more annually from any combination of federal funding sources, PROVIDER is subject to federal audit requirements per Public Law 98-502, "The Single Audit Act". PROVIDER shall comply with OMB Circulars A-122, A-110, and A-133, as applicable. The single audit

report along with any required corrective action plan, if applicable, shall be submitted to COUNTY for review within thirty (30) days following the close of the grant fiscal year(s).

33. If PROVIDER expends less than $500,000 in federal funds annually, PROVIDER will be subject to audit requirements, as stated above, at the discretion of COUNTY.

34. 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.

35. COUNTY shall monitor the entire program under this Contract 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.

36. This Contract 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.

37. Accounting records are considered to be all records relating to the expenditure and reimbursement of funds awarded under this Contract. 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 Contract need to be retained for a minimum of five (5) years subsequent to the expiration date of this Contract, making them available to COUNTY upon request.