

CLARK COUNTY, NEVADA REQUEST FOR QUALIFICATIONS

RFQ NO. 603851-15 MEDICAL, CORE AND SUPPORT SERVICES FOR HIV/AIDS INFECTED AND AFFECTED CLIENTS IN THE LAS VEGAS, RYAN WHITE, TRANSITIONAL GRANT AREA

The RFQ package is available as follows:

- Internet – Visit the Clark County Purchasing and Contracts Division website at <http://www.ClarkCountyNV.gov/Purchasing>. Click on “Current Opportunities” and locate Document No. 603851 in the list of current solicitations.
- Mail – Please fax a request to (702) 386-4914 specifying project number and description. Be sure to include company address, phone and fax numbers.
- Pick up - Clark County Government Center, 500 South Grand Central Parkway, Purchasing and Contracts Division, Fourth Floor, Las Vegas, NV 89106.

A Pre-Proposal Conference will be held on **OCTOBER 15, 2015** at **11:00 a.m.**, at the address specified above in the Gold Conference Room. If your firm is unfamiliar with the County Request for Qualifications (RFQ) procedures and would like to obtain training on the submittal process for this RFP, please contact Sherry A. Wimmer, Purchasing Analyst II, at (702) 455-4476 no later than **WEDNESDAY, OCTOBER 14, 2015**, and a training session will be provided immediately following the pre-proposal conference referenced above.

Proposals will be accepted at the Clark County Government Center address specified above, on or before **NOVEMBER 9, 2015** at **3:00:00 p.m.**, based on the time clock at the Clark County Purchasing and Contracts front desk.

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OCTOBER 5, 2015

GENERAL CONDITIONS

RFQ NO. 603851-15

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

1. TERMS

"COUNTY," as used throughout this document will mean the County of Clark, Las Vegas, Nevada. "BCC" as used throughout this document will mean the Board of County Commissioners which is the Governing Body of Clark County. "CHIEF FINANCIAL OFFICER" as used throughout this document will mean the Clark County Chief Financial Officer or his designee responsible for the Purchasing and Contracts Division. "PROPOSER" as used throughout this document will mean the respondents to this Request for Qualifications. "RFQ" as used throughout this document will mean Request for Qualifications. "TGA" as used throughout this document will mean the Las Vegas, Ryan White, Transitional Grant Area.

"HIV" as used throughout this document will mean Human Immunodeficiency Virus. "HRSA" as used throughout this document will mean Health Resources and Services Administration. "Federal Grant" is the HIV Emergency Relief Grant Program Part A: Eligible Metropolitan Areas/Transitional Grant Areas HRSA Announcement No: HRSA-15-003 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.

2. INTENT

The COUNTY is soliciting proposals to contract with all qualified providers for Medical, Core, and Support Services for HIV/AIDS Infected and Affected Clients in the Las Vegas, Ryan White, Transitional Grant Area for Clark County Social Service. PROPOSER(S) may submit a proposal for one and up to all of the listed services in the Exhibit A, Scope of Work. Each service listed will be evaluated individually and PROPOSER(S) will be qualified on a per service category basis. If you currently have a contract for Ryan White you do not have to reapply unless you wish to provide additional services.

3. SCOPE OF PROJECT

The COUNTY is seeking agencies interested in providing core and support services to individuals infected and affected with HIV and AIDS in the transitional grant area. As described in Exhibit A, the proposed plan must contain a detailed plan of service delivery, data collection activities and a process for quality management and improvement per service category.

Exhibit A details the requirement for the Scope of Work. Exhibit A, Attachment 1, details the Standards of Care for each service category.

4. DESIGNATED CONTACTS

COUNTY'S representative will be Sherry A. Wimmer, Purchasing Analyst II, Clark County Administrative Services Department, Purchasing and Contracts Division, sherryw@clarkcountynv.gov. This representative will respond to questions concerning the scope of work of this RFP and questions regarding the selection process for this RFP.

5. CONTACT WITH COUNTY DURING RFP PROCESS

Communication between a PROPOSER and a member of the BCC or between a PROPOSER and a non-designated COUNTY contact regarding the selection of a proponent or award of this Contract is prohibited from the time the RFP is advertised until the item is posted on an agenda for award of the Contract. Questions pertaining to this RFP shall be addressed to the designated contact(s) specified in the RFP document. Failure of a PROPOSER, or any of its representatives, to comply with this paragraph may result in their proposal being rejected.

6. TENTATIVE DATES AND SCHEDULE

Pre-Proposal Meeting: October 15, 2015, 11:00 a.m. Pacific, Gold Conference Room

Last Day to Ask Questions: October 19, 2015

Last Day County Will Provide Addendum: October 22, 2015

Proposal Due Date: November 9, 2015, 3:00:00 p.m. Pacific

Finalists Selection: November/December 2015

Finalists Oral Presentations: November/December 2015, if requested by County

Final PROPOSER Selection: November/December 2015

Contract Negotiations: November/December 2015

Award & Approval of the Final Contract(s): November/December 2015

Contract Start Date: March 1, 2016

7. METHOD OF EVALUATION AND AWARD

Since the service requested in this RFP is considered to be a professional service, award will be in accordance with the provisions of the Nevada Revised Statutes, Chapter 332, Purchasing: Local Governments, Section 332.115.

The proposals may be reviewed individually by staff members through an ad hoc committee to assist the PURCHASING MANAGER OR HER DESIGNEE. The finalists may be requested to provide COUNTY a presentation and/or an oral interview. The ad hoc staff committee may review the RFP's as well as any requested presentations and/or oral interviews to gather information that will assist in making the recommendation. COUNTY reserves the right to award the Contract based on objective and/or subjective evaluation criteria. This Contract will be awarded on the basis of which proposal COUNTY deems best suited to fulfill the requirements of the RFP. COUNTY also reserves the right not to make an award if it is deemed that no single proposal fully meets the requirement of this RFP.

The fees for the professional services will be negotiated with the PROPOSER(S) selected.

8. SUBMITTAL REQUIREMENTS

The proposal submitted should not exceed 25 pages. Other attachments may be included with no guarantee of review.

All proposals shall be on 8-1/2" x 11" paper bound with tabbed dividers labeled by section to correspond with the evaluation information requested. The ideal proposal will be 3-hole punched and bound with a binder clip. Binders or spiral binding is not preferred or required.

The PROPOSER shall submit one (1) clearly labeled original and 6 copies of their proposal, including one (1) CD or flash drive with an electronic copy of their proposal, preferably in .pdf format. A single .pdf document of the entire proposal is preferred. The name of the PROPOSER'S firm shall be indicated on the spine and cover of each binder (if used) and CD label.

All proposals must be submitted in a sealed envelope plainly marked with the name and address of the PROPOSER and the RFP number and title. No responsibility will attach to COUNTY or any official or employee thereof, for the pre-opening of, post-opening of, or the failure to open a proposal not properly addressed and identified. Proposals are time-stamped upon receipt. Proposals time-stamped after 3:00:00 p.m. based on the time clock at the Clark County Purchasing and Contracts front desk will be recorded as late, remain unopened and be formally rejected. FAXED OR ELECTRONIC SUBMITTALS ARE NOT ALLOWED AND WILL NOT BE CONSIDERED.

The following are detailed delivery/ mailing instructions for proposals:

Hand Delivery

Clark County Government Center
Purchasing and Contracts Division
500 South Grand Central Parkway, 4th Fl
Las Vegas, Nevada 89106

U.S. Mail Delivery

Clark County Government Center
Attn: Purchasing and Contracts, 4th Fl
500 South Grand Central Parkway
P.O. Box 551217
Las Vegas, Nevada 89155-1217

Express Delivery

Clark County Government Center
Attn: Purchasing and Contracts, 4th Fl
500 South Grand Central Parkway
Las Vegas, Nevada 89106

Regardless of the method used for delivery, PROPOSER(S) shall be wholly responsible for the timely delivery of submitted proposals.

9. WITHDRAWAL OF PROPOSAL

PROPOSER(S) may request withdrawal of a posted, sealed proposal prior to the scheduled proposal opening time provided the request for withdrawal is submitted to the Purchasing Analyst in writing or a proposal release form has been properly filled out and submitted to the Purchasing and Contracts Division reception desk. Proposals must be re-submitted and time-stamped in accordance with the RFP document in order to be accepted.

No proposal may be withdrawn for a period of 90 calendar days after the date of proposal opening. All proposals received are considered firm offers during this period. The PROPOSER'S offer will expire after 90 calendar days.

If a PROPOSER intended for award withdraws their proposal, that PROPOSER may be deemed non-responsible if responding to future solicitations.

10. REJECTION OF PROPOSAL

COUNTY reserves the right to reject any and all proposals received by reason of this request.

11. PROPOSAL COSTS

There shall be no obligation for COUNTY to compensate PROPOSER(S) for any costs of responding to this RFP.

12. ALTERNATE PROPOSALS

Alternate proposals are defined as those that do not meet the requirements of this RFP. Alternate proposals will not be considered.

13. ADDENDA AND INTERPRETATIONS

If it becomes necessary to revise any part of the RFP, a written addendum will be provided to all PROPOSERS in written form from the Purchasing Analyst. COUNTY is not bound by any specifications by COUNTY'S employees, unless such clarification or change is provided to PROPOSERS in written addendum form from the Purchasing Analyst.

14. PUBLIC RECORDS

COUNTY is a public agency as defined by state law, and as such, it is subject to the Nevada Public Records Law (Chapter 239 of the Nevada Revised Statutes). Under that law, all of COUNTY'S records are public records (unless otherwise declared by law to be confidential) and are subject to inspection and copying by any person. However, in accordance with NRS 332.061(2), a proposal that requires negotiation or evaluation by COUNTY may not be disclosed until the proposal is recommended for award of a contract. PROPOSER(S) are advised that once a proposal is received by COUNTY, its contents will become a public record and nothing contained in the proposal will be deemed to be confidential except proprietary information. PROPOSER(S) shall not include any information in their proposal that is proprietary in nature or that they would not want to be released to the public. Proposals must contain sufficient information to be evaluated and a contract written without reference to any proprietary information.

If a PROPOSER feels that they cannot submit their proposal without including proprietary information, they must adhere to the following procedure or their proposal may be deemed unresponsive and will not be recommended to the BCC for selection:

PROPOSER(S) must submit such information in a separate, sealed envelope labeled "Proprietary Information" with the RFP number. The envelope must contain a letter from the PROPOSER'S legal counsel describing the documents in the envelope, representing in good faith that the information in each document meets the narrow definitions of proprietary information set forth in NRS 332.025, 332.061 and NRS Chapter 600A, and briefly stating the reasons that each document meets the said definitions.

Upon receipt of a proposal accompanied by such a separate, sealed envelope, COUNTY will open the envelope to determine whether the procedure described above has been followed.

Any information submitted pursuant to the above procedure will be used by COUNTY only for the purposes of evaluating proposals and conducting negotiations and might never be used at all.

If a lawsuit or other court action is initiated to obtain proprietary information, a PROPOSER(S) who submit the proprietary information according to the above procedure must have legal counsel intervene in the court action and defend the secrecy of the information. Failure to do so shall be deemed PROPOSER'S consent to the disclosure of the information by COUNTY, PROPOSER'S waiver of claims for wrongful disclosure by COUNTY, and PROPOSER'S covenant not to sue COUNTY for such a disclosure.

PROPOSER(S) also agrees to fully indemnify COUNTY if COUNTY is assessed any fine, judgment, court cost or attorney's fees as a result of a challenge to the designation of information as proprietary.

15. PROPOSALS ARE NOT TO CONTAIN CONFIDENTIAL / PROPRIETARY INFORMATION

Proposals must contain sufficient information to be evaluated and a contract written without reference to any confidential or proprietary information. PROPOSER(S) shall not include any information in their proposal that they would not want to be released to the public. Any proposal submitted that is marked "Confidential" or "Proprietary," or that contains materials so marked, will be returned to the PROPOSER and will not be considered for award.

16. COLLUSION AND ADVANCE DISCLOSURES

Pursuant to 332.165 evidence of agreement or collusion among PROPOSER(S) and prospective PROPOSER(S) acting to illegally restrain freedom of competition by agreement to bid a fixed price, or otherwise, shall render the offers of such PROPOSER(S) void.

Advance disclosures of any information to any particular PROPOSER(S) which gives that particular PROPOSER any advantage over any other interested PROPOSER(S), in advance of the opening of proposals, whether in response to advertising or an informal request for proposals, made or permitted by a member of the governing body or an employee or representative thereof, shall operate to void all proposals received in response to that particular request for proposals.

17. CONTRACT

A sample of COUNTY'S Standard Contract is attached. Any proposed modifications to the terms and conditions of the Standard Contract are subject to review and approval by the Clark County District Attorney's Office.

18. BUSINESS LICENSE REQUIREMENTSCLARK COUNTY BUSINESS LICENSE / REGISTRATION

Prior to award of this RFP, other than for the supply of goods being shipped directly to a Clark County facility, the successful PROPOSER will be required to obtain a Clark County business license or register annually as a limited vendor business with the Clark County Business License Department.

A. Clark County Business License is Required if:

- i. A business is physically located in unincorporated Clark County, Nevada.
- ii. The work to be performed is located in unincorporated Clark County, Nevada.

B. Register as a Limited Vendor Business Registration if:

- i. A business is physically located outside of unincorporated Clark County, Nevada.
- ii. A business is physically located outside the state of Nevada.

The Clark County Department of Business License can answer any questions concerning determination of which requirement is applicable to your firm. It is located at the Clark County Government Center, 500 South Grand Central Parkway, 3rd Floor, Las Vegas, NV or you can reach them via telephone at (702) 455-4253 or toll free at (800) 328-4813.

You may also obtain information on-line regarding Clark County Business Licenses by visiting the website at http://www.clarkcountynv.gov/Depts/business_license/Pages/default.aspx

19. EVALUATION CRITERIA

County is pre-awarding based on the amount awarded by the Ryan White HIV/AIDS Treatment Extension Act of 2009 HIV Emergency Relief Grant Program Part A: Eligible Metropolitan Areas/Transitional Grant Areas for Grant Year Mar 1, 2015-Feb 29, 2016. Funds for Grant Year Mar 1, 2016-Feb 28, 2017 are contingent upon receipt of Grant Award funds from Health Resources and Services Administration.

Since the service requested in this RFQ is considered to be a professional service, award will be in accordance with the provisions of the Nevada Revised Statutes, Chapter 332, Purchasing: Local Governments, Section 332.115.1.B Professional Services.

The proposals may be reviewed individually by staff members through an ad hoc committee to assist the PURCHASING MANAGER OR HER DESIGNEE. The finalists may be requested to provide the COUNTY a presentation and/or an oral interview. The ad hoc staff committee may review the RFQ's as well as any requested presentations and/or oral interviews to gather information that will assist in making the recommendation. The COUNTY reserves the right to award the contract based on objective and/or subjective evaluation criteria. This contract will be awarded on the basis of which proposal the COUNTY deems best suited to fulfill the requirements of the RFQ. The COUNTY also reserves the right not to make an award if it is deemed that no single proposal fully meets the requirement of this RFQ.

Below is the proposal review process:

- A. Copies will be provided to an ad hoc committee for review and scoring.
- B. Each individual part of the proposal will be reviewed and scored. A total complete score will be assigned based on the total of all component scores.
- C. **PROPOSERS who are government agencies and non-government agencies** must provide submissions for all the evaluation criteria requested in Item 7. EVALUATION INFORMATION. All awards for these PROPOSERS will be made based on a payline method as outlined in grant.
 - i. The payline method operates through the development of overall service category funding levels put forth by the Las Vegas Transitional Grant Area (TGA) Planning Council (Planning Council). Funds available for each funded service category are limited and are pre-determined by the Planning Council.
 - ii. Under this method, all applications for a specific service category will be ranked in order of the Proposer's score (i.e., if there are three Proposers for medical nutritional therapy, those three Proposers, who meet the required qualifications, will be ranked based on their assigned score.

- iii. Proposers meeting the minimum score shall be funded starting with the awarded Proposer with the highest score, until funding in the service category is exhausted. Funding amounts for the specific applications will be based on the Proposer's budget combined with a review and suggestion of funding for the project by the ad hoc committee for reviewing and scoring.
 - iv. **PROPOSER'S must receive a minimum score of 65% to be eligible for award of RFQ. PROPOSERS that receive a minimum score (below 65 – Non-Government) and (below 55 – Government) will not be considered and the PROPOSER may not resubmit a proposal.**
 - v. The Request for Qualifications submittal process will be made available to all new PROPOSERS on an annual basis, prior to each annual allocation of the next year's grant funds. Each service category allocation will be distributed to provide the maximum opportunity to the Transitional Grant Area clients. Should the PROPSER(S) not meet the minimum evaluation of 65% for their initial submittal, the PROSPOSER(S) could resubmit a new proposal the next year, and be re-evaluated with all the new PROPOSER(S).
- D. Current government contractors funded in the 2015-2016 Ryan White Grant year shall receive first allocation of **funds** before all other PROPOSERS receive an allocation.

PRIORITIES AND ALLOCATION PERCENTAGES FOR GRANT YEAR 2016-2017

Ryan White **Part A**
Planning Council

SERVICE CATEGORY	2016-2017 PRIORITY	2016-2017 PERCENTAGE
Outpatient/Ambulatory Medical Care	1	27.00%
Oral Health Care	22	5.00%
Early Intervention Services	9	11.00%
Health Insurance Premium & Cost Sharing Assistance	11	2.00%
Mental Health Services	5	6.00%
Medical Nutrition Therapy	13	4.00%
Medical Case Management	4	30.00%
Substance Abuse Services: Outpatient	12	3.00%
Medical Transportation	3	3.00%
Housing Services	10	2.00%
Food Bank/Home Delivered Meals	6	1.00%
Emergency Financial Assistance	8	2.00%
Health Education/Risk Reduction	14	3.00%
Psychosocial Support Services	16	1.00%
		100.00%
Estimated ** Total Award Amount for 2016-2017		\$4,674,516

Ryan White **Minority AIDS Initiative (MAI)***
Planning Council

SERVICE CATEGORY	2016-2017 PERCENTAGE
Outpatient/Ambulatory Medical Care	50.00%
Medical Case Management	50.00%
	100.00%
Estimated ** Total Award Amount for 2016-2017	\$377,825

*Minority AIDS Initiative funds are used to address the HIV/AIDS care needs of African American, Hispanic and other disproportionately impacted communities who meet Part A eligibility guidelines.

** The estimated total dollar amounts do not reflect FY2016-2017 allocations; it is an estimate only. The actual amounts will be based on the amount of funding provided by **Health Resources and Services Administration (HRSA)** for Grant Year 2016-2017. The percentage column reflects the percentage of the

award amount that will be allocated to that category for Grant Year 2016-2017.

The first page of the Proposal shall contain a statement that declares all information provided therein does not include any Confidential, Proprietary and/or Private information as identified in Sections 13 and 14 of this Request for Qualification. It must also identify that the statement supersedes and nullifies any page in the Proposal that may be marked as Confidential, Proprietary and/or Private and acknowledge that the Proposal will become Public Information upon award. The statement must be signed by the Proposer's Authorized Representative. Failure to provide such declaration may be deemed as grounds for return of the unread proposal and not be considered for award.

All PROPOSERS who are **government agencies and non-government agencies** must provide submissions for all the evaluation criteria requested in this section.

(Non-Government Agency TOTAL **100** POINTS POSSIBLE) (Government Agency **85** Total Points Possible)

Include cover letter specifying Business name, Contact name, address, phone number, fax number, email address, etc.

A. Executive Summary (3 points) Per agency

This section shall serve to provide the COUNTY with the key elements and unique features of the proposal by briefly describing how the PROPOSER is going to accomplish the project. The Executive Summary should include a schedule of major milestones.

Describe the mission and purpose of your agency including staff members, their expertise and the structure of your agency including Board of Directors, hours of operation, and number of locations.

The Executive Summary should also include a list of high risk areas which were identified during the proposal process that are reasons for concern. PROPOSER will not be evaluated on this paragraph and cannot lose evaluation points for listing areas of concern. These concerns will be addressed with the successful PROPOSER(S) during negotiations.

B. Experience (5 points) Per agency

Include a brief resume of all similar projects your firm has performed for the past 3 years. Each project listed shall include the name and phone number of a contact person for the project for review purposes. This section shall include documentation of the PROPOSER's history of adherence to budget and schedule constraints. All firms are encouraged to indicate their experience of performing related work within the state of Nevada or Arizona.

All firms may indicate if they are a minority-owned business, women-owned business, physically-challenged business, small business, or a Nevada business enterprise as defined in **Exhibit B** of the attached contract (**Exhibit A**).

Provide a description of your agency's experience with fundraising. This should include amount of time as a 501 C (3), fundraising events in the past 3 years and other Federal and local funding sources your agency relies on. In addition, provide a description of how your agency will ensure Grant funds are used to supplement not supplant funds and your agency's overall strategy for leveraging funds and ensuring Grant funds are the payer of last resort.

C. Financial Statement (5 points) Per agency

Provide a statement that reflects the PROPOSER's financial ability to complete this project.

Provide most recent A-133 audit or agency audit. If A-133 audit is not applicable please indicate.

D. Compliance with the COUNTY'S Standard Contract (5 points) Per agency

Indicate that your firm accepts the attached Sample Contract, PROPOSER(S) are advised that any exception that is determined to be material may be grounds for elimination in the selection process.

E. Insurance (5 points) Per agency

The PROPOSER's ability to provide the required certificates of insurance as indicated in the attached Standard Contract, Exhibit B, PROPOSER must provide a statement that firm will comply with insurance requirements. **(Not applicable to government agency)**

F. Business License (5 points) Per agency

The PROPOSER's ability to provide the required business license. **(Not applicable to government agency)**

G. Disclosure of Ownership/Principals (5 points) Per agency

PROPOSER must complete and submit the attached Disclosure of Ownership/Principals form with its proposers. **(Not applicable to government agency)**

H. Quality Management (6 point) Per agency

Provide current quality management plan for agency.

I. Adherence to National Monitoring Standards (5 point) Per agency

The National Monitoring Standards are designed to help Ryan White HIV/AIDS Program Part A and B grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. The Standards consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on federal law, regulations, policies and guidance documents.

The National Monitoring Standards are designed to:

- Help grantees comply with federal requirements on proper use of federal grant funds, based on the Ryan White HIV/AIDS Program legislation, federal regulations establishing administrative requirements for HHS grant awards, Office of Management and Budget (OMB) principles, the HHS Grants Policy Statement, HRSA/HAB policies, the Notice of Grant Award and Conditions of Grant Award and DSS program guidance.
- Meet grantee requests for clarity on HRSA/HAB expectations regarding the level, scope and frequency of subgrantee monitoring.
- Provide a single document that includes the minimum expectations for both program and fiscal monitoring.
- Address concerns of HRSA, Congress, and the OIG regarding administrative oversight of Ryan White HIV/AIDS Program grantees and providers/subgrantees.
- Help streamline and standardize Project Officer monitoring and site visit functions.
- Enhance program compliance at the local, state and federal levels – and reduce negative HRSA and OIG audit findings.
- Ensure proper stewardship of all grant funds and activities, whether carried out by the grantee or by a subgrantee.
- Communicate applicable requirements to subgrantees and monitoring them for compliance.

Reference the following links to the HRSA, HIV/AIDS Bureau, and Division of Service Systems for full versions of the Part A

Universal Monitoring Standards for both Fiscal and Program Requirements:
<http://hab.hrsa.gov/manageyourgrant/files/universalmonitoringparta.pdf>

Part A Program Monitoring Standards:
<http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf>

Part A Fiscal Monitoring Standards:
<http://hab.hrsa.gov/manageyourgrant/files/fiscalmonitoringparta.pdf>

Provide a statement of understanding and adherence to the National Monitoring Standards.

J. Staff Qualifications and Availability (5 points overall) Per service category

Provide information concerning the educational background, experience and professional resumes of those persons who would actually perform work on the project. Identify if those persons presently reside in Clark County, Nevada or elsewhere. Indicate the present workload of the project staff to demonstrate their ability to devote sufficient time to meet the proposed schedule.

PROPOSER(S) need not indicate the actual names of employees when submitting resumes subject to the requirements of the RFQ. Fictitious names or numbers may be used (e.g. employee #1). However, if selected as a finalist, PROPOSER(S), upon verbal request, must disclose actual employee names matching the resumes submitted to COUNTY, to be used in performing background verifications. The successful PROPOSER(S) shall not change proposed project personnel for which a resume is submitted without COUNTY approval.

K. Conceptual Treatment of Project and Work Plan (20 points overall) Per service category

Describe in more detail the approach to the project. Include a preliminary project plan that includes:

Please see Exhibit A for the instructions for the narrative related to the Conceptual Treatment of Project and Work Plan. Please be clear and concise in your description of the proposed work plan, service category and processes proposed to be implemented as part of the Scope of Work.

Any assumptions, and any constraints.

List any other Ryan White funding you have applied for or been awarded for Jan 2016 – May 2017. List how the funding from other Ryan White Parts will affect or compliment your proposed Part A project.

Proposed schedule (work plan) including tasks, milestones, dates for completion, COUNTY and PROPOSER resource assignments, critical path and COUNTY's review cycles. State why the PROPOSER is best suited to perform the services for this project.

L. Project Fee (20 points overall) Per service category

Complete the attached budget form in **Exhibit A, Attachment 2**. Follow the directions listed in the budget form; provide detailed narrative for each line-item budget. Complete a separate budget form for each service category PROPOSER is applying for and one budget form for all administrative expenses.

M. Credentials (3 points overall) Per service category

The PROPOSER or principal professionals involved in this service must possess appropriate Nevada or Arizona Professional Licenses. Example: RN, RD, DR. Refer to Exhibit A, Attachment One Standard of Care for each service category for credentials desired for each service category.

N. Work Completed Locally (3 points overall) Per service category

Indicate that your firm will accomplish all work locally. Locally included work completed in Mohave County, AZ, Nye County and Clark County, NV.

Provide a description of the overall TGA, including Mohave County, AZ, Nye County and Clark County, NV in relation to the severity of the HIV/AIDS epidemic in the TGA. This would include prevalence data, how the HIV/AIDS epidemic has shaped the TGA and the impact on underserved populations. Include how your agency fits into this picture.

O. Affiliations (1 point overall) Per service category

If the project is to be accomplished through an affiliation or joint venture of several firms, the names and address of those firms and signed Memorandum of Understanding or agreement, shall be furnished for each.

P. Local Familiarity (3 points overall) Per service category

Provide a statement as to local resources that would be utilized and the degree of the PROPOSER's knowledge and familiarity with the local community's needs and goals.

Describe the client population you currently serve, the level of service provided, frequency of service for each client, and your strategy for reaching underserved populations.

Q. Other (1 point overall) Per service category

Other factors the PROPOSER determines appropriate which would indicate to the COUNTY that the PROPOSER has the necessary capability, competence, and performance record to accomplish the project in a timely and cost-effective manner.

CLARK COUNTY, NEVADA

**CONTRACT FOR MEDICAL, CORE AND SUPPORT SERVICES FOR HIV/AIDS
INFECTED AND AFFECTED CLIENTS IN THE LAS VEGAS, RYAN WHITE,
TRANSITIONAL GRANT AREA
RFQ NO. 603851-15**

//ENTER COMPANY NAME//
NAME OF FIRM
//Enter Designated Contact Name//
DESIGNATED CONTACT, NAME AND TITLE (Please type or print)
//Enter Street Address// //City, State and Zip Code//
ADDRESS OF FIRM INCLUDING CITY, STATE AND ZIP CODE
(XXX) XXX-XXXX
(AREA CODE) AND TELEPHONE NUMBER
(XXX) XXX-XXXX
(AREA CODE) AND FAX NUMBER
//Enter Email Address//
E-MAIL ADDRESS

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 _____ 2015, by and between CLARK COUNTY, NEVADA (hereinafter referred to as COUNTY), and //LEGAL NAME// (hereinafter referred to as PROVIDER), for Medical, Core and Support Services for HIV/AIDS Infected and Affected Clients in the Las Vegas, Ryan White, Transitional Grant Area (hereinafter referred to as PROJECT).

WITNESSETH:

WHEREAS, PROVIDER has the personnel and resources necessary to accomplish the PROJECT within the required schedule and with a budget allowance not to exceed \$ENTER AMT, including all travel, lodging, meals and miscellaneous expenses; and

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

NOW, THEREFORE, COUNTY and PROVIDER agree as follows:

SECTION I: TERM OF CONTRACT

COUNTY agrees to retain PROVIDER for the period from March 1, 2016 through February 28, 2017, subject to the provisions of Sections II and VIII herein. During this period, PROVIDER agrees to provide services as required by COUNTY within the scope of this Contract.

SECTION II: COMPENSATION AND TERMS OF PAYMENT

A. Compensation

COUNTY agrees to pay PROVIDER for the performance of services described in the Scope of Work (Exhibit A) not-to-exceed amount of \$ENTER AMT. COUNTY'S obligation to pay PROVIDER cannot exceed the not-to-exceed amount. It is expressly understood that the entire work defined in Exhibit A must be completed by PROVIDER and it shall be PROVIDER'S responsibility to ensure that hours and tasks are properly budgeted so the entire PROJECT is completed for the said fee. Non-profit PROVIDER may draw down advance program money once at the commencement of the yearly PROJECT for each year of the CONTRACT. Such advance shall not exceed an amount equal to two months of the yearly PROJECT budget dependent on COUNTY determination of need and types of expenses. Requests for any advance must be submitted in writing on the letterhead of the requesting organization and bear the original signature of an authorized representative. COUNTY reserves the right to require any and all expenditures of advance funds to be fully documented prior to approving any reimbursements.

B. Progress Payments

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

C. Terms of Payments

1. Each invoice received by COUNTY must include a Progress Report based on actual work performed to date in accordance with the completion of tasks indicated in Exhibit A, Scope of Work.
2. Payment of invoices will be made within thirty (30) calendar days after receipt of an accurate invoice that has been reviewed and approved COUNTY.
3. COUNTY, at its discretion, may not approve or issue payment on invoices if PROVIDER fails to provide the following information required on each invoice:
 - a. The title of the PROJECT as stated in Exhibit A, Scope of Work, COUNTY'S Contract Number, Project Number, Purchase Order Number, Invoice Date, Invoice Period, Invoice Number, and the Payment Remittance Address.
 - b. Expenses not defined in Exhibit A, Scope of Work, or expenses greater than the per diem rates will not be paid without prior written authorization by COUNTY.
 - c. COUNTY'S representative shall notify PROVIDER in writing within fourteen (14) calendar days of any disputed

amount included on the invoice. PROVIDER must submit a new invoice for the undisputed amount which will be paid in accordance with paragraph C.2 above. Upon mutual resolution of the disputed amount PROVIDER will submit a new invoice for the agreed to amount and payment will be made in accordance with paragraph C.2 above.

4. No penalty will be imposed on COUNTY if COUNTY fails to pay PROVIDER within thirty (30) calendar days after receipt of a properly documented invoice, and COUNTY will receive no discount for payment within that period.
5. In the event that legal action is taken by COUNTY or PROVIDER based on a disputed payment, the prevailing party shall be entitled to reasonable attorneys' fees and costs subject to COUNTY'S available unencumbered budgeted appropriations for the PROJECT.
6. COUNTY shall subtract from any payment made to PROVIDER all damages, costs and expenses caused by PROVIDER'S negligence, resulting from or arising out of errors or omissions in PROVIDER'S work products, which have not been previously paid to PROVIDER.
7. COUNTY shall not provide payment on any invoice PROVIDER submits after six (6) months from the date PROVIDER performs services, provides deliverables, and/or meets milestones, as agreed upon in Exhibit A, Scope of Work.
8. Invoices shall be submitted to: //Enter Street Address//, //City, State and Zip Code//.

D. County's Fiscal Limitations

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

SECTION III: SCOPE OF WORK

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

SECTION IV: CHANGES TO SCOPE OF WORK

- A. COUNTY may at any time, by written order, make changes within the general scope of this Contract and in the services or work to be performed. If such changes cause an increase or decrease in PROVIDER'S cost or time required for performance of any services under this Contract, an equitable adjustment limited to an amount within current unencumbered budgeted appropriations for the PROJECT shall be made and this Contract shall be modified in writing accordingly. Any claim of PROVIDER for the adjustment under this clause must be submitted in writing within thirty (30) calendar days from the date of receipt by PROVIDER of notification of change unless COUNTY grants a further period of time before the date of final payment under this Contract.
- B. No services for which an additional compensation will be charged by PROVIDER shall be furnished without the written authorization of COUNTY.

SECTION V: RESPONSIBILITY OF PROVIDER

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

salaries, benefits, taxes, demands, and regulations of any nature whatsoever.

- B. PROVIDER shall appoint a Manager, upon written acceptance by COUNTY, who will manage the performance of services. All of the services specified by this Contract shall be performed by the Manager, or by PROVIDER'S associates and employees under the personal supervision of the Manager. Should the Manager, or any employee of PROVIDER be unable to complete his or her responsibility for any reason, PROVIDER must obtain written approval by COUNTY prior to replacing him or her with another equally qualified person. If PROVIDER fails to make a required replacement within thirty (30) calendar days, COUNTY may terminate this Contract for default.
- C. PROVIDER has, or will, retain such employees as it may need to perform the services required by this Contract. Such employees shall not be employed by COUNTY.
- D. PROVIDER agrees that its officers and employees will cooperate with COUNTY in the performance of services under this Contract and will be available for consultation with COUNTY at such reasonable times with advance notice as to not conflict with their other responsibilities.
- E. PROVIDER will follow COUNTY'S standard procedures as followed by COUNTY'S staff in regard to programming changes; testing; change control; and other similar activities.
- F. PROVIDER shall be responsible for the professional quality, technical accuracy, timely completion, and coordination of all services furnished by PROVIDER, its subcontractors and its and their principals, officers, employees and agents under this Contract. In performing the specified services, PROVIDER shall follow practices consistent with generally accepted professional and technical standards.
- G. It shall be the duty of PROVIDER to assure that all products of its effort are technically sound and in conformance with all pertinent Federal, State and Local statutes, codes, ordinances, resolutions and other regulations. PROVIDER will not produce a work product which violates or infringes on any copyright or patent rights. PROVIDER shall, without additional compensation, correct or revise any errors or omissions in its work products.
 - 1. Permitted or required approval by COUNTY of any products or services furnished by PROVIDER shall not in any way relieve PROVIDER of responsibility for the professional and technical accuracy and adequacy of its work.
 - 2. COUNTY's review, approval, acceptance, or payment for any of PROVIDER'S services herein shall not be construed to operate as a waiver of any rights under this Contract or of any cause of action arising out of the performance of this Contract, and PROVIDER shall be and remain liable in accordance with the terms of this Contract and applicable law for all damages to COUNTY caused by PROVIDER'S performance or failures to perform under this Contract.
- H. All materials, information, and documents, whether finished, unfinished, drafted, developed, prepared, completed, or acquired by PROVIDER for COUNTY relating to the services to be performed hereunder and not otherwise used or useful in connection with services previously rendered, or services to be rendered, by PROVIDER to parties other than COUNTY shall become the property of COUNTY and shall be delivered to COUNTY'S representative upon completion or termination of this Contract, whichever comes first. PROVIDER shall not be liable for damages, claims, and losses arising out of any reuse of any work products on any other project conducted by COUNTY. COUNTY shall have the right to reproduce all documentation supplied pursuant to this Contract.
- I. The rights and remedies of COUNTY provided for under this section are in addition to any other rights and remedies provided by law or under other sections of this Contract.

SECTION VI: SUBCONTRACTS

- A. Services specified by this Contract shall not be subcontracted by PROVIDER, without prior written approval of COUNTY.
- B. Approval by COUNTY of PROVIDER'S request to subcontract, or acceptance of, or payment for, subcontracted work by COUNTY shall not in any way relieve PROVIDER of responsibility for the professional and technical accuracy and adequacy of the work. PROVIDER shall be and remain liable for all damages to COUNTY caused by negligent performance or non-performance of work under this Contract by PROVIDER'S subcontractor or its sub-subcontractor.
- C. The compensation due under Section II shall not be affected by COUNTY'S approval of PROVIDER'S request to subcontract.

SECTION VII: RESPONSIBILITY OF COUNTY

- A. COUNTY agrees that its officers and employees will cooperate with PROVIDER in the performance of services under this Contract and will be available for consultation with PROVIDER at such reasonable times with advance notice as to not conflict with their other responsibilities.
- B. The services performed by PROVIDER under this Contract shall be subject to review for compliance with the terms of this Contract by COUNTY'S representative, **//COORD//**, **//CODEPT//**, telephone number (702) **//XXX-XXXX//** or their designee. COUNTY'S representative may delegate any or all of his responsibilities under this Contract to appropriate staff members, and shall so inform PROVIDER by written notice before the effective date of each such delegation.
- C. The review comments of COUNTY'S representative may be reported in writing as needed to PROVIDER. It is understood that COUNTY'S representative's review comments do not relieve PROVIDER from the responsibility for the professional and technical accuracy of all work delivered under this Contract.
- D. COUNTY shall assist PROVIDER in obtaining data on documents from public officers or agencies, and from private citizens and/or business firms, whenever such material is necessary for the completion of the services specified by this Contract.
- E. PROVIDER will not be responsible for accuracy of information or data supplied by COUNTY or other sources to the extent such information or data would be relied upon by a reasonably prudent PROVIDER.

SECTION VIII: TIME SCHEDULE

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

SECTION IX: SUSPENSION AND TERMINATION

- A. Suspension

COUNTY may suspend performance by PROVIDER under this Contract for such period of time as COUNTY, at its sole discretion, may prescribe by providing written notice to PROVIDER at least 10 working days prior to the date on which COUNTY wishes to suspend. Upon such suspension, COUNTY shall pay PROVIDER its compensation, based on the percentage of the PROJECT completed and earned until the effective date of suspension, less all previous payments. PROVIDER shall not perform further work under this Contract after the effective date of suspension until receipt of written notice from COUNTY to resume performance. In the event COUNTY suspends performance by PROVIDER for any cause other than the error or omission of the PROVIDER, for an aggregate period in excess of thirty (30) days, PROVIDER shall be entitled to an equitable adjustment of the compensation payable to PROVIDER under this Contract to reimburse PROVIDER for additional costs occasioned as a result of such suspension of performance by COUNTY based on appropriated funds and approval by COUNTY.
- B. Termination
 - 1. This Contract may be terminated in whole or in part by either party in the event of substantial failure or default of the other party to fulfill its obligations under this Contract through no fault of the terminating party; but only after the other party is given:
 - a. not less than ten (10) calendar days written notice of intent to terminate; and
 - b. an opportunity for consultation with the terminating party prior to termination.
 - 2. Termination for Convenience
 - a. This Contract may be terminated in whole or in part by COUNTY for its convenience; but only after PROVIDER is given:
 - i. not less than ten (10) calendar days written notice of intent to terminate; and
 - ii. an opportunity for consultation with COUNTY prior to termination.
 - b. If termination is for COUNTY'S convenience, COUNTY shall pay PROVIDER that portion of the compensation

which has been earned as of the effective date of termination but no amount shall be allowed for anticipated profit on performed or unperformed services or other work.

3. Termination for Default

- a. If termination for substantial failure or default is effected by COUNTY, COUNTY will pay PROVIDER that portion of the compensation which has been earned as of the effective date of termination but:
 - i. No amount shall be allowed for anticipated profit on performed or unperformed services or other work; and
 - ii. Any payment due to PROVIDER at the time of termination may be adjusted to the extent of any additional costs occasioned to COUNTY by reason of PROVIDER'S default.
- b. Upon receipt or delivery by PROVIDER of a termination notice, PROVIDER shall promptly discontinue all services affected (unless the notice directs otherwise) and deliver or otherwise make available to COUNTY'S representative, copies of all deliverables as provided in Section V, paragraph H.
- c. If after termination for failure of PROVIDER to fulfill contractual obligations it is determined that PROVIDER has not so failed, the termination shall be deemed to have been effected for the convenience of COUNTY.

4. Upon termination, COUNTY may take over the work and execute the same to completion by agreement with another party or otherwise. In the event PROVIDER shall cease conducting business, COUNTY shall have the right to make an unsolicited offer of employment to any employees of PROVIDER assigned to the performance of this Contract.

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

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

SECTION X: INSURANCE

- A. PROVIDER shall obtain and maintain the insurance coverage required in Exhibit B incorporated herein by this reference. PROVIDER shall comply with the terms and conditions set forth in Exhibit B and shall include the cost of the insurance coverage in their prices.
- B. If PROVIDER fails to maintain any of the insurance coverage required herein, COUNTY may withhold payment, order PROVIDER to stop the work, declare PROVIDER in breach, suspend or terminate Contract.

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: _____

TO PROVIDER: _____

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

B. Immigration Reform and Control Act

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

C. Non-Discrimination/Public Funds

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

D. Assignment

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

E. Indemnity

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

F. Governing Law

Nevada law shall govern the interpretation of this Contract.

G. Gratuities

1. COUNTY may, by written notice to PROVIDER, terminate this Contract if it is found after notice and hearing by COUNTY that gratuities (in the form of entertainment, gifts, or otherwise) were offered or given by PROVIDER or any agent or representative of PROVIDER to any officer or employee of COUNTY with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending or making of any determinations with respect to the performance of this Contract.
2. In the event this Contract is terminated as provided in paragraph 1 hereof, COUNTY shall be entitled:
 - a. to pursue the same remedies against PROVIDER as it could pursue in the event of a breach of this Contract by PROVIDER; and
 - b. as a penalty in addition to any other damages to which it may be entitled by law, to exemplary damages in an amount (as determined by COUNTY) which shall be not less than three (3) nor more than ten (10) times the costs incurred by PROVIDER in providing any such gratuities to any such officer or employee.
3. The rights and remedies of COUNTY provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

H. Audits

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

I. Covenant

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

J. Confidential Treatment of Information

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

K. ADA Requirements

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

L. Subcontractor Information

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

M. Disclosure of Ownership Form

PROVIDER agrees to provide the information on the attached Disclosure of Ownership/Principals form prior to any contract and/or contract amendment to be awarded by the Board of County Commissioners.

N. Authority

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

O. Force Majeure

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

P. Severability

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

Q. HIPAA - CONFIDENTIALITY REGARDING PARTICIPANTS

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

R. Non-Endorsement

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

S. Public Records

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

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

COUNTY:

CLARK COUNTY, NEVADA

By: _____
YOLANDA T. KING
Chief Financial Officer

DATE

PROVIDER:
//LEGAL NAME//

By: _____
//NAME//
//TITLE//

DATE

APPROVED AS TO FORM:

STEVEN B. WOLFSON
District Attorney

By: _____
ELIZABETH A. VIBERT
Deputy District Attorney

DATE

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

Scope of Project

Funds are provided by U.S. Department of Health and Human Services, Health Resources and Services Administration, Ryan White HIV/AIDS Treatment Extension Act of 2009. The HIV Emergency Relief Grant Program Part A: Eligible Metropolitan Areas/Transitional Grant Areas HRSA Announcement No: HRSA-16-021 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, 2015 – Feb 29, 2016 for the Las Vegas Ryan White TGA. Funds for Grant Year Mar 1, 2016-Feb 28, 2017 are contingent upon receipt of Grant Award funds from Health Resources and Services Administration to the Las Vegas Ryan White TGA.

The purpose of this section is to provide a description of how your agency plans to utilize the allocated funding to provide the highest quality of service based on the Public Health Service Guidelines, the Health Resources and Services Administration (HRSA) mandated core and support service categories, the Las Vegas TGA Planning Council approved Standards of Care and the HSRA required National Monitoring Standards to meet the client's need(s). The timeframe for the contract is March 1, 2016 – February 28, 2017.

PROPOSER(S) may submit a proposal for one and up to all service categories listed. Reference the evaluation criteria for additional information on criteria required per service category.

For each HRSA mandated Core or Support Service Category, which PROPOSER is applying for, PROPOSER must list the Service Category and PROPOSER'S implementation plan including goal(s), objective(s) and evaluation method(s). The implementation plan must specifically detail the following:

- How many clients PROPOSER projects serving
- PROPOSER'S method for determining eligibility
- Ensuring Grant funds are the payor of last resort
- Ensuring clients maintain access and compliance with Grant funded core and supportive services
- How PROPOSER will work in conjunction with other Grant and non-Grant agencies to ensure clients have wrap around supportive services, and your agency's leveraging strategy, in the event the service category does not receive adequate funds in future grant years.
- PROPOSER'S adherence method to Service Category Standard of Care

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.

B. Oral Health Care

Includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

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.

D. Health Insurance Premium & Cost Sharing Assistance

This is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

E. Mental Health Services

Psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

F. Medical Nutrition Therapy

Provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services and nutritional supplements may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian.

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.

Support Service Categories**A. Medical Transportation**

Conveyance services provided, directly or through voucher, to a client so that he or she may access health care services. Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical and support services. Medical transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service.

B. Housing Services

Provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

C. Food Bank/Home Delivered Meals

Provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, also should be included in this item.

D. Emergency Financial Assistance

Provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and

medication, when other resources are not available. Part A programs must allocate, track, and report these funds under specific service categories.

E. Health Education/Risk Reduction

Provision of services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

F. Psychosocial Support Services

Provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support and bereavement counseling. It includes nutrition counseling by a non-registered dietitian, but excludes the provision of nutritional supplements.

**EXHIBIT A – ATTACHMENT 1
STANDARDS OF CARE**

**Las Vegas Transitional Grant Area
Planning Council**

All categories must follow *Universal Programmatic and Administrative Standards of Care* in addition 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:

- o 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 \geq 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 history
- 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
(B.) Oral Health Standards of Care**



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care 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) Oral Health Service Goal:

To maintain and improve the oral health of people living with HIV/AIDS (PLWH/A)

2.2 Las Vegas Transitional Grant Area (TGA) Oral Health Service Objectives:

1. To reduce medical complications related to poor oral health.
2. To reduce dental disease through education to PLWH/A on the importance of good oral health.
3. To reduce dental disease through the provisions of toothbrushes, toothpastes, floss and other necessary dental products imperative to good oral health.

3. Key Services

1. Visit with a dentist for routine dental care or specialty care.
2. Receive a routine dental exam and cleaning every 6 months.
3. Ryan White funded clients will receive oral health care with a cap of \$1,500* per person for medically needed dental services.

Note: Cosmetic dental care is not allowable under Part A funding.

* \$1,500 cap is as of FY2012. Please see section 10, Fees for future changes.

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 Oral Health

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 Oral Health program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline Evaluation

5.1 Dental and Medical History

In order to develop an appropriate treatment plan, the oral health care provider should obtain and complete, for each eligible Part A client, information about the client's health and medication status.

- Clients entering oral health care should have a dental and medical history completed within 60 days of their first visit.
- Established patients should have a complete dental and medical history completed (updated) at a minimum of once per year.

5.2 Dental Treatment Plan

A comprehensive dental treatment plan that includes preventive care, maintenance and elimination of oral pathology should be developed and discussed with the patient. Various treatment options should be discussed and developed in collaboration with the patient. As with all clients, a treatment plan appropriate for the clients health status, financial status, and individual preference should be chosen.

5.3 Oral Health Education

A higher risk of dental issues caries in clients with HIV may be caused by decreased salivary flow, which may occur as a result of salivary gland disease or as a side effect of a number of medications. Also, some topical antifungal medications have high sugar content, possibly resulting in increased caries susceptibility. The adverse effects of using tobacco should also be discussed with the patients. If a patient is a tobacco user, cessation should also be discussed.

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

All staff providing direct Ryan White Part A Oral Health services will hold an academic degree of Doctor of Dental Surgery (DDS).

12. Quality Assurance and Service Measures

12.1 Quality Management and Assurance:

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

12.2 Service Indicators and Measures

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

Agency Compliance Measures for Oral Health 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.

13. Clinical Standards:

The Client Level Outcome Measures are a reflection of a client's progress as they access Oral Health Care. 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).

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 ($CD4 \geq 200$).

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).

14. Summary

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

15. Recommendations

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

16. References and further reading

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

17. Appendices

Not Applicable.

**Las Vegas Transitional Grant Area
Planning Council
(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 \geq 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

(D.) Health Insurance Continuation and Cost Sharing Assistance Standards of Care



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Health insurance premium & cost sharing assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Funds awarded under Parts A, B and C of the Ryan White HIV/AIDS Program may be used to support a Health Insurance Premium and Cost-Sharing Assistance Program, a core medical service, for eligible low-income HIV-positive clients.

- Under this service category, funds may be used as the payer-of-last-resort to cover the cost of public or private health insurance premiums, as well as the insurance deductible and co-payments.
- The exception is that Ryan White HIV/AIDS Program funds may NOT be used to cover a client's Medicare Part D "true out-of-pocket" (i.e. TrOOP or donut hole) costs.
- Consistent with the Ryan White HIV/AIDS Program, "low income" is to be defined by the EMA/TGA, State or Part C Grantee.

Important: Grantees should refer to the HAB Policy Notice-07-05, "The Use of Ryan White HIV/AIDS Program Part B ADAP Funds to Purchase Health Insurance" <http://hab.hrsa.gov/law.htm>

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 Goal

2.1 Las Vegas Transitional Grant Area (TGA) Health Insurance Continuation and Cost Sharing Assistance Service Goal:

To ensure access to medical care and cost effective utilization of Ryan White funds.

3. Key Services

- Provide assistance for health/dental/vision insurance premium payments, co-payments, and deductibles to clients not eligible for coverage by ADAP.

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 Health Insurance Continuation and Cost Sharing Assistance

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 Health Insurance Continuation and Cost Sharing Assistance program from another Ryan White funded program after Part A eligibility is determined and only when other options are not available such as denial or non-eligibility by the State ADAP program making this program the payor of last resort.

5. Clients Rights and Confidentiality

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

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

6. Grievance Procedures-Part A

All providers will ensure that:

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

7. Client Satisfaction

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

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

8. Access, Care Coordination and Provider Continuity

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

9. Fees

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

10. Licensing, Knowledge, Skills and Experience

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

11. Quality Assurance and Service Measures

11.1 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.

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

12. Clinical Standards

The Client Level Outcome Measures are a reflection of our client's progress as they access Health Insurance Continuation and Cost Sharing Assistance 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).

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 \geq 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

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

14. 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.

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. All referenced materials for standards are listed under the Universal Programmatic and Administrative Standards of Care.

16. Appendices

Not Applicable.

**Las Vegas Transitional Grant Area
Planning Council
(E.) Mental Health Standards of Care**



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Mental Health services are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a Mental Health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

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) Mental Health Service Goal:

To provide Mental Health services to minimize crisis situations and stabilize clients' Mental Health in order to positive health outcomes and retention in care.

2.2 Las Vegas Transitional Grant Area (TGA) Mental Health Service Objectives:

1. To address and stabilize current client’s mental health issues in order to promote and maintain access to the TGA system of care.
2. To address and stabilize new client’s mental health issues in order to promote and maintain access to the TGA system of care.

3. Key Services

1. One Mental Health appointment with a certified Mental Health therapist.

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 Mental Health

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 Mental Health program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline Evaluation

5.1 Screening and Intake

Clients should receive a comprehensive Mental Health Screening to be completed within the first three appointments with the Mental Health provider.

At a minimum this screening should include the following:

- o Demographic information
- o Employment status Current living arrangement
- o HIV status
- o Presenting symptoms
- o Alcohol and drug history and current usage
- o History of treatment Medical history
- o Family history
- o Mental status exam Bio psychosocial
- o Diagnostic and Statistical Manual of Mental Disorders (DSM IV) Diagnosis Current Global Assessment of Functioning (GAF) Score
- o Development of treatment plan

5.2 DSM IV Diagnosis

Clients should have a DSM IV diagnosis documented on intake but no later than within the first three appointments with the mental health provider. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides a common language and standard criteria for the classification of mental disorders. The DSM uses a multi-axial or multidimensional approach to diagnosing because rarely do other factors in a person's life not impact their mental health.

It assesses five dimensions as described below:

Axis I: Clinical Syndromes

This is what we typically think of as the diagnosis (e.g., depression, schizophrenia, social phobia)

Axis II: Developmental Disorders and Personality Disorders

Developmental disorders include autism and mental retardation, disorders which are typically first evident in childhood

Personality disorders are clinical syndromes which have a more long lasting symptoms and encompass the individual's way of interacting with the world. They include Paranoid, Antisocial, and Borderline Personality Disorders.

Axis III: Physical Conditions which play a role in the development, continuance, or exacerbation of Axis I and II Disorders

Physical conditions such as brain injury or HIV/AIDS that can result in symptoms of mental illness are included here.

Axis IV: Severity of Psychosocial Stressors

Events in a person's life, such as death of a loved one, starting a new job, college, unemployment, and even marriage can impact the disorders listed in Axis I and II. These events are both listed and rated for this axis.

Axis V: Highest Level of Functioning

On the final axis, the clinician rates the person's level of functioning both at the present time and the highest level within the previous year. This helps the clinician understand how the above four axes are affecting the person and what type of changes could be expected.

5.3. Global Assessment of Functioning

Clients should have a documented Global Assessment of Functioning (GAF) rating on intake but this assessment should take place no later than within the first three appointments with the mental health 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.

5.4. Treatment Plan-Individual Sessions Only

Treatment plans should be created for all clients attending individual sessions. The Mental Health 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 mental health 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.

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

Mental Health services can 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 appropriate credentials identified by the agency.

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. 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 Mental Health 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. 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 Mental Health 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 \geq 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 Mental Health 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
(F.) Medical Nutrition Therapy Standards of Care**



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services and nutritional supplements may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian.

Nutritional services not provided by a licensed, registered dietitian shall be considered a support service. Food, nutritional services and supplements not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian also shall be considered a support service.

Medical Nutrition Therapy Services including nutritional supplements provided by a licensed registered dietitian outside of a primary care visit is an allowable core medical service under the Ryan White HIV/AIDS Program. The provision of food may be provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian.

Nutritional services and nutritional supplements not provided by a licensed, registered dietitian shall be considered a support service under the Ryan White HIV/AIDS Program. Food not provided pursuant to a physician's recommendation and a nutritional plan developed by a licensed, registered dietitian also shall be considered a support service.

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 Nutrition Therapy Service Goal:

To provide medical nutrition services to PLWH/A in the TGA by a licensed registered dietitian

2.2 Las Vegas Transitional Grant Area (TGA) Medical Nutrition Therapy Service Objectives:

1. To provide nutritional assessment, counseling and education to delay HIV disease progression and treat malnutrition, asses and evaluate food security and to minimize the impact of other co - morbidities on the progression of HIV infection.

3. Key Services

1. One visit with a licensed registered dietitian.

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 Nutrition Therapy

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 Nutrition Therapy program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline Evaluation

5.1 Nutrition Screening

Clients entering Medical Nutrition Therapy services should receive a nutrition screening.

5.2. Intake and Initial Assessment

Clients should receive a nutrition and wellness assessment that includes, at a minimum, the following:

- Concerns/questions/requests
- 24 hour diet recall
- Demographic information
- Current infections and medical conditions
- Medical care status
- Weight history and nutritional needs
- Current gastrointestinal symptoms or complications
- Dietary preferences/habits
- Current labs
- Current HIV/AIDS medication
- Life style

Clients should also have an individualized nutrition plan developed and be provided any applicable education concurrently. Referrals should also be provided in order to coordinate services required to implement the plan.

5.3 Nutrition Supplements

If a need is found for nutrition supplements only the registered dietitian may write the recommendation for the dispensing of commercial nutritional liquid/powder supplements to clients.

In order to be eligible for commercial nutritional liquid/powder supplementation, the client must have a compromised nutritional status manifested by one or more of the following:

- Significant weight loss of > 7.5% in < 3 months
- BMI < 18.5 and/or cachexia
- Serum Albumin <2.8
- Malabsorption syndrome
- Neurological or mechanical eating difficulties such as dysphagia
- A diagnosis of cancer with a history or expectation of significant weight loss
- Poor appetite due to a medical condition (i.e. HIV/AIDS, Cancer, Dementia, Kidney Disease, Parkinson's, etc.)
- A pressure ulcer > stage 1 or a non - healing wound
- A feeding tube

Clients receiving nutritional supplementation besides a multivitamin and/or calcium supplement are encouraged to visit the registered dietitian monthly to assess need for continuation of supplementation and maintain efficacy of nutrition plan. Clients receiving a nutrition plan but not receiving nutritional supplementation are also encouraged to follow up monthly to maintain efficacy. Nutrition counseling is also provided to any client requesting to follow - up with a registered dietitian within three months of their initial assessment or reassessment and is not requesting nutritional supplementation.

5.4 Nutrition Reassessment

A reassessment should occur every three to six months for clients continuing nutritional supplementation, clients requesting nutritional supplementation that were assessed three months ago or more, or as requested by a client or referred that has not been seen by the registered dietitian in six months or more.

Clients should also receive a comprehensive nutritional assessment and recommended diet regimen. Clients should also have an individualized nutrition plan developed and be provided any applicable education concurrently. Referrals should also be provided in order to coordinate services required to implement the plan.

5.5 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, along with the reason for case closure. Cases may be closed when the client;

- Client is deceased
- Is relocating out of the service area
- No longer needs the service
- Decides to discontinue the service
- Is improperly utilizing the service

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.
4. 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 Nutrition Therapy may only be provided by a licensed registered dietitian or dietetic technician registered under the supervision of a registered dietitian and shall conform to the requirements of the Nevada or Arizona State Board of Examiners of Dietitians and the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics. Staff should also have a minimum of six months experience in the nutrition assessment, counseling, evaluation and care plans of people living with HIV/AIDS.

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 Medical Nutrition Therapy 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 Medical Nutrition Therapy 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).

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 \geq 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).

Improved Overall Health

- 75% of clients will report an improved overall health from the nutrition supplements they received (such as Boost, food vouchers) over the last 12 months.

Decrease Symptoms

- 75% of clients will report that the nutrition therapy services (such as Boost, food vouchers, or meeting with the nutrition therapist) helped decrease any symptoms they have related to their HIV/AIDS status.

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Medical Nutrition Therapy 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:

- o 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 \geq 200).

Undetectable Viral Load

- 50% of clients will have a viral load that remained undetectable or decreased to \leq 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 (\geq 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 \geq 200).

Undetectable Viral Load

- 50% of clients will have a viral load that remained undetectable or decreased to \leq 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 ($CD4 \geq 200$).

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
- Opiate Assisted Therapy
- Neuro-psychiatric pharmaceuticals; and
- Relapse prevention.

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

1.2 Key Definitions

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

As used herein, the term:

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.
5. 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 \geq 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.

**Las Vegas Transitional Grant Area
Planning Council**
(I.) Medical Transportation Standards of Care



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Medical transportation services are conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services. Medical transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service.

Medical Transportation is an allowable support service under the Ryan White HIV/AIDS Program. Funds may be used to provide transportation services for an eligible individual to access HIV-related health services, including services needed to maintain the client in HIV/AIDS medical care. Transportation should be provided through:

- a. A contract(s) with a provider(s) of such services;
- b. Voucher or token systems;
- c. Mileage reimbursement that enables individuals to travel to needed medical or other support services may be supported with Ryan White HIV/AIDS Program funds, but should not in any case exceed the established rates for Federal Programs. Federal Joint Travel Regulations provide further guidance on this subject.
- d. Use of volunteer drivers (through programs with insurance and other liability issues specifically addressed); or
- e. Purchase or lease of organizational vehicles for client transportation programs. (See also HAB Policy: Maintenance of Privately Owned Vehicles, for further information.) *Note: Grantees must receive prior approval for the purchase of a vehicle.*

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”.

Service Goal and Objectives

2.1 Las Vegas Transitional Grant Area (TGA) Medical Transportation Service Goal:

Provide medical transportation services to clients to ensure adherence to care.

2.2 Las Vegas Transitional Grant Area (TGA) Medical Transportation Service Objectives:

1. Provide needed transportation assistance to clients for their medical and/or social support service appointments.

2. Key Services:

1. One medical transportation visit in the form of one of the following methods:
 - a. One day bus pass
 - b. One van transportation/day
 - c. Gas Voucher

3. 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 Transportation

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 Transportation program from another Ryan White funded program after Part A eligibility is determined.

Eligible utilization of this service category:

Appropriate utilization for Medical Transportation Services includes the following categories:

- Doctor Appointments
- Medical Case Management Appointments
- Mental Health and Substance Abuse Treatment Appointments
- HIV Related Support Groups
- Dental Appointments
- Lab Work
- Pharmacy Visits

Medical Transportation services may not be used to transport clients to social or recreational activities.

5. Baseline Evaluation:

Regardless of the method of delivery of transportation services, all funded medical transportation programs are required to maintain a method to track all requested transportation services and ensure that all of the trips were taken and were appropriately used to access HIV related services. Proper documentation must be obtained and tracked for all clients and services.

5.1 Bus Passes

Bus passes are the appropriate method of transportation to be provided for clients who live inside the Regional Transportation Area of Southern Nevada or the Regional Transportation Area of Northern Arizona. Each agency providing this service must have a mechanism in place for tracking the utilization of bus passes for legitimate medical reasons only.

a. Documentation of Service

It is the client's responsibility to provide a list of eligible appointments on a monthly basis to the designated agency representative prior to transportation services being provided. Additionally, clients must provide documentation of service utilization in accordance with agency policy following the appointment. Such documentation could include originals or copies of the following:

- Medical appointment card (showing date time and location of appointment) that corresponds with the passes they've been provided
- Signature of staff from medical appointment or support group session
- Copy of lab work (must show date and location)
- Pharmacy receipt

5.2 Van Transportation

Transportation by van will be provided by designated rural agencies only as a means for clients living outside of the service area to access medical services provided in the TGA. Agencies providing van transportation must have a mechanism in place for tracking the utilization of this service for legitimate medical reasons only.

a. Documentation of Service

It is the agency's responsibility to maintain a monthly log to ensure Medical Transportation services are utilized only for the intended purpose. This log must contain the following documentation:

- Name of client with URN
- Date of request for transportation
- Date and time of medical appointment
- Name and address of medical provider
- Date and time of pick up from medical provider
- Each trips starting and ending mileage

5.3 Gas Vouchers

Gas vouchers will be primarily used for residents of Nye County but may not necessarily be limited to Nye County in cases where other transportation options are not available or if it is the most cost effective method of transportation.

- Verification of appointments must be provided in order to receive a gas voucher including proof of attendance.
- Gas voucher amounts will depend on the location and distance of the appointment from the client's primary residence.

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. Clients that opt to utilized a "shared" transportation environment, such as van service, will sign a "waiver" and confidentiality agreement to protect themselves as well as the other clients that they will be sharing this service with so that all parties understand that the status of others will be respected by all in the same van.
2. All provider staff will attend HIPAA training as well as any State or County confidentiality trainings offered.
3. The provider will provide assurances and a method for protection of client rights in the process of care provision.
4. 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.

5. 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.
6. 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

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

All van drivers must have a valid State driver's license; attend and successfully complete and pass the following classes: defensive driving and CPR/First Aid.

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 Medical Transportation 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 Transportation 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).

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 \geq 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).

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Medical Transportation 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
(J.) Housing Standards of Care**



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Housing services are the provision of short-term assistance to support emergency, temporary, or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential 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) Housing Service Goal:

To assist homeless and marginally housed PLWH/A in the Las Vegas TGA to secure housing so that they can access and maintain health care and supportive services

2.2 Las Vegas Transitional Grant Area (TGA) Housing Service Objectives:

1. To provide financial assistance to clients that are in need of short term rent assistance as they transition from one residence to another.
2. To provide financial assistance to new clients that are in need of short term rent assistance as they transition from one residence to another

3. Key Services

1. One housing related visit
2. One day of housing assistance

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 Housing

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 Housing program from another Ryan White funded program after Part A eligibility is determined.

Eligible utilization of service

Clients must present the thirty - days or more past due bill notice and exhibit the inability to pay the bill in order to receive Housing assistance. Additionally, in order to be eligible, the person or a member of the resident household must present evidence that he/she is a named tenant under a valid lease or he/she is a legal resident of the premise. To receive a mortgage payment, the eligible person must demonstrate that he/she is the resident owner of mortgaged real property. Assistance is subject to the availability of funding.

5. Baseline Evaluation

Housing Service Activities

Short-term housing payments must be carefully monitored by the provider to assure limited amounts, limited use, and for limited periods of time. Prior to receiving Housing assistance the provider shall assist the client in seeking at least three alternate funding sources in the community.

Clients receiving Housing assistance must also have a Housing Plan documented in the client chart. It should, at a minimum, include the following:

- Identified issues
- Goal/objective
- Service provided
- Monthly and total cost
- Service start date
- Check amount
- Date the check was mailed
- Recipient of check
- Signature of client and case manager

A request is considered approved when all documentation of the denial of three other resources is present and confirmation is received from the supervisor that funding is available. Clients eligible for Housing assistance should receive payment within 7 days of approved request.

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

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

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 Housing 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 clients progress as they access Housing 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).

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 \geq 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).

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Housing 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**
(K.) Food bank/home-delivered meals Standards of Care



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Food bank/home-delivered meals are the provision of actual food or meals. It does not include finances to purchase food or meals, but may include vouchers to purchase food. The provision of essential household supplies, such as hygiene items and household cleaning supplies, also should be included in this item.

Purchase of Non-Food Products:

Funds awarded under the Ryan White HIV/AIDS Program may be used to purchase essential non-food household products as part of a Ryan White HIV/AIDS Program funded Food Bank support service. These include essential items such as:

- Personal hygiene products,
- Household cleaning supplies, and/or
- Water filtration/ purification devices (either portable filter/pitcher combinations or filters attached to a single water tap) in communities/areas where recurrent problems with water purity exist. Such devices (including their replacement filter cartridges) purchased with Ryan White HIV/AIDS Program funds must meet National Sanitation Foundation standards for absolute cyst removal of particles less than one micron. This policy does not permit installation of permanent systems for filtration of all water entering a private residence.

Funds may NOT be used for household appliances, pet foods or other non-essential products.

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) Food bank/home-delivered meals Service Goal:

To improve the nutritional health and quality of life for persons living with HIV disease

2.2 Las Vegas Transitional Grant Area (TGA) Food bank/home-delivered meals Service Objectives:

1. To provide access to healthy and nutritious food necessary to maintain caloric intake and balanced nutrition consistent with each client’s individual care plan.
2. The provision of food services is to augment other public and private resources for food, meals, or food vouchers to individuals in an attempt to ensure there is no regression in health status.

3. Key Services

1. One food bank/home delivered meals visit/voucher
2. Emergency Food Bags

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 Food bank/home-delivered meals

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 Food bank/home-delivered meals program from another Ryan White funded program after Part A eligibility is determined.

Eligible utilization of Food bank/home-delivered meals services:

- Distribution of food vouchers, as well as the purchase of food and hot meals
- Funded food service programs must be licensed, if applicable, and meet inspection requirements for Food Service Sanitation in the city or county of operation.
- Providers providing food vouchers will make every effort to purchase quantities that provide for discounts.

Limitations of Food bank/home-delivered meals service:

- Nutritional Assessment and Nutritional Counseling services are not a part of the Food Bank/Home Delivered Meals service.
- This service is designated only as a supplemental or partial augmentation to other food sources available to clients.
- Funds may not be used to purchase household appliances, pet food or pet products.

5. Clients Rights and Confidentiality

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

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

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

6. Grievance Procedures-Part A

All providers will ensure that:

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

7. Client Satisfaction

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

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

8. Access, Care Coordination and Provider Continuity

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

9. Fees

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

10. Licensing, Knowledge, Skills and Experience:

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

11. Program Data and Reporting

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

12. Quality Assurance and Service Measures

12.1 Quality Management and Assurance

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

12.2 Service Indicators and Measures

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

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

13. Clinical Standards

The Client Level Outcome Measures are a reflection of our client's progress as they access Food Bank/Home Delivered Meals. 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).

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 \geq 200)

Undetectable Viral Load

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

Most Recent Viral Load Undetectable

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

14. Summary

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

15. Recommendations

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

16. References and further reading

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

17. Appendices

Not Applicable.

**Las Vegas Transitional Grant Area
Planning Council
(L.) Emergency Financial Assistance Standards of Care**



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Emergency financial assistance is the provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication, when other resources are not available. Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in the Division of Service Systems Program Policy Guidance No. 2 (formerly Policy No. 97-02).

Ryan White HIV/AIDS Program funds may be used to provide Emergency Financial Assistance (EFA) as an allowable support service.

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

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

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

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

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

1.2 Key Definitions

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

As used herein, the term:

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

Client: includes the terms “patient” and “consumer”.

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

2. Service Goals and Objectives

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

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

2.2 Las Vegas Transitional Grant Area (TGA) Emergency Financial Assistance Service Objectives:

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

3. Key Services

Provide Emergency Financial Assistance for:

- Food
- Housing
- Utilities
- Emergency Medication(s)

4. Eligibility

4.1 Part A

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

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

4.2 Emergency Financial Assistance (EFA)

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

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

Eligible utilization of service

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

- Essential utilities
- Short term housing assistance

- o Short term mortgage assistance
- o Emergency food assistance (including food vouchers, and food stamps)
- o Emergency medication assistance

Clients must present the thirty - days or more past due bill notice and exhibit the inability to pay the bill in order to receive EFA for housing or utilities.

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

Additionally, in order to be eligible, the person or a member of the resident household must present evidence that he/she is a named tenant under a valid lease or he/she is a legal resident of the premise. To receive a mortgage payment, the eligible person must demonstrate that he/she is the resident owner of mortgaged real property.

For utility assistance, the eligible person must have an account in their name with a utility company or proof of responsibility to make utility payments, such as receipts in their name from a utility company.

5. Clients Rights and Confidentiality

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

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

6. Grievance Procedures-Part A

All providers will ensure that:

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

7. Client Satisfaction

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

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

8. Access, Care Coordination and Provider Continuity

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

9. Fees:

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

10. Licensing, Knowledge, Skills and Experience

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

11. Program Data and Reporting

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

12. Quality Assurance and Service Measures

12.1 Quality Management and Assurance

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

12.2 Service Indicators and Measures

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

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

13. Clinical Standards

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

In Medical Care

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

Maintained Adherence to Medical Care

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

Stabilized CD4 T - cell Count

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

Most Recent CD4 Stable

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

Undetectable Viral Load

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

Most Recent Viral Load Undetectable

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

14. Summary

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

15. Recommendations

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

16. References and further reading

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

17. Appendices

Not Applicable.

**Las Vegas Transitional Grant Area
Planning Council**
(M.) Health Education/Risk Reduction Standards of Care



Originated	Ratified
March 2011	November 2012

1. HRSA Service Definition

Health education/risk reduction is the provision of services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

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) Health Education/Risk Reduction Service Goal:

To provide education on health and risk reduction services to HIV+ individuals encourage health behavior, improve health outcomes and decrease transmission rates.

3. Key Services

1. One health education/risk reduction visit.
2. One health education/risk reduction class attended.

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 Health Education/Risk Reduction

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 Health Education/Risk Reduction program from another Ryan White funded program after Part A eligibility is determined.

5. Baseline Evaluation

5.1 Health Education/Risk Reduction Service Activities

1. Service Components
 - a. Implementation of a curriculum in individual and group settings that includes, at a minimum, the following:
 - Goal setting and problem solving strategies
 - Health literacy and HIV/AIDS - related knowledge
 - Navigating the health care system
 - Understanding the relationship between laboratory results and physical health
 - Managing negative emotions
 - Finding and building networks of social support
 - Strategies to increase medication adherence and mitigate against side effects of the medications
 - Cognitive techniques for symptom management
 - Nutrition and exercise
 - Locating resources for support and medical services
 - Methods to reduce the spread of HIV and the impact of other diseases on one's health
 - b. Development of a client self - management improvement plan, in collaboration with the client that addresses and increases the client's capacity in the curriculum's components.
 - c. Tracking of client's progress through the use of assessment tools.
 - d. Adjustment in the improvement plan, as necessary.
 - e. Referral to core and support services, if necessary.

Staff providing Health Education/Risk Reduction services must document the client session in CAREWare, including a case notes entry to reflect the education session that has been completed within five business days of providing the service.

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:

- o 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

Health Education/Risk Reduction staff shall have had at least six months of relevant experience in the areas of outreach work, community services, supportive work with families and individuals, supportive work with youth, corrections, or public relations.

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 Health Education/Risk Reduction 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 clients progress as they access Health Education/Risk Reduction 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).

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 \geq 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).

15. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Health Education/Risk Reduction 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
(N.) Psychosocial Support Standards of Care**



Originated	Ratified
October 2012	

1. HRSA Service Definition

*Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, **HIV support groups**, pastoral care, caregiver support, and bereavement counseling. It includes **nutrition counseling provided by a non-registered dietitian**, but it **excludes the provision of nutritional supplements***

Pastoral Counseling

Funds awarded under the Ryan White HIV/AIDS Program may be used to provide "Psychosocial Support Services" that include pastoral care/counseling services, provided that the pastoral counseling is provided by an institutional pastoral care program (e.g., components of AIDS interfaith networks, separately incorporated pastoral care and counseling centers, or as a component of services provided by a licensed provider, such as a home care or hospice provider). Programs are to be licensed or accredited wherever such licensure or accreditation is either required or available. In addition, Ryan White HIV/AIDS Program funded pastoral counseling **MUST** be available to all individuals eligible to receive Ryan White HIV/AIDS Program services, regardless of their religious or denominational affiliation.

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. Key Services:

1. Conduct HIV Support Groups outside of a mental health service environment with particular focus on the Hispanic male population.
2. Provision of nutritional counseling by a non-registered dietician outside of a medical related visit.

3. Eligibility

3.1 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

3.2 Psychosocial Support

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 Psychosocial Support program from another Ryan White funded program after Part A eligibility is determined as well as which service(s) the client requires: an HIV support group and/or nutritional counseling.

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. 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.

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.

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:

College graduate preferred. Persons hired should be culturally diverse with an understanding of targeted populations and can connect with the Persons Living with HIV/AIDS in the Las Vegas TGA. Qualified individuals should have HIV related experience. If qualified individuals do not have HIV related experience they must receive HIV specific training within six months of hire.

Staff applying to provide nutritional counseling should also be licensed i.e. RN, CNA and should also be able to understand and be able to carry out physician's orders.

10. Quality Assurance and Service Measures

10.1 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.

10.2 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 Psychosocial Support 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.

11. Clinical Standards

The Client Level Outcome Measures are a reflection of our clients progress as they access Psychosocial Support 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).

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 \geq 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).

12. Summary

These service specific standards shall be followed by all funded providers that provide Part A funded Psychosocial Support 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.

13. 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.

14. 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.

16. Appendices

Not Applicable.

EXHIBIT A - ATTACHMENT 2

Service Category:

Item	Detail	Annual Part A Total
1. Personnel:		
Position Title, Name <i>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.</i> RWPA Percentage, Other Percentage	FTE for RWPA Annual Salary x RWPA %	
Total Personnel		\$
2. Fringe Benefits:		
a. <i>List fringe benefits included (ie. Social security, health benefits etc.)</i>	Total Salary x Fringe Benefit %	
Total Fringe:		\$
3. Travel:		
a. List travel location and number of staff attending		\$
Airfare: Amount x # of people		
Lodging: Amount x # of nights x # of people		
Per Diem Meals: amount x # of days x # of people		
Airport Parking: amount x # of days x # of people		
Ground Transportation:		
Other (list):		
b. Mileage: Purpose: Amount per mile x # of months (Home visits: \$0.50 per mile x 12 months)		\$
c.		\$
d.		\$
Total Travel:		\$

EXHIBIT A - ATTACHMENT 2

Item	Detail	Annual Part A Total
4. Equipment:		
a.		\$
b.		\$
Total Equipment:		\$
5. Supplies:		
a.		\$
b.		\$
Total Supplies:		\$
6. Contractual:		
a.		\$
b.		\$
Total Contractual		\$
7. Other:		
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 PROVIDER 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, PROVIDER 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

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

EXHIBIT 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 %
<i>Core Services</i>					
<i>Outpatient & ambulatory</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>AIDS Pharmaceutical Assistance</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Oral Health</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Early Intervention Services</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Health Insurance Program HIC</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Mental Health Services</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Medical Nutrition Therapy</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Medical Case Management</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Substance Abuse Outpatient</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Support Services</i>	\$0.00				
<i>EFA - Housing /Utilities/Food</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Food Bank/Home Delivered Meals</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Housing Services</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Medical Transportation</i>	\$0.00	\$0.00	\$0.00	\$0.00	
<i>Health Ed/Risk Red Prev</i>	\$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
<i>Personnel</i>						
Subtotal Salaries				\$0.00		
Fringe Benefits						
TOTAL PERSONNEL				\$0.00		
<i>Travel</i>						
TOTAL TRAVEL				\$0.00		

EXHIBIT D
REQUEST FOR REIMBURSEMENT

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

**EXHIBIT G
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 Agreement, so that services to be provided and the corresponding maximum payment amount may be decreased or increased at the discretion of COUNTY for services remaining to be provided. COUNTY reserves the right to reduce PROVIDER's funding and to reallocate such funding to other Ryan White providers if it appears the full funding shall not be used by PROVIDER.
 - g. All payments made to PROVIDER from the date of execution of this Agreement, for services provided, shall be reimbursed through a cost-based reimbursement system.
 - h. The Agreement may also be immediately terminated by COUNTY in the event federal funding is reduced or eliminated and for cause as set forth herein. Upon the effective date of any termination, any and all rights and obligations of each party hereto shall be deemed at an end and canceled, except as previously accrued or vested.
3. Restrictions on Grant Expenditures
 - a. TREATMENT EXTENSION ACT funds shall not be used to purchase or improve land, or to purchase, construct, or make permanent improvements to any building, except for minor remodeling, if authorized.
 - b. TREATMENT EXTENSION ACT funds shall not be used to make direct payments to recipients of services.
 - c. TREATMENT EXTENSION ACT funds shall not be used to supplant or replace current state, local, or private HIV-related funding. PROVIDER shall maintain documentation on file assuring that services rendered under this Agreement will use TREATMENT EXTENSION ACT funding as "dollars of last resort" and that the client has no other source of funding to provide such services.
 - d. TREATMENT EXTENSION ACT funds are to be used for HIV/AIDS-related services only. Use of these funds for research, epidemiological surveys, clinical trials, and capital projects is prohibited.
 - e. TREATMENT EXTENSION ACT funds shall not be used to provide items or services for which payment already had been made or reasonably can be expected to be made by third party payers, including Medicaid, Medicare, and/or other federal, state, or local entitlement programs, prepaid health plans, or private insurance. PROVIDER shall provide its Medicare/Medicaid certification number or evidence of the status of becoming Medicare/Medicaid certified.
 - f. COUNTY shall not honor any request for payment for services provided by volunteers at no cost to PROVIDER. COUNTY shall not honor any request for payment for services provided outside of Clark and Nye Counties, Nevada, and Mohave County, Arizona, unless prior written authorization has been obtained from COUNTY.
4. PROVIDER understands and further agrees to the eligibility criteria for the Ryan White Part A Program. Delivery of services is contingent on verification of medical and financial eligibility.
 - a. General Scope of Work for All Providers

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

1. The Statement of Consumer Rights
 2. Disability Act
 3. Labor laws
 4. Sanction policy and/or zero tolerance information
 5. Grievance policy or posted information informing clients that there is a grievance policy.
- (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 TREATMENT 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 Agreement, 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 Agreement.
 - (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 Agreement is valid and enforceable only if sufficient TREATMENT EXTENSION ACT funds are made available to COUNTY by HRSA. Payment for all services provided under this Agreement is expressly contingent upon the availability of such TREATMENT EXTENSION ACT funds. This Agreement may be amended, suspended or terminated effective immediately by COUNTY at any time in the event of a change in, a suspension of or discontinuation of the availability of these funds.
 6. PROVIDER shall comply with all applicable state, federal and county laws and regulations relating to its performance under this Agreement as they now exist and as hereafter amended or otherwise modified. PROVIDER shall perform all services under this Agreement in compliance with the U.S. Office of Management and Budget (OMB) cost principles and uniform administrative requirements as promulgated in its published circulars as well as U.S. Department of Health and Human Services Public Health Service Grants Policy Statements, all HRSA TREATMENT EXTENSION ACT program guidelines, policies and practices and comply with the Universal Health Records Standards issued by HRSA.
 7. PROVIDER agrees that grant funds may only be used for the awarded purpose and are approved expenditures under the guidelines of U.S. Department of Health and Human Services and Health Resources and Services Administration. In the event PROVIDER expenditures do not comply with this condition, that portion not in compliance must be refunded to the COUNTY.
 8. PROVIDER agrees that the expenditure of award funds in excess of approved budgeted amount, without prior written approval by the COUNTY, may result in the PROVIDER refunding to the COUNTY that amount expended in excess of the approved budget.
 9. PROVIDER agrees to comply with the requirements of the Civil Rights Act of 1964, as amended, and the Rehabilitation Act of 1973, P.L. 93-112, as amended, and any relevant program-specific regulations, and shall not discriminate against any employee or offer for employment because of race, national origin, ethnicity, color, gender, sexual orientation, religion, age, or disability (including AIDS and AIDS-related conditions). PROVIDER shall include this non-discrimination clause in all subcontracts/agreements in connection with any service or other activity under this Agreement.
 10. PROVIDER shall also be in compliance with the Equal Employment Opportunity Act, Anti-Kickback Act, the Davis-Bacon Act and OSHA regulations.

11. In accordance with the Immigration Reform and Control Act of 1986, PROVIDER shall not knowingly employ unauthorized or illegal aliens in the performance of this Agreement.
12. PROVIDER agrees to comply with the Americans with Disabilities Act of 1990 (P.L. 101-136), 42 U.S.C. 12101, as amended, and regulations adopted there under contained in 28 CFR 26.101-36.999 inclusive, and any relevant program-specific regulations.
13. PROVIDER certifies, by signing this Agreement, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. This certification is made pursuant to regulations implementing Executive Order 12549, Debarment and Suspension, 28 C.F.R. pt. 67 § 67.510, as published as pt. VII of May 26, 1988, Federal Register (pp.19150-19211). This certification shall be required by PROVIDER of every subcontractor receiving any payment in whole or in part from monies paid pursuant to this Agreement.
14. PROVIDER agrees, whether expressly prohibited by federal, state, or local law, or otherwise, that no funding associated with this award shall be used for any purpose associated with or related to lobbying or influencing or attempting to lobby or influence for any purpose the following:
 - a. any federal, state, county or local agency, legislature, commission, council, or board;
 - b. any federal, state, county or local legislator, commission member, council member, board member, or other elected official; or
 - c. any officer or employee of any federal, state, county or local agency, legislature, commission, council, or board.
15. PROVIDER shall also account for and report funds expended and/or services provided from other funding sources, specifically for the HIV/AIDS programs including but not limited to in-kind contributions, volunteer services, cash match, other grants and all monetary contributions and donations.
16. PROVIDER agrees to disclose any existing or potential conflicts of interest relative to the performance of services resulting from this award. The COUNTY reserves the right to disqualify PROVIDER on the grounds of actual or apparent conflict of interest. Any concealment or obfuscation of a conflict of interest, whether intentional or unintentional, shall automatically result in the disqualification of funding.
17. PROVIDER shall ensure the confidentiality of medical information that contains patient identifiers including name, date of birth, Social Security number, telephone number, medical record number and ZIP code. PROVIDER shall comply with all state confidentiality laws and federal Health Insurance Portability and Accountability Act (HIPAA) regulations that protect all individually identifiable health information in any form (electronic, paper-based, oral) that is stored or transmitted by a HIPAA covered entity.
18. PROVIDER must 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 Agreement, 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 Agreement. This shall include, but not be limited to, site visits, PROVIDER's participation in COUNTY's sponsored training and contractor meetings, timeliness of deliverables and grantee sponsored projects through the Ryan White Part A Planning Council. Results of this review may be considered when evaluating PROVIDER's performance for continued funding in future grant year. This section shall survive the termination of this Agreement.
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 Agreement, COUNTY reserves the right to withhold payment in an amount that corresponds to the harm caused by PROVIDER, and/or to immediately

suspend, modify or terminate this Agreement. Events that may also lead to withholding of funds, and/or suspension, modification or termination include, but are not limited to:

- a. PROVIDER materially breaches this Agreement or is in material violation of any applicable county ordinance or state or federal law in conducting activities under this Agreement.
 - b. PROVIDER fails to maintain any license, registration, or permit required to provide the services specified in this Agreement or fails to utilize licensed personnel, where required by law;
 - c. PROVIDER, either knowingly or unknowingly, misrepresents, in any way, information or data furnished to COUNTY, or submits reports that are materially incorrect, incomplete or delinquent;
 - d. PROVIDER makes improper use of funds;
 - e. PROVIDER fails to resolve, to the reasonable satisfaction of COUNTY, any disallowed or questionable costs and/or operating practices identified in any current or prior fiscal year program monitoring, site visit or audit report;
 - f. PROVIDER engages in unlawful discrimination;
 - g. PROVIDER fails to take timely corrective action in response to written notification by COUNTY;
 - h. PROVIDER is indebted to the United States Government;
 - i. PROVIDER fails to collaborate and cooperate with other TREATMENT EXTENSION ACT funded or non-funded agencies when deemed necessary to provide efficient and effective services to the HIV infected/affected population. This includes failing to attend or send an appropriate representative to HIV/AIDS related meetings scheduled by COUNTY and other agencies;
 - j. PROVIDER fails to accomplish the Scope of Work or fails to meet deliverable due dates specified in this Agreement.
 - k. PROVIDER uses TREATMENT EXTENSION ACT funds for lobbying purposes or fails to submit to COUNTY "Disclosure of Lobbying Activities with Non-Federal Funds" Statement if PROVIDER engages in lobbying activities.
 - l. COUNTY reasonably deems PROVIDER's performance unsatisfactory.
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 Agreement 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 Agreement on an ongoing basis. COUNTY shall advise PROVIDER in advance of the monitoring procedure which shall be used. All information obtained by monitors shall be kept confidential within COUNTY, except as otherwise required by federal or state statutes or regulations.
36. This Agreement may be terminated without cause by COUNTY giving written notice by personal service or Certified Mail to the PROVIDER at least thirty (30) days prior to the effective date of such termination.

37. Accounting records are considered to be all records relating to the expenditure and reimbursement of funds awarded under this Agreement. Records required for retention include all accounting records, including related original and supporting documents that substantiate costs charged to the award activity. Recipients of awards are required to maintain accounting records, identifiable by award number. Such records shall be maintained in accordance with the following:
- a. Records must be retained for at least five (5) calendar years (unless otherwise stipulated) from the date that the final reports have been submitted to COUNTY.
 - b. In all cases, an overriding requirement exists to retain records until resolution of any audit questions relating to individual awards.
 - c. Current job descriptions as well as curriculum vitae, resumes, copies of certificates, licenses, and other pertinent credentials of all employees serving in positions funded under this Agreement need to be retained for a minimum of five (5) years subsequent to the expiration date of this agreement, making them available to COUNTY upon request.

EXHIBIT B
MEDICAL, CORE AND SUPPORT SERVICES FOR HIV/AIDS INFECTED AND AFFECTED CLIENTS
IN THE LAS VEGAS, RYAN WHITE, TRANSITIONAL GRANT AREA
INSURANCE REQUIREMENTS

TO ENSURE COMPLIANCE WITH THE CONTRACT DOCUMENT, PROVIDER SHOULD FORWARD THE FOLLOWING INSURANCE CLAUSE AND SAMPLE INSURANCE FORM TO THEIR INSURANCE AGENT PRIOR TO PROPOSAL SUBMITTAL.

- A. **Format/Time**: PROVIDER shall provide COUNTY with Certificates of Insurance, per the sample format (page B-3), for coverage as listed below, and endorsements affecting coverage required by this Contract within **ten (10) business days** after COUNTY'S written request for insurance. All policy certificates and endorsements shall be signed by a person authorized by that insurer and who is licensed by the State of Nevada in accordance with NRS 680A.300. All required aggregate limits shall be disclosed and amounts entered on the Certificate of Insurance, and shall be maintained for the duration of the Contract and any renewal periods.
- B. **Best Key Rating**: COUNTY requires insurance carriers to maintain during the Contract term, a Best Key Rating of A.VII or higher, which shall be fully disclosed and entered on the Certificate of Insurance.
- C. **Owner Coverage**: COUNTY, its officers and employees must be expressly covered as additional insured's except on Workers' Compensation. PROVIDER'S insurance shall be primary as respects COUNTY, its officers and employees.
- D. **Endorsement/Cancellation**: PROVIDER'S general liability and automobile liability insurance policy shall be endorsed to recognize specifically PROVIDER'S contractual obligation of additional insured to COUNTY and must note that COUNTY will be given thirty (30) calendar days advance notice by certified mail "return receipt requested" of any policy changes, cancellations, or any erosion of insurance limits. Either a copy of the additional insured endorsement, or a copy of the policy language that gives COUNTY automatic additional insured status must be attached to any certificate of insurance. ***Policy number must be referenced on endorsement or the form number must be referenced on certificate.***
- E. **Deductibles**: All deductibles and self-insured retentions shall be fully disclosed in the Certificates of Insurance and may not exceed \$25,000. *If the deductible is "zero" it must still be referenced on the certificate.*
- F. **Aggregate Limits**: If aggregate limits are imposed on bodily injury and property damage, then the amount of such limits must not be less than \$2,000,000.
- G. **Commercial General Liability**: Subject to Paragraph F of this Exhibit, PROVIDER shall maintain limits of no less than \$1,000,000 combined single limit per occurrence for bodily injury (including death), personal injury and property damages. Commercial general liability coverage shall be on a "per occurrence" basis only, not "claims made," and be provided either on a Commercial General Liability or a Broad Form Comprehensive General Liability (including a Broad Form CGL endorsement) insurance form. Policies must contain a primary and non-contributory clause and must contain a waiver of subrogation endorsement. ***A separate copy of the waiver of subrogation endorsement must be provided. A separate copy of the additional insured endorsement is required and must be provided for Commercial General Liability. Policy number must be referenced on endorsement or the form number must be referenced on certificate.***
- H. **Automobile Liability**: Subject to Paragraph F of this Exhibit, PROVIDER shall maintain limits of no less than \$1,000,000 combined single limit per occurrence for bodily injury and property damage to include, but not be limited to, coverage against all insurance claims for injuries to persons or damages to property which may arise from services rendered by PROVIDER and **any auto** used for the performance of services under this Contract. ***A separate copy of the additional insured endorsement is required and must be provided for Automobile Liability policies. Policy number must be referenced on endorsement or the form number must be referenced on certificate.***
- I. **Professional Liability**: PROVIDER shall maintain limits of no less than \$1,000,000 aggregate. If the professional liability insurance provided is on a Claims Made Form, then the insurance coverage required must continue for a period of two (2) years beyond the completion or termination of this Contract. Any retroactive date must coincide with or predate the beginning of this and may not be advanced without the consent of COUNTY.
- J. **Workers' Compensation**: PROVIDER shall obtain and maintain for the duration of this Contract, a work certificate and/or a certificate issued by an insurer qualified to underwrite workers' compensation insurance in the State of Nevada, in accordance with Nevada Revised Statutes Chapters 616A-616D, inclusive, provided, however, a PROVIDER that is a Sole Proprietor shall be required to submit an affidavit (Attachment 1) indicating that PROVIDER has elected not to be included in the terms, conditions and provisions of Chapters 616A-616D, inclusive, and is otherwise in compliance with those terms, conditions and provisions.
- K. **Failure To Maintain Coverage**: If PROVIDER fails to maintain any of the insurance coverage required herein, COUNTY may withhold payment, order PROVIDER to stop the work, declare PROVIDER in breach, suspend or terminate the Contract.

- L. **Additional Insurance:** PROVIDER is encouraged to purchase any such additional insurance as it deems necessary.
- M. **Damages:** PROVIDER is required to remedy all injuries to persons and damage or loss to any property of COUNTY, caused in whole or in part by PROVIDER, their subcontractors or anyone employed, directed or supervised by PROVIDER.
- N. **Cost:** PROVIDER shall pay all associated costs for the specified insurance. The cost shall be included in the price(s).
- O. **Insurance Submittal Address:** All Insurance Certificates requested shall be sent to the Clark County Purchasing and Contracts Division, Attention: Insurance Coordinator at 500 South Grand Central Parkway, 4th Floor, Las Vegas, Nevada 89155
- P. **Insurance Form Instructions:** The following information must be filled in by PROVIDER'S Insurance Company representative:
1. Insurance Broker's name, complete address, phone and fax numbers.
 2. PROVIDER'S name, complete address, phone and fax numbers.
 3. Insurance Company's Best Key Rating
 4. Commercial General Liability (Per Occurrence)
 - (A) Policy Number
 - (B) Policy Effective Date
 - (C) Policy Expiration Date
 - (D) Each Occurrence (\$1,000,000)
 - (E) Personal & Advertising Injury (\$1,000,000)
 - (F) General Aggregate (\$2,000,000)
 5. Automobile Liability (Any Auto)
 - (G) Policy Number
 - (H) Policy Effective Date
 - (I) Policy Expiration Date
 - (J) Combined Single Limit (\$1,000,000)
 6. Worker's Compensation
 7. Professional Liability
 - (K) Policy Number
 - (L) Policy Effective Date
 - (M) Policy Expiration Date
 - (N) Aggregate (\$1,000,000)
 8. Description: CBE or RFP Number and Name of Contract (must be identified on the initial insurance form and each renewal form).
 9. Certificate Holder:

Clark County, Nevada
 c/o Purchasing and Contracts Division
 Government Center, Fourth Floor
 500 South Grand Central Parkway
 P.O. Box 551217
 Las Vegas, Nevada 89155-1217
 10. Appointed Agent Signature to include license number and issuing state.

POLICY NUMBER: _____

COMMERCIAL GENERAL AND AUTOMOBILE LIABILITY

CBE NUMBER AND CONTRACT NAME:

THIS ENDORSEMENT CHANGED THE POLICY. PLEASE READ IT CAREFULLY
ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY AND AUTOMOBILE LIABILITY COVERAGE PART.

SCHEDULE

Name of Person or Organization:

CLARK COUNTY, NEVADA
C/O PURCHASING & CONTRACTS DIVISION
500 S. GRAND CENTRAL PKWY 4TH FL
PO BOX 551217
LAS VEGAS, NEVADA 89155-1217

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule as an insured but only with respect to liability arising out of your operations or premises owned by or rented to you.

CLARK COUNTY, NEVADA, ITS OFFICERS, EMPLOYEES AND VOLUNTEERS ARE INSURED WITH RESPECT TO LIABILITY ARISING OUT OF THE ACTIVITIES BY OR ON BEHALF OF THE NAMED INSURED IN CONNECTION WITH THIS PROJECT.

ATTACHMENT 1

AFFIDAVIT

(ONLY REQUIRED FOR A SOLE PROPRIETOR)

I, _____, on behalf of my company, _____, being duly sworn,

(Name of Sole Proprietor)

(Legal Name of Company)

depose and declare:

1. I am a Sole Proprietor;
2. I will not use the services of any employees in the performance of this Contract, identified as CBE No. 603851-15, entitled MEDICAL, CORE AND SUPPORT SERVICES FOR HIV/AIDS INFECTED AND AFFECTED CLIENTS IN THE LAS VEGAS, RYAN WHITE, TRANSITIONAL GRANT AREA;
3. I have elected to not be included in the terms, conditions, and provisions of NRS Chapters 616A-616D, inclusive; and
4. I am otherwise in compliance with the terms, conditions, and provisions of NRS Chapters 616A-616D, inclusive.

I release Clark County from all liability associated with claims made against me and my company, in the performance of this Contract, that relate to compliance with NRS Chapters 616A-616D, inclusive.

Signed this _____ day of _____, _____.

Signature _____

State of Nevada)
)ss.
 County of Clark)

Signed and sworn to (or affirmed) before me on this _____ day of _____, 20____,

by _____ (name of person making statement).

Notary Signature

STAMP AND SEAL

EXHIBIT C
SUBCONTRACTOR INFORMATION

DEFINITIONS:

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

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

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

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

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

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

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

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

1. Subcontractor Name: _____
Contact Person: _____ Telephone Number: _____
Description of Work: _____

Estimated Percentage of Total Dollars: _____
Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

2. Subcontractor Name: _____
Contact Person: _____ Telephone Number: _____
Description of Work: _____

Estimated Percentage of Total Dollars: _____
Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

3. Subcontractor Name: _____
Contact Person: _____ Telephone Number: _____
Description of Work: _____

Estimated Percentage of Total Dollars: _____
Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

4. Subcontractor Name: _____
Contact Person: _____ Telephone Number: _____
Description of Work: _____

Estimated Percentage of Total Dollars: _____
Business Type: ___ MBE ___ WBE ___ PBE ___ SBE ___ VET ___ DVET ___ ESB

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

**INSTRUCTIONS FOR COMPLETING THE
DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM**

Purpose of the Form

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the Board of County Commissioners (“BCC”) in determining whether members of the BCC should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

General Instructions

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and the appropriate Clark County government entity. Failure to submit the requested information may result in a refusal by the BCC to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

Detailed Instructions

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

Business Entity Type – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting ‘Other’, provide a description of the legal entity.

Non-Profit Organization (NPO) - Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

Business Designation Group – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), Physically-Challenged Business Enterprise (PBE), Veteran Owned Business (VET), Disabled Veteran Owned Business (DVET), or Emerging Small Business (ESB) . This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

- **Minority Owned Business Enterprise (MBE):** An independent and continuing 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 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 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 business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed \$2,000,000.
- **Veteran Owned Business Enterprise (VET):** An independent and continuing Nevada business for profit which performs a commercially useful function and is at least 51 percent owned and controlled by one or more U.S. Veterans.
- **Disabled Veteran Owned Business Enterprise (DVET):** A Nevada business at least 51 percent owned/controlled by a disabled veteran.
- **Emerging Small Business (ESB):** Certified by the Nevada Governor's Office of Economic Development effective January, 2014. Approved into Nevada law during the 77th Legislative session as a result of AB294.

Business Name (include d.b.a., if applicable) – Enter the legal name of the business entity and enter the “Doing Business As” (d.b.a.) name, if applicable.

Corporate/Business Address, Business Telephone, Business Fax, and Email – Enter the street address, telephone and fax numbers, and email of the named business entity.

Nevada Local Business Address, Local Business Telephone, Local Business Fax, and Email – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

Number of Clark County Nevada Residents employed by this firm. (Do not leave blank. If none or zero, put the number 0 in the space provided.)

List of Owners/Officers – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

For All Contracts – (Not required for publicly-traded corporations)

- 1) Indicate if any individual members, partners, owners or principals involved in the business entity are a Clark County full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

- 2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a Clark County full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form. Clark County is comprised of the following government entities: Clark County, Department of Aviation (McCarran Airport), and Clark County Water Reclamation District. Note: The Department of Aviation includes all of the General Aviation Airports (Henderson, North Las Vegas, and Jean). **This will also include Clark County Detention Center.**

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

Signature and Print Name – Requires signature of an authorized representative and the date signed.

Disclosure of Relationship Form – If any individual members, partners, owners or principals of the business entity is presently a Clark County employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a Clark County employee, public officer or official, this section must be completed in its entirety.

DISCLOSURE OF OWNERSHIP/PRINCIPALS

Business Entity Type (Please select one)						
<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Corporation	<input type="checkbox"/> Trust	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Other
Business Designation Group (Please select all that apply)						
<input type="checkbox"/> MBE	<input type="checkbox"/> WBE	<input type="checkbox"/> SBE	<input type="checkbox"/> PBE	<input type="checkbox"/> VET	<input type="checkbox"/> DVET	<input type="checkbox"/> ESB
Minority Business Enterprise	Women-Owned Business Enterprise	Small Business Enterprise	Physically Challenged Business Enterprise	Veteran Owned Business	Disabled Veteran Owned Business	Emerging Small Business
Number of Clark County Nevada Residents Employed:						
Corporate/Business Entity Name:						
(Include d.b.a., if applicable)						
Street Address:				Website:		
City, State and Zip Code:				POC Name:		
				Email:		
Telephone No:				Fax No:		
Nevada Local Street Address: (If different from above)				Website:		
City, State and Zip Code:				Local Fax No:		
Local Telephone No:				Local POC Name:		
				Email:		

All entities, with the exception of publicly-traded and non-profit organizations, must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

Entities include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

Full Name	Title	% Owned (Not required for Publicly Traded Corporations/Non-profit organizations)
_____	_____	_____
_____	_____	_____
_____	_____	_____

This section is not required for publicly-traded corporations. Are you a publicly-traded corporation? Yes No

- Are any individual members, partners, owners or principals, involved in the business entity, a Clark County, Department of Aviation, Clark County Detention Center or Clark County Water Reclamation District full-time employee(s), or appointed/elected official(s)?
 Yes No (If yes, please note that County employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)
- Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a Clark County, Department of Aviation, Clark County Detention Center or Clark County Water Reclamation District full-time employee(s), or appointed/elected official(s)?
 Yes No (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

Signature	Print Name
Title	Date

DISCLOSURE OF RELATIONSHIP

List any disclosures below:
(Mark N/A, if not applicable.)

NAME OF BUSINESS OWNER/PRINCIPAL	NAME OF COUNTY* EMPLOYEE/OFFICIAL AND JOB TITLE	RELATIONSHIP TO COUNTY* EMPLOYEE/OFFICIAL	COUNTY* EMPLOYEE'S/OFFICIAL'S DEPARTMENT

* County employee means Clark County, Department of Aviation, Clark County Detention Center or Clark County Water Reclamation District.

“Consanguinity” is a relationship by blood. “Affinity” is a relationship by marriage.

“To the second degree of consanguinity” applies to the candidate’s first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

For County Use Only:

If any Disclosure of Relationship is noted above, please complete the following:

- Yes No Is the County employee(s) noted above involved in the contracting/selection process for this particular agenda item?
- Yes No Is the County employee(s) noted above involved in any way with the business in performance of the contract?

Notes/Comments:

Signature

Print Name
Authorized Department Representative