



**TO:** SOUTHERN NEVADA DISTRICT BOARD OF HEALTH

**DATE:** May 22, 2008


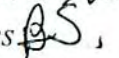
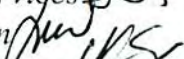

**RE:** *Approval of Amendment Number 5 to Interlocal Agreement with Clark County on Behalf of Clark County Social Service for Funding to Provide Ryan White Part A Services (formerly Ryan White Title I Services)*

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**PETITION #19-08**

**That the Southern Nevada District Board of Health** *approve the attached Amendment Number 5 to Interlocal Agreement with Clark County Social Service for funding to provide Ryan White Part A Services.*

**PETITIONERS:**

Mary Ellen Harrell, *Public Health Nurse Manager*   
Bonnie Sorenson, *Director, Clinics/Nursing Services*   
Michael Walsh, *Director of Administration*   
Lawrence Sands, **DO, MPH**, *Chief Health Officer* 

**DISCUSSION:**

Amendment Number 5 to the Interlocal Agreement awards funding to provide Ryan White Part A Services to provide Care and Support Services to HIV/AIDS infected persons.

**FUNDING:**

Amendment Number 5 is funded by the Department of Health and Human Services through a grant with Clark County. The program areas are funded as follows:

Ambulatory/Outpatient Medical Care	\$ 125,000
Medical Case Management	\$ 522,223
Early Intervention	\$ 448,997
Substance Abuse	\$ 35,000

The total Amendment award to the District is \$1,131,220

**AMENDMENT NUMBER 5  
To The  
INTERLOCAL AGREEMENT  
BETWEEN  
CLARK COUNTY  
AND  
SOUTHERN NEVADA HEALTH DISTRICT**

This Amendment Number 5 to the Interlocal Agreement is made and entered into this \_\_\_\_ day of \_\_\_\_, 2008, by and between Clark County, Nevada, hereinafter referred to as "COUNTY," a political subdivision of the State of Nevada, on behalf of the Clark County Department of Social Service, hereinafter referred to as "CCSS," and SOUTHERN NEVADA HEALTH DISTRICT, hereinafter referred to as "PROVIDER."

**WHEREAS, COUNTY** approved the agreement with **PROVIDER** on June 6, 2006, to provide ambulatory outpatient medical care, ambulatory outpatient medical care Minority AIDS Initiative (MAI), home health services, outpatient substance abuse treatment to eligible clients; and

**WHEREAS, Section VIII, paragraph 18, of the Agreement** authorizes the parties to amend the Agreement and **COUNTY** and **PROVIDER** desire to amend the Agreement.

**NOW, THEREFORE,** for and in consideration of the premises contained herein, the parties agree to the following amendments to the Agreement, effective through February 28, 2009:

1. Replace "WebCIM" with "CCSS approved management information system" throughout the Agreement.
2. Replace Section IV in its entirety with Section IV in Attachment 1.
3. Replace Section VI in its entirety with Section VI in Attachment 2.
4. Replace Exhibit I with the attached Exhibit I.

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

**CLARK COUNTY**

**SOUTHERN NEVADA DISTRICT  
BOARD OF HEALTH**

By: \_\_\_\_\_  
RORY REID, Chairman  
Board of County Commissioners

By: \_\_\_\_\_  
STEVEN KIRK, Chairman  
Southern Nevada District Board of  
Health

ATTEST:

ATTEST:

By: \_\_\_\_\_  
SHIRLEY B. PARRAGUIRRE  
County Clerk

By: \_\_\_\_\_  
LAWRENCE SANDS, DO, MPH  
Chief Health Officer

APPROVED AS TO FORM:

APPROVED AS TO FORM:

By: \_\_\_\_\_  
ROBERT J. GOWER  
Deputy District Attorney

By: \_\_\_\_\_  
STEPHEN R. MINAGIL  
Attorney for the Health District

## ATTACHMENT 1

### **SECTION IV: DESCRIPTION OF SERVICES AND SCOPE OF WORK**

**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.

**PROVIDER** understands and further agrees to the following:

#### **General Scope of Work for All Providers**

1. Utilize the Las Vegas Standards of Care developed by the Ryan White Part A Planning Council as a reference for providing appropriate care to clients in the TGA once they become available. These Standards will be available on the Las Vegas TGA website at <http://www.lasvegasema.org> when finalized.
2. **PROVIDER** shall provide Care and Support Services to HIV/AIDS infected persons regardless of age, race, ethnicity, religion or gender, and sexual orientation which are culturally sensitive, linguistically appropriate and appropriate to patients' functional acuity level.
3. Comply with *National Standards for Culturally and Linguistically Appropriate Services in Health Care* as defined by 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>.
4. Participate in the Las Vegas TGA Continuum of Care where services are organized to respond to the individual or family's changing needs in a holistic, coordinated, timely and uninterrupted manner, thereby reducing fragmentation of care. **PROVIDER** shall submit to **CCSS** copies of current Memoranda of Understanding with other providers within the Continuum of Care.
5. **PROVIDER** must establish a system of written procedures through which a client or their representative may present grievances about the operation of **PROVIDER's** services. **PROVIDER** shall provide these written procedures to **CCSS** 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 I** for 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 I**).

6. **PROVIDER** shall maintain on file and adhere to its current internal and Ryan White Part A grievance and/or sanction procedures made available in English and in Spanish for clients not satisfied with services received from **PROVIDER**.
7. This Agreement is subject to all state and federal laws protecting confidentiality of client medical, behavioral health, and drug treatment information, including federal HIPAA regulations.
8. **PROVIDER** shall obtain written approval from **CCSS** prior to making programmatic changes in the scope of the project.
9. **PROVIDER** shall inform **CCSS**, in writing, of changes in personnel and/or Board compilation specified in this Agreement within one (1) business day of known changes in order to ensure the confidentiality of registered clients.
10. Utilize **CCSS** furnished **CCSS** 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.
11. **PROVIDER** shall ensure that 100% of clients are registered in **CCSS** approved management information system prior to the receipt of services.
12. **PROVIDER** shall refer 100% of clients for eligibility determination.
13. **PROVIDER** shall check eligibility status on 100% of clients prior to the delivery of services.
14. **PROVIDER** shall openly and honestly disclose business practices, written records and client files pertaining to the provision of Ryan White Part A funded services to **CCSS** representatives during scheduled site review visits by **CCSS** staff.
15. **PROVIDER** shall comply with corrective action recommendations as a result of the site review visit.
16. **PROVIDER** shall actively assist in quality improvement effort(s) by the **CCSS** and/or the Ryan White Part A Planning Council by encouraging their clients to participate in various client opinion sampling opportunities which may include ongoing written client satisfaction surveys, personal onsite interviews or focus groups and/or needs assessment for the purpose of ongoing or periodic assessment of client needs to improve the quality of care.
17. **PROVIDER** shall submit documentation/proof of completing any corrective actions identified in the programmatic site visit by due dates specified in the site visit report.
18. **PROVIDER** shall collaborate with **CCSS** by allowing staff to participate in meetings and trainings as attendees and/or as presenters, as needed.

19. At least one (1) **PROVIDER** representative shall attend mandatory bi-monthly MODERNIZATION ACT Provider Meetings, with dates, times and locations to be determined by **CCSS**.
20. **PROVIDER** shall participate in Technical Assistance training as needed and as identified by **CCSS** and **PROVIDER** staff.
21. The following written documents shall be visibly posted within thirty (30) business days of execution of the Agreement.
  - a. The Statement of Consumer Rights
  - b. Disability Act
  - c. Labor laws
  - d. Sanction policy or zero tolerance information
  - e. Grievance policy or posted information informing clients that there is a grievance policy.
25. **PROVIDER** shall supply **CCSS** with a copy of any Direct Service subcontract Agreements within thirty (30) days of execution of that Agreement.
26. **PROVIDER** shall supply **CCSS** with a list of active Board of Directors' members and meetings scheduled to occur seven days after the execution date of this Agreement.
27. **PROVIDER** shall make available meeting minutes, upon request, within five (5) business days of request.
28. **PROVIDER** shall supply **CCSS** with a summary of all current fiscal year funding sources with dollar amounts or estimates of amounts expected no later than ninety (90) days after the execution of this amendment.
29. **PROVIDER** agrees pursuant to HRSA/HAB and the **CCSS** Quality Management requirements to maintain and update annually 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 CCSS with an annual Quality Improvement Plan within sixty (60) days of the executed contract.

30. PROVIDER shall submit the statistical information required to complete the federally mandated annual report no later than forty-five (45) days after the end of the calendar year.
31. PROVIDER shall submit a final invoice for reimbursement of all Ryan White Part A expenditures made through the 2008 grant year, to CCSS no later than sixty (60) days after the close of the 2008 grant year.
32. PROVIDER shall supply CCSS with a copy of their most recent audit within six months of completion of PROVIDER Fiscal Year.

## **PROVIDER SPECIFIC SERVICES AND SCOPE OF WORK**

### **Ambulatory/Outpatient Medical Care Service Requirements and Performance Measures**

**A. PROVIDER shall provide Ambulatory/Outpatient Medical Care, defined by HRSA as follows:**

*“Outpatient/Ambulatory medical care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner 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 includes 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 guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.*

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

1. A minimum of four hundred (400) unduplicated clients shall receive Ambulatory/Outpatient Medical Care services during the award period.
2. PROVIDER shall serve women, infants, children and youth (WICY) and document client numbers for mandated WICY Report. PROVIDER shall report to the CCSS WICY population served upon request.

3. **PROVIDER** shall post a copy of current medical license in accordance with State and/or National requirements to practice within thirty (30) days of the execution of the Agreement.
4. **PROVIDER** shall administer routine health screening tests to 90% of eligible patients. Screening will be consistent with most current PHS guidelines and documentation of any reasons for not providing standard screening will be written in the patient's chart. At a minimum, the following initial screening tests shall be performed for all new patients:
  - a. CD4 count,
  - b. Viral load,
  - c. PAP smear,
  - d. TB testing,
  - e. Syphilis serology screening,
  - f. Gonorrhea testing,
  - g. Chlamydia testing,
  - h. Toxoplasmosis screening and
  - i. Hepatitis testing.
5. Documentation of patient's ongoing medical assessment and treatment will be charted in all client files.
6. **PROVIDER** shall ensure that each referred patient receives timely, effective, and quality Ambulatory/Outpatient Medical Care that meets his/her special needs.
7. **PROVIDER** shall enter client No Show data into CCSS approved management information system.
8. **PROVIDER** shall refer clients for specialty care when necessary and appropriate.
9. Any referral and follow-up information given to a client will be reflected in client chart.
10. **PROVIDER** shall incorporate and ensure compliance with ethical standards as established for all health care providers and legal standards as defined by federal and state governments regulating confidentiality.
11. **PROVIDER** shall incorporate and ensure, to the extent possible, adherence to established HIV clinical practice standards and the most current Public Health Service (PHS) guidelines for treatment and care of adult HIV+ persons.
12. **PROVIDER** shall be able to demonstrate that clients who receive Ambulatory Outpatient Medical Care services are made aware of other medical care options.
13. **PROVIDER** shall encourage physician specialists involved in providing RWI funded care to actively participate in advisory capacities when requested by the Las Vegas Ryan White Planning Council, and/or by the Continuous Quality Management Program of CCSS, specifically regarding updates of standards of care or quality care improvement initiatives for Ambulatory Outpatient Medical Care.

14. **PROVIDER** shall perform routine initial nutritional assessment for 90% of new patients and refer those patients who could benefit from further HIV-specific dietary counseling and nutritional supplementation to the local service provider funded to provide Nutritional Counseling. **PROVIDER** shall document any reasons for not providing assessment in the patient's chart.
15. **PROVIDER** shall do routine mental health and substance abuse screening of 90% of new patients and refer those patients who could benefit from mental health and/or substance abuse services to appropriate local provider(s) experienced with the patients' individual needs. **PROVIDER** shall document any reasons for not providing screening in the patient's chart.
16. **PROVIDER** shall continue to document CD4 counts and Viral Load counts at regular time intervals based on current PHS guidelines for 90% of all patients as a ratio of the annual caseload. Documentation of any reasons for not providing these routine tests will be written in patient's chart.
17. In addition to HIV/AIDS-related care provided, 90% of all patients will receive the following ongoing health screening and preventive care at medically appropriate time intervals: PAP smears, TB testing, syphilis serology screening, gonorrhea testing, Chlamydia testing, lipid profile, fasting blood glucose screening, toxoplasmosis screening, hepatitis testing, Pneumovax administration and influenza vaccine (when available). Documentation of reasons for not providing any routine preventive care treatment or test will be documented in the patient's chart.

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

<b>Program Goals – Outpatient/Ambulatory Medical Care</b>	<b>Performance Measure</b>	<b>Target Percentage</b>	<b>Source</b>
Stabilize or increase CD-4 count from initial count.	Percent of clients who have stabilized or increased CD-4 from initial count.	80%	Chart review CCSS approved management information system
Increase or maintain clients with an undetectable viral load count.	Percent of clients who have an undetectable viral load count from initial count.	80%	Chart review CCSS approved management information system
Increase the service utilization for PLWH/A in communities of	Percent of total service utilization of clients in	80%	Chart review CCSS

color (MAI).	Ambulatory Outpatient Medical Care.		approved management information system
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## Medical Case Management Service Requirements and Performance Measures

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

*“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’s 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 re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.”*

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

1. PROVIDER will document in CCSS approved management information system that newly registered clients have been offered a copy of CCSS-Notice of Privacy Practices.
2. PROVIDER shall complete a client assessment of service needs, individualized service plan and a re-evaluation of the service plan as necessary.
3. Medical Case Management services are to be made available to all eligible clients within the Las Vegas TGA, not merely to clients of the PROVIDER agency. The case management provider(s) shall provide service to local sites, which may include field visits for institutionalized or medically fragile clients.
4. PROVIDER shall research all potential resources available.

### Medical Case Management Specific Requirements:

1. A minimum of two hundred (200) unduplicated clients shall receive Medical Case Management Services during the award period.
2. PROVIDER shall respond to eligible clients within five (5) business days of referral.
3. PROVIDER shall provide ongoing medical case management, client assessment of service needs, individualized service plans and a re-evaluation of the service plan as necessary.

4. **PROVIDER** shall complete a discharge summary within two (2) business days of client discharge.
5. **PROVIDER** agrees to work in collaboration with other service providers to support client's needs.

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

<b>Program Goals – Medical Case Management</b>	<b>Performance Measure</b>	<b>Target Percentage</b>	<b>Source</b>
Increase the number of clients in medical case management services during the award period	Percent of clients who are in medical case management services	85%	Chart Review CCSS approved management information system
Provide continuity of care for clients, as needed, to facilitate access to medical and support services	Percent of clients who receive medical case management services that access medical and/or support services	75%	Chart Review CCSS approved management information system
Improve or maintain adherence to prescription medication compliance for clients.	Percent of clients determined to be in compliance with their prescription medications	80%	Chart Review CCSS approved management information system
Increase or maintain adherence to primary care (ambulatory outpatient medical care ) visits.	Percent of clients with adherence to primary care (ambulatory outpatient medical care) visits	80%	Chart review CCSS approved management information system

## **Early Intervention Services (EIS) Requirements and Performance Measures**

**A. PROVIDER shall provide Early Intervention Services (EIS) defined by HRSA as follows:**

*"Include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to the 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"*

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

1. A minimum of four hundred (**400**) unduplicated clients shall receive Early Intervention Services (EIS) during the award period.
2. **PROVIDER** shall adhere to the eligibility requirements for EIS clients, which is based on a presumptive eligibility policy until HIV infection can be confirmed by the EIS program staff.

## **Substance Abuse Service Requirements and Performance Measures**

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

*"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."*

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

1. A minimum of thirty (**30**) unduplicated clients shall receive Outpatient Substance Abuse Services during the award period.
2. **PROVIDER** shall submit a copy of current documentation of licensed substance abuse provider(s) credentials in accordance with State and/or National requirements to practice within thirty (30) days of the execution of the Agreement.
3. **PROVIDER** shall conduct client substance abuse assessments and maintain Treatment Plans in client file.
4. **PROVIDER** shall provide treatment and/or counseling to address substance abuse (including alcohol, legal and illegal drugs) issues.
5. **PROVIDER** shall, when appropriate, refer or provide clients with mental health counseling.
6. **PROVIDER** shall include in the treatment plan, the requirement for one medical care consultation and document client adherence during substance abuse treatment.

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

Program Goal Adult Outpatient	Performance Measure	Target # or %	Source
Increase the number of clients to have one medical care consultation during substance abuse treatment	Percent of clients who have (at least) one medical care consultation during the substance abuse treatment episode	90%	CCSS approved management information system Chart Review

## ATTACHMENT 2

### SECTION VI: COMPENSATION AND TERMS OF PAYMENT

**PROVIDER** understands that MODERNIZATION 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 MODERNIZATION ACT funding by ensuring all expenditures are **reasonable and necessary**, and are subject to the following:

1. Subject to the receipt of funds from HRSA and subject to Paragraph 5 below, **COUNTY** shall make available to **PROVIDER**, for the grant period March 1, 2008 through February 28, 2009, a total compensation (reimbursement) of **\$1,131,220** for services performed under this Agreement from March 1, 2008 through February 28, 2009 and is conditioned upon receipt of appropriate billing documents, as described herein. This amount shall supersede and replace any and all prior amendments and agreements. **PROVIDER** may allocate no more than 10% of the contract amount for "administrative" costs, as defined by CCSS, HRSA and applicable Office of Management and Budget (OMB) Circulars.
4. 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 budgeted categories not to exceed 10% is permissible with written approval from **COUNTY** under the terms of this Agreement. Any change in the budget amount that exceeds 10% of the total budget amount will require approval by the Ryan White Part A Planning Council and the Board of County Commissioners. 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.
5. **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**.
6. **COUNTY** may at any time, by written order, make changes within the general scope of this Agreement 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 Agreement, an equitable adjustment limited to an amount within current unencumbered budgeted appropriations for this Agreement shall be made and this Agreement 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 Agreement.

7. No services for which an additional compensation will be charged by **PROVIDER** shall be furnished without the written authorization of **COUNTY**.
8. Changes to this Agreement that do not change the compensation amounts paid to **PROVIDER** or do not substantially change the scope of work can be authorized by **COUNTY's** representative.
9. Reimbursement shall be on the following basis:
  - a. Receipt and acceptance by **CCSS** of **CCSS** approved Request for Reimbursement Form.
  - b. Receipt by **CCSS** of additional supporting documentation, as needed.
10. Monthly reimbursement requests received in proper format and with appropriate backup items that are received on or before the 15<sup>th</sup> of each month generally should have a check issued within two weeks. Monthly reimbursement requests received after the 15<sup>th</sup> of the month shall be held for processing until the following month. Holidays, incomplete or improperly submitted requests for reimbursement and unforeseeable circumstances may delay the reimbursement process.
11. **COUNTY** shall not be responsible in any way and shall be held harmless by **PROVIDER** for any unforeseen or unavoidable delays beyond the control of **COUNTY** that may affect the timely processing of payments.
12. **COUNTY** reserves the right to hold reimbursement under this award until any delinquent forms or requirements of grant award are filed. Reimbursement requests shall be submitted no later than sixty (60) days from the end of the month in which request for an extension of time was approved by **COUNTY** prior to the sixty (60) days
13. Within forty-five (45) days of the **CLOSE OF THE AWARD PERIOD**, a complete financial accounting of all expenditures shall be submitted to **CCSS**. Any unobligated funds shall be returned to **COUNTY**, or, if not already requested, shall be deducted from the total amount of this Agreement.

### **COUNTY'S Fiscal Limitations**

1. The content of this section shall apply to the entire Agreement and shall take precedence over any conflicting terms and conditions, and shall limit the COUNTY's financial responsibility as indicated in sub-sections 2 and 3 below.
2. Notwithstanding any other provisions of this Agreement, this Agreement 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 that may become due under this Agreement is limited to the total maximum expenditure(s) authorized by this Agreement.

### **Associated Costs Paid by COUNTY**

In addition to other costs or fees specifically provided for elsewhere in this Agreement, COUNTY shall be responsible for any costs associated with printing, producing, assembling and mailing to participating clients cards, fulfillment materials, newsletters, or any other communications to participating clients which have been requested by COUNTY.

### **Restrictions on Grant Expenditures**

1. MODERNIZATION 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.
2. MODERNIZATION ACT funds shall not be used to make direct payments to recipients of services.
3. MODERNIZATION ACT funds shall not be used to supplant or replace current state, local, or private HIV-related funding. PROVIDER shall maintain on file documentation assuring that services rendered under this Agreement will use MODERNIZATION ACT funding as "dollars of last resort" and that the client has no other source of funding to provide such services.
4. MODERNIZATION ACT funds are to be used for HIV/AIDS-related services only. Research, epidemiological surveys, clinical trials, and capital projects are prohibited.

5. **MODERNIZATION 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.
6. **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**.

## **EXHIBIT I 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. A file of written formal Grievances, and
  - d. 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, PASS Team, Third Floor  
1600 Pinto Lane

Las Vegas, NV 89106.

The undersigned, being duly sworn, depose and say that the foregoing is a true and correct copy of the original document as the same appears in the files of the undersigned, and that the same is a true and correct copy of the original document as the same appears in the files of the undersigned.

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

Notary Public in and for the State of Nevada

My Commission Expires \_\_\_\_\_

Notary Public in and for the State of Nevada

My Commission Expires \_\_\_\_\_

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Type of Grievance as you best understand the core issue following discovery

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