togetherforbetter

AMENDMENT NO. 1
CBE NO. 606498-22
HOSPITAL2HOME PROGRAM

THIS AMENDMENT is made and entered into this _____ day of _____ 20____, by and between CLARK COUNTY, NEVADA (hereinafter referred to as "COUNTY"), and NEVADA SENIOR SERVICE, INC. (hereinafter referred to as "PROVIDER").

WITNESSETH:

WHEREAS the parties entered into an agreement under CBE Number 606498-22, entitled "Hospital2Home Program" dated May 16, 2023 (hereinafter referred to as CONTRACT); and

WHEREAS the parties desire to amend the CONTRACT.

NOW, THEREFORE, the parties agree to amend the CONTRACT as follows:

1. Section I: Term of Contract, Page 1, **add** the following as a second paragraph:

   "On the date of approval, the contract term will align with COUNTY fiscal year (July through June). The second renewal period shall be from January 1, 2025 through June 30, 2026. The third renewal option period shall be from July 1, 2026 through June 30, 2027. And the fourth renewal option period shall be from July 1, 2027 through June 30, 2028."

2. Section II: Compensation and Terms of Payment, Page 1, Subsection A. Compensation

   Originally read:

   "A. Compensation
   COUNTY agrees to pay PROVIDER for the performance of services described in the Scope of Work (Exhibit A) for the not-to-exceed amount of $6,634,482 for the term of the Contract. 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 PROGRAM is completed for the said fee."

   Revised to read:

   "A. Compensation
   COUNTY agrees to pay PROVIDER for the performance of services described in the Scope of Work (Exhibit A), and in accordance with the rate listed therein, for the not-to-exceed amount of $2,752,800 annually. 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 PROGRAM is completed for the said fee."

3. Section II: Compensation and Terms of Payment, Page 1, Subsection C. Terms of Payments, Paragraph 1

Originally read:

"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. All monthly operational expenses must be accompanied by invoices that include a breakdown of all cost and will be verified by COUNTY."

Revised to read:

"1. Each invoice received by COUNTY must include a Progress Roster based on actual work performed to date in accordance with the completion of tasks indicated in Exhibit A, Scope of Work."

4. Section II: Compensation and Terms of Payment, Page 2, Subsection C. Terms of Payments, Paragraph 8

Originally read:

"8. Invoices shall be submitted via email to: CCSSFiscalServices@clarkcountynv.gov."

Revised to read:

"8. Invoices shall be submitted via email to: CCSSFiscalServices@clarkcountynv.gov and SSRAD@clarkCountyNV.gov.

The *Invoice Information for Reimbursement of Expenses – Provider Checklist* is available upon request from CCSS."

5. Section VII: Responsibility of County, Page 4, Subsection B

Originally Read:

"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, Emma Macayan-Hatley, Social Service – Fiscal Unit, telephone number (702) 817-8035 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."

Revised to read:

"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, Management Analyst from the Clark County Social Services' Contract Compliance Team, SSRAD@ClarkCountyNV.gov 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."

6. Section XI: Notices, Page 6, To County

   Originally read:

   "TO COUNTY: Clark County Social Service
   Attention: Fiscal Department
   1600 Pinto Lane
   Las Vegas, Nevada 89106"

   Revised to read:

   "TO COUNTY: Clark County Social Services
   1600 Pinto Lane
   Las Vegas, Nevada 89106"

7. Exhibit A, Hospital2Home Program, Scope of Work, shall be deleted in its entirety and replaced with the attached Exhibit A, Hospital2Home Program, Scope of Work (Revised per Amendment No. 1).

8. The revisions contained herein are effective as of January 1, 2025.

This Amendment No. 1 represents an increase of $8,954,948.

Except as expressly amended herein, the terms and conditions of the CONTRACT shall remain in full force and effect.

PROVIDER:
NEVADA SENIOR SERVICE, INC.

By: _____ Date: 12/3/25
JEFFREY KLEIN
Chief Executive Officer

COUNTY:
COUNTY OF CLARK, NEVADA

By: _____ Date: _____
JESSICA COLVIN
Chief Financial Officer

APPROVED AS TO FORM:
STEVEN B. WOLFSON, District Attorney

By: Sarah Schaerrer Date: Dec 24, 2025
Sarah Schaerrer (Dec 24, 2025 08:14:33 PST)
SARAH SCHAERRER
Deputy District Attorney

EXHIBIT A

HOSPITAL2HOME PROGRAM
SCOPE OF WORK
(Revised per Amendment No. 1)

1.0 Overview

Clark County Social Services (CCSS) provides a variety of services for at-risk people residents of COUNTY who are not assisted by other state, federal, or local programs. Social Services is responsible for ensuring that the COUNTY meets its health, welfare, and community responsibilities as set forth in the Nevada Revised Statutes and County Ordinances with a primary focus on childless adults. Services are designed for various levels of vulnerable adults to address the underlying causes of homelessness and services necessary to support independence.

The current rental crisis, prior surge of COVID-19 cases has exacerbated an already problematic hospital and sub-acute discharge backlog in COUNTY. This has created extensive needs for in-home care supports, communication for resource allocation, and direct hospital discharge with supportive care givers or agencies. In addition to reduced Medicaid rates, the termination of the State of Nevada, ADSD COVID-19 emergency funding resulting in an emergent crisis causing the limitation of service availability to individuals receiving transition and in home supports placing them at risk for homelessness or inhibiting discharge from critically needed hospital and sub-acute beds. The following scope of work addresses two primary objectives to address this problem directly to prevent homelessness for vulnerable adults and unnecessary acute restrictive care due to lack of supports and resources.

2.0 Hospital2Home Care Transitions: Brief History

PROGRAM was developed by PROVIDER in 2017 as a pilot project to create a first in nation dementia capable care transitions model. The pilot was initiated as a component of an Alzheimer's Disease Programs Initiative (ADPI) grant awarded by the Administration for Community Living (ACL) to the Nevada Aging and Disability Services Division.

PROVIDER created PROGRAM based on "Bridge" an evidence-based care transitions model of Rush University Medical Center. PROVIDER successfully piloted the PROGRAM with twenty-five (25) hospital discharges. This success led to PROVIDER receiving subsequent funding of PROGRAM under a three-year grant from 2018-2021. During this time, PROVIDER formalized the intervention adding a series of innovative services including rapid response team approach to discharge crisis management, respite coaching, community and professional education, connections for wrap around services and an established network of collaborative partners. PROGRAM received continuation funding from Covid 19 Emergency Funds to assist with facilitating complex case discharges during the pandemic. The Covid 19 funding expired March 30, 2022.

PROGRAM is designed to undertake relief to effect discharge support for in-patient facilities in COUNTY. Immediate objective is to make available critically necessary acute bed, transition patients successfully to home, avoiding need for readmission and provide access to resources for longer term services and supports. PROVIDER will work as a collaborative partner with Clark County Social Services and the care management teams at UMC and area health facilities.

Care Transitions is designed to aid and support adults with memory loss, complex discharge problems, including persons living alone with a dementia or multiple chronic conditions, and/or those dealing with the effects of COVID-19 and their caregivers, in making a smooth transition from hospital to home. This transitional care program is delivered by interdisciplinary teams who provide care coordination in-person, virtually, and via telephone. PROGRAM offers immediate response, crisis intervention, and respite coaching for each family. PROGRAM is a dedicated team that works directly with professionals in the community while providing caregivers with much-needed support and resources.

PROGRAM swiftly responds to make a smooth transition from hospital to home. Care transition, care coordination, crisis intervention, and respite coaching round out the system of support for clients and caregivers.

3.0 Scope of Services

PROVIDER shall implement an immediate response to target population, within 72 hours, for all COUNTY prioritized referrals. Response includes bedside intake, close coordination with facility care management, on-site at home social work and respite coach support or adding a client to the waitlist if PROGRAM has met monthly capacity caps. COUNTY prioritized referrals are from the following sources:

1. CCSS and other departments identified by CCSS
2. University Medical Center (UMC)
3. Other CCSS approved hospitals
4. Elected Officials

PROGRAM is designed to provide thirty (30) days of intensive support with additional transitional support for up to an additional sixty (60) days. If the sixty (60) day limit is exceeded, each case must receive prior approval from CCSS. Warm hand-offs to the long-term resource CCSS Long Term Care Program to ensure smooth transitions and continuity of care.

Assistance is targeted to relieve UMC, COUNTY cases and other hospitals in COUNTY. Additional targets include transitions from skilled nursing and rehab facilities in order to make bed capacity available for hospital to sub-acute thereby relieving strain on acute bed capacity.

4.0 Target Population and Admission Criteria

Target Population: PROGRAM client population must be acute, sub-acute hospital patients who are considered high risk AND/OR unsafe to discharge. They must also meet at least ONE of the following admission criteria:

Admission criteria:

Complex discharge problems including those that:

- Have cognitive impairment/memory loss;
- Persons living alone with a dementia or multiple chronic conditions;
- People dealing with the effects of COVID-19 and their caregivers;
- Have a chronic health condition/disabling factors of mental health/substance abuse;
- Have an acute medical condition with an identifiable end point of care;
- Be willing to see medical and community staff and comply with recommendations in accordance with treatment plans (Harm reductions methods will be incorporated with treatment plans); and
- Be medically and psychiatrically stable, patient must be ready for discharge to independent living and cannot be suicidal or homicidal.

After sub-acute referrals have entered PROGRAM, then prevention referrals, may be served by this PROGRAM

5.0 Services

The purpose of this section is to provide a description of the services the PROVIDER is required to deliver. The PROVIDER must provide intensive case management, transitional support and referral to permanent housing to a maximum of 62 eligible clients monthly through the following case planning steps:

- Supervision by licensed clinical social worker
- Intensive case management by bachelor-level staff, prioritizing licensed social workers when available.
- PROVIDER trained respite coaches to support family caregivers
- Individualized care plans
- Wrap-around services coordination - connect participants to community resources, long-term care services & supports, (i.e. SNAP, home delivered meals, respite, adult day care, homemaker, personal care, care consultation, etc.)

Services shall be accessible to Limited English Proficient (LEP) clients in their native language.

6.0 Responsibilities of PROVIDER

The purpose of this section is to provide a description of how the PROVIDER is expected to utilize the allocated funding to provide the highest quality of service based on guidelines and monitoring standards set forth by CCSS to meet the necessary service provisions of the funding. The PROVIDER will:

A. Perform background checks on staff and volunteers in accordance with Nevada Revised Statues, Nevada Administrative Codes, and all other applicable federal, state and local regulations.

B. PROVIDER must work collaboratively with community and other providers serving clients to minimize duplication of service and maximize utilization of available resources

C. Terminate assistance only within PROVIDER policy and procedures which shall include an established, formal and transparent process that recognizes the rights of the individuals affected and examine all extenuating circumstances in determining when violations warrant termination so that a program participant's assistance is terminated only in the most severe cases. A copy of the policy must be shared with the client.

D. Participate in regular meetings and conference calls for PROGRAM and be responsible for respective data entry, reporting, and processes for using data to improve service delivery and coordination.

E. PROVIDER is responsible to collaborate with the CCSS and UMC to minimize duplication of service and maximize utilization of available resources.

F. Treat as confidential all information relating to any partner's operations or the general business affairs or any of the operations or general business affairs of the partner (including the partner parent, affiliate, subcontractor for the PROGRAM project, or subsidiary companies) which any other partner may observe or which may be disclosed as a result of the partner performance under this SOW. No partner shall disclose any such confidential information to third parties or use any such information for any purpose other than the performance under this SOW, without the prior written consent of the other partner.

G. Additional Responsibilities:

   a. Employ management, staff, and volunteers with sufficient technical knowledge, skill, and expertise necessary to provide the services while ensuring appropriate staff to client ratios, not to exceed a 40-client caseload. Staffing should be comprised of a multi- disciplinary team.

   b. Be available for consultation regarding the operation and progress of the PROGRAM with all parties to the funding agreement and at other reasonable times with advance notice as to not conflict with PROVIDER'S other responsibilities.

   c. Enter and update agency and program information into Nevada 2-1-1 prior to the commencing of each year of services.

   d. Establish such fiscal and accounting procedures necessary to ensure the proper disbursal of, and account for funds in order to ensure that all financial transactions are conducted. Maintain financial records pertaining to all matters relative to the contract in accordance with standard accounting principles and procedures and retain all records and supporting documentation applicable for a period of five (5) years upon completion of contract, or termination of contract, whichever comes first. Delineate how multiple funding sources for services are allocated appropriate for its designated intended service. All such records relating to any analysis or audit performed relative to the contract shall be retained for five (5) years after such analysis or audit has been performed and any findings have been resolved. In the event that PROVIDER no longer operates in Nevada, it shall be required to deliver a copy of all records relating to the contract with the COUNTY to be retained by the COUNTY and PROVIDER.

e. PROVIDER must submit to COUNTY'S authorized representative a monthly invoice by the 15th calendar day of each month for the previous month's expenses, which includes documentation of client served provided via client rosters; the mutually agreed upon client case fee, and the total amount requested to support the PROGRAM.

f. PROVIDER shall provide written notice to CCSS of any PROGRAM changes during the lifecycle of the contract for which COUNTY'S funds are allocated under the provisions of resolution(s) to be approved and adopted between COUNTY and PROVIDER.

H. PROVIDER will certify to:

a. Maintain the confidentiality of records pertaining to any individual that is provided domestic violence prevention or treatment services through the PROGRAM;

b. Ensure the address or location of any domestic violence project assisted with grant funds will not be made public, except with written authorization of the person responsible for the operation of such PROGRAM;

c. Provide information, such as data and reports.

I. PROVIDER will perform activities to ensure proper PROGRAM administration, including, but not limited to the following:

a. Perform all eligibility determination and documentation.

b. Record all client service transactions, case notes, and supporting documentations as applicable, as close to real time as possible in the MyAdultHomecare electronic medical record database maintained by PROVIDER.

c. Track all data and performance results specific to evidenced based practices and client outcomes.

d. Ensure all appropriate staff are trained in relevant best practices.

e. Ensure all appropriate staff is trained in and understand PROVIDER database.

f. Adhere to PROVIDER policies and procedures for data management.

g. Ensure incident management measures are in place to identify, analyze, and correct hazards to minimize adverse impact on operations.

7.0 Performance Outcomes

All outcomes align *with* the vision of CCSS, which is self-sufficiency for at-risk people through a variety of services.

Outcome #1 (DISCHARGES): Clients will be successfully discharged to a home, family, or long-term care setting.	
Major Tasks Necessary to Realize Outcomes (Activities):	Output **Resulting from Tasks:**
Staff will assess clients for specific needs and work together to establish a discharge destination (home, family, community).	Number of assessments administered
H2H ICM (Intensive Case Manager) will identify target discharge destination and funding sources available (and apply for financial support if needed based on housing destination).	Number of discharge plans
H2H ICM (Intensive Case Manager) will work with clients and family caregivers to establish a safe discharge plan.	Number of discharges
H2H ICM will assist client to acquire necessary items for the discharge destination including immediate supports for nutrition, medication and financial supports for placement.	Number of discharges supports arranged
Target & Indicator: 90% will be discharged to home or community setting.	
Outcome Measurements: CMIS/H2H Roster - Number of clients that are successfully discharged.	

Outcome #2 (READMISSIONS): Clients will not require hospital readmission for same diagnosis within 30 days of discharge	
Major Tasks Necessary to Realize Outcomes:	**Output Resulting from Tasks:**
Staff will assess client's health and home supports situation to determine potential to mitigate need for readmission.	Number of assessments administered
ICM (Intensive Case Manager) will assist clients in applying for and obtaining supports that increase their ability to successfully remain in the community safely. PROVIDER will support client with need as the referral is pending.	Number of supportive services referrals
PROGRAM will assess and screen clients for post-discharge medical needs, make appropriate referrals, and support clients in improving and maintaining their medical stability.	Number of assessments administered Number of medical services referrals
Licensed staff will assess and screen clients and family caregivers for mental health needs.	Number of assessments administered Number of client services provided
Target & Indicator: 90% will not be readmitted to the hospital for the same diagnosis within thirty (30) days of discharge.	
Outcome Measurements: 30-day readmission rate of under 10%.	

8.0 Quality Assurance

1. Quarterly reports describing the PROGRAM'S progress will be due 30 days after the end of each quarter as follows:

   - Quarter 1: July 1 – September 30 : Due October 30
   - Quarter 2: October 1 – December 31: Due January 30
   - Quarter 3: January 1 – March 31: Due April 30
   - Quarter 4: April 1 – June 30: Due July 30

   CCSS will create the report format and associated PROGRAM metrics.

2. PROVIDER will implement a quality assurance plan component to facilitate client feedback on quality of services, which must include at least one of the following: client satisfaction surveys during and at the completion of service delivery; and/or regularly-scheduled opportunities to meet with agency leadership to discuss programs. PROVIDER will submit a written procedure for implementing the client feedback mechanism(s), and report on its progress quarterly when submitting monthly reports.

3. CCSS will evaluate the PROVIDER'S performance under this contract. Such evaluation shall include assessing the PROVIDER'S compliance with all contract terms and performance standards and may occur monthly, quarterly, semi-annually, and/or annually

9.0 Performance Requirements

1. Eligible cases will be entered real-time client service information in the MyAdultHomecare electronic medical record database maintained by PROVIDER.

2. Number of clients who were referred and linked to mental health, substance abuse treatment or other supportive services and status of these referrals/linkages for these clients;

3. Number of clients referred by partnering sector to include managed care organizations and hospitals and those who were referred for services but could not be served by the program and the reason(s) why;

4. Number of ongoing clients served by the PROVIDER by the referring entities;

5. Number of new clients served by the PROVIDER by the referring entities;

6. Number of clients self-selected out of the program, including the number of days in services and the reason(s) why they did not continue to participate.

7. Other items determined to be pertinent to the assessment of the program.

10.0 Compensation

1. COUNTY agrees to pay PROVIDER for performance of services described in this Scope of Work. PROVIDER shall submit to COUNTY a monthly invoice by the 15th of each month for expenses incurred the previous month; and a client roster.
2. Upon compliance with the requirements in this Contract, PROVIDER shall be compensated based on the line- item as outlined in the line-item category section below.
3. All other remuneration will remain on a reimbursement basis unless specifically waived by COUNTY. Reimbursement will be paid after eligible expenses have been incurred; contract in conformance with the terms and conditions of said Contract.

11.0 Line-Item Category

Fee for service of $3,700.00 per clients up to the maximum amount of 62 clients per month

12.0 Definitions

H2H Intensive Case Management (ICM) is differentiated from other forms of case management through factors such as smaller caseload size, not to exceed 40 clients; professional team management; inclusion of respite coaches; direct provision of support/coaching services; emphasis on caregiver decompression/stress management; caregiver behavior management coaching; emphasis on both short- and long-term problem solving; and connection to long-term resources and supports; and a significantly higher intensity of services in comparison to standard case management and a supportive facilitative approach to working with clients and family caregivers. H2H experience has demonstrated that this intensive approach to case management with supports is highly effective in preventing hospital readmissions for the same diagnosis; increases the ability for clients to age in place in the community; decreases caregiver stress and the desire to institutionalize. The goals of the H2H ICM model are to engage clients and family caregivers in a trusting relationship, assist in meeting their basic needs and immediate needs (e.g., nutrition, medication, follow-on medical), and help them access community-based long-term services and supports. The fundamental elements of H2H ICM include a team approach combined with low caseloads per case manager ratio combined with trained respite coaches, which translates into more intensive and consistent services for each client.