AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND LIFEMOVES

THIS AMENDMENT TO THE AGREEMENT, entered into this ___ day of_____, 2018, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and LifeMoves, hereinafter called "Contractor";

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, the parties entered into an Agreement on June 27, 2017 to provide homeless and community health outreach services to San Mateo County's unsheltered homeless population for an amount not to exceed $712,000 for the term of July 1, 2017 through June 30, 2018;

WHEREAS, the parties wish to amend the Agreement to extend the term by two years to June 30, 2020 and add funds in the amount of $1,424,000 for a new maximum amount not to exceed $2,136,000, in order to allow for the continuation of the street based outreach and housing focused case management services to San Mateo County's unsheltered homeless population.

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. **Section 1. Exhibits and Attachments is hereby amended to read as follows:**
The following exhibits and attachments are attached to this Agreement and incorporated into this Agreement by this reference:

Exhibit A (revised 3/2018) - Program Description and Services
Exhibit B (revised 3/2018) - Method and Rate of Payments
Exhibit B1 - Budget
Exhibit C (revised 3/2018) - Performance Reporting and Monitoring
Exhibit D - Clarity
Attachment I - § 504 Compliance
Attachment P - Personally Identifiable Information

2. **Section 2. Services to be performed by Contractor is hereby amended to read as follows:**

In consideration of the payments set forth in this Agreement and in Exhibits B and B1, Contractor shall perform services for County in accordance with the terms, conditions, and specifications set forth in this Agreement and in **Exhibits A (revised 3/2018)**, **C (revised (3/2018)**, D, and Attachment P.

3. **Section 3. Payments is hereby amended to read as follows**

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in **Exhibits A (revised 3/2018)**, C, D, and Attachment P, County shall make payment to Contractor based on the rates and in the manner specified in **Exhibits B (revised 3/2018)** and B1. County reserves the right to withhold payment if County determines that the quantity or quality of the work performed is unacceptable. In no event shall County's total fiscal obligation under this Agreement exceed **TWO MILLION ONE HUNDRED THIRTY SIX THOUSAND DOLLARS** ($2,136,000). In the event that County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by County at the time of the termination or expiration of the Agreement. Contractor is not entitled to payment for work not performed as required by this Agreement.

4. **Exhibit A (revised 3/2018) replaces original Exhibit A in its entirety and is attached hereto.**

5. **Exhibit B (revised 3/2018) replaces original Exhibit B in its entirety and is attached hereto.**

6. **Exhibit C (revised 3/2018) replaces original Exhibit C in its entirety and is attached hereto.**

7. **All other terms and conditions of the agreement dated June 27, 2017, between the County and Contractor shall remain in full force and effect.**

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

For Contractor: LIFEMOVES

Contractor Signature	Date	Contractor Name (please print)
[signature]	5/7/2018	Bruce Ives

COUNTY OF SAN MATEO

By:
President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:
Clerk of Said Board

Exhibit A (revised 3/2018)
Program Description and Services

LifeMoves
Homeless Outreach Services and Community Health Outreach Services
FY 2017-20

A. Purpose

The purpose of this Agreement between the County and Contractor is to provide homeless outreach and community health outreach services. Specific program components include: outreach and engagement, case management, multi-disciplinary team meetings, rapid response to community inquiries or referrals of unsheltered homeless persons, and community health outreach services for the homeless. Community health outreach services will comprise of care coordination, including: transportation to medical appointments, picking up medication, establishing and evaluating adherence to case plan, and providing medical needs assessments and intensive follow-up.

The goal of homeless outreach services is to provide services and support to unsheltered homeless individuals and households with the purpose of assisting them with becoming housed. Homeless outreach services coordinates closely with the Coordinated Entry System ("CES") established by San Mateo County Human Services Agency ("HSA") to act as an integrated part of the community's homeless crisis response system. The goal of community health outreach services is to provide assistance to unsheltered homeless individuals and households to help them access primary and specialty medical care. Homeless outreach services will focus on the housing plan, while community health outreach services will focus on physical and behavioral health (in collaboration with medical providers).

B. Services to be Provided

Services will be targeted specifically to unsheltered (living outdoors, in vehicles, or other places not meant for human habitation) homeless individuals, households, or unaccompanied youth, who are residents of San Mateo County and are disconnected from mainstream services, homeless services, and other support systems. This includes those with disabilities, little to no income, evictions, criminal convictions, alcohol and/or other substance use, mental and physical health challenges, and other barriers to maintaining housing.

Contractor shall serve both those who are referred by CES as well other unsheltered individuals living in the County encountered by Contractor's outreach staff, in order to target services towards clients who have been unsheltered the longest and are most in need of services.

Clients served by community health outreach services must be eligible for Medi-Cal and enrolled as a Health Plan of San Mateo ("HPSM") member, or in

progress to become enrolled, per the requirements of the County's Whole Person Care ("WPC") pilot program.

Program participants will be San Mateo County residents at the time of service provision. Case management and housing plans may include strategies for out-of-county permanent housing solutions. However, if a client moves out of County, services under this contract would cease and Contractor shall identify resources and service providers in the area of relocation to transfer services.

Services are provided on a county-wide basis to ensure that services are available to County residents no matter where in the County they are residing.

Program Oversight

Contractor shall:

- Designate a program manager/director who will be responsible for overall program operations, including quality assurance and improvement, consistency of services, ongoing training and supervision of staff, partnerships with stakeholders, data tracking, and performance outcomes. This program manager will not be the outreach case manager for a region, but rather will focus on overall program oversight, management and training of program staff.
- Maintain a written program model, documenting processes, written guidelines and criteria for all program components of homeless outreach and community health outreach services. The program model will include information on the process to access services, how services are targeted to those with the highest level of needs, and include reasons why a client may be terminated from case management. Update program documentation as modifications are made to CES to ensure the outreach services roles align with the homeless system's structure.
- Work with HSA to strategize on connecting unsheltered homeless individuals and families to shelter and permanent housing.
- Follow CES policies and procedures on application, referral, and placement into shelters and housing programs.
- Work with the San Mateo County Health System, including Street Medicine, Behavioral Health and Recovery Services ("BHRS"), and Healthcare for the Homeless/Farmworker Health Program ("HCH") as the WPC pilot is implemented and will update policies, procedures, and training as needed based on the implementation of the WPC pilot.
- Provide initial and ongoing training, supervision and support to ensure that outreach staff are trained to work with hard-to-reach and hard-to-serve clients, who may otherwise be disconnected from mainstream and homeless system services and supports.
- Provide ongoing, comprehensive staff trainings on best practices in working with homeless individuals with complex needs, safety protocol and procedures, Housing First, motivational interviewing, engaging hard-to-serve clients, job functions and responsibilities, emergency response protocol, reporting of suspected child abuse/neglect and elder abuse,

strategies for assisting clients with exploring housing plans (including housing alternatives other than formal homeless programs, such as family reunification, shared housing, etc.) and Homeless Management Information System ("HMIS") data entry and service documentation.
- Ensure that staff are aware of, and well connected to, the array of services available within the community, including maintaining current knowledge of referral/application processes for shelters, housing resources, voucher and subsidy programs, senior housing, affordable housing, shared housing, substance use treatment programs, long-term care/medical facilities, mental health services, Aging and Adult Services, public benefits (Social Security, CalFresh, General Assistance, health coverage programs, etc.) and other applicable resources.
- Provide outreach staff with support, training, and case consultation as needed with staff who have clinical expertise to brainstorm additional methods for engaging and serving clients.

Program Philosophy and Design

Contractor will develop, document, and maintain updated program policies and procedures, including:

- Services consistent and aligned with Housing First principles.
- Consistent process for receiving, documenting, and responding to referrals and requests for service.
- Thorough, accurate, and timely documentation of all services in the San Mateo County Clarity HMIS system.
- Services targeting the hardest-to-serve homeless individuals and families, and actively moving the greatest number of unsheltered individuals towards permanent housing.
- Implementation of a person-centered, strengths-based approach tailoring case management to each client.
- Collaboration with safety net providers, homeless services, medical and behavioral health providers, substance use treatment programs, law enforcement, and other applicable partners and stakeholders.
- Structure, membership, and processes of multi-disciplinary team meetings.
- Collaboration with safety net providers, homeless providers, medical and behavioral health providers, substance use treatment programs, law enforcement, and other applicable partners.
- Grievance procedures.
- Confidentiality policies and procedures.
- Safety and emergency protocol, and incident reporting.
- Process for receiving all referrals for case management from the CES.

Contractor, in partnership with HSA, will collaborate closely with the Homeless and Safety Net system ("H&SN"). In addition, Contractor will not screen out households based on criteria such as a minimum income threshold, employment, criminal history, disability, evidence of "motivation", etc. Program is centered on a Housing First approach that values the needs of the individual.

Homeless outreach services and community health outreach services are provided county-wide, structured in a regional manner. HSA may make modifications to the regional model in the future based on shifting community needs and the evolving structure of the homeless system; contractor would be notified in writing of any modifications.

Current Regional Model:

Area	Cities/Areas Included
1	Burlingame, San Mateo, Central/South Coast, Highlands, Baywood, Parks
2	Foster City, Redwood City, Woodside, Atherton, Portola Valley, North Fair Oaks, West Menlo Park, Parks
3	East Palo Alto, San Carlos, Belmont, Menlo Park, Parks
4	South San Francisco, San Bruno, Millbrae, Hillsborough, Airport, Parks
5	Half Moon Bay, Pacifica, Daly City, Broadmoor, Brisbane, Colma, Parks

Program Components

Outreach and Engagement

Contractor shall conduct outreach and engagement to build relationships based on trust and respect between unsheltered clients and service providers to establish a pathway to permanent housing. Outreach staff will be trained in, and implement best practices in engagement, such as motivational interviewing and interventions in the field, in a trauma-informed and culturally competent manner with respect to the individual's right to accept or deny services.

Under this program component, Contractor shall:

- Identify and provide outreach to areas where unsheltered homeless people concentrate, such as parks, near or inside abandoned buildings, transit stations, and other areas not meant for human habitation.
- Build positive relationships with unsheltered homeless individuals to provide pathways to housing and connection to other homeless system and/or mainstream service.
- Conduct a standardized assessment to identify immediate needs and short-term interventions, such as direct assistance for basic needs (food, clothing, hygiene, etc.) or emergency calls for urgent medical needs.
- Develop and maintain close working relationships with Street Medicine, Community Health Outreach Workers ("CHOW"), BHRS, and other partners in order to provide appropriate referrals with the individuals/households receiving outreach and engagement.
- Assess and facilitate short-term housing interventions, such as access to an emergency shelter or other rapid homeless services, residential

treatment programs, and medical facilities as a step toward permanent housing.

- If an individual or household is only able to be located at specific times of day (i.e. homeless individual's whereabouts are unknown during the daytime hours but he is known to be at a specific park each evening), Contractor will make efforts to connect with the individual, even if that is outside of typical business hours.
- On days when inclement weather is activated, conduct additional outreach to notify unsheltered homeless individuals of the inclement weather that is approaching and assist them with accessing shelter (including the inclement weather program).
- Working closely with CES, Homeless Outreach Team ("HOT") will follow the process established by HSA for connecting unsheltered individuals/households with homeless services via CES.
- The policies for CES for adults are being developed at the time of this contract development. HSA is the lead on developing the policies, and HSA has and will consult with the CES provider Samaritan House and the HOT program leadership on the aspects of CES policies related to unsheltered individuals/households. As HSA develops and modifies changes to CES policies/procedures, LifeMoves will implement new or modified policies, procedures, training, and support for their staff to align with the current CES policies/procedures established by HSA and the CES provider.
- Refer and help connect any individual/household with a medical need to medical care, via the Street Medicine program and other health care resources.
- Working closely with HSA, conduct field surveys and/or counts and other information-gathering initiatives, including One Day Homeless Counts.

<u>Rapid Response</u>

Contractor shall respond to requests for homeless outreach services in an effort to make contact and provide support to unsheltered homeless individuals or families. Inquiries for rapid response may come from service providers, medical providers, law enforcement, City or County staff, and other stakeholders or community members.

Under this program component, Contractor shall:

- Establish a process for receiving (via phone and email), responding to, tracking, and reporting rapid response requests and outcomes.
- Communicate the process for making inquiries to service providers, medical providers, law enforcement, City and County staff, and other stakeholders and community members.
- Deploy outreach staff to locations reported by inquiries within 24 hours of the inquiry being made, including coverage after business hours and on weekends.
- If outreach staff are able to locate the individual/household, outreach staff will provide outreach and engagement activities as outlined above to assess immediate needs and implement short-term interventions.

- If outreach staff are unable to locate the individual/household, staff will follow up at least two times within 10 calendar days to try to contact and engage the individual/household.
- Document rapid response activities in an accurate and timely manner.

Case Management

Outreach staff that establish a rapport with individuals/households through continued outreach and engagement shall provide intensive services to support individuals/households in linkages to mainstream supportive services and case plans toward permanent housing. Active case management individuals/households are those who have been referred to the Outreach staff by the CES based on the prioritization assessment tool and the CES policies established by HSA. Case management will only be provided to individuals/households referred by CES. In addition, outreach staff will only provide "Intensive Case Management" to, or add to the Multi-disciplinary Team ("MDT") list, clients who are referred and approved by CES.

As the target population of homeless outreach services is those who have been unsheltered the longest and with the highest needs, clients' reception of services may fluctuate and clients may sometimes be difficult to locate or connect with. In these cases, case managers will continue to implement strategies of engagement to try to continue providing services and continue to implement the housing plan.

If an individual's/household's whereabouts become unknown, contractor will make active efforts over a number of weeks to locate the client, including inquiring at possible locations such as hospitals, correctional facilities, recent locations, and asking other partners and service providers, as allowable by confidentiality policies.

It is understood that some individual's/household's housing plans may take significant time to implement, especially for clients with significant housing barriers and high levels of need. Individuals/households will not be removed from active case management unless they deny continued case management after long periods of attempted engagement from Contractor, including attempting various methods of engagement techniques and partnering with any applicable partners. An individual/household may be re-enrolled in case management at a later date, if referred by CES.

Individuals/Households on the case management list may also be on the MDT case list, if they have given applicable consent for case conferencing in the MDT meeting. If individuals/households do not give consent to participate in the MDT meeting, they will still receive case management services, though they will not be discussed during MDT meetings.

Under this program component, Contractor shall:

- Provide client-centered, trauma-informed, and harm-reductive case management respecting each individual's strengths, preferences, varying needs, and housing goals.

- Create and implement housing-focused case plans guided by Housing First principles, with the primary objective as returning unsheltered homeless people to safe, secure housing as quickly as possible.
- Provide linkages to mainstream, primary health, and behavioral health services based on each client's unique needs, and continued coordination with partner service providers serving clients through their agencies or systems.
- Provide case management contact and services at appropriate frequency and intensity to support each client in their housing plan, with a minimum of monthly in-person contact.
- Maintain and develop knowledge of housing strategies and resources in County, including eligibility requirements, referral and application processes, and availability/capacity of resources such as:
    - Rapid re-housing (RRH)
    - Housing Readiness Program (HRP)
    - Permanent Supportive Housing (PSH)
    - Supportive Services for Veterans (SSVF)
    - Veterans Affairs Supportive Housing vouchers (VASH)
    - Moving to Work vouchers
    - Senior housing resources
    - Affordable housing resources
    - Shared housing resources
    - Behavioral Health and Recovery Services supported housing programs
    - Current practices for successful rental applications for market rate housing
    - Other subsidized and/or supportive housing resources
    - Detoxification/substance use treatment programs including residential treatment programs, long-term care facilities, etc.
- Maintain close collaboration with CES lead agency.
- Follow CES policies established by HSA, and CES procedures established by CES lead agency, for assessing clients with the CES assessment tool in partnership with the CES lead agency staff. Establish HOT procedures to partner with CES lead agency. Train all HOT staff on CES procedures and CES assessment protocol.
- Assist clients with becoming "document ready" and with processes for accessing various housing programs listed above, including direct support with obtaining identification and verification documents from agencies such as the Social Security Administration and the California Department of Motor Vehicles.
- Encourage utilization of shelters as a temporary place to stay while clients pursue permanent housing.
- Plan for and implement transition of care and services to other support services or case managers when clients successfully transition into shelter or other housing.
- Identify non-housing related services that clients are already connected to or enrolled with, and coordinate communication and co-case management

to facilitate access, care, and transparency on roles and responsibilities in case planning toward permanent housing.
- Connect clients to community health outreach services for support in accessing health coverage and medical care, and follow up.
- Monitor case progress, reassess needs, and revise case plans and strategies as needed.
- Maintain case files of individual/household case management progress, pertinent client information, document case management activities and progress notes in Clarity HMIS in an accurate and timely manner.
- Follow safety and emergency response protocol, including contacting emergency responders when necessary and reporting critical incidents.
- Follow CES policies and procedures for referral, application, and enrollment into housing programs upon implementation of CES.

Multi-Disciplinary Team Meetings

Multi-disciplinary teams (MDTs) are a collaborative environment for service providers and community stakeholders to discuss services, needs and challenges, and to coordinate solutions for unsheltered homeless people working with outreach staff.

MDT meetings occur monthly, and are organized by geographic region, following the current regional model (there are currently two meetings on the coastside). At MDT meetings, outreach staff present information on clients who are receiving case management; outreach staff present the housing-focused case plan, updates on progress toward housing, barriers, and challenges. MDT members may provide suggestions, resources and at times can provide direct assistance in facilitating communication or services with the clients. HSA may make modifications to the number, frequency or structure of MDT meetings based on shifting community needs; if this occurs, HSA will consult with Contractor and additionally, Contractor will be notified in writing of any modifications.

Under this program component, Contractor shall:
- Provide information on the MDT model to clients and obtain consent for case conferencing if clients are willing.
- Maintain participant list and contact information of active MDT members, and respond to community inquiries or requests to join the MDT.
- Maintain documented policies regarding which agencies and stakeholders participate in MDTs and utilize policies to respond to any requests to join the MDT, in collaboration with HSA.
- Maintain confidentiality policy regarding MDTs.
- Maintain written MDT procedures.
- At each MDT meeting
    - Case managers providing services to clients in the MDT region or area will present case information on consenting clients receiving case management. The case manager will present the client's housing-focused case plan, updates on the progress toward housing, eligibility for various housing resources, barriers,

challenges, concerns, needs, and can request suggestions or support from MDT participating agencies.
    - A second outreach staff member will facilitate the meeting and write notes to document all action items and next steps for each client's housing-focused case plan.
    - Within four business days of the meeting, Contractor will distribute action item notes to MDT members.
- In collaboration with HSA, maintain active participation of key partners.
- Update MDT on current case management caseload/capacity, and any changes in outreach staffing.
- Conduct outreach and engagement to unsheltered homeless individuals at the request of MDT members during MDTs or via email or phone request.
- Maintain schedule and calendar invitations for all MDT meetings, including coordinating meeting locations and sending reminders for MDT meetings. Contractor may request support from HSA in utilizing HSA conference rooms if needed.

Community Health Outreach Services

San Mateo County's WPC pilot aims to improve access to care, care coordination, and quality of care for individuals who are high service utilizers and face barriers to connecting with primary and behavioral health, social, and housing services.

As part of the WPC pilot, community health outreach staff will provide culturally sensitive engagement and health-focused case management services to unsheltered individuals that are disconnected from service systems.

Under this program component, Contractor shall:

- Collaborate with homeless outreach staff and other partner providers to receive referrals of unsheltered individuals, or households in need of services.
- Ensure compliance with all WPC requirements and policies.
- Engage with unsheltered individuals/households to provide information and referrals to health and community resources.
- Conduct an assessment of immediate medical needs, implement short-term interventions, and provide ongoing engagement to follow up on emerging needs.
- Assist clients with enrolling in health coverage or refer clients to resources that can assist them with enrolling in health coverage programs.
- Track to ensure that clients are either enrolled as an HPSM Medi-Cal member, or in progress to become enrolled as an HPSM Medi-Cal member. If a client is not eligible to be an HPSM Medi-Cal member, the client cannot be served under this program component and Contractor will refer the client to other resources to help them connect to health services.
- Create a care coordination and management plan, and support client's adherence to the plan by:
    - Connecting with primary and behavioral health care providers.

    - Scheduling and accessing medical appointments, including appointment reminders, transportation, and accompaniment as needed.
    - Supporting clients with filling medication prescriptions, creating a plan to ensure compliance with prescriptions.
- If a client has discharge instructions from a hospital, assist client with complying with the discharge instructions
- Collaborate with hospital and other medical treatment facilities on exit planning to avoid discharge into unsheltered homelessness and ensure follow up on medical services or medications
- Track whether appointments are kept and the number or percentage of unsheltered individuals receiving consistent health care increases, along with other program activities in a timely and accurate manner
- Collaborate closely with medical providers such as Street Medicine, Care Navigators, and others.
- Participate in applicable planning meetings for the WPC program.
- Submit reporting to the Health System according to the requirements of the WPC program.
- As the County's WPC Pilot is implemented, the specific roles of the Community Health Outreach (CHO) staff may be modified as the specific roles and collaborative responsibilities are further defined for WPC Navigators, other WPC partners, and CHO staff. HSA may issue a revised description of this program component in writing to clarify roles as the WPC pilot is implemented.
- Ensure that services provided are not billable to/reimbursable by Medi-Cal
- Meet with evaluators to assess the WPC pilot if needed.
- Understand that continued funding for Community Health Outreach Services, as part of the WPC pilot, is contingent upon certain deliverables. Funding for the pilot program will be available based on meeting the deliverables and achievement of the metrics.

Quality Assurance and Continuous Quality Improvement

Contractor will conduct quality assurance control and continuous quality improvement, including: ongoing training, coaching, and reviewing services and data to ensure quality of services, consistency of services and adherence to policies and procedures.

Contractor will conduct ongoing reviews of services and documentation of services (file reviews).

Contractor will implement systematic process to collect ongoing feedback from clients, homeless and safety net providers, and other stakeholders.

Other Contractor Responsibilities

- Provide services that are culturally appropriate to the populations served.

- Hire, train, and supervise homeless outreach and community health outreach staff. Staff will be provided with initial training and orientation and ongoing training, supervision, evaluation and support.
- Maintain policies, procedures, and tools for staff and update as needed to align Housing First principles and enable outreach staff to identify and serve the hardest-to-serve.
- Provide services that are low-barrier, meaning that participants are not screened out or discharged from the program based on having too little or no income, active substance abuse or a history thereof, a criminal record, or perceived “lack of motivation”.
- Maintain timely, accurate client records of all clients served in the San Mateo County Clarity/HMIS database (see Exhibit D). All client records will be entered into Clarity. Data entry will be entered during or as soon as possible after the services. Under all circumstances, data entry will be completed within 4 business days of the service provision.
- Critical Incident Report – All critical incidents will be reported via email within 24 hours to HSA staff, including the events of: death, homicide, suicide or suicide attempt, and assault (to another client or staff) and any other significant incident involving any HOT client or staff.
- Provide the County a schedule of coverage, and a coverage plan for services during any time that the Contractor will not be open for services during regular business hours (i.e. staff training, holidays observed by the Contractor that are not County holidays).
- Participate in County Homeless Redesign and the Coordinated Entry System.
- Participate in point-in-time counts and surveys.
- Provide a budget summarizing how the contract funds will be spent. Contractor will need approval from HSA for any budget change-requests.

Exhibit B (revised 3/2018)
Method and Rate of Payments

LifeMoves
Homeless Outreach Services and Community Health Outreach Services
FY 2017-20

In consideration of the services provided by Contractor and subject to the terms of the Agreement, County shall pay contractor based on the following fee schedule and terms.

A. General Payment Terms

Availability of Funding:
County may terminate this Agreement in whole or a portion of services based upon availability of federal, state or county funds by providing a thirty (30) day written notice to Contractor.

Quality of Work:
The County reserves the right to withhold payment if County determines that the quantity or quality of the work performed is unacceptable. If the County should find that the quantity or quality of work is unacceptable, County shall notify Contractor in writing with a detailed statement and plan to correct performance. Contractor shall respond to County within fifteen (15) days of receipt of statement with a plan to confirm what steps will be taken to correct performance.

Payment Rates:
County shall have the option to adjust funding across line items in the Budget shown in Exhibit B1 and across fiscal years and quarters as agreed by both parties and approved by the County in writing as long as it does not exceed the total agreement obligation.

Right of County to Request Additional Services:
The County may request additional related services under this agreement and adjust program rates for the programs described within this agreement to accommodate the addition of services as agreed upon by both parties as long as it does not exceed the total agreement obligation and is not restricted by any grant or specific funding agreements.

B. Program Budget Overview

Fiscal Year	Homeless Outreach Services Component	Community Health Outreach Component (WPC funding)	Total Amount
2017-18	$511,252	$200,748	$712,000
2018-19	$511,252	$200,748	$712,000

2019-20	$511,252	$200,748	$712,000
Total	$1,533,756	$602,244	**$2,136,000**

The $602,244 Community Health Outreach component is funded by Whole Person Care. All services, costs, and invoices related to this funding must be tracked separately, so that the Community Health Outreach component can be reported on independently from the Homeless Outreach Services component.

C. Method and Rate of Payments

Contractor shall invoice HSA quarterly for actual costs incurred, based on the budget shown in Exhibit B1 for services shown in Exhibit A. Contractor shall submit two invoices each quarter, each with the applicable supporting documentation.

1. Homeless Outreach Services component
2. Community Health Outreach component

For any staff who provides services on both program components, Contractor will track their time separately for the Homeless Outreach Services component and for the Community Health Outreach component.

Contractor shall submit invoice with supporting documentation, and all required reporting by the 20th of the month for the prior quarter's operating expenses, direct client support, salaries and wages, and administration costs for services in accordance with the scope of work in Exhibit A and the budget in Exhibit B1. The fourth (4th) quarter invoice must be submitted by June 25th due to fiscal year-end processing.

Reporting Period	**Due Date for Invoice** (with reporting, supporting documentation)
Q1 (July-September)	October 20th
Q2 (October- December)	January 20th
Q3 (January-March)	April 20th
Q3 (April-June)	June 25th

Invoices shall be emailed to Brian Eggers at BEggers@smcgov.org or the designated HSA contact.

County will pay Contractor upon the receipt and approval of invoices. Payments are contingent upon receipt of quarterly reports. If reports are delayed, Contractor understands that payments will be delayed until the report that corresponds with that quarterly invoice is received by the County.

In no event will services, taxes and fees exceed the total Agreement obligation of **TWO MILLION ONE HUNDRED THIRTY SIX THOUSAND DOLLARS** ($2,136,000).

Exhibit C (revised 3/2018)
Performance Reporting and Monitoring

LifeMoves
Homeless Outreach Services and Community Health Outreach Services
FY 2017-20

Quarterly reporting is a requirement of payment. Delays in submission of complete reports will delay payments of invoices to Contractor.

Performance Measures

Measure	17-18 Target	18-19 Target	19-20 Target
Homeless Outreach Services			
Number of unduplicated clients who receive outreach and engagement services	340	340	340
Number of unduplicated clients served through case management (not exclusively clients on MDT list)	200	200	200
Number of clients receiving case management who move into Emergency Shelter, Transitional Housing, or other temporary destinations (e.g. temporarily living with family or friends)	40	80	90
Number of clients receiving case management who move into Permanent Housing	60	40	48
Percentage of Rapid Response requests that are responded to within 24 hours (response can be considered contact made with client, or attempted in person)	85%	87%	90%
Percentage of stakeholders who report above average satisfaction levels in regard to Homeless Outreach and Community Health Outreach services in their communities *(this measure will be reported only on a semi-annual basis, in January and June)*	90%	90%	90%
Community Health Outreach Services			

Of individuals on the WPC list referred to Contractor to be located, percentage who are successfully located	60%	70%	80%
Of the WPC individuals who are located by Contractor, percentage or number of clients who Contractor will engage in services, such as connecting to a Care Coordinator, Street Medicine team or other medical provider for a screening; connecting to transportation or housing services; or connecting to other available services.	100 unduplicated individuals, or 80% of clients located if number of referrals is less than 125	120 unduplicated individuals, or 85% of clients located if number of referrals is less than 141	140 unduplicated individuals, or 90% of clients located if number of referrals is less than 156

The County shall have the option to modify performance measures, goals, and targets by written notice and agreement of Contractor. The County shall give the Contractor advance notice of any modifications and will also discuss changes with the Contractor.

In addition, the San Mateo County's WPC program is required to submit performance measure metrics to the State of California, as part of the WPC pilot the general WPC metrics are listed below. HSA and Contractor understand that this is a pilot project that includes the participation of multiple entities. Contractor further understands that it will be requested to engage with many of these entities, and Contractor commits to be an active participant in any such discussions. As the County WPC program is implemented, HSA and/or the Health System will notify the Contractor regarding any additional WPC metrics and data that will need to be reported on. The initial WPC metrics are listed below.

WPC Pilot Metrics	Target by End of Pilot
Emergency Department (ED) visits	Decrease by 25%
Inpatient utilization	Decrease by 25%
Follow up after hospitalization for mentally ill clients	40% of eligible population
Initiation and engagement of AOD dependence treatment	35%/50% of eligible population
Assignment of Care Coordinator*	57.88% of eligible population
30 day all cause readmissions	25.72% of eligible population
Completion of suicide risk assessments	23.15% of eligible population
Percentage of diabetic patients with HbA1c less than 8	23.15% of eligible population
Percent of homeless participants receiving housing services that were referred for housing*	34.73% of eligible population
Proportion of participating beneficiaries with comprehensive care plan accessible by the entire care team within 30 days	18% of eligible population

**WPC metrics which Community Health Outreach Worker Program will have direct impact on helping to achieve in the WPC Pilot.*

- Submit quarterly performance reports to HSA within 20 days of the end of the previous quarter. Reports will include the following:

  Quarterly reports
  Quarterly reports will include the following and be used as documentation for invoicing.

  i. Number of clients served during the reporting quarter under:
     a) Rapid Response
     b) Outreach and Engagement
     c) Case Management
  ii. Performance measure report (results for performance measures listed in table above for the current quarter and for fiscal year-to-date).
  iii. Narrative describing trends, successes, challenges during the reporting period.

- Contractor will provide a brief, one-time paragraph about this Measure K-funded initiative and its goals, to be used for Measure K dashboard and other public documents to highlight the purpose and impact of the program.

- Submit annual program report within 20 days of the end of the fiscal year. Annual program report will provide information on the impact that homeless outreach and community health outreach services had throughout the entire service year and annual results for each performance measure.

- Contractor will provide HSA with annual financial audit statements in accordance with generally accepted government auditing standards within nine months of fiscal year end for each year of the Agreement.

- Contractor will submit additional reports or data as requested by HSA or the Health System.

- Contractor will participate in Site Review/Contract Compliance Visits with HSA designated staff. Visits will occur at least once per year, with increased frequency if areas for improvement arise. Contractor will receive at least two weeks advanced notice unless there is an urgent programmatic need to expedite the process.

- Contractor will participate in homeless outreach evaluations, analysis of the homeless system conducted by HSA, as well as technical assistance provided by HSA or an HSA contracted provider such as HomeBase.

- HSA may request additional data from contractor and/or retrieve reports from Clarity to understand client requests, services, and outcomes. Contractor will receive at least two weeks advanced notice unless there is an urgent programmatic need to expedite the data/report.

- The Health System may request additional reporting from the Contractor for WPC planning, evaluation, and reporting purposes.

- All reports shall be emailed to Brian Eggers at BEggers@smcgov.org or the designated HSA contact.