EXHIBIT A
PROGRAM DESCRIPTION AND PERFORMANCE REQUIREMENTS

Contracting Department	Health Care Services Agency Administration and Indigent Health
Contractor Name	Tri-City Health Center
Contract Period	July 1, 2019 – June 30, 2020
Type of Services	Homeless street outreach and engagement, street health services and triage, collaboration with housing and community organizations to secure housing and benefits for clients, enabling services, short-term case management, laboratory/diagnostic tests, medication formulary, healthcare navigation services, supportive services/referrals.
Procurement Contract No.	18187

I. Program Name

South County Street Health Outreach

II. Contracted Services

Contractor shall provide:

1. *Street Outreach and Engagement:*
    a. Attend to basic needs prioritized by clients, e.g., distributing basic necessities and supplies (e.g., hygiene kits);
    b. Provide problem-solving support (e.g., identifying a place for a warm breakfast, pet care);
    c. Provide health education and information about health and community services.

2. *Street Health Services and Triage:*
    a. Medical assessments and brief psychosocial assessments and triage;
    b. Treatment of conditions commonly associated with being homeless, e.g., respiratory infections, heat and cold-related illness, wound care, skin and foot problems, nutritional deficiencies
    c. Vaccinations (e.g., flu, Hepatitis A, B,Tdap); arranging for or providing screenings (e.g. HIV, Hepatitis C)
    d. Troubleshooting pharmacy related barriers, such as regularly picking up medications;
    e. Crisis assistance and brief behavioral health interventions (e.g. Motivational Interviewing, Problem Solving Therapy;
    f. Harm reduction strategies for Sexually Transmitted Disease (STD) prevention and Substance Use Disorders (SUD) including Narcan distribution;
    g. Linkage to Medication Assisted Treatment (MAT) for substance use disorders including management of buprenorphine treatment;
    h. Benefits Advocacy;
    i. Support with selecting a provider of the client's choice or re-engaging in care at an assigned clinic, and problem-solving around reasons for not connecting with an assigned medical home, including assisting with clinic paperwork and transitional period transportation assistance;
    i. Triage and referral to the appropriate level of care (e.g., brick-and-mortar primary care, urgent care, specialty care and dental clinics, emergency departments);
    j. Medi-Cal and HealthPAC enrollment and renewal assistance, and assistance with other public benefits for which the client may be eligible;
    k. Contractor shall accept clients at Contractor's brick-and-mortar clinic in a timely manner. Clinic will be prepared to treat conditions of particular concern to people experiencing homeless, such as HIV, Hepatitis C; and Medication Assisted Treatment (i.e., buprenorphine) for opioid

addiction. Timely access is defined in accordance with the State of California's timely access to care standards https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx

l. Contractor shall complete all Street Health and Triage services pursuant to applicable licenses regarding mobile unit licensure and pharmacy dispensing.
m. Contractor shall provide medical supplies, limited laboratory and medication dispensing services as part of the Street Health program. Examples include: medical supplies on hand to address acute health needs in the field including diagnosing and attending to small wounds, respiratory infections, foot care, blood pressure, and "small labs" (checking glucose and cholesterol levels).

3. Collaboration with Housing and Community Organizations to Secure Housing and Benefits for Eligible Clients:

a. Assist clients with gathering identification documents required for getting housing; many documents are already on file with health care providers for the purposes of Medi-Cal and public benefits enrollment. Contractor shall coordinate with regional Housing Resource Centers (HRCs) to gather client documentation required for Alameda County's Coordinated Entry assessment process to become eligible for Permanent Supportive Housing.
b. Coordinate with HRCs to coordinate services for clients on the HRC's "By-Name lists."
c. Coordinate with participating agencies on AB 210, which permits multi-disciplinary teams using County protocol to share and exchange information that expedites linkage of individuals and families to housing and services.
d. Coordinate with Alameda County Behavioral Health (ACBH) outreach teams and ACCESS to support clients who need to connect to specialty mental health and Substance Use Disorder (SUD) treatment services.
e. Contractors shall not participate in activities related to abatement of encampments.

III. Program Information and Requirements

A. Program Goals

Contractor shall provide services to accomplish the following goals:

1. Remove barriers to health services for homeless Alameda County residents who would not otherwise access services due to the competing pressures of daily survival, distrust of the health care system, stigma associated with being homeless, and bureaucratic and transportation navigation challenges.
2. Prevent deterioration of physical and behavioral health status;
3. Appropriate and timely utilization of emergency, inpatient, and crisis health care services;
4. Housing stability through partnerships and collaborations with other community-based organizations;
5. Increased income through benefits enrollment and support of disability cases through adequate and timely documentation.

B. Target Population

Contractor shall provide services to the following populations:

1. Service Groups

Contractor shall provide services to:

a. Alameda County residents who are homeless. As defined by Per Section 330(h)(5)(A), the term "homeless individual" means "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing."
b. Priority for services shall be unsheltered individuals (people who are living in a place not meant for human habitation).

Contractor shall make it a priority to serve:

a. Unsheltered individuals. "Unsheltered" refers to homeless individuals who are living in places not meant for human habitation.

b. Unsheltered individuals who are not engaged/well-linked to a primary care clinic.

c. Unsheltered individuals with a medical (including dental) condition who can benefit from:

    i. Primary care medical, dental, mental health services (mild/moderate), or
    ii. Assistance with Medi-Cal or HealthPAC enrollment, and navigating health plan benefits and other public programs,
    iii. Navigation support to gain access other parts of the health care system, e.g., medical specialties, specialty mental health services, Substance Use Disorder (SUD) treatment, and if necessary, Emergency Medical Services (EMS).

2. Referral Process to Program

1. Clients served under this program shall be identified through outreach conducted by the Street Health Outreach Team at designated service locations. Services are voluntary, meaning that individuals may choose to engage or not engage.
2. Contractor shall accept referrals of clients in its geographic area from Alameda County Health Care for the Homeless.
3. Contractors are discouraged from responding to additional outside referrals that divert resources away from maintaining a consistent schedule at designated encampments or locations. Teams may consult with Alameda County Health Care for the Homeless to triage incoming referrals.

3. Program Eligibility

Contractor shall only serve clients who:

Contractor shall serve clients in the following geographic area:

South County (Fremont and surrounding areas)

Contractor's Street Health Outreach Team shall tailor its selection of outreach settings to the needs of the population of the geographic area. Selection of outreach settings shall be determined and mutually approved by the Contractor and HCSA. Services may be offered at encampments, streets, cars, parks, shelters, libraries, bus stations, and public buildings, etc. with the objective of

developing a relationship of trust with Alameda County residents who are unsheltered and homeless.

In South County and suburban areas, unsheltered homeless are more dispersed and there are fewer encampments. Street Health Outreach Team shall maximize its service reach by outreaching at encampments in combination with outreaching at homeless shelters and homeless-serving organizations.

4. Limitations of Service

N/A

C. Program Requirements

Contractor shall maintain program services at the following minimum levels:

1. Program Design

Alameda County's Street Health Outreach model is comprised of the following components:

a. **Maintenance of a Consistent Site Schedule.** Contractor shall develop and maintain consistent schedule for each site and submit schedule to ACHCH. Contractor shall build trust and rapport with unsheltered homeless individuals, (e.g. outreaching in a welcoming and professional manner, working with informal encampment leaders).

b. **Street Outreach and Client Engagement.** The purpose of outreach is to build rapport with homeless individuals through consistent, progressive engagement and work to identify medical and behavioral health needs. Contractor shall focus outreach on the broader population within an encampment or location and those with higher needs will be connected to the appropriate member of the team for more intensive services.

Contractor shall ensure that outreach is provided by a minimum of two staff (team members may include community partners) in order to ensure safety. At no point in time shall Contractor staff conduct outreach with a team of fewer than 2 people.

Assessment and Triage of Basic Medical Needs in the Field. The Contractor shall support clients to establish a meaningful connection with an assigned primary care, brick and mortar medical home selected by the client. Those with high needs shall be prioritized with intensive visits and services to improve health and permanent housing opportunities. Contractor shall have capacity to assign medical back-up (i.e., Contractor's NPs, PAs, MDs) for the RN to consult when certain clinical scenarios arise.

c. Collaboration and Partnership

Alameda County Health Care for the Homeless shall support collaborations by sharing available information on scheduling and services among the Street Health Outreach Teams, and the Health Care for the Homeless mobile unit Additionally, Health Care for the Homeless shall foster communication and information-sharing with Alameda County Behavioral Health (ACBH) Crisis Response teams, and ACBH Full Service Partnerships focused on homeless. Other possible areas of collaboration include the following:

- Meetings to share information, discuss cases, and coordinate referrals. Representatives from Alameda County Behavioral Health (ACBH) will attend on a periodic basis.

- Outreach Providers Training and Education Series sponsored by Alameda County Health Care for the Homeless.

- Collaboration with the regional Housing Resource Centers (HRCs) and other organizations serving shared clients to connect and re-connect clients to housing services.

2. Discharge Criteria and Process

A patient discharge policy and procedure will be developed in collaboration with the county and submitted within one month of the start of this contract

3. Hours of Operation

Hours of operation shall be determined and mutually approved by the Contractor and HCSA.

Contractor shall maintain the following minimum hours of operation:

Field-based hours of operation (20 hours). Contractor shall create a monthly schedule, with the team visiting encampments during the same day and time range to foster engagement and ensure consistency. Times at encampments/locations will be determined based on encampment/location size and needs; frequency per location will generally begin with twice a week and will taper off over time as needs are met. The team shall arrive at sites per the schedule and work to address weather and other related factors to prevent cancellations.

Hours may fall outside of regular business hours to meet the needs of the population in the geographic area. Contractors may occasionally offer flexible hours based on the needs of the community.

Individual Patient Scheduling. Appointments shall be scheduled for both office and field-based support for patient follow-up as clinically indicated;

4. Service Delivery Sites

Service locations shall be determined and mutually approved by the Contractor and HCSA. Contractors shall collaborate with the County to adjust service locations within the geographic area in order to move with the service population.

In addition to providing direct outreach and clinical services at encampments and other locations in the Contractor's service area, the Contractor shall provide services at the following brick-and-mortar clinic:

Main Street Village (MSV) Clinic – 3607 Main Street, Fremont, CA 94539 or any TCHC Primary Medical Care Clinic location

5. **Minimum Staffing Qualifications**: Staffing should reflect (RN, social worker, CHOW) familiarity with street culture and the cultural competency required to successfully serve the priority population in regards to race/ethnicity, language, gender, sexual orientation and expression, and clients' experiences with and perceptions of the health care system.

   a. The staffing model is as follows:

i. *Program Manager* at a minimum of 0.10 Full Time Equivalent (FTE): Oversight of contract management and submission of all required deliverables and reporting, producing both client-level data and evaluation outcome reports, supporting the Team to track outcomes, and ensuring Team development of protocols and procedures, including linkage of homeless clients to a brick and mortar clinic.

ii. *Community Health Outreach Worker (CHOW)* at a minimum of 1.0 FTE.

1. Client outreach, engagement, and relationship development.
2. Identification of potential new sites, staying up to date with local resources, and development of new regional relationships.
3. Health education and harm reduction including naloxone trainings.
4. Medi-Cal and benefits advocacy
5. Lead coordinator with housing outreach providers and Housing Resource Centers.
6. Providing and tracking referrals, scheduling and reminding clients of appointments.
7. Reinforcing behavior and mobilizing social support, facilitating client empowerment to fully engage with all members of their health care team,
8. supporting maintenance of improvements in health status,
9. coordinating with service providers, e.g., substance use disorder (SUD) treatment services.

iii. *Registered Nurse (RN) Care Manager* at a minimum of 1.0 FTE. Responsible for providing basic medical care within the scope of an RN in the context of a variety of clinical scenarios, including medical assessments, wound care and skin assessments, vaccinations (e.g.., flu, Hepatitis A), assessment of respiratory illnesses, and caring for clients with active substance use disorders. Contractors may refer to the LA Dept. of Health Services' *RN Pilot Protocols for Street-Based Engagement, 2017* as a reference.) The RN Care Manager will work with providers and negotiate with pharmacies on behalf of clients; serve as the patient care plan lead (development of care plan for patient and coordination of responsibilities with CHW; measuring progress towards the goals outlined in care plan). It is not the intention of this service to treat urgent or emergent scenarios; staff shall call 911 in the event of a medical emergency.

iv. *Social Worker (ASW or MFTi)* at a minimum of 1.0 FTE. Responsible for short-term, intensive case management services:

1. Support clients with navigating mental health and substance use treatment systems, helping individuals obtain safe, affordable and permanent housing, developing a support network.
2. Linking clients to the appropriate level of care, accompanying clients to appointments, consulting with other care-givers, providing counseling and advice, teaching living skills, and advocating on behalf of clients
3. Short-term, intensive case management services are carried out within the context of on-going behavioral health assessments, care planning and monitoring, and crisis intervention.
4. The Social Worker shall hold a caseload of up to 20 individual clients at one time who are identified to need more in-depth case management services.

b. Contractor shall use the following guidelines to allocate the Street Health Outreach Team's staff time:

- 50 percent (3 days) in the field doing outreach, engagement, providing services, care plan development, care coordination, case conferencing for complex clients;
- 30 percent (1.5 days) of staff time in the field or office-based working with clients who require more intensive care coordination for medical, mental health and substance use disorder conditions, and
- 20 percent (.5 days) of Contractor's operational hours shall be spent on data tracking, Learning Community/designated meetings, and administrative activities.

IV. Contract Deliverables and Requirements

A. Detailed Contract Deliverables

Contractor shall provide the following services/deliverables:

1. Contractor shall submit an updated organizational chart reflecting all positions in the clinic within one month of commencement of contract.

2. Contractor shall submit job descriptions to the County for all street health outreach team positions, including the program manager, within one month of contract commencement. Contractor shall have and maintain current job descriptions on file with HCSA for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this agreement. Job descriptions shall specify the minimum qualifications for services to be performed and shall meet the approval of HCSA. Contractor shall submit revised job descriptions meeting the approval of the Department prior to implementing any changes or employing persons who do not meet the minimum qualifications on file with the HCSA.

3. Contractor shall submit a plan for training, supervising and supporting staff to prevent staff turnover that is typically associated with homeless services within one month of contract commencement.

4. Identify staff lead responsible for facilitating daily Street Health Outreach Team huddles to share information, discuss cases, and to coordinate workflows prior to delivering services.

5. Develop and implement policies and procedures to support Street Health Outreach Team activities:
   a. Policy and procedure for linking clients from an encampment/shelter/unsheltered street site to a brick-and-mortar medical home for services.
   b. Contractor shall have a client and staff safety policy and procedure in place prior to deploying Street Health Outreach Team.
   c. Contractor shall have a process for staff to report sentinel events as defined by the Joint Commission, including a death of a patient, which will lead to a subsequent investigation, summary, and next steps, all of which must be reported within 8 weeks of the event being reported. If the current, established plan is changed Tri-City will submit to HCSA with the following monthly report.
   d. Contractor shall establish and maintain a written policy which describes the Contractor's internal process for resolving patient and potential patient complaints and grievances.

6. Contractor will have established a clinician back-up schedule for the Street Health Outreach Team, with quarterly updates provided to ACHCH, or as requested.

7. Contractor will provide ACHCH with a current Street Health Outreach Team site and service locations schedule, with updates provided every subsequent month.

8. Contractor will develop and utilize a client and service tracking log. Street Health Outreach Team will maintain an Excel tracking sheet running log of 100-150 clients for each month, with the intent to develop in-depth relationships and provide critical resources that move clients in a positive direction, as documented through UDS, RBA metrics and other ACHCH required forms. See attachment A2 for list of data fields to include in the tool. A Microsoft Excel file is acceptable.

9. Utilization Report
    a. ACHCH Data and Patient Reporting Requirements & Microsoft Excel file of encounter data (see Attachment A3)

V. Reporting and Evaluation Requirements

Monthly reports shall be due by the 15th day of the month following the end of the month. Quarterly reports shall be due by the 15th day of the month following the end of the quarter. Annual UDS Report shall be due January 15th 2020.

Contractor is required to enter Result Based Accountability (RBA) Measures in the County's Clear Impact Software by the 15th of the month.

A. Evaluation Requirements

The County utilizes the Results Based Accountability (RBA) framework and Clear Impact performance software to track program performance. The Contractor is required to implement County RBA metrics listed below. Any changes that the Contractor wishes to make to the RBA document should be discussed with the County.

Process Objectives	"How Much" Performance Measure	Data Collection Tool
By June 30th, 2020, contractor will provide health care services to at least 60 unique clients per month, based on a rolling outreach log containing a minimum of 120 clients.	# unique clients receiving health care services	EHR
By June 30th, 2020, 150 clients will be enrolled in or reconnected to a medical home.	# of clients who have been enrolled in or reconnected to a medical home	EHR
By June 30th, 2020, 175 clients will receive an outreach assessment to determine basic needs.	# of clients who receive an outreach assessment to determine basic needs	County Outreach Assessment Tool
A) By June 30th, 2020, contractor will provide 600 outreach encounters	# outreach encounters completed	Outreach Tracking Log

Quality Objective	"How Well" Performance Measure	Data Collection Tool
By June 30th, 2020, Street Health Outreach Team will have attended 80% of learning community meetings/ events / activities	% of learning community meetings/events/activities that Street Health Outreach Team has attended	Scanned ACHCH Sign-in sheets kept by ACHCH Administration
By June 30th, 2020, 90% of clients will receive assistance with enrollment or renewal in MediCal, Medicare or HealthPAC	% of clients who received assistance with enrollment or renewal in MediCal, Medicare or HealthPAC	EHR
By June 30th, 2020, 80% of clients will be linked to a housing resource center.	% of clients linked to a housing resource center	EHR or Excel Tracking Sheet

Impact Objective	"Is Anyone Better Off" Performance Measure	Data Collection Tool
By June 30th, 2020, 50% of clients who have a care plan have completed it.	% clients who have a completed care plan	EHR
By June 30th, 2020, 90% of clients with a medical home will have at least three documented visits, with one being a PCP, within six months	% of clients in a medical home who have >= 3 documented visits, w/1 PCP visit within 6 mos. **(based on home clinic data only)**	EHR or patient self-report (if medical home is other than contractor)
By June 30, 2020, 175 clients will have received social services support for identification documentation, food security, benefits enrollment, etc.	# of clients who completed a Fee Waiver form for new or replacement California ID/License # clients who have received /replaced a Social Security card # of clients who are enrolled in CalFresh # of clients who have completed paperwork for public benefits (SSI, GA, etc)	EXCEL Worksheet

B. Reporting Requirements

1. Process Performance Measures

A. # unique clients receiving health care services
B. # of clients who have been enrolled or reconnected to a medical home
C. # of clients who receive a outreach assessment to determine basic needs

2. Quality Performance Measures

A. % of learning community meetings/events/activities that Street Health Outreach team has attended

B. % of clients who received assistance with enrollment or renewal in MediCal, Medicare or HealthPAC
C. % of clients linked to a housing resource center

3. Impact Performance Measures

A. % of clients who have a completed care plan
B. % of clients in a medical home who have >= 3 documented visits, w/1 PCP visit within 6 mos.
C. # of clients who completed a Fee Waiver form for new or replacement California ID/License
D. # clients who have received /replaced a Social Security card
E. # of clients who are enrolled in CalFresh
F. # of clients who have completed paperwork for public benefits (SSI, GA, etc)

4. Other Reporting Requirements

a. Contactor shall submit **monthly** progress reports, referencing the activities and performance measures listed in Sections IV and V of this Exhibit. Progress reports shall include performance measures achieved during the reporting period as well as cumulative, year-to-date totals. All reports shall be completed and information relayed in a manner so that they can be viewed as public documents. Contractor shall not provide any Personally Identifiable Health Information or other confidential or protected data to County.

C. Other Evaluation Requirements

1. Contractor has the option to submit one RBA metric to add to the required metrics. The Contractor shall identify one process, one quality and one impact metric. These measures shall be submitted to the ACHCH Quality Director within one month of contract activation.

2. Contractor shall submit aggregated patient level data to the County to verify RBA metrics submission, upon request.

VI. Additional Requirements

A. Quality Improvement

Contractor is required to participate in the following activities:

1. Report incidents and sentinel events to the ACHCH internal quality committee
2. Attend quarterly Contractor quality meetings
3. Identify and report issues related to program/clinic effectiveness that impact ability to implement program model to internal ACHCH quality committee.
4. Participate in two data "deep dive" site visits per contract year.
5. Patient Satisfaction/Experience Surveys
   Contractor shall administer the ACHCH patient experience survey with clients served by the Contractor under this contract. Contractor shall use a designated data collection and analysis tool to provide periodic feedback on patient satisfaction and experience to Health Care for the Homeless leadership and its own
   program/ management team. Health Care for the Homeless reserves the right to conduct periodic quality audits of hard copy patient surveys.

5. Alameda County HCH will provide technical assistance support to Street Health Teams twice monthly in the field.

B. Certification/Licensure

Contractor shall have and maintain current:

Contractor shall maintain all required licenses and special permits issued by federal, state, and local agencies to the services it provides, including but not limited to the California Health and Safety Code, Division 2, and Title 22 and Title 17 Code of Regulations, or successors thereto.

Contractor shall obtain and maintain credentialing under the Alameda Alliance for Health and Anthem Blue Cross.

Contractor shall maintain certification to participate in the Medicare and Medi-Cal programs under Title 18 and 19 of the federal Social Security Act, and/or all other such future programs necessary to fulfill its obligation under this Agreement.

Contractor shall notify the contract manager immediately by telephone, and in writing within five days, when there is a change in the license and/or certification of any program, service, department, or facility providing services under this Agreement.

Contractor shall ensure that all personnel are licensed, certified, and credentialed in accordance with all legal requirements, and are qualified by training and experience to perform the services they are assigned to perform.

As a contractor providing services within the ACHCH health center scope of project, Tri-City Street Health Outreach Team is responsible for maintaining its operations, including development and implementation of its own operating procedures, in compliance with HRSA Health Center Program requirements listed under Health Center Program Statute- Section 330 of the Public Health Service (PHS) Act (42 U.S.C §254b), as defined in the most recent version of HRSQ's Health Center Program Compliance Manual. Additionally, Tri-City must comply with any homeless population-specific ACHCH health center policies, such as Sliding Scale Fee Discount policy. All clinical and enabling services reported to ACHCH must be included in the most current ACHCH HRSA health center scope of project.

C. Other Requirements

1. It is the responsibility of the contractor to ensure that all services are provided in accordance with pertinent laws, regulations, codes and permits; professionally recognized standards; prevailing standards of medical practice in the community; and all provisions of this contract, including record-keeping and reporting requirements, whether provided by Contractor at a Contractor site, or through referral to an outside provider.

2. Contractor shall deliver health services that demonstrate a high quality of care as defined by prevailing professional standards, by HCSA, and by consumers of these services. These services shall be provided by Contractor in a manner consistent with principles of professional practice and ethical conduct and reflect concern for the acceptability, accessibility, and cost of services.

3. Contractor shall promptly handle complaints, appeals, and grievances. An individual may file a complaint, appeal or grievance with the County or the Contractor. If an individual files a complaint, appeal, or grievance with Contractor, the county delegates to Contractor the responsibility of handling in a professional manner and in accordance with all County policies that complaint, appeal or grievance.

At no time shall an individual's medical condition be permitted to deteriorate because of delay in provision of care that Contractor disputes. Fiscal and administrative concerns shall not influence the independence of the medical decision-making process to resolve any medical disputes between an individual and Contractor. Contractor shall establish and maintain a written policy which describes the Contractor's internal process for resolving patient and potential patient complaints and grievances. The policy shall be made available for review upon County's request. The Contractor shall designate a contact person for the County to contact regarding complaints, appeals and grievances that are filed with the County.

4. The Alameda County Health Care for the Homeless is funded by taxpayers' dollars. As such, it is important that the public be informed about the organizations that are receiving funds through Alameda County Health Care Services Agency (HCSA). Therefore, Contractor shall acknowledge the use of Health Care for the Homeless funding in statements or printed materials as outlined in the guidelines listed below:

a. Contractor shall announce funding award only after the contract has been fully executed and announcement of activities have been discussed with the Health Care for the Homeless Administrator.

b. Contractor shall agree to use official attribution logos and language provided by HCSA for promotional materials, public awareness campaigns and/or special events.

c. Contractor shall acknowledge Health Care for the Homeless funding in all materials produced for the purpose of public education and outreach regarding the recipient's funded project. These materials would include, but are not limited to, brochures, flyers, media ads or public service announcements, presentations and handouts, telephone hold messages and outdoor ads. All printed materials and promotional products will include the following language:

i. Funded by Alameda County Health Care for the Homeless

d. Materials produced with Health Care for the Homeless funding may be reproduced only if no changes are made to the content or design of the material, it contains the appropriate acknowledgement of funding from Health Care for the Homeless, and the recipient will not be additionally reimbursed for use or reproduction.

e. Alameda County reserves the right to request additional information. The approval of County to a requested change shall not release Contractor from its obligations under this Agreement.

D. Entirety of Agreement

Contractor shall abide by all provisions of the Human Services Master Contract General Terms and Conditions, all Exhibits, and all Attachments that are associated with and included in this contract.

Contractor agrees to the supplemental terms and conditions contained in the following attachments to this Exhibit A:

- Attachment A1 - Sample Consumer/Client Flow
- Attachment A2 - Client and Service Tracking Log Data Fields
- Attachment A3 – ACHCH Patient Visit Utilization Data Reporting

EXHIBIT B
PAYMENT TERMS

I. Budget Summary

Budget Item	Program Total	ACHCH Funding
Personnel Expenses		
Salaries:		
Project Manager (11% FTE)	$13,400	$13,400
Nurse Practitioner (100% FTE)	111,000	90,000
Licensed Social Worker (100% FTE)	72,000	60,000
Community Health Outreach Worker (100% FTE)	52,000	52,000
Care Coordinator (50%)	26,000	-
Care Coordinator (100%)	47,000	-
Benefits	115,705	77,545
Personnel Expenses Subtotal	**437,105**	**292,945**
Operating Expenses		
Travel:		
Staff Travel Reimbursement	7,000	7,000
Client Travel Vouchers	5,000	5,000
Equipment:		
2 HP EliteBook 840 G5 Laptop	3,000	3,000
2 Cellphones	200	200
Hot Spot Equipment	240	240
Supplies:		
Medical and Pharmacy Supplies	10,000	10,000
Office Supplies	2,000	-
Other:		
Hotel Vouchers	6,750	6,750
Client Gap Funds	5,000	5,000
Cellphone Service	1,680	1,680
Operating Expenses Subtotal	**40,870**	**38,870**
Indirect Expenses (Not to exceed 10.00% of total allocation)	**18,185**	**18,185**
Total	**$496,160**	**$350,000**

Alameda County is not obligated to pay actual expenses exceeding the amounts set forth in the Budget Summary under the column "ACHCH Funding", unless prior written approval for those expenses has been obtained and appropriate budget adjustments are made so that the total budget amount is not exceeded.

II. Terms and Conditions of Payment

A. Reimbursement

1. Contractor shall invoice the County during the contract period for actual expenses incurred according to the following schedule:

Invoice	Service Period, FY 2019-20	Submission Deadline

First	July 1 to July 31, 2019	August 15, 2019
Second	August 1 to August 31, 2019	September 15, 2019
Third	September 1 to September 30, 2019	October 15, 2019
Fourth	October 1 to October 31, 2019	November 15, 2019
Fifth	November 1 to November 30, 2019	December 15, 2019
Sixth	December 1 to December 31, 2018	January 15, 2020
Seventh	January 1 to January 31, 2020	February 15, 2020
Eighth	February 1 to February 28, 2020	March 15, 2020
Ninth	March 1 to March 31, 2020	April 15, 2020
Tenth	April 1 to April 30, 2020	May 15, 2020
Eleventh	May 1 to May 31, 2020	June 15, 2020
Twelfth	June 1 to June 30, 2020	July 15, 2020

2. Contractor shall invoice the County on a **monthly** basis during the contract period for actual expenses incurred. Total payment under the terms of this Agreement shall not exceed **$350,000** and monthly payments may not exceed **$29,167** without prior written approval from Alameda County Health Care Services Agency (HCSA). The last invoice shall be based on actual expenses incurred, but shall not exceed the remaining balance of the contract and must be received no later than **July 15, 2020**.

3. Contractor shall submit invoices, with all required progress reports in accordance with the reporting requirements, to Alameda County Health Care Services Agency (HCSA).

4. Funds shall be used solely in support of the project's program budget and may not be used for any purpose other than those specified in this Agreement without prior written approval from the Alameda County Health Care Services Agency. Reimbursement is limited to actual expenses and in accordance to the items and costs as set forth in the Budget Summary.

5. County shall use its best efforts to process invoice submitted for reimbursement by contractor within ten (10) working days of receipt of invoice, required report and any other requested documentation. Invoices will be reviewed by and not paid until approved by the Alameda County Health Care Services Agency.

B. Invoicing Procedures

Contractor shall invoice the County in accordance with the schedule of payment in Section II.A.1 above. Invoices must include the Purchase Order (PO) number, service period and all required reports (see Exhibit A, Section VI Reporting Requirements), and shall be sent to:

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
ATTN: TERRI MOORE, ACHCH CONTRACTS MANAGER
1404 FRANKLIN STREET STE 200
OAKLAND CA 94612

Attachment A1

SAMPLE CONSUMER/CLIENT FLOW

1. **OUTREACH, ENGAGEMENT, INTAKE.**

   a. Intake procedures involve engaging with an unfamiliar client at a homeless encampment or location; the client has expressed interest in receiving on-going case manager support with improving health outcomes. Intake procedures for treatment include signed written or verbal consent for treatment, and collection of client's personal information for entry in the EHR.

   b. Engagement will likely take place over several visits.

   c. Every patient, regardless of level of engagement, will be offered a business card with Contractor's cell phone, Contractor shall inform each patient of the Street Health Outreach schedule, and when they can expect the Contractor to return to the encampment.

   d. Services are voluntary. Prior to the provision of medical or behavioral health services, Contractor shall ensure all appropriate consent, privacy, and release of information forms are completed by the patient.

2. **ASSESSMENT**

   Clinical assessment is completed over the first 1-3 meeting(s) with a client and will include a medical assessment and a brief psychosocial assessment.

3. **INTERVENTION(S) AND FOLLOW-UP.**

   Every patient will be notified that they can follow-up with their health care provider at the Contractor's clinic or other medical home. They will receive information on the relevant address, phone numbers and the hours of operation including the best days for walk-ins.

4. **TRANSPORTATION**

   Contractor shall provide transportation assistance for services (car, bus, BART, Uber and/or Lyft transportation) to primary medical clinics and laboratories (e.g., Quest) to address urgent health needs.

5. **HEALTH INSURANCE AND BENEFITS**

   All clients will be offered health services, regardless of their health insurance status. Pursuant to the Contractors' and the Health Care for the Homeless Sliding Fee Scales, the Contractor shall not require payment from homeless individuals for services

delivered under this contract. Contractor shall provide assistance to clients to enroll in insurance (e.g., Medi-Cal enrollment, HealthPAC enrollments and renewals) and benefits for which they may be eligible (e.g., CalFRESH).

6. DOCUMENTATION AND MEDICAL RECORDS

a. One outreach encounter form shall be completed per encounter.

b. Paper Charts are used in the field. Paper charts used in the field shall be stored in a locked backpack. Paper charts and notes shall be secured or destroyed upon return to the office according to Contractor's policies and procedures.

c. Electronic Health Record. All encounters will be documented by the provider in the EHR upon return to the Contractor's office.

7. RE-ASSESSMENT OF PROGRESS.

Re-assessment of progress will be made at subsequent encounters.

8. **CARE PLAN CHANGE.**

Care plan changes will be made as the client's need change.

Attachment A2

Client and Service Tracking Log Data Fields
(Microsoft/Excel file is acceptable)

a. Client information
   i. First and Last Name, preferred name/nickname.
   ii. Demographic information including self-reported age, gender, race/ethnicity, language, sexual orientation, homeless status.
   iii. Medi-Cal ID, Social Security and other identifying information to facilitate benefits enrollment.
   iv. Best method to contact client, e.g., phone, location.
   v. Health Insurance status, e.g., Medi-Cal, uninsured (HealthPAC), Medicare, VA.
   vi. Other benefits status, e.g. SSI, CalFresh, military.
   vii. Preferred pharmacy and medication pick-up.
   viii. Health, income, housing, and transportation needs
   ix. Plan for coordination with outside agencies, incl. case management.
   x. Care plan based on client-derived, collaborative goals, e.g. safety, basic needs, accessing medical, dental, substance use treatment.
   xi. Street Health Outreach Team service contacts
   xii. Date of service contact(s)

b. Street Health Outreach Team service contacts
   i. Date of service contact(s)
   ii. # total service contacts

c. Type of Street Health Outreach Team services provided:
   i. Engagement activities, e.g., transportation assistance, hygiene kits accepted.
   ii. Medical and behavioral screenings and assessments completed.
   iii. Care plan completed.
   iv. Additional on-site services, e.g., assessments, vaccinations, skin and wound care, problem-solving, motivational interviewing, harm reduction (e.g., naloxone), case management.

v. Referrals initiated and completed including type (e.g. primary, specialty, emergency services), date referral was initiated, kept vs. not kept, reason for not kept (e.g., client refused, lost to follow up).

2. Client and service tracking log including the items below (Microsoft Excel file is acceptable).

b. Client information

xiii. First and Last Name, preferred name/nickname.

xiv. Demographic information including self-reported age, gender, race/ethnicity, language, sexual orientation, homeless status.

xv. Medi-Cal ID, Social Security and other identifying information to facilitate benefits enrollment.

xvi. Best method to contact client, e.g., phone, location.

xvii. Health Insurance status, e.g., Medi-Cal, uninsured (HealthPAC), Medicare, VA.

xviii. Other benefits status, e.g. SSI, CalFresh, military.

xix. Preferred pharmacy and medication pick-up.

xx. Health, income, housing, and transportation needs

xxi. Plan for coordination with outside agencies, incl. case management.

xxii. Care plan based on client-derived, collaborative goals, e.g. safety, basic needs, accessing medical, dental, substance use treatment.

xxiii. Street Health Outreach Team service contacts

xxiv. Date of service contact(s)

b. Street Health Outreach Team service contacts

iii. Date of service contact(s)

iv. # total service contacts

c. Type of Street Health Outreach Team services provided:

vi. Engagement activities, e.g., transportation assistance, hygiene kits accepted.

vii. Medical and behavioral screenings and assessments completed.

viii. Care plan completed.

ix. Additional on-site services, e.g., assessments, vaccinations, skin and wound care, problem-solving, motivational interviewing, harm reduction (e.g., naloxone), case management.

x. Referrals initiated and completed including type (e.g. primary, specialty, emergency services), date referral was initiated, kept vs. not kept, reason for not kept (e.g., client refused, lost to follow up).

c. Client information

xxv. First and Last Name, preferred name/nickname.

xxvi. Demographic information including self-reported age, gender, race/ethnicity, language, sexual orientation, homeless status.

xxvii. Medi-Cal ID, Social Security and other identifying information to facilitate benefits enrollment.

xxviii. Best method to contact client, e.g., phone, location.

xxix. Health Insurance status, e.g., Medi-Cal, uninsured (HealthPAC), Medicare, VA.

xxx. Other benefits status, e.g. SSI, CalFresh, military.

xxxi. Preferred pharmacy and medication pick-up.

xxxii. Health, income, housing, and transportation needs

xxxiii. Plan for coordination with outside agencies, incl. case management.

xxxiv. Care plan based on client-derived, collaborative goals, e.g. safety, basic needs, accessing medical, dental, substance use treatment.

xxxv. Street Health Outreach Team service contacts

xxxvi. Date of service contact(s)

b. Street Health Outreach Team service contacts

v. Date of service contact(s)
vi. # total service contacts

c. Type of Street Health Outreach Team services provided:

xi. Engagement activities, e.g., transportation assistance, hygiene kits accepted.
xii. Medical and behavioral screenings and assessments completed.
xiii. Care plan completed.
xiv. Additional on-site services, e.g., assessments, vaccinations, skin and wound care, problem-solving, motivational interviewing, harm reduction (e.g., naloxone), case management.
xv. Referrals initiated and completed including type (e.g. primary, specialty, emergency services), date referral was initiated, kept vs. not kept, reason for not kept (e.g., client refused, lost to follow up).

Attachment A3

ACHCH DATA AND PATIENT VISIT REPORTING REQUIRMENTS AND DEFINITIONS

ACHCH Patient Visit Utilization Data Reporting

Reportable Visits:

Reportable visits are documented, individual, face-to-face contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing services. Health centers should count only visits that meet all these criteria.

To count as reportable visits, the services must be documented in a chart that is kept by the contracted provider. Included in patient visit documentation maintained by contracted provider should be consent documentation and verification of release of information signed by patient.

Submission of Reportable Visits

ACHCH contractors are required to submit a monthly report of all reportable health center visits provided by contractor. This report should be submitted before the 15th of the following month. Submission must be made in excel format through a secure FTP system arranged by the ACHCH program.

Required patient data for each reported visit

Required patient data for each reported visit is sent to and stays in the possession of ACHCH. Date required for each reported visit includes the following:

Visit Provider Type	Visit Subsite	Patient Social Security Number
Patient First Name	Patient Last Name	Patient Birth Date
Patient Gender Identity	Patient Ethnicity	Patient Race
Patient Sex assigned at birth	Patient Sexual Orientation	
Patient Diagnosis for clinical encounters	Visit Enabling Service Codes for enabling service encounters	Visit CPT Codes for clinical encounters
Patient Monthly Income	Patient Income Source	Patient Medical Payer Source
Patient Homeless Status	Patient Translation Needed	Patient Veteran Status

This required patient data is detailed later in this document.

Provider Types

Health center staff must be a provider for purposes of providing countable visits. Please note: Not all health center staff who interact with patients qualify as providers. The 2018 UDS Manual provides a list of health center personnel and the usual status of each as a provider or non-provider for UDS reporting purposes.

Independent Professional Judgment

To meet the criterion for independent professional judgment, providers must be acting on their own, not assisting another provider, when serving the patient. Independent judgment implies the use of the professional skills gained through formal training and experience and unique to that provider or other similarly or more intensively trained providers.

For example, a nurse assisting a physician during a physical examination by taking vital signs, recording a history, or drawing a blood sample does not receive credit as a separate visit.

Counting Multiple Visits by Category of Service

Multiple visits occur when a patient has more than one visit with the HCH health center in a day. Most commonly, a patient may receive both a medical visit and an enabling visit at the same time. These distinct services must be provided by two distinct providers working in the capacity of their credentialed position (for example an MD does not report enabling services encounters). Multiple visits must be reported as distinct visits (ie separate rows when electronically reported).
On any given day, a patient may have only one visit per service category, as described below.

Maximum Number of Visits per Patient per Day

# of Visits	Visit Type	Provider Examples
1	Medical	physician, nurse practitioner, physician assistant, certified nurse midwife, nurse
1	Dental	dentist, dental hygienist, dental therapist
1	Mental health	psychiatrist, licensed clinical psychologist, licensed clinical social worker, psychiatric nurse practitioner, other licensed or unlicensed mental health providers
1	Substance use disorder	alcohol and substance use disorder specialist, psychologist, social worker
1 for each provider type	Other professional	nutritionist, podiatrist, speech therapist, acupuncturist
1	Vision	ophthalmologist, optometrist
1 for each provider type	Enabling	case manager, health educator

- Patient Consent and HIPAA acknowledgement
- Specific definitions for each Data Reporting element
- PHI reporting procedures
- Incomplete data – returned data reports
- Different Attachment for RBA/Quality Reporting Requirements by each contractor

Visit Provider Type	Enter the **type of provider** providing a documented, face-to-face encounter. Encounter type is either **Service/Enabling** or **Clinical**; provider type must correspond to encounter type. (i.e. Nurse – Medical or Case Manager – Service/Enabling).
Visit Subsite	Name of site where services provided.
Patient Social Security Number	xxx-xx-xxx
Patient First Name	
Patient Last Name	
Patient Birth Date	dd/mm/yyyy
Patient Gender Identity	M/F
Patient Ethnicity	**UDS Ethnicity Categories:** Latino or Hispanic

	Not Hispanic Unknown/Refused
Patient Race	**UDS Race Categories**: White Asian Native Hawaiian Other Pacific Islander Black/African-American American Indian/Alaska Native More than one race Unreported/refused to report
Patient Sex assigned at birth	
Patient Sexual Orientation	
Patient Diagnosis for clinical encounters	ICD10 Code for **Clinical Encounters** (including Mental Health & Clinical substance use). ADA Codes for Dental Visits
Visit Enabling Service Codes for enabling service encounters	**ACHCH Enabling Services Types for Services Encounters only**. A medical encounter will NOT include any services code types. A service encounter will not include any ICD10 codes. *Medical and Service encounters provided by two different providers in the same day are submitted as two separate visits*. Medical Referral Health/Financial Benefits Counseling Housing Assistance Employment Assistance Food Assistance Nutrition Education Other Health Education Alcohol/Drug Counseling/Referral Mental Health Counseling/Referral Transportation Assistance Dental Referral Optometry Referral Other Dental Case Management
Visit CPT Codes for clinical encounters	
Patient Monthly Income	$ Amount
Patient Income Source	GA WIC Wages, Pension or Employment

	VA Food Stamps Unemployment None Other SSI/SSA Unknown Cal Works/TANF Child Support
Patient Medical Payer Source	Medi-Cal FFS Medicare Private Insurance Sliding Scale VA Medical Other None Unknown HealthPAC Medi-Care Managed Care Alameda Alliance Medi-Care Managed Care Blue Cross Medi-Medi
Patient Homeless Status	**Patients must be screened for homelessness and most recent housing status inputted for every visit.** Not currently homeless Shelter Recovery Center Doubling up Street Transitional Homeless-Unknown Situation Other Hotel/Motel Permanent supportive housing
Patient Translation Needed	English Spanish Other
Patient Veteran Status	Y or N