Amendment No. 2
to
Contract No. NI130000022
for
Social Services
between
AUSTIN TRAVIS COUNTY MENTAL HEALTH & MENTAL RETARDATION CENTER
DBA
AUSTIN TRAVIS COUNTY INTEGRAL CARE
and the
CITY OF AUSTIN

(*PSH 1115 Waiver*)

1.0 The City of Austin and the Contractor hereby agree to the contract revisions listed below.

2.0 The total amount for this Amendment to the Agreement is *Six Hundred Thousand dollars* **($600,000)**. The total Agreement amount is recapped below:

Term	Agreement Change Amount	Total Agreement Amount
Basic Term: (Sept. 30, 2013 - Sept. 29, 2014)	n/a	$ 250,000
Amendment No. 1: Add Funding to Contract	$ 300,000	$ 550,000
Amendment No. 2: Extension Option #1 (Sept. 30, 2014 - Sept. 29, 2015)	$ 600,000	$ 1,150,000

3.0 The following changes have been made to the original contract EXHIBITS:

Exhibit A.1 -- Program Work Statement is deleted in its entirety and replaced with a new **Exhibit A.1 -- Program Work Statement.**

Exhibit A.2 -- Program Performance Measures is deleted in its entirety.

Exhibit B.1 -- Program Budget and Narrative is deleted in its entirety and replaced with a new **Exhibit B.1 -- Program Budget and Narrative.**

Exhibit D – HMIS Reporting Requirements is added to the Contract.

4.0 **Sections 4.1.1** and **4.1.2** are added to the Contract:

4.1.1 The Contractor shall expend City funds according to the approved budget categories described in Exhibit B.1, Program Budget and Narrative.

4.1.1.1 Budget Revision: The Contractor may make transfers between or among budget categories with the City Contract Manager's prior approval, provided that:

i. The cumulative amount of the transfers between direct budget categories (Personnel, Operating Expenses, Direct Assistance and/or Equipment/Capital Outlay) is not more than 10% of the program period total –or– $50,000, whichever is less;
ii. the transfer will not increase or decrease the total monetary obligation of the CITY under this Contract; and
iii. the transfers will not change the nature, performance level, or scope of the program funded under this Contract.

4.1.1.2 Transfers between or among budget categories in excess of 10% will require the City Contract Manager's approval, and must meet all of the conditions outlined in Section 4.1.1.1 (ii) and (iii) above.

i. The CONTRACTOR must submit a Budget Revision Form to the CITY prior to the submission of the CONTRACTOR'S first monthly billing to the CITY following the transfer.

4.1.2 Payment to the Contractor shall be made in the following increments:

4.1.2.1 For the program period of September 30, 2014 through September 29, 2015, the payment from the City to the Contractor shall not exceed **$600,000** (*Six Hundred Thousand dollars*).

5.0 **Section 4.7.8** is added to the contract:

Contractor shall expend City budget in a reasonable manner in relation to contract time elapsed and/or contract program service delivery schedule. If cumulative expenditures are not within acceptable amounts, the City may require the Contractor to: 1) submit an expenditure plan, and/or 2) amend the contract budget amount to reflect projected expenditures, as determined by the City.

6.0 **Section 4.8.1** is modified:

4.8.1 Reimbursement Only. Expenses and/or expenditures shall be considered reimbursable only if incurred during the current program period identified in Section 4.1.2, directly and specifically in the performance of this Contract, and in conformance with the Program Work Statement. Contractor agrees that, unless otherwise specifically provided for in this Contract, payment by the City under the terms of this Contract is made on a reimbursement basis only; Contractor must have incurred and paid costs prior to those costs being invoiced and considered allowable under this Contract and subject to payment by the City.

7.0 **Section 4.8.3(11)** is modified:

11. Purchases of tangible, nonexpendable property, including fax machines, stereo systems, cameras, video recorder/players, microcomputers, software, printers, microscopes, oscilloscopes, centrifuges, balances and incubator, or any other item having a useful life of more than one year and an acquisition cost, including freight, of over five thousand dollars ($5,000).

8.0 **Section 4.12.6** is modified:

4.12.6 City will contact the Board Chair to verify that the auditor presented the financial audit report/financial review to the Contractor's Board of Directors or a committee of the Board.

i. Contractor's Board Chair must submit a signed and dated copy of the HHSD Board Certification form to the City as verification.

ii. In lieu of the Board Certification form, Contractor must submit a signed copy of the approved Board meeting minutes to the City, indicating the following:
   a) The Board of Directors, or a committee of the Board, has met with the independent auditor;
   b) The Board of Directors has authorized and accepted the financial audit report/financial review.

City will deem the financial audit report/financial review incomplete if Contactor fails to submit either the Board Certification form or the Board minutes as required by this section 4.12. Approved and signed Board minutes reflecting acceptance of the financial audit report/financial review will be due to the City within forty-five (45) days after the audit is due to the City. Board minutes regarding approval of the Contractor's financial audit report/financial review will be verified with the Contractor's Board Chair.

9.0 **Section 4.13.2** is modified:

Written notification must be given to the City within five (5) calendar days of delivery of nonexpendable property (defined as anything that has a life or utility of more than one (1) year and an acquisition cost, including freight, of over five thousand dollars ($5,000)) in order for the City to effect identification and recording for inventory purposes. Contractor shall maintain adequate accountability and control over such property, maintain adequate property records, and perform an annual physical inventory of all such property and report this information in the Annual Summary (close out) report due sixty (60) days after the end of the Contract Term.

10.0 **Section 8.1** is modified:

Criminal Background Checks. Contractor and Subcontractor agree to perform a criminal background check on every employee or volunteer whose duties place him or her in contact with children under eighteen (18) years of age, seniors 55 years of age and older, or persons with Intellectual and Developmental Disabilities (IDD). Contractor shall not assign or allow any employee or volunteer to be in direct contact with children, seniors 55 and older, or persons with IDD if the employee or volunteer would be barred from contact under the rules established by Title 40 of the Texas Administrative Code.

9.0 **Section 8.2.1** is added to the Contract:

The Contractor or Subcontractor(s) seeking an exemption for a food enterprise permit fee must present this signed and executed social services contract upon request to the City. (*Source: City of Austin Ordinance 20051201-013*)

10.0 MBE/WBE goals were not established for this Contract.

11.0 Based on the criteria in the City of Austin Living Wage Resolution #020509-91, the Living Wage requirement does not apply to this Contract.

12.0 By signing this Amendment, the Contractor certifies that the Contractor and its principals are not currently suspended or debarred from doing business with the

Federal Government, as indicated by the Exclusion records found at SAM.gov, the State of Texas, or the City of Austin.

13.0 All other Contract terms and conditions remain the same.

BY THE SIGNATURES affixed below, this Amendment is hereby incorporated into and made a part of the above-referenced contract.

CONTRACTOR

Signature:

AUSTIN TRAVIS COUNTY MENTAL HEALTH & MENTAL RETARDATION CENTER *DBA* AUSTIN TRAVIS COUNTY INTEGRAL CARE
David Evans Executive Director
1430 Collier Street
Austin, TX 78704

Date: 12.3.14

CITY OF AUSTIN

Signature:

City of Austin
Purchasing Office
PO Box 1088
Austin, TX 78767

Date: 12/17/14

Program Work Statement

Contract Start Date 9/30/2013 *Contract End Date* 9/29/2015

Program Goals and Objectives

Austin Travis County Integral Care (ATCIC) proposes the creation of an Assertive Community Treatment Team (ACT) that specializes in the provision of intensive community based services for people who have a history of chronic homelessness and who have tri morbid conditions such as mental illness, a substance use disorder and a chronic medical condition – or comorbid conditions, as appropriate per program and delineated in the Performance Measures. The goal of this program is to provide intensive housing/community based treatment services for individuals with complex needs to obtain and maintain housing stability. The program's objectives are to promote wellness by assisting consumers to maintain housing, avoid hospital inpatient readmissions, and avoid involvement in the criminal justice system, as well as medication adherence, and recovery from substance abuse.

ATCIC will continue its involvement in the assessment, planning and implementation of Permanent Supportive Housing (PSH) in the City and will work collaboratively with ECHO and other community partners in developing a community prioritization strategy. Using existing data, we will identify the most vulnerable consumers and high users of services. ATCIC will explore and continue establishing relationships with housing providers and private landlords to identify the housing stock needed to serve the target population.

ATCIC will develop and test data systems by requesting data reports from our community partners (e.g. ICC's health information exchange) as well as our own EHR system in order to track performance outcomes and identify any reporting gaps. Once identified, the gaps will be addressed by creating or updating data collection tools and coding within existing databases; or by tracking in alternate sources such as Microsoft Access or Microsoft Excel.

Evidence demonstrates that when vulnerable individuals, such as the chronically homeless, are connected to medical services and behavioral health services and are no longer focused on just providing their immediate basic needs, they can begin to focus on preventive and routine care. With the support of housing stability, medication management and behavioral health services delivered by this program, consumers will become stable and thus rely less on emergency room use.

Due to the complexity of the target population, it is anticipated that it will take approximately 8-12 months to fully engage 15 participants and assist them in securing housing. Along with housing stability services, the team will provide comprehensive medical and behavioral health interventions. Once the trusting relationship is established, services will address the skills development in how to utilize appropriate medical services such as medical services provided by the team instead of visiting the ER for non- emergency situations.

This project will reduce emergency service utilization in year 2 and year 3 by providing intensive supports and developing stronger connections to the ACT. The program will improve the consumers experience, assist them with better managing their chronic medical conditions, provide behavioral health and physical health education and promote recovery, thus reducing the need for ED visits.

ATCIC is a performing provider for eight DSRIP projects. As part of this initiative, ATCIC will participate in region-wide, anchor-led meetings with the opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. ATCIC will participate with Central Health, to foster the development of topical learning collaborative that will bring together all levels of stakeholders who are involved in DSRIP projects.

Program Clients Served

The target population for this program is adult individuals who have experienced chronic homelessness and have tri-morbid or co-morbid diagnoses, including a physical disability, persistent mental illness and/or a co-occurring substance use disorder. All consumers served by this program will be at or below 30% area median income with severe barriers to housing stability. Individuals will be high users of emergency services such as ED and EMS, state hospital beds, criminal justice systems and emergency shelters. This target population is the population ATCIC regularly serves. ATCIC has a contract with the Texas Department of State Health

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Services (DSHS) to provide specialty behavioral health services such as ACT, behavioral rehabilitation services, homeless outreach and supportive housing services among multiple other services. ATCIC will also utilize ECHO's coordinated assessment process and prioritization system to identify the consumers to be served by this program.

All Clients/Consumers that participate in the City ACT program must:

- Meet the HUD definition of Chronic Homelessness
  - Homeless status must be documented by a signed (1) Homeless Eligibility Form or Homeless Self-Declaration Form (These forms must be developed by the agency and be approved by the City contract manager)
  - Client/Consumer information must be entered into Homeless Management Information System (HMIS)
- Have tri-morbid or co-morbid conditions (depending on the program) including diagnoses of mental illness, substance use disorder(s), and chronic health condition(s)
- All formal eligibility documents are to be completed within 2 months of program entry including :
  - A government –issued identification; OR
  - A signed Self-Declaration of Identity

Regarding income eligibility, income information is an outcome measure tracked by ATCIC's housing service programs. Income will be tracked by staff and information provided to the Housing Authority City of Austin (HACA) for recertification purposes. ATCIC will also utilize ECHO's coordinated assessment process and prioritization system to identify the consumers to be served by this program. Information will be gathered from the Austin Resource Center for the Homeless (ARCH), ICC, the criminal justice system and ATCIC's Utilization Management Department to identify the individuals in most need to be served by this program.

The consumers to be served by the City and ATCIC's other grant with DSHS will fund 45 separate individuals. This program will meet HUD's goal to provide chronically homeless individuals with Permanent Supportive Housing utilizing a Housing First philosophy and service approach.

ATCIC has a commitment to diversity and inclusion and makes every effort to ensure that bi-lingual staff is available as needed. Bi-lingual employees are recruited to provide culturally and linguistically diverse staff. By employing staff who understand the health benefits and practices prevalent in the broader community, we promote a culture of inclusion and tolerance that respects different aspects of diversity including gender, ethnicity, language, culture, sexuality and age.

ATCIC has developed policies in alignment with CLAS standards to ensure that the highest standards are met in the provision of culturally and linguistically appropriate services.

- ATCIC subscribes to Language Line, a service that provides 24-hour interpreter services in a broad variety of languages.
- The Annual Employee Training Day was devoted to celebrating cultural diversity and supporting the continued development of a culturally and linguistically diverse work force.
- ATCIC hired a diversity and on-boarding specialist in 2013.
- Ongoing, monthly diversity and inclusion training is provided for new employees and supervisors.
- All employees are required to complete a course in accepted practices for cultural diversity each year.
- ATCIC bulletins, reports and consumer information are routinely translated into Spanish.
- Individuals providing cultural and linguistic services, including deaf services, must hold the appropriate certifications.
- Ongoing activities are regularly monitored by the Board of Trustees, Executive Director, the Senior Management Team and ATCIC's Diversity Committee.

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Program Services and Delivery

Assertive Community Treatment (ACT) is a treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness. A team of professionals whose backgrounds and training include social work, rehabilitation, counseling, nursing and psychiatry will provide ACT services to the target population outlined in this application. Among the services ACT teams provide are: case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual's ability to live successfully in the community. ACT services will be available 24 hours per day, 365 days per year.

Services for the consumers enrolled in the permanent supportive housing program (PSH will begin with outreach and engagement, and will include ongoing intensive case management for the duration of the consumer's tenancy. Case Management services will be available from 8:00 to 5:00 Monday – Friday. However, assistance will be available 24 hours per day from the on call staff within the team. Consumers enrolled in PSH will receive an array of services including case management, psychiatric services and primary care via our integrated care programs, referrals to employment services as appropriate to augment income, and assistance with applying for benefits that may assist in maintaining stable housing.

The primary difference in the services for PSH from other traditional permanent housing programs is the staffing ratio and the Harm Reduction (HR) approach to intervention. These case managers will not be alone in managing the program as they will be working closely with the housing, clinic teams and the PATH outreach teams. This team approach and partnership will allow for more comprehensive outreach and therefore facilitate easier access to behavioral health services and primary care for the consumer. The case managers will work closely with existing teams within our continuum and will visit the consumers in their apartments weekly and communicate closely with property managers and land lords.

ATCIC will utilize a HR approach that focuses on reducing the negative consequences of drugs and alcohol use, and other lifestyles or decisions that a consumer may make. The two primary goals are clinical stability and social stabilization, both of which support the maintenance of housing. While consumers are requested to meet with case managers and create a person centered care plan, including the case manager and other supports, they will not be exited from the program for failure to reach the goals developed in the plan.

The case manager will address behavioral health concerns, physical health concerns, income, housing and self-care issues. The main focus is on teaching skills and addressing issues that threaten the maintenance of housing. The case manager will utilize motivational interviewing techniques as part of the interventions to identify the consumer's ambivalence about changing behaviors and motivate them to work toward achieving their goals.

ATCIC will follow a HR/Housing First (HF) model that accepts the reality that not all traditional approaches to stability and sobriety work for many people. The team will provide a continuum of care internally to allow for client choice in intensity of services and for outreach and engagement to occur within the team. This model will require case managers to work outside the confines of rigid service plans and team structures with expectations for goal attainment and will promote active outreach, engagement and team work across multiple programs within the organization. The program will utilize peer providers to support, mentor and train consumers as they obtain and maintain housing and achieve recovery.

Consumers enrolled in the program will also be service-connected to ATCIC's Integrated Care Clinic that has opened in Dove Springs. Consumers will receive Behavioral Health Care, Primary Care services and Substance Abuse services from an interdisciplinary team trained to address their complex needs. The Primary Care services will be provided by a Primary Care team from CommUnity Care imbedded within the behavioral health team.

Lastly, this program will include Housing Based Case Management, which is a holistic approach utilized in PSH to assist individuals in housing while addressing basic needs for stability and wellness. The team works

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together to address basic needs first and address any barriers identified that could jeopardize housing stability. Services are focused on addressing first the needs for safety, food and shelter and then progress to linkage to benefits, behavioral health care, physical health services and substance use treatment needs based on consumer self-identified goals.

Consumer to Staff Ratio: The treatment team ratio will be 1 case manager to 10 consumers following the HF/PSH Act best practice standards. This consumer staff ration will facilitate the provision of intensive individualized treatment services.

Staff will engage consumers in their natural environment and provide them with "hands on" support and assistance to help them live in the community. The proposed team will work collaboratively with our existing ACT team, the PATH outreach and engagement team, and our housing and community teams located at the ARCH to identify eligible consumers and develop engagement strategies to assist them with housing stability and intensive wrap around services. The treatment team will make the community the primary focus of treatment. Treatment will consist of reaching out to consumers to deliver medications and individualized services and supports needed to live in the community.

Additionally, ATCIC works closely with local hospitals via the Utilization Management Department to coordinate admissions and discharge, as well as a staff member assigned to Austin State Hospital. Case managers will coordinate and communicate with hospital staff to assist consumers and provide continuity of care after discharge.

Identification of eligible program participants has already started through a recently awarded grant from DSHS to provide housing assistance for 40 chronically homeless individuals with tri-morbid conditions. We are working with the ECHO prioritization work group to identify these individuals and will be ready to begin the implementation of the ACT team services if awarded this project. Furthermore, ATCIC will begin the hiring process of the two case managers needed as soon as the contract is executed. Finally, we will work with Neighborhood Housing and Community Development Office to develop and expand the program capacity by providing housing subsidies to more consumers as funding becomes available.

ATCIC operates 13 housing projects and has relationships with more than 20 independent landlords in the community. The individuals served by this program will have an array of housing choices. Consumers will be engaged in the location and selection of their housing. ATCIC has already begun searching for landlords in anticipation of this programs implementation. The ACT team staff will work collaboratively with ATCICs housing locators to facilitate the placement of consumers in scattered site efficiency units or on ATCIC owned housing units as they become available. Units will be identified from existing units located in the private market at several of ATCICs housing partner's properties, which are currently located in multiple areas of the city. ATCIC is currently exploring new partnerships in the Dove Springs neighborhood to provide the option of living close to our new Dove Springs integrated health care clinic.
ATCIC has also worked collaboratively with the HACA to establish a procedure to distribute NHCD vouchers to this population. ATCIC has an established relationship with HACA in the management of two Shelter Plus Care grants funded by the local Continuum of Care. ATCIC will work with HACA to expand the existing relationship to include this program.

The relationship will be structured and operate in accordance with the principles of PSH/HF, which call for a division of the roles and responsibilities of the Landlord/property manager and the service delivery team. This differentiation allows for the property manager to assume the role of enforcing the regulations of the lease while the supportive service teams assist the individual in learning skills to maintain housing stability. The service team role will be to respond to the consumers' needs and to facilitate the relationship between the property manager and the consumer. The team will be responsive to the landlords concerns and will assist with crisis intervention when needed. While the landlord enforces the lease, the service team works with the consumer by providing motivational intervention and harm reduction approaches to assist the consumer maintain their housing.

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The Housing First (HF) approach proposed for this project to serve the chronically homeless is based on the notion that housing is a basic human right, and so should not be denied to anyone, even if they are abusing alcohol or other substances. The HF model, thus, is philosophically in contrast to models that require the homeless to abjure substance-abuse and seek treatment in exchange for housing.

Additionally, HF does not only provide housing. The model also provides wraparound case management services to the tenants. This case management provides stability for homeless individuals, which increases their success. It allows for accountability and promotes self-sufficiency. The housing provided through a supported Housing First program is permanent and "affordable," meaning that tenants pay 30% of their income towards rent. The proposed HF program will target individuals with disabilities. This housing is supported through two HUD programs. In summary, the Principles of HF are:

1) Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance;
2) The provider is obligated to bring robust support services to the housing. These services are predicated on assertive engagement, not coercion;
3) Continued tenancy is not dependent on participation in services;
4) Units targeted to most disabled and vulnerable homeless members of the community;
5) Embraces harm-reduction approach to addictions rather than mandating abstinence. At the same time, the provider must be prepared to support resident commitment to recovery;
6) Residents must have leases and tenant protections under the law;
7) Can be implemented as either a project-based or scattered site model.

The team will work closely with the landlord/ property manager to assist the consumer in understanding the roles and responsibilities of the program/ lease and expectations of tenancy. The team will works closely with landlords to identify concerns or behaviors prior to concerns becoming lease violations. The team will develop behavioral interventions utilizing motivational interviewing skills to assist consumers with maintaining housing while addressing any concerns or challenges. The team will intervene early to prevent the consumer from violating the lease and will assist with lease violation resolutions if needed.

ATCIC has not been involved with managing security deposits. Case managers will provide assistance with advocacy and landlord tenant negotiations, when needed, related to maintaining security deposits after program discharge.

ATCIC agrees to collect and report program income. The program income is to be returned to the respective **PSH 1115 Waiver** program and used to provide eligible services to eligible clients. Program income is gross income directly generated by the grant-supported activity or earned as a result of the award. Program income includes, but is not limited to, income from fees for services performed such as direct payment, or reimbursements received from Medicaid, Medicare, private insurance or any third-party payers. Direct payment includes, but is not limited to enrollment fees, premiums, deductibles, cost sharing, co-payments, coinsurance, or other charges. ATCIC agrees to add program income to Contract funds and use program income to further eligible project or program objectives. ATCIC shall ensure that systems are in place to account for program income. Program income will be reported in the Monthly Expenditure Report and on other report formats as required by HHSD.

System for Collecting and Reporting Program Data

As a homeless services provider, ATCIC enters data related to 4 HUD funded programs in HMIS. ATCIC recognizes the importance of HMIS in our continuum of care as it provides the ability to use standardized assessment tools to collect data the community has identified as crucial to the community's planning and service provision missions. ATCIC will follow the HMIS Data Quality Assurance Plan and the policies and procedures as it relates to usage, data entry requirements, confidentiality and other usage terms as applicable.

ATCIC has two assigned staff to enter data into HMIS. These staff members are responsible for the monitoring of the data entered in the system and data validation reports. ATCIC has been using HMIS over the years with

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high validity and data accuracy. ATCIC is actively involved with ECHO's effort to improve HMIS data collection and will provided information as requested.

Performance Measures

This program will have quarterly performance reporting requirements as well as requirements for high data quality in the Homeless Management Information System (HMIS).

REQUIRED OUTPUT MEASURES

OUTPUT # 1	1st 12-month (9/30/2013 - 9/29/2014)	2nd 12-month (9/30/2014 – 9/29/2015)	3rd 12-month (9/30/2015 – 9/29/2016)	36-month TOTAL (unduplicated for total period)
Unduplicated count of individuals with tri-morbid conditions receiving ACT Team Services.	8	15	0	23
Must serve a minimum of 23 clients in program				
Explanation for measurement of Output #1: Clients enrolled in services. Data collected via ATCIC's electronic medical record.				

OUTPUT # 2	1st 12-month (9/30/2013 - 9/29/2014)	2nd 12-month (9/30/2014 – 9/29/2015)	3rd 12-month (include rollover) (9/30/2015 – 9/29/2016)	36-month TOTAL (unduplicated for total period)
Unduplicated count of individuals with tri-morbid conditions receiving ACT Team Services that are stably housed				

OUTPUT # 3	1st 12-month (9/30/2013- 9/29/2014)	2nd 12-month) (9/30/2014 – 9/29/2015)	3rd 12-month (9/30/2015 – 9/29/2016)	36-month TOTAL (unduplicated for total period)
Unduplicated count of individuals with co-morbid conditions receiving ACT Team Services	15	15	0	30
Must serve a minimum of 30clients in program				
Explanation for measurement of Output #3 Clients enrolled in services. Data collected via ATCIC's electronic medical record.				

OUTPUT # 4	1st 12-month (9/30/2013- 9/29/2014)	2nd 12-month) (9/30/2014 – 9/29/2015)	3rd 12-month (9/30/2015 – 9/29/2016)	36-month TOTAL (unduplicated for total period)
Unduplicated count of individuals with co-morbid conditions receiving ACT Team Services that are stably housed				

REQUIRED OUTCOME MEASURES

Total Program Performance – OUTCOME # 1- Category 2, Improvement Measure.	1st 12-month (9/30/2013- 9/29/2014)	2nd 12-month (9/30/2014 – 9/29/2015)	3rd 12-month (9/30/2015 – 9/29/2016)

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The number of individuals with tri-morbid conditions receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment (numerator)	N/A	2	3
The number of individuals with tri-morbid conditions receiving specialized interventions (denominator)	N/A	8	15
The percentage of individuals receiving specialized interventions who demonstrate improved functional status on the ANSA.	N/A	20%	20%

Total Program Performance – OUTCOME # 2- Category 2, Improvement Measure.	1st 12-month (9/30/2013-9/29/2014)	2nd 12-month (9/30/2014 – 9/29/2015)	3rd 12-month (9/30/2015 – 9/29/2016)
The number of individuals with co-morbid conditions receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment (numerator)	N/A	3	6
The number of individuals with co-morbid conditions receiving specialized interventions (denominator)	N/A	15	30
The percentage of individuals receiving specialized interventions who demonstrate improved functional status on the ANSA.	N/A	20%	20%

Total Program Performance – OUTCOME # 3- Category 3, Improvement Measure. Year 2 & 3	1st 12-month (9/30/2013-9/29/2014)	2nd 12-month (9/30/2014 – 9/29/2015)	3rd 12-month (9/30/2015 – 9/29/2016)
The sum of the "**overall score**" from all ANSA assessments completed during the measurement period. (numerator)	TBD	TBD	TBD
The total number of ANSA assessments completed during the measurement period. (denominator)	>22	>38	>45
Explanation for measurement for outcome # 2: ANSA assessments conducted on all PSH program clients served by ATCIC "Overall Score" in the numerator must be calculated with the guidance provided by HHSC in the IT-11.26c_Adult Needs and Strength Assessment.			

Performance Evaluation

ACT combined with PSH is a clinically effective approach to managing the care of individuals diagnosed with severe and persistent mental health conditions who have experienced chronic homelessness. Evidence demonstrates that ACT and PSH, if correctly targeted to high users of services including in-patient care, can substantially reduce the costs of hospital care while improving outcome and patient satisfaction.

While it is challenging to quantify the cost avoidance benefits of this program due to the data sharing challenges among our systems of care, ATCIC will attempt to collect baseline data on the individuals participating in this program. The data will be collected by obtaining information from existing medical records, EMS reports and self-report. Baseline information will be gathered for the individuals selected for the program prior to housing and outcome measures collected every three months after engagement and housing placement. Measures to be assessed will follow the contract requirement in addition to the collection of quality of life, income stability and client satisfaction measures.

Evidence indicates significant reduction of emergency service utilization and ACT and PSH improves recipient outcomes. By comparing recipients before and after receiving ACT services or PSH, studies have shown recipients experience greater reductions in psychiatric hospitalization rates, emergency room visits and higher levels of housing stability. Research has also shown that ACT is more satisfactory to recipients and their families and is no more expensive than other types of community- based care. We anticipate the results of our data collection efforts will result in similar outcomes.

Program Work Statement

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Service Coordination with Other Agencies

ATCIC has a partnership with CommUnity Care where staff are able to assist consumers with obtaining MAP cards and to access MAP covered services. Staff help consumers obtain resources from the Best Single Source Plus (BSS Plus) Program to assist with basic needs such.as rent, mortgage, utility assistance and housing supports. Staff is able to refer consumers to any of the 12 participating agencies however; the most utilized agencies are Caritas and Front Steps.

Service Collaboration with Other Agencies

ATCIC has a large network of providers and a strong relationship with CommUnity Care. ATCIC will assist the individuals served by this program and access all needed services to address their behavioral and physical health needs. The team will work diligently to advocate on behalf of the consumers served to ensure proper access and service provision. Additionally, ATCIC will work with other homeless service providers to expand access to benefits and access to BSS+ resources.

ATCIC's staff work closely with community organizations to meet the primary health, mental health and substance abuse treatment needs of its consumers including housing and employment services providers. ATCIC works collaboratively with other homeless service providers and is part of multiple initiatives in the community to address gaps in services such as the lack of affordable housing options and permanent supportive housing. ATCIC has formal relationships with Front Steps, CommUnity Care and Goodwill to provide holistic care to consumers in housing. Informal working collaborative relations are in place with Caritas, Salvation Army and Trinity among others to address the complex needs of the target population.

In addition to the comprehensive services offered by the ACT team, individuals enrolled in this program will be connected to a medical home with an array of services such as peer support services, supported employment, wellness management and recovery, homeless prevention assistance funds, residential substance treatment and relapse prevention interventions among others.

Participants will be able to access the services initially and over time through their medical/behavioral health clinic and the ACT Team. A person centered plan or treatment plan is developed with all consumers engaged in services and they are educated in accessing those services. Services are reviewed every 90 days to assess progress and to develop new goals and services over time.

No MOU was crafted for this program.

Client Need	Agency providing service	Funding Source
Utility costs	ATCIC Caritas	DSHS Homeless prevention –rapid rehousing assistance funds, BSS+
Basic needs such as food, transportation, clothing, etc.	Caritas, Salvation Army	BSS+, Vouchers purchased by ATCIC with Middleburg Donation Funds
Medical Services	CommUnity Care	HF-PSH ACT City funding, 1115 DSRIP Project-Integrated Care Service Project
Behavioral Health Services	ATCIC	HF-PSH ACT City funding, , 1115 DSRIP Integrated Care
Connection to mainstream benefits	ATCIC/ CBO function, Legal Aid	DSHS General Revenue
Housing search and placement	ATCIC	HF-PSH ACT City funding, DSHS
Other case management	Supported Employment/ ATCIC	DSHS

Program Work Statement

Contract Start Date	9/30/2013	*Contract End Date*	9/29/2015

Community Planning Activities

ATCIC staff are involved with our local continuum of care, and Ending Community Homeless Organization (ECHO). ATCIC is actively engaged with the PSH Leadership Committee with the City of Austin to assess the needs of homeless individuals with SMI and to develop strategies to improve services and availability of affordable housing. ATCIC's CEO and Chief Program Operations Officer serve on broad based collaborative efforts that lead Austin's planning process to develop strategies to address homelessness and behavioral health. As the local mental health authority, ATCIC is actively engaged in the prioritization of services and funding strategies needed for the sustainability of PSH for individuals with mental illness or co-occurring disorders and has been involved with the Community Care Collaboration, Psychiatric Services Stakeholders Committee, Crisis Intervention Committee and the Bureau of Justice Agency Committee addressing behavioral health and homeless issues.

Program Budget and Narrative

Program Start 9/30/2014
Program End 9/29/2015

	City Share	Other	Total
Salary plus Benefits	$462,094.00	$0.00	$462,094.00
General Operations Expenses	$128,256.00	$0.00	$128,256.00
Consultants / Contractual	$0.00	$0.00	$0.00
Staff Travel	$1,600.00	$0.00	$1,600.00
Conferences	$0.00	$0.00	$0.00
Operations SubTotal	$129,856.00	$0.00	$129,856.00
Food and Beverages for Clients	$0.00	$0.00	$0.00
Financial Direct Assistance to Clients	$0.00	$0.00	$0.00
Other Assistance	Furniture, IDs, medical, transportation, etc.	Please Specify	Please Specify
Other Assistance Amount	$8,050.00	$0.00	$8,050.00
Direct Assistance SubTotal	$8,050.00	$0.00	$8,050.00
Capital Outlay Amount	$0.00	$0.00	$0.00
Total	$600,000.00	$0.00	$600,000.00

Detailed Budget Narrative

Salaries plus Benefits	*Salaries with associated FICA, Worker's Comp, Health, Unemployment and Life Insurance.*
General Op Expenses	*Program and operating supplies/equipment and occupancy, communication, interpreter services, audit, insurance, training, printing, copying and marketing expenses, and administrative expenses.*
Consultants / Contractual	
Staff Travel	*Staff travel and conference expenses outside of Travis County.*
Conferences	
Food and Beverage	
Financial Assistance	
Other Assistance	*Additional supports provided to/for clients in the form of household items, transportation, medical needs and identification to assist with housing stability.*
Capital Outlay	

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HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS) REPORTING REQUIREMENTS

Organizations receiving funding from the City of Austin for homelessness prevention and homeless intervention services are required to utilize the local Homeless Management Information System (HMIS) to track and report client information for individuals who are at risk of homelessness or who are homeless. A high level of data quality is required. The Ending Community Homelessness Coalition (ECHO) currently serves as the local HMIS administrator.

Requirements Include:

- All settings for client records will be in accordance with HMIS policy in order to reduce duplication of records and improve service coordination
- HMIS user licenses must be purchased for staff entering data into City-funded programs (may use City funds for licenses)
- Organizations must have an ECHO HMIS Memorandum of Understanding
- Data quality report(s) submitted monthly with a rating of "Excellent" or "Acceptable"
- Participation in Annual Point-in-Time Count, Annual Homeless Assessment Report (AHAR), and other required HUD reporting
- Participation in the required annual training for each licensed user as well as attendance at required City-sponsored training(s) regarding HMIS and CTK ODM System

Periodic reporting to the City will include levels of compliance with all requirements listed above as well as any feedback regarding the HMIS system.

If data quality reports fall below minimum standards, payments may be withheld until reports improve to "Excellent" or "Acceptable" ratings.

These requirements also pertain to all Subcontractors serving people who are homeless under this agreement.