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Placer County Innovation Project Brief

Background and Need

A needs assessment was conducted by Marbut Consulting in 2014/2015 to identify areas for strengthening the service delivery system. The findings indicated the need for a connected, integrated system of care to meet the needs of the chronically homeless, as well as the need for innovative approaches to engaging individuals with the highest risk. Three distinct homeless locations in the county were identified (Roseville, Auburn, North Lake Tahoe).

A Homeless Count conducted in 2015 found that 59% of the adult homeless self-reported as having a serious mental illness and 39% a substance abuse disorder. There were 38% of the homeless who were sheltered and 62% remained unsheltered. 70% of the homeless were between 25 and 59 years of age and 8% were over 60. There were 37% who reported that they were survivors of domestic violence. In addition, the Marbut Consulting study found that over 50% of the chronically homeless are over 51 years of age.

Additional data also illustrates the unmet needs of the chronically homeless in Placer County. Placer rental vacancies are less than 1.6%, while California rental vacancies are 3.4%. Placer's chronic homeless population is significant at 45%, with California's chronic homeless population at 25% and the national number at 15%.

Several programs have been developed over the past few years to help address the needs of the homeless in Placer County. These programs include utilizing MHSA System Transformation/Development funding to develop additional housing programs through Advocates for Mentally Ill Housing (AMIH), The Gathering Inn, a homeless shelter in Roseville; Right Hand, a homeless shelter in Auburn; the Homeless Resource Council of the Sierras (HRCS); and other programs. While these programs have been actively involved with the homeless, there are still opportunities to strengthen services, expand the continuum to include health care organizations, improve collaboration across agencies, and evaluate outcomes for persons who have multiple needs. In addition to homelessness, many of these individuals will also have other complex problems including mental health, substance use disorders, and/or chronic health conditions.

Many stakeholder meetings were held during Marbut Consulting's analysis. Marbut also spoke directly to homeless and chronically homeless individuals to gain insight into their challenges and needs. The final Marbut Consulting report was presented to the Mental Health Services Act (MHSA) Community Planning group, the Campaign for Community Wellness, which includes consumers and family members. Stakeholder input was obtained throughout the development of this Innovation project.

Project Summary

The vision of the Placer County Homeless Integrated Care Coordination and Evaluation Innovation Plan is to:

- Build upon our existing infrastructure and organizational programs that serve the homeless;
- Learn how to strengthen collaboration, coordination, and data sharing across the system;
- Create a cohesive safety net that meets the complex needs of persons who are homeless;

- Utilize evaluation activities to share outcomes, identify barriers to success, and identify if we are making a difference; and
- Create a continuous evaluation and feedback process to modify and improve services and collaboration throughout the project.

The Placer Innovation Plan supports this goal by creating the capacity to build collaboration across organizations; develop Memorandums of Understand and Business Associate Agreements with multiple organizations to facilitate sharing information; identify practices to identify high-need individuals and help them access the appropriate level of care; and share outcomes and identify barriers to success.

The Placer Innovation Plan will expand upon the strong collaboration practices developed over years of system of care development to help build a cohesive safety net of services across diverse organizations. This system will help identify individuals; provide outreach to engage individuals; develop strategies and tools to assess health, mental health, and substance use service needs; and provide warm handoffs to the appropriate services while continuing to coordinate services and ensure success. This development of systematic collaboration and data sharing will help identify, engage, assess, and deliver coordinated services to successfully meet the individual's needs to achieve positive outcomes, such as stable housing, management of chronic health and behavioral health needs, and positive social support networks. A Plan, Do, Study, Act (PDSA) model will be used to continuously improve collaboration, coordination, and data to help measure and learn from our results.

The HICCE Project will utilize the Systems Management, Advocacy, and Resource Team (SMART) model of interagency coordination and collaboration to study how to address both system-level issues as well as the needs of persons who are homeless, mentally ill, and may have chronic health conditions. HICCE Innovation activities will utilize the lessons learned through the development of SMART to identify opportunities to share resources, information, data, and services, to strengthen collaboration across multiple organizations, including hospitals, Emergency Departments, Federally Qualified Health Centers (FQHC), and managed care plans. This collaboration and coordination of services will expand service and housing options; increase housing placements; change the community culture of how to address homelessness; and help to address community stigma.

Placer HHS has recently been awarded funding to develop a Whole Person Care (WPC) pilot project. The WPC will strengthen and compliment the Innovation Plan to address the needs of persons who are homeless, mentally ill, use substances, and/or have chronic health conditions. The WPC pilot will target those persons who are high utilizers of health care services. The target population will be those persons who are high need who may have a mental health or substance use disorder, and are homeless, and/or who may have a chronic health condition. This WPC project matches the focus of this Innovation project and will allow efforts to be doubled through the use of federal funds.

By combining the activities of the WPC pilot project with the goals of the Innovation Plan, we will be able to strengthen both projects. A number of different organizations are committed to participating in the WPC pilot and learning how to strengthen collaboration, coordinate services, and develop data sharing protocols. With the involvement of these multiple organizations and agencies, the Innovation Project has additional funding, support, and organizational commitment to ty new approaches to improve services. The Innovation Project will greatly benefit from the WPC pilot by having a larger network of organizations willing to participate. This network will strengthen the commitment to learn new strategies across all organizations.

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To maximize the effects of the coordinated and collaborative approaches, the HICCE Project will be designed to help individuals who are chronically homeless with a mental illness or co-occurring mental health and substance use disorder, and/or chronic health condition, to receive outreach and engagement, as well as Comprehensive Complex Care Coordination, so that they can exit homelessness and return to permanent housing. HICCE services will be offered without preconditions (such as employment, income, absence of criminal record, chronic health or mental health conditions, or sobriety). Collaborative, multi-agency coordinated services will be tailored to the meet needs of the individual.

The HICCE Project will utilize the "Housing First" evidence-based model to help support individuals who are homeless. The Housing First model has been used to successfully address homelessness (US Interagency Council on Homelessness – USICH) by identifying housing, providing financial assistance to initially pay rent and move-in supplies, and offering intensive case management and peer support services, to help individuals find housing and remain stable in their housing while linking them to needed health services and benefits. Placer County will enhance this model to also address the significant needs of those who are chronically homeless, with mental illness, and/or who are experiencing chronic health conditions.

In addition, community partners provide services and supports to this population who will be engaged in this project. Partner agencies, such as Advocates for Mentally Ill Housing (AMIH) and MHSA Shared Housing (Timberline and Placer Street Apartments), provide important resources for this project. On a broader community scale, Placer Independent Resources Services (PIRS), county housing authorities, HUD housing, and a number of apartments and other housing resources will also provide a valuable resource to this project.

Through this project, Placer County will develop an integrated community-based collaborative to effectively address the issue of chronic homelessness; utilize technology as a tool to provide real-time data exchange across multiple agencies to help individuals access services and achieve positive outcomes; and identify collaborative efforts that help accelerate system change at both the micro and macro level. Our hope is that stigma will be reduced as a result of this Innovation Project.

This Innovation Project is innovative because it expands the scope of the project beyond the traditional behavioral health organizations that work together and includes local hospitals, Emergency Departments, FQHCs, public health, and managed care plans. This approach will create the opportunity to learn how to develop a cohesive safety net to quickly identify the high-need individuals, engage and link them to needed services, and evaluate the success of the collaboration. In addition, although the WPC pilot may not be considered "innovative" by some, it has been successfully implemented only in large metropolitan areas that benefit from comprehensive county-run services; the model has not yet been successfully implemented in a smaller county. Partnering the HICCE Project with the WPC pilot in Placer County is an opportunity to test these collaborative models within a medium-size county.

Evaluation Activities

This innovative project will evaluate collaborative efforts to track the community change necessary to solve this problem. Evaluation activities will collect information on the supportive services network to understand how homeless, mentally ill individuals with chronic health conditions access and receive services across multiple agencies. There will be an exchange of real time data for persons who are enrolled in this program, across multiple organizations, so appropriate interventions can have the most impact.

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The HICCE Project will evaluate the implementation of the specific evidence-based strategy by adding health workers to the Outreach and Engagement Team; enhancing collaboration and coordination across agencies; creating communication and data sharing protocols to identify, link, and support individuals to access services and achieve outcomes; and establishing linkages across agencies so individuals who are served by multiple programs are all working on the same Coordinated Treatment Plan.

The project will use the following instruments for the evaluation of the project activities:

- Interagency Collaboration Activities Scale (University of Southern Florida)
- Service level information:
    - Referrals across agencies
    - Coordinated Treatment Plan developed
    - Services Received
    - Individual outcomes
    - Client Perception of Services
- Other evaluation instruments

HICCE evaluation efforts will track and report on several goals and outcomes. The goals for improving collaboration include the engagement of diverse partner agencies; interagency collaboration and coordination of agencies; and a positive impact on client access to services. Outcomes for individuals include reduced days homeless; improved Health and Behavioral Health indicators; and the receipt of culturally- and linguistically-relevant services. Timely identification of high-need individuals, timely access to services (e.g., health, behavioral health, housing), improved outcomes, and Client Perception of Services.

Evaluation data and reports will be used to inform partner agencies of improved collaboration and coordination; communicate successes and barriers to services; inform stakeholders of any modification and changes in services to improve outcomes; and share experiences with other counties to support a learning collaborative.

The evaluation activities will be developed and implemented with guidance from an evaluation committee, oversight by the Placer County Behavioral Health Board, stakeholder groups, Campaign for Community Wellness Program Review team, the Whole Person Care Lead Entity Council, WPC Leadership Committee, and System of Care management team. Outcomes and lessons learned will be shared with the HICCE Team and systematically throughout the system, including regional and/or statewide meetings that involve other counties.

I.D.E.A. Consulting will coordinate with county staff and stakeholders to support the evaluation of the Innovation project. This organization has extensive experience in evaluating MHSA activities and numerous federal and state grants, across several counties in California, as well as in other states. In addition, this organization has been evaluating MHSA activities for Placer County for over two years. This relationship allows for information to be easily obtained from county and contract providers, health care providers, managed care plans, and other entities to measure the implementation of this project.

In addition to implementing and tracking interagency system changes, outcomes will be collected and analyzed. This data will include demographic information; housing activities; length of time/stability in housing; linkages to resources and needed services; Client Perception of Services; and other core outcomes. Collaboration activities that promote the development and enhancement of coordinated, accessible services will also be evaluated. These may include information on service linkages between the ED, hospitals, FQHCs, mental health and substance use disorder providers, homeless programs, and other community providers.

Strategies for strengthening this interagency collaboration will be identified and documented, to help learn from HICCE Project.

Budget

The annual budget for the HICCE Project is estimated as follows:

- Personnel: $396,000
- Operations: $191,655
- Contracts: $96,246
- Evaluation: $96,099
- Total: $780,000/year

The total innovations funding efforts will be $3.9 million for the five-year project.

Additional funding sources for the entire project include: Whole Person Care Pilot funds; County contributions; Federal Medi-Cal dollars; and housing funds contributed by Sutter Foundation.