Mental Health Services
Oversight & Accountability Commission

NEVADA COUNTY INNOVATION PLAN
HOMELESS OUTREACH AND MEDICAL ENGAGEMENT (HOME) TEAM PROJECT

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
❑ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. *(Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
❑ Local Mental Health Board Approval Date:_____
❑ Completed 30-day Public Comment Period Dates:_____
❑ BOS Approval Date:_____ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: 1/8/19 *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: January 2019 ***Note: Date requested above is not guaranteed until MHSOAC staff verifies that all requirements have been met.***

County Name: Nevada County Behavioral Health

Date submitted: 12/11/18

Project Title: Homeless Outreach and Medical Engagement Team (HOME)

Total amount requested: $2,395,892.02

Duration of project: 5 Years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☒ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

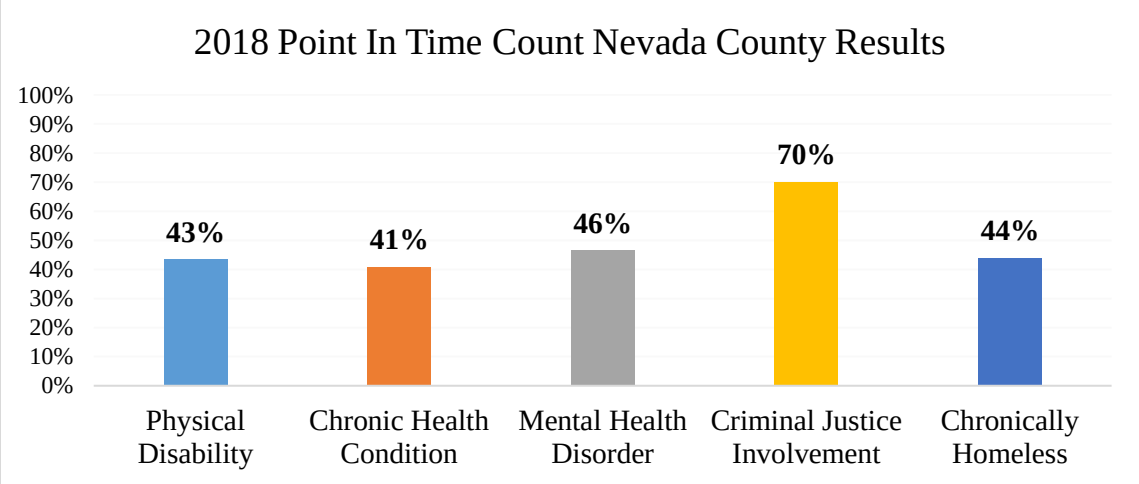
What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Like many communities in California, homelessness is a significant problem in Nevada County. Perhaps somewhat unique to our community, though, is the proportion of our homeless population who has been unsheltered for more than a year and is considered chronically homeless. We are well above state averages for this group; 44% of people surveyed in our 2018 Point in Time count met the chronically homeless definition versus the state average of 28%. This exposes the urgent need in

Nevada County to create programming that is more effective at engaging our most difficult and hard to reach homeless community members.

Throughout our stakeholder process, our community has strongly expressed the desire to focus our Innovation project on those experiencing homelessness in Nevada County. In a rural county which covers over 956 square miles and has minimal public transportation, many of our homeless community members are physically isolated. In addition, a culture of independence and distrust of government permeates our county and adds to the challenges of engaging people in supportive services. Reaching this population is a high priority for the Nevada County Board of Supervisors. The Board has identified the Health and Human Services Agency's plan to address homelessness as a top board priority in early 2018. This plan specifically includes an increased supply of low barrier "Housing First" units within our community and an increased focus on outreach and engagement for people who are difficult to reach.

While we have implemented programs that provide case management services in the community to help identify and link homeless mentally ill individuals to services, we continue to struggle to be effective in reaching our most vulnerable population of chronically homeless people. We have found that these individuals often distrust traditional service delivery models, and are therefore ineligible for certain services and opportunities such as housing that requires engagement with mental health services or sobriety. This distrust has been exacerbated by anti-camping enforcement and camp removals recently implemented in our local incorporated jurisdictions largely in response to wildfire concerns. These actions have increased the level of distrust felt by homeless individuals who are reluctant to engage with Behavioral Health system staff out of fear of being removed from their camping location or losing their belongings. Meanwhile, the demand from community members and local businesses for assistance with engaging this population continues to increase.



According to our 2018 Point In Time (PIT) Count, 272 people in Nevada County are homeless, although our HMIS system currently identifies over 475 homeless people and anecdotal evidence from service providers puts the estimate even higher. In addition to our high percentage of people who have been homeless for a long time, 41% of those surveyed in our 2018 PIT Count identified as suffering from chronic health conditions, and 43% reported having a physical disability. This high percentage of people self-reporting as having unmet physical health needs illustrates the opportunity

for a creative strategy to engage this population in care. Unmet physical health needs often create a barrier to accessing other necessary services such as behavioral health treatment, substance use treatment, and housing. In addition, unaddressed physical health issues and chronic conditions also result in high utilization of emergency and urgent medical care (Behr & Diaz, 2016). Offering to address these physical health and disability issues may be a critical entry point for engaging these individuals in other services.

A second and related defining characteristic of our homeless population in Nevada County is the high degree of criminal justice involvement faced by this population. In our 2018 PIT count, 70% of individuals self-reported having been involved in the criminal justice system. Our county has created a multidisciplinary team of county departments focused on the Stepping Up Initiative, which aims to reduce the number of incarcerated individuals with mental illness, and has also expressed concern about the warm handoff process for this target population as they exit jail. Interrupting this cycle of homelessness and incarceration is a high priority for the county.

Lastly, substance use is a significant challenge for most of our residents who struggle with long-term homelessness. Unfortunately, the vast majority of housing options in our county, including our only local emergency shelter and many of our permanent supportive housing programs, have sobriety requirements that limit access to these resources. A contributing factor to our high percentage of chronically homeless individuals in Nevada County is our inability to shelter or house much of this population due to their substance use issues.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

It is our goal to create an innovative Homeless Outreach and Medical Engagement Team (HOME) that includes a Nurse, Personal Services Coordinator, and Peer Specialist to identify physical health, mental health, and substance use disorder needs in a welcoming and destigmatizing manner. The HOME team will meet with individuals who are experiencing chronic homelessness at locations in the community where they are living. This team will employ strategies directed at the specific needs of Nevada County community members struggling with chronic homelessness. The team will engage people through:

- Providing physical health care services first, which is a less stigmatized form of care than substance use or mental health services
- Embedding a person with lived experience in the team who will be able to address issues of mistrust in this population
- Offering low barrier, housing first options that do not require sobriety or service engagement for entrance

- Creating a close connection with the County jail and law enforcement staff so that people who are arrested or incarcerated are quickly offered services and housing

The first challenge for the HOME team will be to build relationships with chronically homeless individuals who have developed a fear and distrust of service providers. The peer team member will be invaluable in educating the team in the best strategies for engagement and in providing the initial relationship connections with community members. Experience in other communities has demonstrated that embedding medical care within an outreach team is also an effective way to engage homeless individuals (Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph, 2009). The Nurse will be able to both triage critical issues as well as conduct assessments to identify chronic and acute health conditions, including linking the individual to health services and primary care connections. The team will be based out of a van so in addition to being highly mobile, they will be able to transport people to more intensive medical care as needed.

In addition to field-based outreach, the HOME team will also work closely with key partners such as the hospital, homeless shelter, law enforcement, and jail. In order to divert people with mental illness and substance use challenges out of the criminal justice system as quickly as possible, the team will respond to requests from law enforcement and the jail. The team will attempt to engage individuals prior to arrest or incarceration and offer them support and housing instead. They will also collaborate with the existing Forensic Liaison to improve the warm handoff and supportive services available to those who would otherwise exit our jail into homelessness. This engagement is intended to result in a positive and measurable reduction in the cycle of homelessness and incarceration.

The HOME team will be able to make referrals to low barrier master-leased housing units, without preconditions of sobriety or engagement with traditional County Behavioral Health services. The County will most likely contract with AMI Housing (Advocates for the Mentally Ill) to master-lease private homes and/or apartment units. AMI Housing has already successfully master-leased several homes in our community for permanent supportive housing for our Full Service Partnership clients, and has developed good rapport with many local landlords in our community who are willing to rent their homes. The units will likely be located in one of the two incorporated cities in the Western side of our county in order to be close to services and amenities. The units will either be private homes with six or less units or individual apartment units so as not to require any special permits or licensing. There will be minimum of 12 master-leased units funded through our Innovation project, with a ramp-up period built in to the first year to allow for the location and acquisition of the units. These units will be supported by a housing Personal Services Coordinator who will provide a continuum of services and support as these individuals enter housing, including strategies for maintaining housing stability and linkage to benefits and other services such as substance use and behavioral health treatment, as applicable. The housing Personal Services Coordinator will also be involved in the acquisition of the master-leased units and will be the first point of contact for any issues that may arise with the units and/or neighbors. Our county has already seen initial success in this model through our Bridges to Housing program, which houses vulnerable individuals with a focus on behavioral expectations as opposed to traditional house rules of sobriety and engagement in treatment. This project will expand that type of housing opportunity as well as add the element of direct placement from a camping or unsheltered setting into this housing. All tenants will sign admission agreements similar to a lease for a one-year initial period, with the opportunity to extend

for an additional year as needed. Our goal is to use the housing as a bridge to permanent housing, and we will work with each client individual to ensure access to permanent and sustainable housing that fits their specific income and living needs. In addition, the HOME team will have access to flex funds which can be used for some of the costs associated with engaging a person and addressing some of their primary needs. A specific focus of this flex funding will be medications and triage supplies an individual may need to address their health issues.

The innovative composition of the HOME team, combined with the access to low barrier housing, will allow our County to lower the numbers of chronically homeless individuals in our community. The team will be trained in critical modalities such as Motivational Interviewing and Mental Health First Aid. The Personal Services Coordinator, and perhaps others on the team, will have a background in substance use services including a CADAC credential. Our Peer Specialist will complete our local peer training course. While our traditional outreach model has always included a Personal Services Coordinator, we have never utilized a Nurse or a Peer Specialist to directly engage individuals out in the community. The HOME team will develop creative and innovative strategies to quickly engage homeless and high-risk individuals in services, begin meeting their needs, and link them to services. HOME will assist the individual in developing a strong, positive support network to help promote ongoing recovery and wellness.

Services provided by the team will be culturally relevant, and individuals will be linked to resources that are sensitive to their age, race, ethnicity, sexual identity, consumer culture, religion, and health needs. Providing access to vocational training, education, and employment will also be a long-term goal. The implementation of this innovative, holistic team to address immediate needs, including offering immediate health care, will help Nevada County learn how to effectively engage high-need chronically homeless individuals and expedite services to meet their immediate and long-term needs.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

This innovation project makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The HOME team project design draws on a number of strategies we have tested in other settings and combines them in a unique way to address the specific goal of lowering our persistently high percentage of chronically homeless individuals. This program will build on some separate pilot efforts in our county, including our low barrier Bridges to Housing program and our existing Personal Services Coordinator positions that are focused on homeless connections. In addition we will draw from experience we gained integrating physical health and mental health services for clients of the Behavioral Health Department. The program also builds on the learnings from other communities around the most effective models in engaging and successfully housing long term chronically homeless individuals.

Specifically we will utilize our learnings from a three-year Health Resources and Services Administration (HRSA) Rural Health Grant we received in 2012. During this project, we worked closely with a local Federally Qualified Health Center (FQHC) to integrate health and mental health services for clients of our Behavioral Health Department. The grant utilized a Nurse and Peer Counselors to support adults with a serious mental illness to access health care, understand their chronic health conditions, and coordinate health services between primary care and psychiatry to improve health outcomes. HOME will utilize strategies learned from this project to apply to persons who are homeless and have complex health, mental health, and substance use issues.

Through this grant, we found that the integration of primary care and behavioral health has a significant impact on the health and well-being of persons with a Serious Mental Illness. Many individuals do not access primary care and/or know how to manage their chronic health conditions. Similarly, Behavioral Health staff do not typically understand chronic health conditions or have the skills needed to help clients improve their health functioning. Through coordinated and integrated health, behavioral health, and substance use treatment services, clients can improve their health conditions and achieve positive outcomes. This model has been effective at improving continuity of care and we believe it will be effective when implemented with persons who are chronically homeless, helping to create positive health and wellness outcomes for these at-risk individuals who are not already connected to services.

A second source of learnings on which this program is based is our experience to date with outreach and engagement. Nevada County's strategy has historically consisted of Personal Services Coordinators engaging individuals in homeless shelters or occasionally in the field, with a strong focus on connection with traditional behavioral health and/or substance use disorder services. In researching other counties' homeless outreach strategies, we believe that communities have more success when the outreach team focuses first on physical health care as compared to mental health services. We have reviewed a variety of street medicine teams that include nurses providing physical health care in the field or in focused clinics. These teams are proving to be highly successful in building a connection with hard to serve individuals (Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph, 2009). Our Home team program design builds upon these successes by having a nurse as a core partner, but supplements this with a Peer Specialist which we believe will add a stronger capacity for connection and building trust.

Additionally, outreach teams typically gauge housing readiness based on engagement with traditional services such as mental health care and progress towards sobriety. Nevada County's HOME Innovation project is unique in that housing will be offered upfront to individuals, regardless of engagement in traditional behavioral health or substance use services. In line with the "Housing First" principles, this project assumes that housing should be the first step in breaking down barriers that individuals may be experiencing, including physical health needs, behavioral health needs, or substance use disorder needs. Without stable housing, individuals often have difficulty maintaining necessary appointments, and Personal Services Coordinators experience challenges with continued engagement and relationship development when they cannot easily and consistently locate their clients. We have begun offering this low barrier, housing first approach in Nevada County through

our Bridges to Housing program. The HOME team project will build upon the successes we are seeing by linking that housing strategy to direct outreach and engagement.

A final area of learning that this project draws from is around the importance of closely linking supportive services to the criminal justice system. Unique to Nevada County is the coexistence of the Probation and Public Defenders departments alongside the Behavioral Health department within the Health and Human Services Agency structure of the county. This ensures a very close working relationship between these program areas. The HOME team program design capitalizes on this connection by utilizing referrals and warm hand offs from these key partners as well as from law enforcement and jail staff.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

This project aims to engage a minimum of 30 unique individuals per year, and directly support at least 12-15 people per year in attaining and sustaining stable housing. Across the five (5) project years, it is estimated that HOME will engage 150 adults, ages 18 and older. This estimate is based on the average caseload of our outreach Personal Services Coordinators, adjusted slightly downwards to account for the HOME team's focus on chronically homeless individuals in our community.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The Innovation HOME team project will serve individuals ages 18 years and older who are experiencing chronic homelessness. This population will include all persons, regardless of gender, race, ethnicity, sexual orientation, and language. These individuals do not access traditional services, and may be fearful of the behavioral health service delivery system. Homeless individuals who are in jail and are ready to be released will also be eligible for services. HOME will coordinate services with jail staff and the Forensic Liaison to identify high-risk persons ready for release from the jail. Early identification of these individuals will allow HOME staff to meet with the individual to begin developing a relationship and assess needs for housing benefits and other services while still in jail.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The HOME team is a unique program design created to address the specific need of reducing a disproportionately large population of chronically homeless individuals in our rural county. Elements of the program build upon successes experienced elsewhere, but by combining medical care with peer support, together with a housing first approach, we believe we will be able to successfully engage and support a population that has proven to be difficult to stabilize. In addition, by utilizing the close relationships inherent within our unique Health and Human Services Agency structure and by capitalizing on the opportunities of our recent expansion of substance use disorder

services through opting into the Organized Delivery System, this project builds creatively upon our natural assets. Homelessness is experienced differently in small rural counties than in urban centers. The challenges of expansive geography, unique cultural and social norms, and limited services all have influenced our program design. Nevada County is excited to tackle the challenge of creating an effective homeless outreach and engagement program for a rural setting.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

The California Whole Person Care projects have created a variety of strategies to meet the needs of homeless persons in the state. This pilot project has identified successful strategies for engaging persons who are homeless, identifying ways to coordinate services with hospital Emergency Departments (ED) to identify when high-risk individuals receive ED services, and link individuals to needed services in the community. These projects help illustrate effective practices for this high-risk population. This project builds on some of the most successful elements of the Whole Person Care pilot while adding specific unique elements that reflect the needs of our rural county.

As described above, project design for the HOME team builds upon some of the best practices for outreach and engagement for chronically homeless populations while adapting and combining those strategies to best fit our rural community. For example, a study of a mobile crisis team conducted by Lyons, Cook, Ruth, Karver, & Slagg found that embedded Peer Specialists made the team significantly more effective, writing; "consumer staff are more willing and better to engage mentally ill people on the street." Additionally, a study by Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph found that centering a homeless outreach program around health care resulted in reductions in drug use, homelessness and health complaints. The HOME program design combines the successful strategies from each of these efforts in hopes of even greater success with our particularly challenging chronic population. While Peer Specialists have been shown to have positive effects on health issues such as HIV treatment and condom use for those experiencing homelessness (Deering et. al 2009; Fogarty et al. 2001), there is inadequate research on the effects of Peer Specialists with regard to longer term and ongoing health, mental health, and substance use disorder treatment services. Furthermore, the majority of mobile health programs serve urban areas (Centrone, 2009), and there are significant learning opportunities for implementing this type of model in a rural setting. As a small, rural county, it is essential that we are creative at improving access to services. Additionally, the Department of Housing and Urban Development (HUD) has shifted in recent years to explicitly support the low-barrier, Housing First approach.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

The primary learning goal of the HOME Project is to understand what strategies are effective in engaging the specific population of long-term unsheltered individuals within the context of rural communities. Specifically, we wish to assess the effectiveness of a unique multi-disciplinary team in engaging persons in the field who are chronically homeless and linking them to needed services including immediate housing, health and behavioral health care, benefits, and other adjunct services (e.g., caring for their pets; cell phones; tents).

The specific learning objectives and key evaluation outcomes that will be measured are outlined below:

1. Will creating a HOME Team that is comprised of the Nurse, Personal Services Coordinator, and Peer Specialist increase the number of homeless individuals who engage in services (Substance Use Disorder treatment, SSI/SSDI benefits, CalFresh, etc)?
2. Will the HOME Team nurse's ability to immediately address the individual's health care needs help develop a trusting relationship and help engage individuals in services?
3. Will offering a low barrier housing option increase the number of individuals who move into a safe and stable housing situation?
4. Will the HOME Team's coordination with law enforcement and probation decrease the number of persons re-arrested?
5. Will the HOME Team's coordination with law enforcement increase the number of inmates (with no identifiable address) leaving the jail who have a plan for securing safe and stable housing at the time of release from jail?
6. Will the HOME Team increase the number of homeless individuals who access health care services?
7. Will the HOME Team increase the number of homeless individuals who access mental health and/or substance use services, including residential treatment?
8. Will participants in the program develop positive social connections?
9. Will persons who receive HOME Team services report improved outcomes and positive perception of services?

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The critical innovative element of our program design is the unique composition of our outreach team, as well as the capacity of the team to immediately link people to housing. The learning goal for this project is to determine if these two elements are effective in engaging and successfully housing the specific population of chronically homeless individuals. The specific learning objectives listed above demonstrate our efforts to understand which aspects of the program are the critical elements of success. If the HOME team is able to engage and house people who have been unsheltered for a year or more, we hope to discern which elements of the program design are

allowing us to be successful in a rural community with a population that is challenging to build trust with.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

This Innovative Project is examining the success of the HOME team model of using a Nurse, Personal Services Coordinator, and Peer Specialist in improving engagement of persons who are homeless, and offering welcoming and timely services to help individuals achieve positive outcomes of safe and stable housing; immediate health and behavioral health care; and access to benefits and other adjunct services.

The HOME Project evaluation will have several components and the data collected for each objective is outlined below:

1. *Will creating a HOME Team that is comprised of the Nurse, Personal Services Coordinator, and Peer Specialist increase the number of homeless individuals who engage in services (Substance Use Disorder treatment, SSI/SSDI benefits, CalFresh, etc)?*

   Service-level data will be collected to measure engagement activities; referrals and linkages to services; number of contacts and duration of services; the number of services; and location of services. This data will provide information on timely engagement and access to services. Many individuals who are homeless are very suspicious of governmental agencies, and do not trust people trying to offer help. As a result, engagement may take several attempts and weeks, or even months, of outreach to reduce the barriers to service engagement. The number of attempts to engage, the role of each member of the HOME Team, and amount of time spent will be measured.

2. *Will the HOME Team nurse's ability to immediately address the individual's health care needs help develop a trusting relationship and help engage individuals in services?*

   The types of health care services delivered by the nurse to help engage each individual will be documented. This will help identify the key nursing behaviors that help engage individuals in services. This may include wound care, answering health care questions, helping secure needed medications, and other immediate health concerns. The time to link the individual to ongoing health care will also be measured.

3. *Will offering a low barrier housing option increase the number of individuals who move into a safe and stable housing situation?*

The amount of time from HOME Team engagement to date of moving into the low barrier housing option, and length of time stably housed, will be measured.

4. *Will the HOME Team's coordination with law enforcement and probation decrease the number of persons re-arrested?*
   The number of arrests, parole violations, days in jail, and living situation at time of release from jail, and length of time to being housed, will be measured. As law enforcement becomes more engaged in the activities of the HOME Team, situations where individuals are diverted from the jail will be documented, when available.

5. *Will the HOME Team's coordination with law enforcement increase the number of inmates (with no identifiable address) leaving the jail have a plan for securing safe and stable housing at the time of release from jail?*

   See data from #5 above.

6. *Will the HOME Team increase the number of homeless individuals who access health care services?*

   The number of persons assisted by the HOME Team who become enrolled in FQHC or other health care services will be documented. The individual's perception of their health on a Perception of Care survey will be administered annually.

7. *Will the HOME Team increase the number of homeless individuals who access mental health and/or substance use services, including residential treatment?*

   The number of persons assisted by the HOME Team who receive mental health and/or substance use services and the individual's perception of improved mental health and/or substance use on a Perception of Care survey administered annually. The number and percentage of chronically homeless individuals that the HOME team engages with who are diagnosed with a serious mental illness will also be measured.

8. *Will HOME Team members in the program develop positive social connections?*

   The number of persons assisted by the HOME Team who report improved social connections on a Perception of Care survey administered annually.

9. *Will persons who receive HOME Team services report improved outcomes and positive perception of services?*

   The number of persons assisted by the HOME Team who report improved outcomes on a Perception of Care survey administered annually.

Services will be evaluated to assess the timeliness of services and outcomes over time. Individuals will be surveyed using a Perception of Services Survey periodically to obtain their experience in

receiving services and the impact of services on their outcomes. This will provide important information on continually improving services and identify opportunities for celebrating success.

Individual perception of services and outcomes will be measured at least annually to determine if services are helping to improve outcomes. Health, mental health, substance use, living situation, and other key outcomes will be included.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

Nevada County has a long history of contracting for specialty mental health services, substance use services, and integrated health services. NCBH staff provide ongoing management and oversight of all behavioral health contracts, and services have been exemplary from these organizations. It is anticipated that one or more of the existing organizational providers that currently has a contract with NCBH will be selected to implement the HOME project. Evaluation activities will be utilized to provide ongoing feedback on access, quality, and cost-effectiveness of services, as well as outcomes achieved.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Nevada County held 11 meetings throughout the county to get community input. We received consistent community feedback that future Innovation plans should be focused on those in our community experiencing homelessness. Once our plan was developed, it was posted on our County website for 30-day public review from November 6th through December 7th. When the plan was posted, an email was sent to our MHSA contact lists, which contains over 175 individuals including family members, mental health consumers, contractors, community based organizations, and staff from various departments within Nevada County. Additionally, an email press release was sent to all major media outlets that serve Nevada County, including legal advertisements advising the public of the public comment period and location of the Innovation plan. Lastly, public comment was received at our Public Hearing that was held at our Mental Health Board Meeting on December 7th, 2018.

As a result of federal grant funding via SAMHSA that was awarded during the public comment period, Nevada County removed MHSA funding of the Personal Services Coordinator and increased the FTE of the Nurse from 0.5 FTE to 1.0 FTE. Increasing the Nurse from 0.5 FTE to 1.0 FTE was

also suggested during the public comment period by the Nevada County Public Health Nursing Director. Additionally, Nevada County increased the salary of the Peer Specialist to align with industry standards.

Community Program Planning Meetings	
Date	**Meeting**
9/21/2017	MHSA Steering Committee & Community Meeting Eric Rood Center in Nevada City, Video Conferencing in Truckee
10/30/2017	MHSA Steering Committee & Community Meeting Eric Rood Center in Nevada City, Video Conferencing in Truckee
3/27/2018	MHSA Steering Committee & Community Meeting Eric Rood Center in Nevada City, Video Conferencing in Truckee
3/28/2018	MHSA Steering Committee & Community Meeting Joseph Center in Truckee
7/10/2018	MHSA Steering Committee & Community Meeting Eric Rood Center in Nevada City, Video Conferencing in Truckee
11/1/2018	MHSA Steering Committee & Community Meeting Eric Rood Center in Nevada City, Video Conferencing in Truckee
11/2/2018	Mental Health Board Meeting Crown Point Building in Grass Valley
11/6/2018	Nevada County Health Collaborative Meeting Eric Rood Center in Nevada City
11/15/2018	Nevada County Coordinating Council (NCCC) Meeting Eric Rood Center in Nevada City
12/3/2018	Hope and Healing Meeting Hospitality House Offices
12/7/2018	Mental Health Board Meeting & Public Hearing Crown Point Building in Grass Valley

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

a) *Community Collaboration*
b) *Cultural Competency*
c) *Client-Driven*
d) *Family-Driven*
e) *Wellness, Recovery, and Resilience-Focused*

f) *Integrated Service Experience for Clients and Families*

The HOME services will reflect and be consistent with all of the MHSA General Standards. Enhanced community collaboration and cross-organization coordination of services is one of the primary strategies of our Innovation Project. These activities closely align with the General Standards. All services will be culturally and linguistically competent. It is our goal to hire a bilingual and/or bicultural Peer Specialist, if possible, to help meet the needs of our Latino community. In addition, we will strive to provide culturally-sensitive services to the LGBTQ community, adults and older adults, consumers, and family members, to support optimal outcomes. Services will be client and family driven, and follow the principles of recovery, wellness, and resilience. These concepts and principles of recovery incorporate hope, empowerment, self-responsibility, and an identified meaningful purpose in life. Services will be recovery-oriented and promote choice, self-determination, flexibility, and community integration to support wellness and recovery.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Stakeholders have been and will be actively involved in all components of the HOME project. This involvement includes ongoing input into planning, prioritizing services for the homeless, creative methods for engaging, assessing, and meeting the needs of high-risk individual, design of the implementation and evaluation activities, and ongoing funding. Meetings will be held at least quarterly with stakeholders and organizations to discuss implementation strategies, identify opportunities to strengthen services, and celebrate HOME successes. Data on access to services, service utilization, and client outcomes will also be reviewed with stakeholders to provide input on the success of the project and the sustainability and/or expansion of services throughout the five years and beyond. Furthermore, HOME program data, challenges, and learnings will be shared at the biweekly Homeless Outreach Team (HOT) meetings, which is a collaborative group for anyone in the community who is contributing to or impacted by homeless outreach efforts, including participating local service providers, law enforcement and advocates. Data will also be reviewed to ensure that services are delivered in a culturally responsive manner. Access to services by different cultures will be reviewed for various ethnic and cultural groups, including but not limited to Transition Age Youth; Older Adults; veterans; LGBTQ+, and those with chronic health conditions.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The HOME project will create the opportunity to develop and strengthen services to individuals who have been unsheltered for a year or more. It is anticipated that the majority of persons served will have a serious mental illness. A core function of the HOME team will be to connect individuals to appropriate care such as mental health services, but this connection will be secondary to establishing trust through outreach, providing medical care and offering housing. Because this population has traditionally been untrusting of county services, the warm hand off to a mental health care provider will take time. However, by providing peer support as well as a long term relationship with a Personal Services Coordinator, we are hopeful that this team will be more successful connecting this population to traditional care. In addition, if the HOME team model is successful, the county will sustain the program through MHSA funds, county realignment and Medi-Cal funding, so that high-risk individuals will continue to receive services to meet their needs. Throughout the duration of the project, we will be exploring how to build the capacity of the team to bill Medi-Cal for services that may be reimbursable. If the project is successful, the County will also apply for HUD permanent supportive housing vouchers for units filled by chronically homeless individuals with serious mental illness. Throughout the program, the housing Personal Services Coordinator will attempt to secure income for program participants that would sustain long-term housing solutions, either in the HOME-supported units or in other permanent housing units. Furthermore, it is anticipated that by the end of the HOME project, additional housing will be available through the No Place Like Home program. Additionally, we will explore future partnerships with our local hospitals and mental health providers for sustainable funding of the HOME program.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

HOME activities are planned for a five-year implementation cycle to ensure sufficient time to develop a comprehensive, coordinated HOME service delivery model, and to learn the most effective way to engage, develop a trusting relationship, identify health and other needs, provide services, and link to community-based services to ensure positive outcomes over time. This project will include identifying successful strategies for integrating and coordinating services to meet the needs of individuals.

Information learned from the innovation project will be disseminated to stakeholders throughout the county, and at regional and statewide meetings. This project is a high-priority for the Board of Supervisors, so HOME will provide periodic reports to the BOS to share information and report successes of the program. Similarly, the Behavioral Health Board will receive periodic reports on the outcomes of HOME, as well as obtain ongoing input into improving service, to ensure that a continuous quality improvement process is in place. In addition, the Behavioral Health Director will share lessons learned from this project with the Small Counties sub-group of the California Behavioral Health Directors Association. The learnings from this project should be highly relevant

to other rural counties struggling with a persistent population of homeless people who are difficult to engage in services and housing. Ongoing data and evaluation activities will help us to learn how to refine services and identify the most effective strategies for different populations of people who are homeless. Similarly, evaluation of the role of each HOME member will help to identify the needs of the team and the homeless, to ensure that staffing levels meet the needs of the individuals being served.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Homeless; medical outreach; housing first; criminal justice; Peer Specialist

TIMELINE

A) Specify the expected start date and end date of your INN Project

The HOME project is anticipated to begin in February or March of 2018, contingent on the scheduled presentation to the MHSOAC and subsequent approval. It is expected that the HOME project will end in February or March of 2023.

B) Specify the total timeframe (duration) of the INN Project

It is anticipated that the HOME project will be funded for five (5) years.

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Timeline	Milestone/Activities
March-June 2019	Select partner provider(s) for implementation and enter into contract(s) Begin looking for available housing units
March 2019 – March 2024	Provide updates on HOME team successes, challenges, and learnings during quarterly MHSA Community meetings
July 2019 – March 2024	HOME Team begins participation with Homeless Outreach Team (HOT) meetings, which is a collaborative group for anyone in the community who is contributing to or impacted by homeless outreach efforts, including participating local service providers, law enforcement and advocates. meetings; continues biweekly throughout 5-year project period Ongoing relationship building with key institutional partners such as law enforcement, jail staff, hospital, homeless shelter staff
July/August 2019	Secure outreach vehicle for HOME team

July - September 2019	HOME team begins street engagement and relationship development with individuals experiencing homelessness Master-lease housing units and begin placement of target population into units
January - February 2020	Analyze evaluation outcomes for Year One of Program implementation Ongoing search for more HOME Program housing units
March 2020 - June 2019	Contract renewals for HOME partner providers Successful attainment of HUD vouchers to provide ongoing housing stability Increased Medi-Cal revenue from team activities
January – March 2024	Final Innovation Program Report Hold Evaluation Review Community and Stakeholder Meetings Finalize sustainability planning where applicable

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The total requested Innovation budget is $2,395,892.02 over 5 years.

Personnel Costs:

- 1.0 Nurse at $101,244.18 per year with anticipated Cost of Living Adjustments (COLA) for 5 years; Total = $527,942.64
- 1.0 Peer Specialist at $43,764.20 per year with anticipated Cost of Living Adjustments (COLA) for 5 years; Total = $227,745.45
- 1.0 Housing Coordinator at $53,387.29 per year with anticipated Cost of Living Adjustments (COLA) for 5 years; Total = $277,829.58
- The 1.0 Personal Services Coordinator will be funded through federal grant funding via SAMHSA.

Direct Operating costs will total $957,354.03 over the 5-year project period and will include mileage, vehicle maintenance, supplies, flexible funds for client program expenses including medications, and expenses for the master-leased units including rent, utilities, furniture, and repairs. Specifically, $127,200 per year will be allocated for rent, utilities, and repairs for a minimum of 12

master-leased units, with a smaller amount of $63,600 allocated for the first year to allow for a ramp-up period while locating and acquiring the units. Indirect operating costs will total 10% of direct operating costs for administrative functions likely performed by contractors, in addition to $149,315.38 of anticipated administration support by Nevada County Behavioral Health staff including a Program Manager, the MHSA Coordinator (Administrative Analyst II), and the MHSA Evaluator (Administrative Analyst II).

It is anticipated that in Year One of the program, the HOME team will utilize up to $30,000 to purchase a vehicle to be used for outreach purposes.

Approximately $12,000 per year will be utilized to contract with an evaluator for program evaluation design, data collection, and ongoing analysis of the program, with an additional $4,000 towards evaluation start-up costs in the first program year.

Federal Financial Participation (FFP) – Non-MHSA Funding: It is anticipated that Nevada County will receive $186,697.60 in FFP funding, depending on the amount of Medi-Cal billable activities performed by the HOME team.

AB 114: This Innovation plan will use FY 08/09, 09/10, 10/11, 13/14, and 14/15 funds that were deemed reallocated to Nevada County via AB 114. The total amount of AB 114 funds that will be expended prior to June 30, 2020 is $493,460.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Salaries	**198,394.66**	**202,362.56**	**206,409.81**	**211,064.68**	**215,285.97**	**1,033,517.67**
2	Direct Costs	**-**	**-**	**-**	**-**	**-**	**-**
3	Indirect Costs (contractor 10% admin)	**49,598.67**	**50,590.64**	**51,602.45**	**52,766.17**	**53,821.49**	**258,379.42**
4	Total Personnel Costs	**247,993.33**	**252,953.19**	**258,012.26**	**263,830.84**	**269,107.46**	**1,291,897.09**
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5	Direct Costs	**127,269.33**	**207,369.66**	**207,469.33**	**207,571.00**	**207,674.70**	**957,354.03**
6	Indirect Costs (contractor 10% admin)	**31,817.33**	**51,842.42**	**51,867.33**	**51,892.75**	**51,918.68**	**239,338.51**
7	Total Operating Costs	**159,086.67**	**259,212.08**	**259,336.67**	**259,463.75**	**259,593.38**	**1,196,692.53**
NON-RECURRING COSTS (equipment, technology)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
8	**Vehicle**	**30,000.00**	**-**	**-**	**-**	**-**	**30,000.00**
9		**-**	**-**	**-**	**-**	**-**	**-**
10	Total Non-recurring costs	**30,000.00**	**-**	**-**	**-**	**-**	**30,000.00**
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
11	Direct Costs	**-**	**-**	**-**	**-**	**-**	**-**
12	Indirect Costs	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
13	Total Consultant Costs	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
14		**-**	**-**	**-**	**-**	**-**	**-**
15		**-**	**-**	**-**	**-**	**-**	**-**
16	Total Other Expenditures	**-**	**-**	**-**	**-**	**-**	**-**
BUDGET TOTALS							
Personnel (line 1)		**198,394.66**	**202,362.56**	**206,409.81**	**211,064.68**	**215,285.97**	**1,033,517.67**
Direct Costs (add lines 2, 5 and 11 from above)		**127,269.33**	**207,369.66**	**207,469.33**	**207,571.00**	**207,674.70**	**957,354.03**
Indirect Costs (add lines 3, 6 and 12 from above)		**97,416.00**	**114,433.05**	**115,469.79**	**116,658.92**	**117,740.17**	**561,717.92**
Non-recurring costs (line 10)		**30,000.00**	**-**	**-**	**-**	**-**	**30,000.00**
Other Expenditures (line 16)		**-**	**-**	**-**	**-**	**-**	**-**
TOTAL INNOVATION BUDGET		**453,079.99**	**524,165.27**	**529,348.93**	**535,294.59**	**540,700.84**	**2,582,589.62**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Innovative MHSA Funds	24,424.80	30,729.92	31,040.94	31,397.68	31,722.05	149,315.38
2	Federal Financial Participation	24,424.80	30,729.92	31,040.94	31,397.68	31,722.05	149,315.38
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-	-
5	Other funding*	-	-	-	-	-	-
6	**Total Proposed Administration**	**48,849.60**	**61,459.83**	**62,081.87**	**62,795.35**	**63,444.10**	**298,630.75**
EVALUATION							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Innovative MHSA Funds	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
2	Federal Financial Participation	-	-	-	-	-	-
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-	-
5	Other funding*	-	-	-	-	-	-
6	**Total Proposed Evaluation**	**16,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**12,000.00**	**64,000.00**
TOTAL							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**TOTAL**
1	Innovative MHSA Funds	**421,716.54**	**485,455.90**	**490,557.87**	**496,420.22**	**501,741.48**	**2,395,892.02**
2	Federal Financial Participation	**31,363.46**	**38,709.37**	**38,791.05**	**38,874.37**	**38,959.35**	**186,697.60**
3	1991 Realignment	-	-	-	-	-	-
4	Behavioral Health Subaccount	-	-	-	-	-	-
5	Other funding*	-	-	-	-	-	-
6	**Total Proposed Expenditures**	**453,079.99**	**524,165.27**	**529,348.93**	**535,294.59**	**540,700.84**	**2,582,589.62**
*If "Other funding" is included, please explain.							