

# MIDD II Briefing Paper

**114 Existing MIDD Program/Strategy or New Concept Name: Familiar Faces**

Existing MIDD Program/Strategy Review  MIDD I Strategy Number \_\_\_\_\_ (Attach MIDD I pages)

New Concept  (Attach New Concept Form)

Type of category: New Concept

**SUMMARY:** This briefing paper & concept is directed at addressing access to housing, as well as providing the systems level improvement framework needed to bring the Familiar Faces Future State Vision (see graphic in section B.3.) to scale for all people in King County. The Familiar Faces initiative, a component of the King County Health and Human Services (HHS) Transformation Plan, promotes systems coordination for individuals who are high utilizers of the jail (defined as having been booked four or more times in a twelve-month period) and who also have a mental health and/or substance use condition.<sup>1</sup> The focus of this paper is on the supportive housing aspects of the Familiar Faces strategy, which includes coordinated entry to prioritize Familiar Faces for permanent supportive housing and other low-income housing and housing supports, based on individual need.

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***The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.***

## A. Description

- 1. Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New**

<sup>1</sup> <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/coordination.aspx>.

**Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This briefing paper & concept is directed at addressing access to housing, as well as providing the systems level improvement framework needed to bring the Familiar Faces Future State Vision (see graphic in section B.3.) to scale for all people in King County. The Familiar Faces initiative, a component of the King County Health and Human Services (HHS) Transformation Plan, promotes systems coordination for individuals who are high utilizers of the jail (defined as having been booked four or more times in a twelve-month period) and who also have a mental health and/or substance use condition.<sup>2</sup> The focus of this paper is on the supportive housing aspects of the Familiar Faces strategy, which includes coordinated entry to prioritize Familiar Faces for permanent supportive housing and other low-income housing and housing supports, based on individual need.

This concept requires MIDD funds for housing resources to secure dedicated housing units, thus adding to system capacity, for individuals with criminal justice histories and involvement. Specifically, 20 -40 permanent supportive housing (PSH) units and 15-30 transitional units of housing are proposed, depending on resource availability.

Many barriers exist for individuals with criminal histories to accessing housing, including eligibility for vouchers and Permanent Supportive Housing options via homeless housing programs in King County. Indeed, local efforts are being made towards a homeless Coordinated Entry system for all,<sup>3</sup> but this system will not address three key needs of Familiar Faces:

- The need for housing on demand, especially when a court-ordered jail release into services is being considered. Courts will not release individuals to homelessness, and quick access to an array of housing options is critical in order to reduce the amount of time individuals spend in jail. In some situations, Familiar Faces many need a transitional housing component to address this need for quick access to temporary housing.
- The need for no barrier housing that is available for Familiar Faces with criminal histories that may exclude them from housing available via Single Adult Coordinated Entry, specifically. In addition, Coordinated Entry does not offer housing on demand and long wait times for a unit or voucher can be devastating to a Familiar Faces who many have been otherwise eligible for diversion from jail, reentry from jail to services or prevent future criminal justice involvement.
- Due to the difficulty and significant wait times in securing permanent housing for Familiar Faces, this population will need access to transitional housing resources to provide initial housing stability and tenancy skill building while awaiting placement in PSH.

This paper also outlines additional elements to be co-implemented with MIDD support to achieve system-wide improvements needed to offer diversion opportunities, achieve outcomes, and leverage other funding (e.g. Medicaid waiver<sup>4</sup>) for this complex population. This provides a holistic picture of a re-imagined health and human services system to achieve the Triple Aim of better health, better care, and lower costs for this population of focus.<sup>5</sup> Many of these complementary elements are being addressed via other MIDD briefing papers, and via concepts submitted by King County to the State of

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<sup>2</sup> <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/coordination.aspx>.

<sup>3</sup> <http://allhomekc.org/coordinated-entry-for-all/>.

<sup>4</sup> <http://www.hca.wa.gov/Releases/HCA%20Seeks%20Medicaid%20Transformation%20Waiver%208-25-15.pdf>.

<sup>5</sup> Washington State Common Measure Set for Health Care Quality and Cost. Cited from <http://wahealthalliance.org/washington-health-alliance-releases-first-results-on-washington-common-measure-set-for-health-care-cost-and-quality/> on 01-23-16.

Washington for Section 1115 Global Medicaid Waiver process.<sup>6</sup>

- **Identification and Targeting:** including implementation of the Predictive Risk Intelligence System (PRISM),<sup>7</sup> the State’s web-based clinical support application featuring predictive modeling tools and data integration to support care management for high-risk Medicaid clients.
- **Diversion\*:** looking to utilize a diversion framework via Law Enforcement Assisted Diversion (LEAD)<sup>8</sup>, which is paving the way nationally in offering a new approach to diversion that is upstream and steeped in changing police response from that of criminalization to a harm reduction approach when encountering individuals in behavioral health crisis or struggling with behavioral health issues in the community. In addition, campuses of health that can serve as diversion sites are critical to the diversion continuum. [\*Refer to *BP 37, 51, 64, 66 South County Crisis Center (Schoeld)* and *BP 23 Law Enforcement Assisted Diversion (LEAD) Maintenance and Expansion (Fox)*.]
- **Coordination and Triage:** including identification of Familiar Faces through implementation of a shared care plan/client registry, including alignment with Coordinated Entry for homeless housing and use of a high-utilizer notification system [Emergency Department Information Exchange (EDIE)<sup>9</sup> or similar] to manage emergency department and jail utilization.
- **Flexible care teams\*:** including outreach and case management (housing, social services, mental health and substance use), transitions from and community integration after incarceration, and primary care management [\*Refer to *BP 44 Familiar Faces Cultural Care Management Teams (Benet)*.]
- **Integrated services:** including expansion of the Mental Health Integration Program (MHIP)<sup>10</sup> and Screening, Brief Intervention and Referral to Treatment (SBIRT)<sup>11</sup> to provide integrated evidence-based physical and behavioral health services to the target population, including during incarceration.

**2. Please identify which of the MIDD II Framework’s four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area (Select all that apply):**

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> <b>Crisis Diversion</b>      | <input type="checkbox"/> <b>Prevention and Early Intervention</b> |
| <input checked="" type="checkbox"/> <b>Recovery and Re-entry</b> | <input checked="" type="checkbox"/> <b>System Improvements</b>    |

**Please describe the basis for the determination(s).**

Although Familiar Faces are identified by King County jail utilization under a re-entry approach, the future state vision strives for a system in which the jail is seldom utilized and is not the access point for any anyone, including Familiar Faces, with unmet health and human service needs. A system of care that centers access to housing and provides opportunities for intervening with individuals is paramount, including preventing future criminal justice involvement for those currently in jail. A system that identifies Individuals in the community, rather than in jail or hospital settings, through utilization of

<sup>6</sup> [http://www.hca.wa.gov/hw/Pages/medicaid\\_transformation.aspx](http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx)

<sup>7</sup> Court, B. J., Mancuso, D. Zhu, C. & Krupski, A. (2013). “Comprehensive Care Coordination for Chronically Ill Adults.” *Predictive Risk Intelligence System (Prism): A Decision-Support Tool for Coordinating Care for Complex Medicaid Clients*.

<sup>8</sup> <http://leadkingcounty.org/>

<sup>9</sup> <http://www.healthcare-informatics.com/blogs/david-raths/improving-emergency-department-information-flow-pacific-northwest>

<sup>10</sup> <https://aims.uw.edu/washington-states-mental-health-integration-program-mhip>.

<sup>11</sup> <http://www.integration.samhsa.gov/clinical-practice/SBIRT>.

other community-based resources (e.g. crisis diversion centers, interface with Law Enforcement Assisted Diversion,<sup>12</sup> etc.) is ideal. Providing housing has been shown to be a key element in reducing recidivism.<sup>13</sup>

## **B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes**

- 1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

According to a fact sheet by the National GAINS Center for Behavioral Health and Justice Transformation, the re-entry, or criminal justice involved population has differing needs from individuals with mental health conditions who do not have criminal justice involvement.<sup>14, 15</sup> Individuals returning from jail may have housing needs based on supervision (e.g. probation, community corrections) requirements. Housing options that provide a balance between criminal justice supervision and flexible social service provision are needed. A continuum of options, including service-enriched options and emergency housing are ideal for serving individuals with behavioral health conditions and criminal justice involvement. The level of service intensity in housing also depends on the level of functioning and support needs of the individual Familiar Face.

### **Need Identified by Familiar Faces Current State Mapping**

Using Lean management tools, the Familiar Faces Design Team (a large cross-sector team from multiple community-based and governmental organizations) spent approximately five months between October 2014 and February 2015 developing an understanding of the current state of the systems serving the Familiar Faces population. Process walks (“walking in the shoes” of a Familiar Face), across various systems, were conducted in order to gain a firsthand understanding of how the Familiar Faces were enrolled, treated, and referred. In early March 2015, the Familiar Faces Design Team held a two-day event and compiled this information together to complete the *Current State Map* for the Familiar Faces population. There were a few key themes that emerged from the event including:

- Currently it’s not a system; it’s more a collection of uncoordinated services;
- The current “system” is program centric and system serving, not person-centered;
- Funding stream requirements drive the current system (e.g. eligibility);
- There are philosophical differences across various organizations in the system;
- A need to stop “brick and mortar thinking” that services need to be facility-based, and explore more virtual and mobile options.

While there is no shortage of excellent stand-alone programs in the region to try to address the needs of the Familiar Faces, overall fragmentation, uncoordinated care, poor outcomes, growing costs to the

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<sup>12</sup> <http://leadkingcounty.org/>. Accessed on 12/23/15.

<sup>13</sup> *Public Safety Brief: Housing and Public Safety*. Justice Policy Institute, published November 1, 2007, accessed on the web 1/17/15 at <http://www.justicepolicy.org/research/1952>

<sup>14</sup> Roman, CG (2009). *Moving Towards Evidence-based Housing Programs for Persons with Mental Illness in Contact with the Criminal Justice System*. Fact Sheet. The CMHS National GAINS Center (accessed on the web 1/17/16).

<sup>15</sup> <http://www.samhsa.gov/gains-center>

health, social services, and criminal justice systems, and the community at large continue to abound. Most importantly, despite the number of available service programs, the overall health and social outcomes for the Familiar Faces has not improved.

It became clear that a new approach is necessary to achieve the vision called for in the King County HHS Transformation Plan and improve health and social outcomes for the Familiar Faces population. Past efforts have generally occurred in silos, have been programmatically focused, and have failed to affect broad cross-sector policy changes. Two key elements have helped to guide this new transformative effort:

- Working across program sectors to partner in a better way, and
- Putting the people and communities at the center of decisions about funding, policy and programs.

### Over 50 percent of Familiar Faces Experience Homelessness<sup>16</sup>

Data below are from the document, “King County One Night County Summary of 2015 Data”<sup>17</sup> provided by All Home (formerly the Committee to End Homelessness). According to the 35th annual One Night Count of people who are experiencing homelessness in King County, which took place on the night of January 22, 2015, the following are data collected for those individuals by homeless status, race, and behavioral health disorder, disability or other condition.

**Table 1: 2015 One Night Count**

2015 One Night Count	
Unsheltered	3,772
Emergency Shelter (ES)	3,282
Transitional Housing (TH)	2,993
<b>TOTAL</b>	<b>10,047</b>

**Table 2: Summary of 2015 One Night Count by Race**

	2015 One Night Count				General Population <sup>18</sup>
	Sheltered Homeless Population			Combined	
	ES	TH			
Black/African American	41%	45%	2,665	42%	6.6%
White	45%	37%	2,561	41%	70.8%
Multi-racial	6%	11%	526	8%	4.7%
Native American/ Alaska Native	3%	2%	184	3%	1.9%
Asian/Pacific Islander	6%	6%	351	6%	16.7%
(Of Hispanic Origin)	(11%)	(13%)	(761)	(12%)	(9.2%)
	<b>Total number of people</b>			<b>6,275</b>	

<sup>16</sup> Srebnik, D., *Familiar Faces: Current State – Analyses of Population*. (September 28, 2015), data summary packet provided to the Familiar Faces Design Team Current State Mapping.

<sup>17</sup> *King County One Night Count: Summary of 2015 Data*. All Home King County (2015).

<sup>18</sup> General Population data cited from: <http://quickfacts.census.gov/qfd/states/53/53033.html>.

**Table 3: Summary of 2015 One Night County by Behavioral Health Disorder, Disability or Condition<sup>19</sup>**

2015 One Night Count			
	Emergency Shelter	Transitional Housing	All
Mental illness	529	539	<b>1,068</b>
<i>(serious mental illness: a subset)</i>	344	251	595
Alcohol or substance abuse	434	445	<b>879</b>
<i>(chronic substance abuse: a subset)</i>	242	178	420
Physical disability	330	359	<b>689</b>
HIV/AIDS	15	9	<b>24</b>

**Availability of Housing Resources not Commensurate to the Need**

Seattle/King County is a national leader in the creation of permanent supportive housing, having funded 4,034 units of housing in the last 10 years for single adults, including single adults who are experiencing chronic homelessness. This new inventory is still inadequate to meet the need, with PSH unit turnover averaging 35-40 per month. All Home, King County’s Continuum of Care for those in need of housing, identified that the lack of sufficient on-going service and rental assistance for populations with high service needs is impeding its ability to further leverage the capital and operating funds required to produce additional units of supportive housing needed to house people experiencing homelessness.<sup>20</sup>

**2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

A range of housing options, including permanent supportive housing from a Housing First approach, is critical to address the needs of the Familiar Faces population. In some instances, a housing ready approach may be appropriate for those Familiar Faces under court supervision.<sup>21</sup> By facilitating quick access to housing upon release from custody or when diverted from jail, Familiar Faces will be provided with a critical component of community stability, a roof overhead and a safe place to sleep indoors.

The following housing-related services will be provided under this proposal:

- Permanent supportive housing to stabilize and support housing tenure;
- Range of housing models, including transitional housing, to accommodate and support individual stabilization and recovery;
- Leverage the Single Adult Coordinated Entry system in development in King County<sup>22</sup> for any Familiar Face who is eligible to receive housing options under this system. This may be a viable

<sup>19</sup> Totals are more than 100% and exceed the total number of individuals in ES and TH because individuals are identified by race and ethnicity separately in the data, while both race and ethnicity are presented in Table 2. For the Point-in-Time Count, the U.S. Department of Housing and Urban Development does not allow unknown race to be reported; data are extrapolated for all individuals based on individuals for whom race is identified.

<sup>20</sup> <https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>. Accessed 01/22/16.

<sup>21</sup> Roman, CG (2009). *Moving Towards Evidence-based Housing Programs for Persons with Mental Illness in Contact with the Criminal Justice System*. Fact Sheet. The CMHS National GAINS Center.

<sup>22</sup> U.S. Department of Housing and Urban Development Office of Community Planning and Development, “Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status,” (2014).

option for Familiar Faces who may be living in emergency, respite or transitional housing.. Service providers (via Familiar Faces care management teams and others serving Familiar Faces) will be trained as *housing assessors*. Housing assessors are staff from designated community agencies and may be office-based, based out of Assessment Hubs, be designated as the assessor for their agency, or may be part of a mobile outreach team. All housing assessors are required to complete a Homeless Management Information System (HMIS) intake and housing assessment with individuals in need of housing and pull, from HMIS, “housing matches” available to each individual. The housing assessor will then pass the referrals to the individual’s case manager or *housing navigator*. Housing assessors’ responsibilities include, but are not limited to the following:

- Operating as the initial contact for the Coordinated Entry and Assessment;<sup>23</sup>
- Conducting a housing assessment;
- Notifying clients of eligibility and referral decisions;
- Submitting referrals to the receiving program through HMIS;
- Participating in case conferences as needed; and
- Responding to requests by the system manager, as appropriate.

**Cross-Sector Data Collection** is needed to efficiently and effectively identify and serve individuals with complex needs. The evaluation unit of the King County Behavioral Health and Recovery Division has proposed cross-sector data sharing that will support the work of Familiar Faces, the Health & Housing Partnerships,<sup>24</sup> and Physical-Behavioral Health Integration<sup>25</sup> more broadly. Building on the County’s role as a ‘hub’ for cross-sector data, the project will catalyze relationships between King County and other service sector partners. The data structures developed would also support analysis of population-level risk, needs, and outcomes for the Accountable Community of Health (ACH) in King County.<sup>26</sup>

**Housing & Care Management Teams** are critical to support Familiar Faces in housing. As a related concept they are addressed in other briefing papers (#44) and Section 1115 Global Medicaid Waiver concept paper (attached at end of this document). A care management team (CMT) will provide on-site services in the Familiar Face’s housing location, based on need identified by the Familiar Face. It is critical that CMTs are working closely with housing providers and on-site housing staff. These CMTs will offer the following:

- Intensive, flexible community-based services using a flexible CMT with integrated mental health and substance use disorder treatment, along with primary health care and employment training, that supports the re-entry process in coordination with the jurisdiction when the individual is court-involved (with staff to client ratios no larger than 1:15 to assure frequent contact and availability);
  - CMTs should have a mental health professional, substance use disorder specialist, peer support/community behavioral health workers (often the “golden thread”), vocational specialists or occupational therapists (for lower functioning individuals), psychiatric prescribing resources and a medical staff (a Registered Nurse or Licensed Practical Nurse);

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<sup>23</sup> <http://www.kingcounty.gov/socialservices/Housing/ServicesAndPrograms/Programs/Homeless/HomelessFamilies/CoordinateEntry.aspx>.

<sup>24</sup> Health & Housing Partnerships: Strategic Guidance for Health Centers and Supportive Housing Providers, Corporation for Supportive Housing. (December 2015). Available at: <http://www.csh.org/wp-content/uploads/2015/12/CSH-Health-Housing-Partnerships-Guide.pdf>.

<sup>25</sup> [http://www.hca.wa.gov/hw/pages/integrated\\_purchasing.aspx](http://www.hca.wa.gov/hw/pages/integrated_purchasing.aspx).

<sup>26</sup> <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/ach.aspx>.

- Non-traditional hours to include round the clock, face-to-face crisis response, a housing preservation service for participants and landlords, and the availability of respite housing for crisis periods; and
- Anti-oppressive practices to address individual level discrimination Familiar Faces encounter in their daily lives, recognizing and challenging institutional and structural racism, classism, and ableism. This includes providing behavioral health treatment that addresses historical and cultural trauma as sources of substance use and other behavioral health conditions..<sup>27</sup>

**3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

For populations who are most at risk for criminal justice involvement, supportive or affordable housing has been shown to be a cost-effective public investment, and lowers corrections and jail expenditures;<sup>28</sup> moreover, such housing meets the actual needs of the individuals instead of criminalizing behavioral health conditions and homelessness.

Having a criminal history is not a predictor of housing success, and thus individuals with criminal justice backgrounds or involvement are just as likely as other individuals with behavioral health issues experiencing homelessness, to be successful in housing.<sup>29</sup> This can contradict the expectations of housing operators and policy makers, as well as public opinion, related to housing for individuals with a history of criminal justice involvement, including the Familiar Faces population.

**Health & Human Services Transformation, Familiar Faces Individual Level Strategy**

The King County HHS Transformation Plan was developed in 2013 in partnership with community stakeholders to set forth a plan for an accountable, integrated system of health, human services, and community-based prevention. The Plan has the goal that by 2020:

*“The people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.”<sup>30</sup>*

To catalyze improvement in the system’s performance for everyone, the HHS plan called for an initial focus on areas where improved performance is most critical – for the individuals and communities with the poorest outcomes. The plan also had to align with, and be fundamentally committed to, the larger countywide goal of achieving equity and social justice for all King County residents. Following preliminary scoping conversations with several internal and community stakeholders during 2014, an initial population of focus emerged, the Familiar Faces. These individuals commonly experience

<sup>27</sup> White, W. & Sanders, M. (2004). *Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities*. Posted at [www.bhrm.org](http://www.bhrm.org).

<sup>28</sup> *Public Safety Brief: Housing and Public Safety*. Justice Policy Institute, published November 1, 2007, accessed on the web 1/17/15 at <http://www.justicepolicy.org/research/1952>

<sup>29</sup> Malone, DK (2009). *Assessing Criminal History as a Predictor of Future Housing Success for Homeless Adults with Behavioral Health Disorders*. *Psychiatric Services* 60(2), pp.224-230.

<sup>30</sup> <http://www.kingcounty.gov/elected/executive/health-human-services-transformation.aspx>. Accessed on 12/23/15.

complex chronic health conditions, histories of trauma, substance use, and chronic homelessness or instability in housing and other aspects of their lives.

The implementation of the Affordable Care Act has brought new opportunities for the community to work together to achieve the Triple Aim of better health, better care, and lower costs for this population of focus. These changes include expanded Medicaid coverage, the statewide move towards integration of the mental health, chemical dependency, and physical health systems, and the emerging ACH and system delivery reform efforts.

The Familiar Faces Future State Vision<sup>31</sup>, pictured below, centers these individuals in a flexible CMT, the core team providing services and “golden thread” support and connection to other health and human services, as determined by the Familiar Faces. Some of the other general areas for improvement that were identified to make progress towards the future state vision, and are important to the success of the Familiar Face:

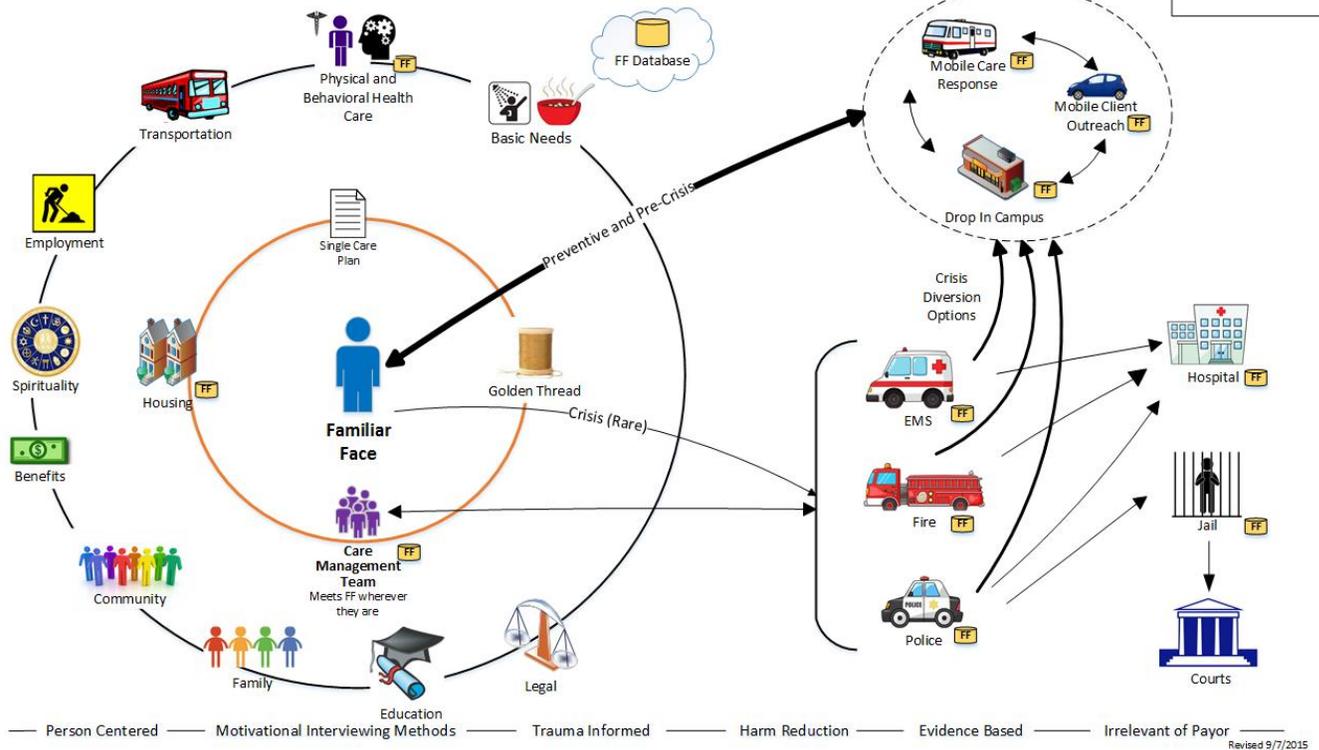
- The need for a single, standard and consistent care plan;
- Access to other human services (beyond the core CMT) as identified by the Familiar Faces, which also utilize service approaches that are trauma-informed and based on motivational interviewing techniques, aligned with harm reduction and anti-oppressive practices;
- Development of outreach and quick response processes;
- Unconditional and flexible funds regardless of payer;
- Development of standard work for jails and emergency departments;
- Development of standards and standard work for warrant prevention and quashing;
- Policy Improvements for law enforcement; and
- Definition and development of a community support team.

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<sup>31</sup> <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx> Accessed 12/30/15.

## Familiar Faces Future State Vision v.1.6 DRAFT

**LEGEND**  
 ED: Emergency Department  
 EMS: Emergency Medical Services  
 FF: Familiar Face



**4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice . Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

### Permanent Supportive Housing<sup>32</sup> (Evidence-based practice)

The Corporation for Supportive Housing’s (a national housing advocacy, policy and best practice organization) Returning Home Initiative demonstrated the effectiveness of pairing supportive housing with systems change to break the cycle of criminal justice involvement for thousands of people nationally.<sup>33</sup> Lessons learned included:

- In-reach and immediate connection to housing is critically important;
- Coordination with the court system and probation/parole is critical to maintaining a strong connection with clients even if they are re-arrested or re-incarcerated;
- Robust services are necessary to keep people housed; and
- Accurate and comprehensive assessment of clients prior to release is critically important to match the right intervention to the right population.<sup>34</sup>

### Housing First approach<sup>35</sup> (Evidence-based practice)

<sup>32</sup> Substance Abuse and Mental Health Services Administration. *Permanent Supportive Housing: The Evidence*. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2010.

<sup>33</sup> <http://www.csh.org/resources/returning-home-emerging-evidence-and-lessons-learned/>. Downloadable pdf entitled: *Ending the Cycle of Homelessness and Criminal Justice Involvement through Supportive Housing*. June 2011. Accessed 12/28/15.

<sup>34</sup> *Ibid*, *Ending the Cycle of Homelessness and Criminal Justice Involvement through Supportive Housing* (June 2011).

The program will use a Housing First approach to engage and rapidly house frequent institutional users who are experiencing homelessness. Housing First is an approach that centers on providing individuals experiencing homelessness with housing as soon as possible and regardless of involvement in other services. Once housed, other services can be provided as needed. This housing is provided as quickly as possible and housing is not time-limited (preferably, permanent). Services are offered as long as necessary and should adjust as appropriate based on need. Housing is not predicated on other service involvement or on sobriety. Housing cannot be removed due to lack of utilization of services offered.<sup>36</sup> The CMT will work closely with other resources providing housing to accomplish this system-wide approach to housing.

### **Harm Reduction<sup>37</sup> (Best practice)**

A harm reduction framework will be applied to all housing and CMT-related services. Harm reduction is a strategy directed toward individuals or groups that aims to reduce the harms associated with certain behaviors. When applied to substance use, harm reduction accepts that a continuing level of drug use in society is inevitable and defines objectives as reducing adverse consequences.<sup>38</sup> Harm reduction incorporates a spectrum of strategies to address conditions of harmful behavior along with the behavior itself (often referred to as “meeting people where they are at”). All of these strategies that fall under harm reduction, based on individual need, can be provided in the housing context and relate to housing stability and tenure in important ways.

There is no universal definition or formula for harm reduction implementation, given the multiple different interventions and policies designed to serve an individual. However, there are some key principles, such as accepting the individual regardless of the behavior, understanding the complex continuum of behaviors, and acknowledging that there are clearly safer ways to engage in certain behaviors, and establishing quality of individual/community life and well-being as the criteria for successful interventions. Furthermore, this should be a nonjudgmental, non-coercive provision of services and resources; this strategy should promote self-efficacy, recognize the realities of poverty, class, racism, social isolation, past trauma, sex-based discriminations and all other social inequalities that affect an individual’s vulnerability to, and capacity for, effectively changing behavior.<sup>39</sup>

Harm reduction is an important context for all health and human services support to Familiar Faces, who find themselves criminalized, in large degree, due to their behavioral health disorders, especially substance abuse. While a criminal justice response is understandable if crime threatens personal or community safety, the broader use of law enforcement as a response to substance use is questionable. One can argue that the ‘War on Drugs’ approach actually produces harm, as large numbers of individuals become needlessly incarcerated for simple possession of illicit substances. This is an expensive response that has a negative and disruptive impact on individuals, families and communities.

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<sup>35</sup> <http://homeless.samhsa.gov/channel/housing-first-447.aspx>

<sup>36</sup> [http://www.endhomelessness.org/page/-/files/1425\\_file\\_WhatIsHousingFirst\\_logo.pdf](http://www.endhomelessness.org/page/-/files/1425_file_WhatIsHousingFirst_logo.pdf).

<sup>37</sup> <http://homeless.samhsa.gov/Channel/Harm-Reduction-273.aspx>

<sup>38</sup> [Harm reduction: An approach to reducing risky health behaviours in adolescents](#), *Pediatrics & Child Health*, 2008 January; 13(1): 53–56.

<sup>39</sup> <http://harmreduction.org/about-us/principles-of-harm-reduction/>.

**5. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Housing outcomes will align with the All Home Strategic Plan<sup>40</sup> and United States (U.S.) Department of Housing and Urban Development (HUD) guidelines to make homelessness rare, brief and one time. Metrics, established by the All Home Coordinating Board<sup>41</sup> in 2016 for projects serving single adults are as follows:

- 70 percent of individuals exiting transitional housing will secure permanent housing upon exit;
- 80 percent of individuals receiving rapid rehousing services will secure permanent housing; and
- 90 percent of individuals entering PSH will retain housing for one year.

Desired outputs:

King County envisions four types of outputs, which are aspirational. Starting with the one or two most readily developed would move the system closer to the County's collective care coordination aims.<sup>42</sup>

**Output Type I – “Lookup” Capacity**

Individual-level cross-sector data would be viewable by clinical care coordinators. Examples of viewable information could include: Medicaid eligibility, jail bookings, psychiatric and medical diagnoses, jail health involvement, history of connection to mental health or substance use services, homelessness, Predictive Risk of Mortality (PRISM) scores,<sup>43</sup> emergency departments (EDs) and hospitalizations.

**Output Type II – Care Planning**

Like the EDIE system – or in coordination with it - the envisioned data structures would include the ability for care coordinators to enter and view care plans.

**Output Type III – Target Lists**

The proposal would provide the ability to “push out” lists of individuals, selected on the basis of flexible criteria, (e.g., diagnoses, homelessness, an ED encounter, a fourth jail booking, etc.) as ‘alerts’ to provide care management and coordination.

**Output Type IV – Data Extraction**

The data structures would allow creation and extraction of individual-level linked datasets based on similarly flexible criteria. Data extracts would support outcome and cost analysis.

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<sup>40</sup> <http://allhomekc.org/the-plan/>.

<sup>41</sup> <http://allhomekc.org/committees/coordinating-board/>.

<sup>42</sup> Srebnik, D., X-sector Data for Care Coordination (XDAC): A Proposal for KCIT support. Submitted January 14, 2016 for consideration.

<sup>43</sup> Pollack, M., Ruttimann, U., and Getson, P., *Pediatric risk of mortality (PRISM) score*, *Critical Care Medicine*, 1988 Nov; 16(11):1110-6.

**Table 4: Proposed Data Sources**

<b>Data sources currently available</b>	<b>Notes</b>	<b>Possible additional data sources</b>
Medicaid eligibility files (MCO)	DCHS available	PRISM - beyond lookup capacity
DAJD jail bookings	DCHS available*	Housing Authority(s)
Misdemeanor jail bookings	DCHS available*	Medicare claims
Jail Health Services diagnosis, meds	PHSKC	Emergency Med. Services data
Public mental health service data	DCHS available*	Connection to Link4Health, etc.
Public substance use service data	DCHS available*	Courts
Sobering Center data	DCHS available*	Sheriff
Homeless Management Information System (HMIS)	DCHS – soon	King County Medical examiner
Health Care Authority claims data –including EDs/Hospitals	PHSKC/DCHS -time lag	

\*may need amendments to data sharing agreements

**C. Populations, Geography, and Collaborations & Partnerships**

**1. What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program: (Select all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> All children/youth 18 or under                     | <input checked="" type="checkbox"/> Racial-Ethnic minority (any)                  |
| <input type="checkbox"/> Children 0-5                                       | <input checked="" type="checkbox"/> Black/African-American                        |
| <input type="checkbox"/> Children 6-12                                      | <input checked="" type="checkbox"/> Hispanic/Latino                               |
| <input type="checkbox"/> Teens 13-18  | <input checked="" type="checkbox"/> Asian/Pacific Islander                        |
| <input checked="" type="checkbox"/> Transition age youth 18-25              | <input checked="" type="checkbox"/> First Nations/American Indian/Native American |
| <input checked="" type="checkbox"/> Adults                                  | <input checked="" type="checkbox"/> Immigrant/Refugee                             |
| <input type="checkbox"/> Older Adults                                       | <input checked="" type="checkbox"/> Veteran/US Military                           |
| <input type="checkbox"/> Families   | <input checked="" type="checkbox"/> Homeless                                      |
| <input type="checkbox"/> Anyone   | <input checked="" type="checkbox"/> GLBT  |
| <input checked="" type="checkbox"/> Offenders/Ex-offenders/Justice-involved | <input checked="" type="checkbox"/> Women   |
| <input type="checkbox"/> Other – Please Specify:                            |   |

**Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.**

**DATA | Familiar Faces in 2013 and 2014<sup>42</sup>**

The following data<sup>44</sup> (Table 5) shows the Familiar Faces and demonstrates incarceration of individuals with behavioral health conditions who often experience homelessness because of lack of affordable

<sup>44</sup> Srebnik, D., *Familiar Faces: Current State – Analyses of Population*. (September 28, 2015), data summary packet provided to the Familiar Faces Design Team Current State Mapping.

housing, right service fit and other social service supports/access that is needed to address the social determinants of health.

**Table 5: Familiar Faces Summary Results**

Defining Familiar Faces	2013		2014		TOTAL	
	N	%	N	%	N	%
People who had at least 4 bookings	1348	100%	1330	100%	2678	100%
....of those, had JHS BehHealth or SUD flag*	1134	84.1%	1124	84.5%	2258	84.3%
plus others who had MH or SUD tx	139	10.3%	128	9.6%	267	10.0%
<b>TOTAL with behavioral health indication</b>	<b>1273</b>	<b>94.4%</b>	<b>1252</b>	<b>94.1%</b>	<b>2525</b>	<b>94.3%</b>

\*Jail Health Services Behavioral Health “flag” =mood, psychosis or trauma diagnosis or psychiatric meds (during year)

JHS – Substance Use Disorder (SUD) “flag” =alcohol diagnosis, drug diagnosis, alcohol detox, opiate detox, referred for SUD treatment while in jail, or at risk for alcohol/drug detox upon jail intake during year

***FINDING:** nearly all people with 4+ bookings in a year have a behavioral health indicator.*

**Table 6: Gender of Familiar Faces**

Gender	2013		2014		TOTAL		2013 unduplicated persons in jail
	N	%	N	%	N	%	
Female	210	16.5%	205	16.4%	415	16.4%	20.2%
Male	1063	83.5%	1047	83.6%	2110	83.6%	79.70%
Total	1273	100.0%	1252	100.0%	2525	100.0%	100%

**Table 7: Race of Familiar Faces (2013)**

Race	N	%	N	%	N	%	2013 unique persons in jail*	KC adult population (census)
White	603	47.4%	679	54.2%	1282	50.8%	63.7%	69.6%
Black	544	42.7%	456	36.4%	1000	39.6%	26.6%	6.1%
Native	51	4.0%	51	4.1%	102	4.0%	2.6%	0.8%
Asian	70	5.5%	59	4.7%	129	5.1%	6.3%	16.8%
Other/Unknown	5	0.4%	7	0.6%	12	0.5%	0.6%	2.3%
	1273	100.0%	1252	100.0%	2525	100.0%		

\*percent of White goes down by ~4 percent when examining bookings rather than unduplicated people i.e., whites are less likely to have multiple bookings.

***FINDING:** Familiar Faces are disproportionately people of color\* compared with King County as a whole and overall jail population (African American and Native American).*

### **Summary of Familiar Faces Data.<sup>45</sup>**

Succeeding in matching data to identify common clients was a significant process victory for the Familiar Faces initiative as several City of Seattle and King County Departments, including the Department of Adult and Juvenile Detention, Public Health—Seattle & King County/Jail Health Services and other housing and social service partners, broke down traditional hurdles to share information. This exercise in gathering data gave a much more comprehensive picture of this high utilizer population and revealed the following.

- The Familiar Faces are disproportionately people of color compared with King County as a whole and overall jail population (see Table 1 below);
- In 2013, there were 1,273 Familiar Faces while in 2014, there were 1,252;
- 94 percent of all people with four or more jail bookings within a 12 month period have a behavioral health indicator;
- 93 percent had at least one acute medical condition (average 8.7 conditions), and 51 percent had at least one chronic health condition (average 1.8 conditions);
- More than 50 percent were homeless;
- The Most Serious Offenses were:
  - Non-compliance (41%) – Failure to appear for court, supervision violations, etc.
  - Property crime (18%)
  - Drugs (13%);
- Only 8.5 percent of 2014 Familiar Faces had opted-in to any of the three specialty courts during 2014 (Drug Diversion, Regional or Municipal Mental Health);
- About 50 percent of the 2013-2014 Familiar Faces (aged 24 and under) have had contact with the juvenile justice system; and
- Despite having at least four bookings in the King County Jail, over 40 percent of Familiar Faces also had municipal jail episodes during the same year.

**2. Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection:**  
County-wide

Familiar Faces are coming into contact with the criminal justice system across the entire County. Housing opportunities will be made available, to the extent possible based on resources, in the communities of the Familiar Faces' choice.

**3. What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

The leadership (Familiar Faces Steering Committee) and design teams of the Familiar Faces strategy provide a large, cross-sector partnership, already in place, that is necessary for the alignment and oversight of the housing resource proposed for Familiar Faces in this briefing paper. Lean principles and evaluation resources will be needed in order to practice on-going Plan, Do, Check, Act (PDCA) cycles to

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<sup>45</sup> Srebnik, D., *Familiar Faces: Current State – Analyses of Population*. (September 28, 2015), data summary packet provided to the Familiar Faces Design Team Current State Mapping.

ensure the program is implemented from a continuous improvement perspective by both the providers of housing (and CMTs) and the oversight/funding body. New partnerships are needed that leverage existing, collaborative relationships with law enforcement in order to promote diversion when these Familiar Faces do come into contact with police because of a behavioral health or other crisis. New partnerships with local housing providers and landlords will also need procuring.

The current cross-sector table for Familiar Faces includes the following, all of which can play a design and implementation role in housing development:

- Behavioral healthcare providers (Community Psychiatric Clinic, Downtown Emergency Services Center, Evergreen Treatment Services, Harborview Medical Center Mental Health Services, Sound Mental Health, Valley Cities Counseling & Consultation);
- Primary care (NeighborCare, Harborview Medical Center); Public Health-Seattle & King County (Healthcare for the Homeless Network and Jail Health Services), Emergency Response and Community Health Clinic;
- All five Medicaid Managed Care Organizations in King County;
- Public Defender Association (Law Enforcement Assisted Diversion program);
- King County Department of Adult and Juvenile Detention;
- Seattle Police Department;
- King County Sheriff's Office;
- Seattle Municipal Court;
- King County District Court;
- King County Superior Court;
- Pioneer Human Services (housing department);
- Plymouth Housing Group,
- King County Department of Community and Human Services/Diversion and Reentry Services staff;
- King County Department of Public Defense;
- King County Prosecuting Attorney's Office;
- Seattle City Attorney's Office;
- King County Executive's Office;
- City of Seattle Mayor Ed Murray's Policy staff; and
- City of Seattle Human Services Department.

#### **D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches**

##### **1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

The following factors and drivers will or may impact the need for this new concept.

- Refer to the attached paper (at end of this Briefing Paper) for Section 1115 Medicaid Waiver concept submitted to the Washington State Healthcare Authority;<sup>46</sup>
- According to a U.S. Department of Justice News Release, "...making it a crime for people who are homeless to sleep in public places, when there is insufficient shelter space in a city, unconstitutionally punishes them for being homeless;"<sup>47</sup>

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<sup>46</sup> [http://www.hca.wa.gov/hw/Pages/medicaid\\_transformation.aspx](http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx)

- Coordinated Entry and Assessment (CEA)<sup>48</sup> – a requirement of King County by US Housing and Urban Development;
- All Home Community Strategic Plan;<sup>49</sup> and
- Law Enforcement Assisted Diversion (LEAD) expansion and partnerships with Familiar Faces.

**2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

Obvious barriers include the lack of available, affordable housing capacity in the current local system. Indeed, an article by recently retired DESC executive director, Bill Hobson, states,

*“Any realistic attempt to minimize homelessness, Hobson said, would require massive investment in creating housing, something government does not appear to have the money and resolve to tackle,”<sup>50</sup>*

Seattle and King County are national leaders in the creation of PSH, having funded 4,034 units of housing in the last 10 years for single adults and individuals experiencing chronic homelessness.. However, this inventory is inadequate to meet the need. King County’s All Home identified that the lack of sufficient on-going service and rental assistance for populations with high service needs is impeding the ability to further leverage the capital and operating funds required to produce additional units of supportive housing needed to house people experiencing homelessness.

Furthermore, HUD regulatory definitions of homelessness and chronic homelessness limit eligibility for a large portion of the county continuum’s homeless housing – requiring either that an individual be continually homeless for 12 months, or have four documented episodes of homelessness over the last three years; or be literally homeless at the time of assessment.<sup>51</sup> Although the local homeless housing system prioritizes high needs/high system utilization for entry into supportive housing, the HUD definition of homelessness can create a significant barrier to accessing this housing. MIDD funding can help redirect units that are currently offline to Familiar Faces, thus expanding the inventory of housing for this population. All Home mentions this as part of their strategic plan and recommends, *“An Expansion of Pre-Adjudication and Sentencing Alternatives”<sup>52</sup>* to mitigate this very issue.

Due to these reasons, this new concept proposes and requests funding to lease transitional housing capacity in King County to temporarily house up to 15 Familiar Faces in a timelier manner while they await placement in PSH.

**3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

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<sup>47</sup> U.S. Department of Justice. *Justice Department Files Brief to Address the Criminalization of Homelessness*. Justice News. The United States Department of Justice. (August 6, 2015).

<sup>48</sup> U.S. Department of Housing and Urban Development Office of Community Planning and Development “Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status.” (2014).

<sup>49</sup> <http://allhomekc.org/the-plan/>

<sup>50</sup> <http://www.seattletimes.com/seattle-news/huge-ally-to-seattles-homeless-retires-after-31-years/>

<sup>51</sup> <https://www.hudexchange.info/resource/1928/hearth-defining-homeless-final-rule/>

<sup>52</sup> <http://allhomekc.org/the-plan/>

If not done in close coordination with Coordinated Entry efforts underway in King County, there could become a fragmented “sister” system for Familiar Faces. Indeed, tracking individuals via the Homeless Management Information System is critical. Also, given waiting lists for housing, if Familiar Faces receive priority for scarce housing resources, criminal activity could be incentivized.

**4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Long wait times for Familiar Faces to access housing means longer jail stays and often a lack of jail diversion opportunities. Often, when courts are able to release individuals with behavioral health conditions to treatment and housing, it is a large mitigating factor in the case where prison (Department of Corrections) time may have been considered when the Familiar Face is charged with a felony.

**5. What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

At this time, there are few dedicated housing options for Familiar Faces, or criminal justice involved individuals in general, with the exception of some small programs offering transitional housing to individuals in the adult specialty courts and some limited PSH for individuals dismissed on legal competency who do not meet civil commitment criteria under Chapter RCW 71.05 Revised Code of Washington<sup>53</sup> (i.e. the Forensic Intensive Supportive Housing Program). These options are not to scale and involve restrictive referral and eligibility criteria.

## **E. Countywide Policies and Priorities**

**1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This new concept fits within the Sequential Intercept Model<sup>54</sup> and can offer early diversion and jail reentry support to the individuals served by the various outreach and care management teams proposed in other MIDD II Briefing Papers (*BP 44 Familiar Faces Cultural Care Management Teams*, Benet) and the 1115 Global Medicaid Waiver concept submissions. Other pertinent initiatives include:

- 2015 Declaration of State of Emergency for Homelessness - King County and City of Seattle;<sup>55</sup>
- Single Adult Coordinated Entry in King County;
- King County Executive’s Recidivism Reduction and Re-entry Initiative;
- HHS Transformation Initiative, specifically Familiar Faces, Physical-Behavioral Health Integration, and Communities of Opportunity<sup>56</sup> (geographic focus options);

<sup>53</sup> <http://app.leg.wa.gov/RCW/default.aspx?cite=71.05>.

<sup>54</sup> <http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544>. Accessed 01/23/16.

<sup>55</sup> <http://www.seattletimes.com/seattle-news/politics/mayor-county-exec-declare-state-of-emergency-over-homelessness/>. Accessed 01/23/16.

<sup>56</sup> <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/coo.aspx>

- LEAD operations and policy; and
- 1115 Global Medicaid Waiver, options for Demonstration Programs (Delivery System Reform Incentive Payment or “DSRIP”<sup>57</sup>).

**2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

All programs and services provided under the Familiar Faces strategy will embody a person-centered approach that is rooted in all of the principles of recovery and self-determination. Trauma-Informed Care (TIC) is a vital and critical aspect of the Familiar Faces Future State Vision framework and a fundamental service delivery approach for all housing and housing-related services. King County recently received a federal grant for Train-The-Trainer resources and support for the Familiar Faces strategy in order to build up local TIC expertise and infuse it across all jail re-entry and diversion programs in King County. This grant, provided by the Substance Abuse and Mental Health Service Administration’s GAINS Center for Behavioral Health and Justice Transformation, is entitled “*How Being Trauma-Informed Improves Criminal Justice System Responses 2016 Train-the-Trainer.*” King County was selected among 58 applications for just six awards nationally. The training process will begin in April 2016, well before MIDD II is implemented.

**3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County’s EQUITY and SOCIAL JUSTICE work?**

The greatest impact of disproportionate incarceration in the U.S. and Washington State involves the Black community, particularly Black men. According to a publication by Black Minds Matter, African American/Black people are 20 percent more likely to experience serious mental health conditions than the general (U.S.) population<sup>58</sup> and experience disparity across several social determinant factors, including increased rates of homelessness, poverty, unemployment, food insecurity, exposure to violence and incarceration (see Familiar Faces jail statistics in section C.1., Tables 4-7). Black people comprise 13 percent of the U.S. general population, but 38 percent of the U.S. prison population.

In a study conducted by Beckett, Nyrop, & Pflingst (2006), University of Washington professor Dr. Katherine Beckett found that racially disproportionate drug arrest rates in Seattle cannot be explained by comparing commission rates, but are actually the result of policing practices that have a racially disparate impact.<sup>59</sup> Furthermore, there are long-standing, widely known issues with the lack of culturally responsive and culturally specific services and re-entry opportunities available in King County for individuals from nonwhite racial and ethnic groups.

This new concept incorporates a culturally informed and culturally responsive approach that is critical to the housing services provided to non-white Familiar Faces. This proposal will provide ample service delivery learning and education to providing culturally responsive and culturally specific services to Familiar Faces and other individuals residing in King County who can (or do) utilize publicly-funded behavioral health and primary care services. Many people of color in the jails are also living in extreme poverty and experiencing homelessness. Often, when these individuals come into contact with law enforcement because of these and other issues (living on the street, experiencing behavioral health

<sup>57</sup> [http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/](http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/).

<sup>58</sup> “Fact Sheet: *How Does Mental Health Challenges Impact the African American Community?*” Black Minds Matter, January 2015. Web. [http://www.cibhs.org/sites/main/files/file-attachments/how\\_do\\_mh\\_concerns\\_impact\\_af\\_am\\_community.pdf](http://www.cibhs.org/sites/main/files/file-attachments/how_do_mh_concerns_impact_af_am_community.pdf).

<sup>59</sup> Beckett, K., Nyrop, K. & Pflingst, L. *Race, Drugs and Policing: Understanding Disparities in Drug Delivery Arrests*. 44 *Criminology* 1, 105-138 (2006).

crises, engaging in survival economies), they are taken to jail in lieu of addressing the root cause of the matter: lack of access. Indeed, access to housing and services is critical to stop the cycle of incarceration.

## **F. Implementation Factors**

### **1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)?**

The following resources will be needed to implement this new concept:

- Housing provider and support staff training in Trauma Informed Care and Motivational Interviewing;
- Housing provider and support staff training in care coordination to best work with the Familiar Faces CMTs;
- Funds to assist with the mitigation of any damage that occurs to dedicated units, furniture or appliances.

### **2. Estimated ANNUAL COST. \$501,000-\$1.5 million Provide unit or other specific costs if known.**

The estimated annual cost to place an individual in PSH is \$18,000; the estimated annual cost to place an individual in transitional housing is \$10,800. Additional funds are requested as a landlord incentive to mitigate any damage that occurs to dedicated housing units.

Small Scale Implementation: A capacity of 20 PSH units for Familiar Faces is proposed at an annual cost of \$360,000. An additional \$162,000 per year is requested to secure transitional housing capacity for 15 individuals who are awaiting PSH placement. Mitigation/landlord incentive costs are requested at \$25,000 per year at this level. The total request for small scale implementation is \$547,000 per year.

Large Scale Implementation: A capacity of 40 PSH units for Familiar Faces is proposed at an annual cost of \$720,000. An additional \$324,000 per year is requested to secure transitional housing capacity for 30 individuals who are awaiting PSH placement. Mitigation/landlord incentive costs are requested at \$50,000 per year at this level. The total request for large scale implementation is \$1,094,000 per year.

### **3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

There may be some opportunity to work with HUD-Veterans Affairs Supportive Housing, the Seattle Housing Authority and King County Housing Authority Sponsor-based Housing Voucher Programs, and the King County Veterans and Human Services Levy to procure more housing resources beyond the financial scope of this briefing paper.

### **4. TIME to implementation: At least a year from award**

#### **a. What are the factors in the time to implementation assessment?**

Factors include identifying housing resources and vouchers, orienting housing providers to the project, training and education on the Familiar Faces strategy and service framework (e.g. Motivational Interviewing, Trauma Informed Care, Harm Reduction) and a competitive bid via the King County combined funders Notice of Funding Availability (NOFA) process (in collaboration with the DCHS Housing and Community Development staff).

#### **b. What are the steps needed for implementation?**

See above answer to 4.a.

**c. Does this need an RFP?**

Yes, through a King County combined funders NOFA typically involving the following local sponsors:

- City of Seattle,
- King County,
- A Regional Coalition for Housing,
- United Way of King County,
- Seattle Housing Authority, and
- King County Housing Authority.

**G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?**

The proposal relates to another MIDD II briefing paper entitled: *BP 44 Familiar Faces Cultural Care Management Teams*

**New Concept Submission Form**

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

**#114 Working Title of Concept: Familiar Faces**

Name of Person Submitting Concept: Liz Arjun

Organization(s), if any: King County Department of Community and Human Services, Public Health-Seattle & King County

Phone: 206.263.2107

Email: Elizabeth.arjun@kingcounty.gov

Mailing Address: 401 Fifth Ave. Suite 900, Seattle, WA 98101

*Please note that county staff may contact the person shown on this form if additional information or clarification is needed.*

*Please share whatever you know, to the best of your ability.*

*Concepts must be submitted via email to [MIDDconcept@kingcounty.gov](mailto:MIDDconcept@kingcounty.gov) by **October 31, 2015**.*

**1. Describe the concept.**

Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Fund implementation of the following elements of the Familiar Faces ideal design to accelerate improvements, achieve outcomes, and leverage other funding (e.g. Medicaid waiver):

- Identification and Targeting: including implementation of PRISM, the State's high-utilizer

predictive modeling tool

- **Coordination and Triage:** including identification of Familiar Faces through implementation of a shared care plan/client registry, and use of a high-utilizer notification system (EDIE or similar) to manage emergency department and jail utilization
- **Intensive care teams\*:** including outreach and case management (housing, social services, mental health and substance use), transitions from and community integration after incarceration, and primary care management
- **Integrated services:** including expansion of the Mental Health Integration Program (MHIP) and Screening, Brief Intervention and Referral to Treatment (SBIRT) to provide integrated evidence-based physical and behavioral health services to the target population, including during incarceration.
- **Supportive Housing:** including coordinated entry to prioritize Familiar Faces for housing using Section 8 or Shelter + Care vouchers.

\*Using models that are already in place in the community, e.g. REACH/LEAD, peer bridgers, Health Care for the Homeless interventions, community health workers

**2. What community need, problem, or opportunity does your concept address?**

Please be specific, and describe how the need relates to mental health or substance abuse.

The Familiar Faces Initiative, a priority of the King County Health and Human Services Transformation Plan, is a broad-scale systems improvement effort focused on adults who are booked into the County jail four or more times in a 12-month period and who also have a mental health and/or substance use disorder condition. These individuals also have high levels of chronic medical conditions, housing instability, chronic homelessness and unemployment.

The hypothesis is that if system improvements can be made that result in better health and social outcomes for these individuals, the lessons learned will have much broader implications in how our region moves forward with other system improvements.

**3. How would your concept address the need?**

Please be specific.

Strategic improvements, rigorously evaluated to ensure effectiveness, would contribute to an improved system for the Familiar Faces in our region to achieve the following outcomes:

- Improved Health
- Improved Housing Stability
- Reduced ED Usage
- Reduced Criminal Justice Involvement
- Improved Client Satisfaction

**4. Who would benefit? Please describe potential program participants.**

Data matched between the King County Departments of Community and Human Services (Division of Mental Health Chemical Abuse and Dependency Services), Department of Adult and Juvenile

Detention, Public Health- Seattle & King County (Jail Health Services) indicate that during 2013 and 2014 approximately 1,200 individuals met the criteria (booked 4 or more times in a one-year period who also had a mental health or substance use disorder). In addition to the system improvements that could improve the outcomes for this “sentinel” population, it is anticipated that these improvements will result in improvements for many other individuals receiving King County services.

Cross-sector participation would include partners from health, housing, human services, first responders, and criminal justice. Familiar Faces would also participate in the design and implementation of solutions. Familiar Faces, service providers, County and City government and the residents of Seattle and King County would benefit from system improvements.

**5. What would be the results of successful implementation of program?**

Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Long-term outcomes include:

- Improved Health
- Improved Housing Stability
- Reduced ED Usage
- Reduced Criminal Justice Involvement
- Improved Client Satisfaction

The Familiar Faces Initiative is currently undergoing a Results-Based Accountability Process to develop an outcomes framework that will identify measurable short-, medium-, and long-term results.

**6. Which of the MIDD II Framework’s four strategy areas best fits your concept? (you may identify more than one)**

- ✓  **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
- ✓  **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
- ✓  **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
- ✓  **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

**7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?**

This concept directly targets this population.

**8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.**

Organizations from health, housing, human services, first responders, and criminal justice are already engaged and necessary for this initiative to be successful. Familiar Faces would also participate in the design and implementation of solutions.

**9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?**

**Pilot/Small-Scale Implementation:** \$ # of dollars here per year, serving # of people here people per year

**Partial Implementation:** \$ # of dollars here per year, serving # of people here people per year

**Full Implementation:** \$ # of dollars here per year, serving 1,200 people per year

Once you have completed whatever information you are able to provide about your concept, please send this form to [MIDDConcept@kingcounty.gov](mailto:MIDDConcept@kingcounty.gov), no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at [MIDDConcept@kingcounty.gov](mailto:MIDDConcept@kingcounty.gov).

**King County Section 1115 Waiver Concept Submission (January 15, 2016)**

<p><b>Contact Information</b></p>	<p>Liz Arjun, King County; 206.263.9107; <a href="mailto:Elizabeth.arjun@kingcounty.gov">Elizabeth.arjun@kingcounty.gov</a></p> <p><b>Which organizations were involved in developing this project suggestion?</b>  Over the past year, a multi-sector design team in King County has engaged in planning sessions that informed the development of the “Familiar Faces” initiative. Their work has informed this project suggestion, and its implementation would come under the auspices of the Familiar Faces Steering Committee</p>
<p><b>Project Title</b></p>	<p><b>Intensive Community-Based Care Teams for Adults With Complex Health and Social Needs Including Justice System Involvement (King County Familiar Faces)</b></p>
<p><b>Problem Statement</b></p> <p>It is well established that a small subset of the population accounts for the majority of health care costs. While innovative models of care management for the Medicaid population with complex needs continue to evolve, relatively few focus on individuals transitioning into and out of the criminal justice system, a group that includes many low-income adults with significant physical and behavioral health needs who face various economic, social, legal, and housing challenges. When the ACA expanded coverage, many previously uninsured adults with justice system involvement became eligible for Medicaid. Partners in King County were especially successful in enrolling eligible individuals into Medicaid, including many justice-involved adults.</p> <p>While Medicaid rules preclude the use of Medicaid resources for people while they are incarcerated, the need to better coordinate care for these beneficiaries as they enter, leave, or are diverted from local jails is critical for improving their health and social outcomes – and for controlling costs in Medicaid. Studies have found that justice system involvement has been associated with higher hospital and ED utilization, for example. Local data analysis of this population confirms the extent of complex health issues: a King County data analysis found that during calendar years 2013 and 2014, more than 1,273 and 1,252 individuals, respectively were booked into the King County Jail system four or more times. Of these two cohorts; 94 percent had a behavioral health condition (including mental</p>	

health and or substance use disorder), 93 percent had at least acute medical condition, 51 percent had at least one chronic medical condition, and more than 50 percent were homeless.

The Familiar Faces Initiative, a current initiative of focus for the King County region’s Accountable Community of Health during its design year, is a broad-scale systems improvement effort focused on individuals booked into the King County Jail four or more times in a 12-month period who also have a mental health and/or substance use disorder. In 2015, this Initiative pulled together a cross sector Design Team which includes representatives from housing providers, substance use providers, mental health providers, community health centers, Medicaid Managed Care Organizations, Public Health-Seattle & King County, the King County Department of Community and Human Services, the City of Seattle, criminal justice organizations including courts, police, and the King County Department of Adult and Juvenile Detention to design a system for the population focused on achieving the following outcomes: improved housing stability, improved health, improved housing stability, reduced emergency department usage, reduced criminal justice involvement, improved client satisfaction and lowered costs.

A recent report from the Center for Health Care Strategies, “Opportunities to Improve Models of Care for People with Complex Needs: Literature Review”<sup>i</sup> identifies a set of evidence-based strategies for improving outcomes and lowering costs for high-need, high-cost populations. The review cites care model aspects that have been associated with improved outcomes, such as the use of intensive, multi-disciplinary care teams, effective targeting, physical/BH integration, the incorporation of trauma-informed approaches, patient activation strategies, and addressing housing stability, among others. These key elements are found in the proposed project design for Familiar Faces. The CHCS literature review contains the key findings and outcomes (including cost reductions) for the most recent studies of care management models for high-risk, high cost populations. Examples include models such as Hennepin Health, whose preliminary results have shown a shift in care from ED and hospital to outpatient settings, and the percentage of patients receiving optimal diabetes, vascular, and asthma care has increased, as has patient satisfaction.

This project would have a significant impact on Medicaid beneficiaries in moving this complex population from a reliance on episodic use of high cost, intensive services such as the Emergency Department, inpatient hospitalizations and the King County Jail, to a community-based model of harm reduction interventions and primary care that includes access to support in navigating the criminal justice system and access to needed social supports.

**Project Description**

*Which Medicaid Transformation Goals<sup>ii</sup> are supported by this project/intervention? Check box(es)*

- X Reduce avoidable use of intensive services
- X Improve population health, focused on prevention  
Accelerate transition to value-based payment
- X Ensure Medicaid per-capita growth is below national trends

*Which Transformation Project Domain(s) are involved? Check box(es)*

- X Health Systems Capacity Building
- X Care Delivery Redesign  
Population Health Improvement – prevention activities

**Target Population**

Three groups would be target for this intervention in the King County Region Including:

- Adults who are frequent users (defined as having been booked four or more times into the King County Jail) who also have a mental health or substance use disorder.
- Individuals who are diverted from a jail booking by law enforcement through the Law Enforcement Assisted Diversion Program (LEAD) program who have a mental health and/or substance use disorder.
- Youth involved in the juvenile justice system who have a mental health and/or substance use disorder. Data indicate that more than 50 percent of the Familiar Faces population between the ages of 19-24 had at least one encounter with the juvenile justice system. This does not include Familiar Faces over the age of 24 and is therefore likely an underrepresentation of the proportion of the population that has touched the juvenile justice system before ever becoming a “Familiar Face”.

**Relationship to Washington’s Medicaid Transformation goals.**

This project will reduce avoidable use of intensive services, such as hospital emergency rooms and inpatient hospitalizations, jails stays; and impact the Medicaid cost per capita growth to remain below the national average.

**Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.**

The overarching goal of the Familiar Faces Design Team is to improve health and social outcomes by implementing the comprehensive “Future State Vision” in the King County region. This Medicaid project would accelerate the refinement and testing of a core element of the Future State Vision: Community-Based Intensive Flexible Care Management Teams with connections to criminal justice system supports. As detailed further in the project metrics section, expected outcomes include: improved housing stability, improved health, improved housing stability, reduced emergency department usage, reduced criminal justice involvement, improved client satisfaction and lowered costs.

These Care Teams are designed to be community-based and not belong to one system, one agency or one program and will be centrally managed in the Region to ensure standardization and minimize duplication across the system. Care Teams would be equipped with tools to be electronically connected and use of single care plan either through the Emergency Department Information Exchange (EDIE) or by becoming a testing site for Link4Health. Most importantly, these community-based teams would allow for the flexibility necessary to provide continuity of care serve a population whose needs change, who may flow in and out of coverage, whose managed care plan may change, and whose access to care management should be able to flex and move with the person without disrupting trusting relationships.

**Links to complementary transformation initiatives**

- **King County Mental Illness and Drug Dependency (MIDD) Action Plan**- Local levy in the King County Region that provides more than \$50 million annually to support programs for people suffering from mental illness and chemical dependency, diverting them from jails and emergency rooms by getting them proper treatment.
- **Law Enforcement Assisted Diversion (LEAD)**- A current model in the King County Region, has seen great success as a promising practice to divert low-level offenders from the criminal justice system by ensuring the health and social support needs for the individual are addressed. LEAD contracts with an outreach organization equipped to provide these services while prosecutors and law enforcement manage criminal justice involvement to keep the individual in the community.
- **Physical and Behavioral Health Integration Subcommittee/King County Accountable Community of Health**- The King County Accountable Community of Health has established a Design Committee tasked with developing a model of fully integrated health care for the region. This work is happening in close collaboration with the

Familiar Faces Initiative and is expected to propose similar design elements, e.g. Community-Based Care Teams.

- **Coordinated Entry for Housing and Housing Supports-** One of the foundational supports necessary for improving outcomes for the Familiar Faces population is access to housing and associated supports; data indicate that over half of the population was identified as homeless. The supportive housing supports that would be developed under Initiative 3 could potentially be accessed as a resource for some of the Familiar Faces. However, this will not address the overall lack of available housing for the population in the region. While it is understood that Medicaid cannot make capital investments to increase the housing resources in the region, it will be important to continue to advocate for these resources in the region.
- **SAMHSA Trauma-Informed Care “Train the Trainer”:** King County, along with the Washington State Department of Corrections, the City of Seattle and other key partners from the Familiar Faces Initiative were recently awarded a SAMHSA grant to help develop a Trauma-Informed System, one of the foundational elements of the Familiar Faces Future State Vision. This funding and technical assistance supports development of comprehensive trauma-informed approach across the health and human service and criminal justice systems in the region.

**Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.**

This project builds upon multi-sector work done to date in King County through the Familiar Faces Initiative that includes representatives from the criminal justice system, community-based mental health and substance abuse providers, hospitals, housing providers, managed care plans and local government. This project has been one fostered by the King County ACH and would continue to involve a multi-sector implementation team.

#### **Core Investment Components**

#### **Proposed activities and cost estimates (“order of magnitude”) for the project.**

##### **Project Manager for the Familiar Faces Steering Committee:**

As strategies are implemented, refined, and expanded, this will be the entity responsible for the development of procedures/protocols/MOU development among the many partners involved. This entity will also be responsible for monitoring data to determine if course corrections are necessary in order to achieve overall outcomes, where cost shifting or cost savings are occurring and potentially serve as a place where shared savings are negotiated. This committee is also responsible for monitoring and oversight of other related strategies that will support the Intensive Community-Based Care Teams, including selection and testing of care tools such as EDIE or Link4Health to support care planning and the recently awarded SAMHSA Trauma-Informed Care grant. Estimated Cost for Project Manager: \$125,000/year

##### **Intensive Community Based Care Teams:**

Each care team will serve approximately 25 individuals. Care teams would include the following components: ARNP, mental health professionals with substance use expertise, care manager with substance use disorder, mental health or co-occurring disorder expertise, OT/vocational support, peer or community health worker and housing support specialist. Some of these positions would be funded by traditional Medicaid sources; others would be funded by this project. Given ongoing negotiations, it is unclear how much would be paid for via these funds and how much would need to be paid for via the project. At a minimum we anticipate that care manager and peers/community health workers would be paid for via the project. Estimated costs are below:

#### **Care Team Costs**

Care manager with substance use disorder expertise, mental health and co-occurring disorders expertise-(depending on need of client)	\$100,000/year
Peer or Community Health Worker	\$50,000/year
<b>Total per Care Team</b>	<b>\$150,000/year</b>

**Total Estimated Costs, Number of Individuals Served & PMPY**

	Individuals Served	Number of Teams	Team & Project Manager	PMPY
Year 1	250	10	\$1,625,000.00	\$6,500.00
Year 2	500	20	\$3,125,000.00	\$6,250.00
Year 3	1,000	40	\$6,125,000.00	\$6,125.00
<b>Total</b>			<b>\$10,875,000.00</b>	

**How long it will take to fully implement the project within a region where you expect it will have to be *phased in*.**  
Two years

**The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.**  
Work is ongoing in the King County Office of Performance of Strategy and Budget to better understand the costs associated with serving the Familiar Faces population in the current system. This includes costs associated with jails stays, court proceedings, behavioral health care costs. We are just beginning to receive claims information about physical health care costs. This information will help us to better understand the ROI opportunities. Based on previous work in the region, we can estimate at a minimum a 15% reduction in emergency department costs and a 10% reduction in hospitalization costs for the population. Because we are just beginning to obtain claims data for the population, we do not have the full picture yet of what this translates into on a per person basis. We anticipate having more information to better understand the ROI opportunities by June 2016.

**Project Metrics**

The Familiar Faces Steering Committee is working to identify specific measures that can be tied to the overall outcomes that the Future State Vision was developed to address. These measures will pull from the statewide common metrics set and Medicaid starter set. *Potential Examples* are given below.

**Improved health status**

- Access to Preventive/Ambulatory care

**Improved housing stability**

- Attainment of housing/reduced homelessness
- Retention in housing for 12+ months (HUD)

**Reduced criminal justice involvement**

- Reduced jail admissions and days

**Reduced avoidable hospital and ED use**

- Reduced 30-day all-cause readmission

**Improved client satisfaction with quality of life (QOL)**

- Improved WHOQOL physical, emotional, social QOL

## MIDD II Briefing Paper

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<sup>1</sup> [http://www.chcs.org/media/HNHC\\_CHCS\\_LitReview\\_Final.pdf](http://www.chcs.org/media/HNHC_CHCS_LitReview_Final.pdf)