MIDD Briefing Paper

BP 44 Familiar Faces Culturally Responsive Care Management Teams

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 New Concept focuses on individuals with a mental health and/or substance use disorders who are high utilizers of the criminal justice system (specifically, the King County Jail) — the so-called "Familiar Faces". Many of these individuals experience complex chronic health conditions, histories of trauma, substance use, and chronic homelessness or instability in housing and other aspects of their lives and are familiar to these various systems; hence the term Familiar Faces.

Care Management Teams (CMTs) proposed in this briefing paper entail intensive, flexible community-based services using a flexible and care approach with integrated mental health and substance use disorder treatment, along with primary health care and employment training, into a single comprehensive team that supports the reentry 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 therapist (for lower functioning individuals), psychiatric prescribing resources and a medical staff (Registered Nurse). CMT's will provide services in nontraditional 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.

In short, CMTs will have high staff-to-client ratios to assure frequent contact and availability and address the community locations (rather than clinic-based) that will be provided. The following staffing constellation will provide the staffing framework for CMTs serving 60 to 80 individuals, depending on need and level of functioning of the individual:

- Mental Health Professionals
- Chemical Dependency Professionals (CDP) and CDP Trainees
- Registered Nurse or other nursing staff (to address medical/primary care needs and lead coordination with primary care providers)
- Dedicated Prescriber time
- Occupational Therapist
- Peer Support (Community Health Worker)

Collaborators:

Name	**Department**
Liz Arjun	DCHS - Transformation

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Margo Burnison	**DRS Contract Monitor**	**DCHS**

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

This New Concept focuses on individuals with a mental health and/or substance use disorders who are high utilizers of the criminal justice system (specifically, the King County Jail) — the so-called "Familiar Faces". Many of these individuals experience complex chronic health conditions, histories of trauma, substance use, and chronic homelessness or instability in housing and other aspects of their lives and are familiar to these various systems; hence the term Familiar Faces.

Care Management Teams (CMTs) proposed in this briefing paper entail intensive, flexible community-based services using a flexible and care approach with integrated mental health and substance use disorder treatment, along with primary health care and employment training, into a single comprehensive team that supports the reentry 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 therapist (for lower functioning individuals), psychiatric prescribing resources and a medical staff (Registered Nurse). CMT's will provide services in nontraditional 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.

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Additionally, these culturally responsive and culturally specific CMTs will provide services from an anti-oppressive practice approach in order to address individual level discrimination Familiar Faces encounter in their daily lives by 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 rather than traditional medical models, which are steeped in white culture.[1]

All of the following core competencies are expected to be suffused throughout the services provided by the CMTs and are addressed in section B.4:

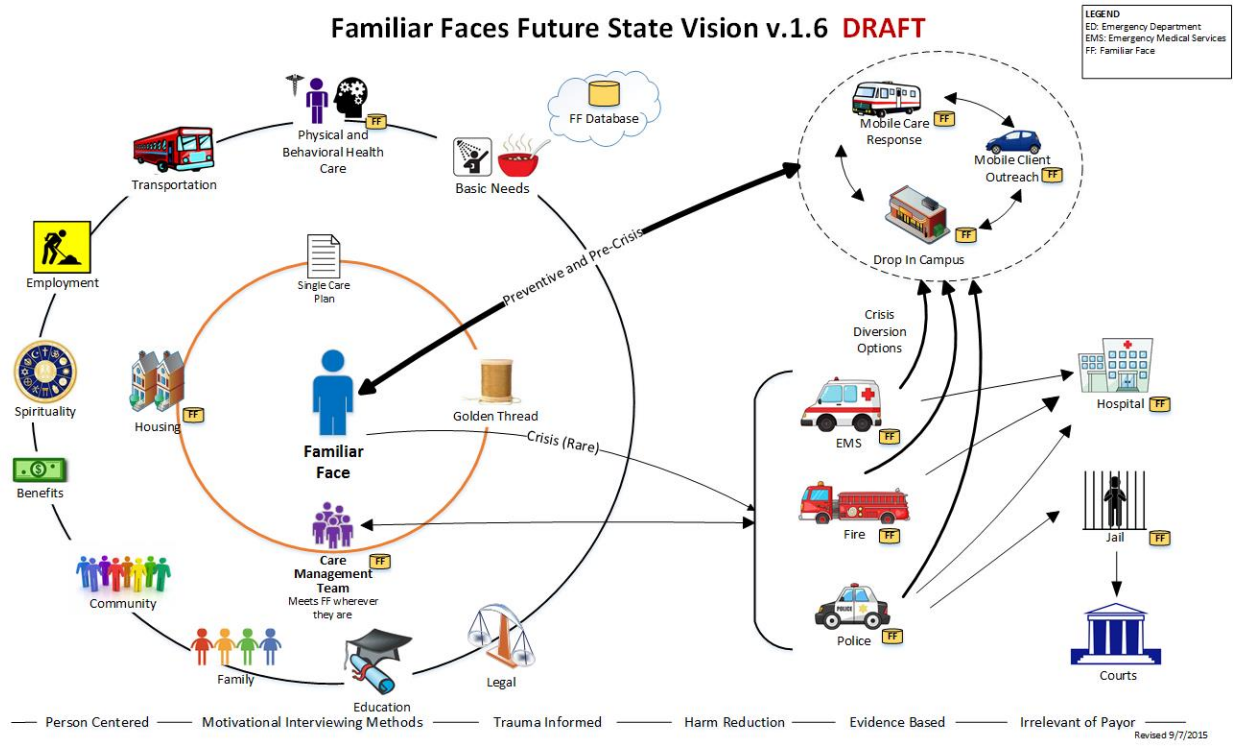
1. Motivational Interviewing
2. Permanent Supportive Housing from a Housing First Approach
3. Assertive Outreach/Engagement
4. Trauma Informed Care
5. Harm Reduction
6. Integrated Care and Care Coordination
7. Culturally Responsive Services; Equity and Social Justice

Diversion Framework for CMT: Law Enforcement Assisted Diversion[2] (LEAD)
LEAD will provide a community-based, single point of contact for CMT referrals, diversion, and criminal justice system coordination. LEAD was founded in Seattle/King County in 2011 and now replicated nationally, is a key partner to behavioral health diversion options in King County. LEAD allows diversion prior to jail booking and prosecution for individuals in behavioral health crisis or struggling with behavioral health issues in the community. Individuals are diverted at the point of law enforcement contact to case management services and provided with advocacy and the resources they need to reduce the behaviors that drive their criminal justice involvement. In addition, LEAD offers a community engagement aspect, focused on culture shift towards a harm reduction approach because it is proven more successful, over time, in reducing problematic behavior than standard zero-tolerance approaches. LEAD allows the formal justice system also to coordinate decision-making (e.g., prosecutors' decision whether to file a new case, whether to seek detention, whether to dismiss, whether to quash a warrant) in order to increase the likelihood that LEAD participants' individual intervention plans with their case managers can succeed. LEAD has been independently evaluated by a research team funded by the Arnold Foundation and found to reduce recidivism compared to similarly situated people who receive "business as usual" justice system responses; it also costs less than standard court-based processing. Presently in King County, individuals suspected of subsistence-level drug crimes or sex work, are eligible for LEAD diversion; LEAD participants, however, often have committed crimes against people or property as a result of their drug involvement. LEAD individuals with certain violent criminal conviction history are excluded from diversion, but may be considered "social contact referrals" (people known to commit drug offenses or prostitution but for whom probable cause to arrest does not presently exist). Familiar Faces have a more comprehensive array of services available; however, LEAD diversion and social contact referrals could be broadened to facilitate a referral of Familiar Faces who would not otherwise be referred to LEAD. The CMT will be working closely with LEAD program operations, which may be one of the referral paths in identifying Familiar Faces in the community for ICMT services.

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

Statement about MIDD II Briefing Paper Concepts Intersections

This Culturally responsive and culturally informed CMT new concept aligns with a service system and array that creates a robust health and human services system that not only provide the supports the Familiar Face wants and needs (left side of below map) but also offers the outreach and diversion aspect of this picture (***See map and table on next page***).



Together, this briefing paper, along with the following address an entire *System of Care* for any complex population with behavioral health issues that encounters the criminal justice system:

Care Management Teams (left side of map)	• *BP 44 Familiar Faces Culturally Responsive Care Management Teams*
Diversion (Crisis Diversion Options on top right – "Drop In Campus")	• *BP 23 Law Enforcement Assisted Diversion Maintenance and Expansion* • *BP 37 51 64 66 South County Crisis Center* • *ES 10b Crisis Diversion Facility* • *BP 74 Outreach and Interdisciplinary Case Management for Chemically Dependent Adults who Utilize Dutch Shisler Service Center*
Outreach (top right, "Mobile Crisis Response and Mobile Outreach")	• *ES 1b BP 34 39 63 72 Outreach System of Care* • *BP 115 Eastside Homelessness Outreach Team* • *BP 73 Mobile Medical Program* • *BP 35 Homeless Outreach Coordination*
Court & Jail-Based Options	• *ES 11a ES 12a BP 52 79 80 Jail Reentry System of Care* • *BP 118 133 136 Competency Continuum of Care*

(bottom right)	• *ES 11b BP 8 BP 93 Regional Mental Health Court Services and Continuous Improvement Welbaum*
Housing to Support Familiar Faces (top left)	• *BP 114 Familiar Faces*

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):
   ☒ **Crisis Diversion** ☐ **Prevention and Early Intervention**
   ☒ **Recovery and Re-entry** ☒ **System Improvements**
   Please describe the basis for the determination(s).

Although Familiar Faces are identified by King County jail utilization under a reentry approach, the hope is that these CMTs will be intervening with individuals and preventing future criminal justice involvement, and some individuals may be identified in the community through utilization of other community-based resources (e.g. crisis diversion centers, interface with Law Enforcement Assisted Diversion[3], etc.) This care management approach via the FFFSV offers multiple opportunities for system-wide improvements.

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.**

The Familiar Faces Future State Vision (FFFSV) centers these individuals in a Care Management Team (CMT). The CMT is the core team providing services and "golden thread" support and connection for the Familiar Faces. The CMT includes the flexibility to accommodate and address the level of care and specific needs the individual has at the time of enrollment, and ongoing, regardless of payer. The care team uses evidence-based approaches including trauma-informed care and motivational interviewing[4]. Some of the other general areas for improvement that were identified to make progress towards the FFFSV, and are important to the success of the flexible CMT, include:

- 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;

[3] http://leadkingcounty.org/. Accessed on 12/23/15.
[4] http://www.motivationalinterview.net/clinical/whatismi.html. Accessed on 12/23/15.

- 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.

In order to address the equity and social justice goals and the number of individuals identified as Familiar Faces who are non-white, several culturally responsive care management teams will be needed. Community-based agencies already providing culturally specific and culturally responsive behavioral health, primary care and reentry support services will be sought to provide the Familiar Faces with CMTs. Addressing trauma as a result of both interpersonal violence and childhood experiences as well as historical and cultural trauma will be critical for the healing of the individuals served by these CMTs. Exploring alternative interventions which are culturally informed, such as substance use disorder treatment for historically disempowered communities,[5] will be foundational to how services are delivered.

There are long-standing, widely known issues with the lack of culturally responsive and culturally specific services and reentry opportunities available in King County for individuals from non-white racial and ethnic groups, who are overrepresented in the local criminal justice system. An anti-oppressive practice lens is critical to the behavioral health services provided to non-white Familiar Faces. Provision of training in anti-oppressive frameworks for 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 would be a system service improvement. Many people of color in King County 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 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 treatment, housing, jobs, support, healing and recovery, and access to a community of people who care and value them as people, is critical to stopping the cycle of incarceration.

In 2013, King County, in partnership with community stakeholders, developed a plan for an accountable, integrated system of health, human services, and community-based prevention – referred to as the King County Health and Human Services (HHS) Transformation Plan. 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."[6]

To catalyze improvement in the system's performance for everyone, the plan called for an initial focus on areas where improved performance is most critical – for the individuals and communities experiencing 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: individuals with a behavioral health disorder who are high utilizers of the King County Jail, the Familiar Faces. These individuals commonly experience complex

[5] White, W. & Sanders, M. (2004). *Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities*. Posted at www.bhrm.org.
[6] http://www.kingcounty.gov/elected/executive/health-human-services-transformation.aspx. Accessed on 12/23/15.

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

Table 1: Racial disproportionality of the Familiar Faces population (Source: Familiar Faces data[7])

Race	2013 cohort	%	2014 cohort	%	Total 2013 + 2014	%	Unique persons in jail (2013)*	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/Unk	5	0.4%	7	0.6%	12	0.5%	0.6%	2.3%
TOTAL	1273	100.0%	1252	100.0%	2525	100.0%		

*The percentage of White race goes down by approximately four percent when examining total bookings rather than unduplicated people (i.e., whites are less likely to have multiple bookings).

FINDING: Familiar Faces are somewhat more likely to be male and non-white than the overall jail population.[8]

Background – Familiar Faces Individual level strategy

The Familiar Faces initiative promotes systems coordination for individuals who are high utilizers of the King County 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. 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 Accountable Communities of Health and system delivery reform efforts.

Familiar Faces Current State Mapping. Using Lean 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 put 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, not people centric;
- Funding stream requirements drive the current system;
- There are philosophical differences across various organizations in the system;
- Need to stop "brick and mortar thinking" that services need to be facility-based, and explore more virtual and mobile options.

[7] Data compiled during the Familiar Faces Design Team process, summer of 2015.
[8] Ibid, Familiar Faces Design Team (2015).

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

To achieve the vision called for in the King County HHS Transformation Plan and improve health and social outcomes for the Familiar Faces population, it became clear that a new approach was necessary. Past efforts have generally occurred in silos, have been programmatically focused, and have failed to affect broad cross-sector policy changes. In transforming how King County does business, two key elements have helped to guide this new 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.

Other Familiar Faces Data.[9] 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 disproportionally people of color compared with King County as a whole and overall jail population;
- 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 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 common Most Serious Offenses (MSO) 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.

Homelessness. Data below are from the document, *"King County One Night County Summary of 2015 Data"* [10] provided by All Home (formerly the Committee to End Homelessness). According to 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 by race for those individuals:

Table 2: Race and ethnicity of individuals served in emergency shelters (ES) and transitional housing (TH) programs (by percentage of homeless and general populations)

[9] Ibid, Familiar Faces Design Team (2015).

[10] *King County One Night Count: Summary of 2015 Data*. All Home King County (2015).

2015 One Night Count					
	Sheltered Homeless Population				General Population[11]
	ES	TH	Combined		
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%)
	Total number of people			6,275	

Notes: 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.

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

Community-based agencies already providing culturally specific and culturally responsive behavioral health treatment, primary care and reentry support services will be sought to provide these Familiar Faces CMTs.

The following services will be provided via culturally informed and culturally responsive CMTs throughout the County with an initial focus on those communities who are overrepresented in jails in King County: Black/African American, Native American/Alaska Native and Latino residents of King County and those who are homeless upon release. Specific interventions will be matched to each racial/ethnic group and include the following.

Housing-Related Services

- Permanent supportive housing to stabilize and support housing tenure provided in concert with Coordinated Entry efforts, partnerships with housing providers and local housing authorities and other permanent supportive housing resources proposed to support the Familiar Faces population (*See BP 114 Familiar Faces*);
- Range of housing models to accommodate and support individual stabilization and recovery;
- CMT staff will be trained as *housing assessors* under the Single Adult Coordinated Entry system in development in King County.[12] [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 Assessment*;

[11] General Population data cited from: http://quickfacts.census.gov/qfd/states/53/53033.html.

[12] 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).

- 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.

A harm reduction framework will be applied to all CMT 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.[13] 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").

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.[14]

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.**

The greatest impact of disproportionate incarceration in the United States 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[15] and experience disparity across several social determinant factors, including increased rates of homelessness, poverty, exposure to violence and incarceration (see Familiar Faces jail statistics above). African American/Black people make up 40 percent of the population experiencing homelessness in the U.S. and are disproportionately affected by poverty, food insecurity and unemployment. Nationally, 12 percent of Black/African American people live in deep poverty (less than 50% of the federal threshold), compared to six percent of the general U.S. population. Black/African American children are more likely to be exposed to violence than other children and also experience inter-generational trauma. Nationally, Black people make up 13 percent of the population, but 38 percent of the U.S. prison population.

[13] Harm reduction: An approach to reducing risky health behaviours in adolescents, Pediatrics & Child Health, 2008 January; 13(1): 53–56.
[14] http://harmreduction.org/about-us/principles-of-harm-reduction/.
[15] "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.

In a study conducted locally by Beckett, Nyrop, & Pfingst (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.[16]

In *The Sentencing Project* report by Mauer and King (2007), the researchers found that the U.S. rates of incarceration are the highest of any industrialized country and, when sorted by race and ethnicity (by state), showed high disproportionality certain racial/ethnic groups.[17] The data showed Whites are incarcerated at a rate of 412 per 100,000 White residents; Blacks are incarcerated at a rate of 2,290 per 100,000 Black residents; and Latinos are incarcerated at a rate of 742 per 100,000 Latino residents. Indeed, African Americans/Blacks are incarcerated 5.6 times and Latinos at 1.8 times the rate of Whites.

There are limited studies on the effectiveness of providing culturally competent behavioral health treatment[18] that is culturally informed and culturally responsive. Few comparative studies exist, and there is a lack of consistency in outcome measures across multiple studies; however, outcomes are currently so disparate for ethnic minorities and racial groups, it is critical that a new path be forged. Providing culturally competent services has the potential to improve health outcomes, increase the efficiency of clinical and support staff, and improve client satisfaction with services.[19]

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

While many evidence-based practices (EBPs) will be embedded in the CMT model, the use of anti-oppressive practices to complement recovery oriented and person-centered approaches, is critical. As most mental health/substance use disorder treatment EBP's are researched on a predominantly White population, it is important to have a critical and continuous improvement lens to these CMTs to ensure that services are not perpetuating marginalization and negatively impacting those individuals being served, furthering their disenfranchisement with the publicly-funded services system.

The U.S. Department of Health and Human Services (HHS) Office of Minority Health has a listing of *The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care,*[20] which provides some guideposts for providers of CMT to align with the populations they serve and ensure that services are culturally responsive and informed. In the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities,*[21] several strategies that are called out directly relate to the provision of the CMT, including *reduce disparities* (strategy I.B.[22]) in access to primary care services and care coordination, which focuses on migrant workers, people experiencing homelessness and residents of

[16] Beckett, K., Nyrop, K. & Pfingst, L. Race, *Drugs and Policing: Understanding Disparities in Drug Delivery Arrests*. 44 Criminology 1, 105-138 (2006).
[17] Mauer, M. & King, R.S. *Uneven Justice: State Rates of Incarceration by Race and Ethnicity 4* (The Sentencing Project 2007).
[18] Anderson, L.M., Scrimshaw, S.C., Fielidng, J.E., Normand, J., Task Force on Community Preventive Services. *Culturally Competent Healthcare Systems: A Systematic Review*. American Journal of Preventive Medicine, 2003; Vol. 24, No. 3S, pp. 68-79.
[19] Brach, C., Fraser, I. *Can Cultural Competency Reduce Racial and Ethnic Disparities? A Review and Conceptual Model*. Med Care Res Rev, *2000*; 57 (sup 1): 181-217.
[20] https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards.
[21] U.S. Department of Health and Human Services. *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*. Washington, D.C.: U.S. Department of Health and Human Services, (April 2011).
[22] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed 12/28/15.

public housing. Community-based health teams (e.g. health home model) are recommended in order to establish agreements with primary care providers and other health care providers to improve care coordination. Another HHS Action Plan strategy (II.C.3[23]) calls for an increase in the diversity and cultural competency of clinicians, including behavioral health workers. The CMT provides an opportunity for King County to direct resources at some of the County's most marginalized populations, and align with national best practices on care coordination and treatment services that are culturally responsive and informed.

The following evidence-based, best and promising practices will embedded in the New Concept along with culturally competency services.

Motivational Interviewing (Evidence-based practice)

Motivational interventions aim to respect and promote client choice. It is a directive, client centered approach for eliciting behavior change by helping clients to explore and resolve ambivalence. [24]

Permanent Supportive Housing from a *Housing First* approach (Best 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.[25] 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.[26]

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 approach 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 and other services are not to be connected to each other. Housing cannot be removed due to lack of utilization of services offered.[27] The CMT will work closely with other resources providing housing to accomplish this system-wide approach to housing.

Assertive Outreach/Engagement (Best practice)

Motivational interventions, which aim to respect and promote client choice, are the hallmark of assertive engagement. The support system works together to plan engagement strategies and is creative in their attempts to meet people "where they are at" in readiness for change. Clinical

[23] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf. Accessed 12/28/15.

[24] Rollnick, S. & Miller, W.R. (1995). *What is motivational interviewing?* Behavioural and Cognitive Psychotherapy, 23, 325-334. Cited from http://www.motivationalinterview.net/clinical/whatismi.html.

[25] 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.

[26] Ibid, *Ending the Cycle of Homelessness and Criminal Justice Involvement through Supportive Housing* (June 2011).

[27] http://www.endhomelessness.org/page/-/files/1425_file_WhatisHousingFirst_logo.pdf.

judgement is used to determine when these assertive engagement techniques need to be applied and to what degree. When motivational interventions have not worked, therapeutic limit-setting and other alternatives may be needed in the on-going planning process for assertive outreach and engagement.[28] Ongoing assessment of the individual's needs and corresponding level of care will be done at regular intervals.

Trauma-Informed Care (Best practice)

The experience of arrest, incarceration, and possible conviction is traumatic. For persons who have a mental illness this experience is often layered on a history of trauma, both in adulthood and childhood. Research suggests up to 50 percent of persons with a severe mental illness have a rate of three or more adverse childhood experiences (including abuse, neglect, and witnessing violence).[29] These traumatic experiences can be dehumanizing, shocking or terrifying, and often include betrayal of a trusted person or institution and a perceived loss of safety. Trauma can induce powerlessness, fear, recurrent hopelessness, and a constant state of alertness. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection.

Trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma that traditional service delivery approaches may exacerbate;, services and programs are delivered in a manner intended to avoid re-traumatization. This includes understanding the person's need to be respected, informed, connected, and hopeful regarding their own recovery and the interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression and anxiety).

CMT services must be trauma-informed, recognizing the impact of these experiences on a person. Trauma-informed services offer choice whenever possible, respect the dignity of the person, and support individuals in re-authoring their personal narrative, moving from "criminal" to community citizen, as well as from "victimhood" to personhood.

Trauma-focused Intervention | Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM) (Evidence-based practice)[30]

SPECTRM is an approach to client engagement that is based on an appreciation of the "culture of incarceration" and its attendant normative behaviors and beliefs. People with serious psychiatric disorders experience high rates of incarceration.[31] Through their experience in the uniquely demanding and dangerous environment of jail and prison, many develop a repertoire of adaptations that set them apart from persons who have not been incarcerated. The so-called inmate code—which includes rules and values such as do not snitch, do your own time, and do not appear weak—may manifest in certain behaviors such as not sharing any information with staff, minding one's business to an extreme, and demonstrating intimidating displays of strength. Although these behaviors help the person adapt during incarceration and act as survival skills in a hostile setting,

[28] *TMACT Protocol for Assertive Engagement & Consumer Self-Determination & Independence.* Cited from TEAGE, G., Monroe-Devita, M (2008, May) *Enhancing Measurements of ACT Fidelity: The Next Generation* as presented at the 24th Annual Assertive Community Treatment Association Conference, Indianapolis, Indiana, May 14-17, 2008.

[29] Lu, Weili, Mueser, Kim T., Rosenberg, Stanley D., Jankowski, Mary Kay. *Correlates of Adverse Childhood Experiences Among Adults with Severe Mood Disorders,* Psychiatric Services, 2008 (59):1018-1026.

[30] Rotter, M., McQuistion, H.L., Broner, N. and Steinbacker, M. Best Practices: The impact of the "Incarceration Culture" on Reentry for Adults with Mental Illness: A Training and Group Treatment Model. Psychiatric Services. 2005 (56): 265-267.

[31] Lamb HR, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. Psychiatric Services 49:483–492, 1998 Abstract, Medline

they seriously conflict with the expectations of most therapeutic environments and thus interfere with community adjustment and personal recovery. Simultaneously, mental health providers are frequently unaware of these patterns and misread signs of difficult adjustment as resistance, lack of motivation for treatment, evidence of character pathology, or active symptoms of mental illness. As a result, providers often experience unwarranted concerns about safety and lose opportunities for early and empathic engagement.

Intensive Case Management[32] (Evidence-based practice)
Intensive Case Management (ICM) or an alternate evidence-based model shall be used for the wraparound services provided in this project. The ICM model was designed for persons with severe mental illness who are either high users of services or not using traditional mental health services at all. The ICM model incorporates a full support philosophy and uses a multidisciplinary team approach. It involves assertive outreach, assessment of consumer need, and negotiation and care coordination. It combines the principles of case management with a low staff-to-consumer ratio;[33] active ICM caseloads are limited to 15 persons per case manager. The ICM team integrates services and coordinates with the courts, law enforcement, community services, housing providers, probation and/or the Department of Corrections as appropriate. The team encourages family involvement, where possible, and natural supports. It provides 24-hour crisis services.
The APIC Model of reentry support from jail by The National GAINS Center[34] (Best practice)
The Assess, Plan, Identify and Coordinate (APIC) model describes elements of reentry planning associated with successful reintegration for individuals with mental illnesses or other special needs who are being released from jails to the community. The APIC model is particularly important for breaking the cycle of repeated homelessness and incarceration.

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?

A Results-Based Accountability (RBA) framework is useful for identifying the target population level outcomes for all MIDD II work. At the system and program level, outcomes should be aligned with broader HHS Transformation outcomes in the Accountable Community of Health and Physical Behavioral Health Integration (Cross-Systems Performance Measures[35]) as well as the *Washington State Performance Measures Starter's Set* approved by the Performance Measures Coordinating Committee on December 17, 2014.[36]

The overarching outcomes for the Familiar Faces initiative, that these CMT's will be one aspect of, are based on a RBA framework:

1. Improved health,

[32] Addy, J., Mundil, K., Parker, T., Talbott, P. (2008). *Intensive Case Management for Behavioral Health Jail Diversion: The Lancaster County, Nebraska Approach.* American Jails. January/February 2008
[33] Myer, Piper S., Ph.D. and Morrissey, Joseph P., Ph.D. (2007). *A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas.* Psychiatric Services. American Psychiatric Association: 58:121-127, January 2007.
[34] Osher, F., Steadman, H.J., Barr, H. (2002) A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model: Delmar, NY: The National GAINS Center.
[35] SB 5732/HB 1519 (2013), *Cross-system performance measures for health plan contracting and system monitoring*, Adult Behavioral Health Services Task Force, posted by the Washington State Department of Health and the Health Care Authority: http://www.wspha.org/wp-content/uploads/2015/03/Wiesman-Teeter-Health-System-Transformation.pdf.
[36] http://www.hca.wa.gov/hw/Pages/performance_measures.aspx. Accessed 12/28/15.

2. Improved housing stability,
3. Reduced Emergency Department usage,
4. Reduced criminal justice involvement, and
5. Improved client satisfaction.

These culturally specific and culturally responsive Familiar Faces CMTs would have specific program-level outcomes focused on:

- A reduction in the annual number of Familiar Faces of color who are cycling through jails in King County;
- Increased access and penetration of Familiar Faces of color to behavioral health services;
- Increased access of Familiar Faces served to primary care and Apple health enrollment;
- Reduced deaths of Familiar Faces enrolled in these CMTs due to behavioral health conditions, chronic medical issues and/or chronic homelessness; and
- Increased diversion access and system response for criminal justice stakeholders, thus reducing the number of people with behavioral health conditions in King County jails.

C. Populations, Geography, and Collaborations & Partnerships

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

☐ **All children/youth 18 or under**	☒ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☒ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☒ **Immigrant/Refugee**
☒ **Older Adults**	☒ **Veteran/US Military**
☐ **Families**	☒ **Homeless**
☐ **Anyone**	☒ **GLBT**
☒ **Offenders/Ex-offenders/Justice-involved**	☒ **Women**
☐ **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.

Initial CMTs will focus on the three populations who are most overrepresented in the local jail system:

- Black/African American individuals,
- Latino individuals, and
- Native American/Alaska Native individuals.

Twenty percent of the Familiar Faces in each cohort year (2013 and 2014) experience severe and persistent mental illness, and over half experience homelessness. Over 80 percent have substance use issues, 93 percent have at least one acute medical condition(s), and 51 percent have at least one chronic

medical condition(s). A small percentage have gone through the competency process (some dismissed and referred to civil commitment assessment via Chapter 10.77 Revised Code of Washington[37].

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

Some CMTs may have a specific regional focus in King County based on participant choice and availability of housing. Care Management Teams will be provided throughout the County.

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 and design teams of the Familiar Faces initiative provide a large, cross-sector partnership, already in place, that is necessary for the alignment and oversight of the CMTs. Lean principles and evaluation resources will be needed in order to practice ongoing Plan, Do, Check, Act (PDCA) cycles to ensure the program is implemented from a continuous improvement perspective by both the providers of the 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.

The current cross-sector table for Familiar Faces includes 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, 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 (DCHS)/Diversion and Reentry Services staff, King County Department of Public Defense, King County Executive's Office, City of Seattle Mayor Ed Murray's Policy staff, and many more across human services and criminal justice. All of these partners can play a design and implementation role in CMT development.

Specifically, collaborations are necessary with the following governmental and non-profit agencies:

- Public Defender Agency - Law Enforcement Assisted Diversion (LEAD) program operations and the LEAD Policy Coordinating Group
- City of Seattle Municipal Court, including Mental Health Court/Veterans Treatment Court
- Seattle Fire Department
- Seattle Police Department
- King County Executive's Office
- King County Prosecuting Attorney's Office
- King County Department of Public Defense

[37] http://apps.leg.wa.gov/RCW/default.aspx?cite=10.77. Accessed 12/28/15.

- King County Department of Judicial Administration, including Adult Drug Diversion Court
- King County District Court, including Regional Mental Health Court/Regional Veterans Court
- King County Superior Court
- King County Department of Adult and Juvenile Detention, including the Community Corrections Division
- King County Sheriff's Office
- King County Regional Veterans Initiative Project
- King County Veterans Program
- City of Enumclaw Police Department and Municipal Jail
- City of Issaquah Police Department and Municipal Jail
- City of Kent Corrections Facility
- City of Kirkland Police Department and Municipal Jail
- South Correctional Entity and it coalition cities and municipal courts
- Seattle Housing Authority
- King County Housing Authority
- Plymouth Housing Group
- Public Health – Seattle & King County, including King County Jail Health Services
- Washington State Criminal Justice Training Commission
- Washington State Department of Corrections
- Washington State Department of Social and Health Services, including the Behavioral Health Service Integration Administration, Western State Hospital, and Belltown Community Service Office
- Northwest Justice Project
- WA State Department of Veteran Affairs, including Veterans Integration Services
- U.S. Department of Veteran Affairs, including Veterans Health Administration
- Suburban police departments throughout King County
- Suburban fire departments throughout King County
- Multiple community-based, non-profit behavioral health and housing providers under contract with King County DCHS/Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD)

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?

Health Care Reform and HHS Transformation are important drivers for this proposal. As shown by the Familiar Faces future state vision (FFFSV), the proposal is impacted via the commitment of a group from across different sectors to a common agenda for solving a specific social problem. The Familiar Faces population is engaging in services across a number of different service sectors, funded by different sources, consisting of different programs and different outcomes. The question to be answered is whether, by bringing these different sectors together to focus on a set of shared outcomes using the RBA framework, lasting improvements can be made for this population. This aligns with the intent of the Affordable Care Act and King County HHS Transformation.

Physical Behavioral Health Integration : CMTs Will Provide Integrated Physical and Behavioral Health Care Coordination

The Familiar Faces Design Team identified services, programs and agencies that were providing excellent services ("pockets of excellence"), and some programs have successfully integrated services across agencies and health care sectors. Examples include programs utilizing staff and teams from various medical, behavioral health, and housing agencies to provide outreach, medical, and behavioral health services to the individuals experiencing homelessness. Medicaid payment reform and the integration of risk for physical and behavioral health provide an opening for the community to build on such successes to improve care coordination and the quality of care. This ICMT can offer new opportunities to eliminate disconnects in treatment that cause fragmentation and reduce access to care. It can thus address the Washington State goals of achieving parity in terms of access to medical and behavioral health treatment.

Physical and behavioral health care coordination and integration for complex, high needs populations require models that operate very differently from the current usual practice. A person-centered system of care that includes an ongoing effort to coordinate general medical, behavioral, and community based health services and supports, is crucial.

In addition, CMT participants will need an established comprehensive care plan that all providers serving the participants have access to. Shared performance measures that include both behavioral health and general medical indicators will be needed. Goals should include greater access to preventive care, primary care, and health and wellness programs, as well as better access to mental health and substance abuse treatment services. [38]

Medical Home models provide a good framework for understanding the overarching goals of improved care coordination across behavioral health and primary care needs. Medical home models have established five functions that can be adapted to the ICMT model.[39]

- Comprehensive care: An established care team of providers that coordinate in order to meet the individuals' physical and mental health care needs, including prevention and wellness, acute care and chronic care.
- Patient-Centered: Relationship based care that takes the whole person into account and partners with the individual and self-identified supports. Understanding and respect of each individual's unique needs, culture, values and preferences are required.
- Coordinated Care: Medical home models identify this as coordinated with the broader health care system, including specialty care, hospitals, and community services and supports. ICMT individuals will also have the added need of criminal justice services that will need to be added to this coordination, as well as housing and other self-identify needs.
- Accessible Services: A need to have shorter wait times, enhanced in-person hours, around-the-clock telephone or electronic access to a care team member and alternative methods of communication (i.e. email, texts).
- Quality and Safety: A commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based and best practices, engaging individuals and supports, engaging in performance measurement and improvement, and sharing quality and safety data publicly.

[38] Smith, Erlich and Sederer (2013). *Integrated General Medical and Behavioral Health Care: The New York State Perspective.* Psychiatric Services Vol. 64, No. 9, pp 828-831.
[39] https://pcmh.ahrq.gov/page/defining-pcmh

The FFFSV puts the Familiar Face at the center of a care team that includes the flexibility to accommodate the level of care and specific needs the individual has at the time, regardless of payer. The CMT is one that uses a trauma-informed approach and motivational interviewing methods, and is evidence-based. Some of the general areas for improvement that were identified to make progress towards this vision include:

- The need for a single, standard and consistent care plan;
- A cloud dashboard and system to address real-time issues;
- An agreed upon portfolio of human services based in a Familiar Faces driven approach that uses trauma-informed motivational interviewing approaches aligned with harm reduction;
- Development of outreach and quick response processes;
- Unconditional and flexible funds regardless of the funder;
- Development of standard discharge planning (continuity of care) protocols for jails and emergency departments;
- Drop-in campuses connected virtually with telehealth that may also serve as diversion points for first responders;
- Development of standards and procedures for warrant prevention and quashing;
- Policy improvements for law enforcement;
- Definition and development of a community support team/Care Management Team;
- Publicly-funded benefits reform to provide funding flexibility for Familiar Faces to access resources they need to achieve stability and remain stable in the community; and
- A system for on-demand access to housing.

These culturally informed/responsive CMTs will be informed by the data and planning of the Familiar Faces work and the LEAD program. With systems-level change that the Familiar Faces initiative can help to implement and sustain, it will be possible to provide more upstream diversion programs and reduce the number of individuals who cycle through the jails. The FFFSV calls for a flexible CMT that offers services to center the Familiar Faces and expand and contract to meet the needs of the individual.
In addition to alignment with LEAD, the King County Executive's Recidivism Reduction and Reentry (RRR) strategies are another area of enhanced focus on reentry from jail in order to impact recidivism in King County. The RRR also has a close connection to the King County Equity and Social Justice Initiative (ESJ), a critical aspect of these CMTs.

Another driver that will have an impact on the need for this approach is Washington State's effort to reform the health care delivery system through a Medicaid 1115 waiver. If obtained, the waiver will provide additional policy flexibilities and funding to support efforts focused on achieving the triple aim of better health, better quality of care and lowered costs. This potential opportunity could provide the additional support and policy tools necessary to bolster the proposed New Concept.

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?

A potential barrier is the lack of experience of behavioral health agencies providing services from an anti-oppressive practice lens, as well as this being a new and unprecedented body of work for County staff to oversee. Lean continuous improvement with PDCA cycles, as well as continual assessment of client perceived satisfaction, will be a key aspect. Consultation from the King County Office of ESJ and outside experts on anti-oppressive practices in healthcare will also be needed.

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?**

If services are not provided from an anti-oppressive practice lens that is culturally informed and responsive, systemic and structural inequities can be perpetuated further alienating Familiar Faces of color from getting access to the resources they need to thrive and live meaningful lives in their communities, apart from the criminal justice system.

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?**

Potential unintended consequences if the New Concept is not implemented include the continued and increasing criminalization (further moderated by race and ethnicity) of Familiar Faces of color in King County. Dismal health outcomes will continue with increased mortality and decreased life expectancy rates for these individuals without intervention that is focused and culturally informed and responsive.

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?**

There are some approaches in King County, especially among those working against interpersonal violence (e.g. Northwest Network) and those agencies providing culturally specific services, who offer culturally competent services that can be learned from, and brought to scale, for the CMTs. At this time specific reentry-focused CMTs, from an ESJ and culturally informed/responsive framework, do not exist. However, there are behavioral health providers offering culturally-specific services that can be built upon and further developed to a reentry population like Familiar Faces.

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 proposed fits within the Sequential Intercept Model and can offer early diversion and jail reentry support to the individuals served by the CMT. Other pertinent initiatives include:

- 2015 Declaration of State of Emergency for Homelessness - King County and City of Seattle
- Housing and Urban Development expectation for outreach and day center
- Single Adult Coordinated Entry in King County
- King County Executive's Recidivism Reduction and Reentry initiative
- HHS Transformation Initiative, specifically Familiar Faces, Physical-Behavioral Health Integration, and Communities of Opportunity (geographic focus options)
- LEAD operations and policy
- 1115 Global Medicaid Waiver, options for Demonstration Programs (Delivery System Reform Incentive Payment or "DSRIP")

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

As noted extensively herein, this entire CMT approach is person-centered and rooted in all the principles of recovery and self-determination. Trauma Informed Care is a vital and critical aspect of the Familiar Faces Future State Vision framework and a fundamental service delivery approach for this program.

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

The CMTs will be serving the Familiar Faces who are overrepresented by racial and ethnic minorities. Staff training related to delivering direct services from an ESJ perspective will be necessary for the organization (provider) selected as the successful bidder for this work via a Requests for Proposals (RFP) process. The contractor will need to demonstrate a staff plan, training plan and institutional commitment to racial justice and embedding anti-oppressive practices in service delivery. All services need to be culturally informed and responsive to the individual. MHCADSD Diversion and Reentry Services staff will work closely with the contractor to assist with ESJ related staff and organizational leadership training, racial equity toolkits, cultural responsive and anti-oppressive practices. MHCADSD staff will engage with the King County Office for ESJ to strategize addressing structural barriers.

Disability justice is another key ESJ issue that needs to be addressed in order to promote equity and best serve individuals in this program. Stigma and discrimination related to mental health disability are still quite present in the dominant culture. MHCADSD works to promote recovery and reduce stigma, but much work still needs to be done, especially with regards to staff training on how institutions provide behavioral health services. In addition, criminal justice, housing and primary care are other systems that can stigmatize and criminalize disability.

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.)**?**
   - Staffing for each CMT
   - County Administrative/Oversight resources (Diversion and Reentry Services Section in MHCADSD) to assist in procurement, clinical oversight of evidence-based and anti-oppressive practices and contract monitoring (may need an additional Project/Program Manager II FTE);
   - Outside training and ongoing consultation from experts in Anti-Oppressive practices and Cultural Competency Behavioral Health Treatment;
   - Community-based organizations (ideally culturally specific providers or providers with an organizational commitment to racial and social justice) to provide the direct service CMTs; and
   - A continuum of housing resources from Coordinated Entry prioritization efforts, shelter and transitional housing resources for immediate jail releases, sponsor-based vouchers from Seattle and King County Housing Authorities, and set-aside Permanent Supportive Housing units. Permanent housing resources are separate from the CMT's proposed in this briefing paper.

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

Each CMT will serve 60 to 80 Familiar Faces of color and other marginalized groups (e.g. LGBTQ and women). Direct service costs are estimated at $800,000 per year, which includes all care management team direct service staff, and some respite and transitional housing. Permanent housing resources will also be needed and are addressed in another briefing paper (BP 63 Familiar Faces) and coordinated entry will also be utilized. Most Familiar Faces will need less intensive services over time, which is important so new Familiar Faces can be served. Additional funding may be needed for a County BHRD DRS Project/Program Manager II FTE for contract development and monitoring. Total annual estimated costs are projected at $850,000 to $950,000.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**
    - A single demonstration CMT for Familiar Faces is currently being developed using King County Veterans and Human Services Levy funds, and was approved in January 2016

This demonstration pilot will operate along a continuum of ongoing program improvement, performance monitoring, and outcome evaluation. These will be implemented so desired results for all program participants are achieved. Data to be collected and assessed will include performance measures and outcomes required/desired by funders, stakeholders, and the County. These measures and outcomes will be discussed and agreed upon during final contract negotiations and will use a Results-Based Accountability (RBA) framework in alignment with the broader Familiar Faces strategy. Data and reporting mechanisms will also be finalized during contract negotiations.
Examples of performance measures required by funders include number served each month, number in permanent housing each month, number exited to homelessness or institutions each month. Examples of performance measures and outcomes of interest to the county include: Medicaid enrollment, reductions in jail use, reductions in psychiatric hospitalizations, increases in community tenure, stable housing tenure, reductions in crisis episodes, engagement with primary care/mental health/substance use providers, and reductions in preventable emergency department use. The proposed program model will suggest meaningful performance measures and outcomes and the agency may suggest these in their proposal. It is expected that any EBP incorporated into the proposed program model will undergo ongoing fidelity reviews.

The County and the contracting agency will implement a continuous quality improvement process and Plan, Do, Study, Act (PDSA) cycles that will include frequent (probably monthly) program team meetings to examine implementation progress and interim measures of success. The purpose of these meetings is entirely mutual learning and program improvement. While this process will be a contractual requirement, programmatic issues identified for improvement will not be subject to contract sanctions. The County is moving toward performance based contracting and, to that end; the contract for this program will include performance measures tied to reimbursement.

- MHCADSD contractors are currently leveraging Medicaid for primary care and some behavioral health care in King County; and
- The Medicaid 1115 waiver that Washington has applied for from the Centers for Medicare and Medicaid Services would provide the policy framework, and additional funding and flexibility, to further support and expand this work via a Delivery System Reform Incentive Payment Program (DSRIP demonstration project.

4. **TIME to implementation: 6 months to a year from award**
    a. **What are the factors in the time to implementation assessment?**

A single demonstration CMT for Familiar Faces is currently being developed, and can be used as the blueprint for these bodies of work. Thus, time to implementation would be accelerated as the demonstration program is expected to be up and running by mid-2016.

b. What are the steps needed for implementation?

An RFP will be required for direct services and training/consultation. Additional contract monitor staffing may be needed in the MHCADSD Diversion and Reentry Services section.

c. Does this need an RFP?

Yes.

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?

Homelessness Linked to Jail

Among individuals enrolled in the King County's mental health system, those who are experiencing homelessness are four times as likely to be jailed, than those with housing. Among the Familiar Faces study, over 50 percent of the 2013 and 2014 cohorts are experiencing homelessness, which is conservative data, given underreporting to the data source (HMIS[40]).

A Criminal Justice Response to a Health and Human Services (HHS) Issue

Many individuals with complex social and health issues regularly interact with the King County Jail system, in part due to an inability to effectively engage with fragmented HHS systems, and due to fundamental structural inequities. These inequities stem from the application of a criminal justice response to a health and human services/public health issue. Bad policies (e.g. War on Drugs) have played a large role in this multi-decade trajectory. A more robust HHS system for these individuals is paramount to avoid criminalizing this problem that fills the courts and jails with individuals who need access to housing, treatment resources, and life opportunities (employment, supportive relationships, connection to the community and family).

Finally, incarceration often results in loss of housing and publicly-funded benefits including Medicaid-funded healthcare coverage (i.e. Apple Health), separation from treatment, and a criminal history that disqualifies individuals for future housing. Public services, hospital emergency departments, jails and psychiatric hospitals are inundated with individuals in crisis. Many clients are frequent users who have complex and chronic needs that cannot be met effectively or efficiently in these high-cost settings. Frequent users are often involved in several systems of care—behavioral health, social services, criminal justice, and housing—as well as in the health care system. Repeated visits to jails, emergency rooms, and hospitals result in inflated expenses, often absorbed by public systems, which drive up costs for everyone.

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.

#44

Working Title of Concept: Familiar Faces Culturally Responsive Care Management Teams

[40] Homeless Management Information System, 2015.

Name of Person Submitting Concept: Jesse Benet, Liz Arjun and Travis Erickson
Organization(s), if any: King County Health and Human Services Transformation Initiative
Phone: 206-263-8956
Email: jesse.benet@kingcounty.gov
Mailing Address: 401 5th Avenue, Ste. 400, Seattle, WA 98104

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 by ***October 31, 2015****.*

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

In order to address the equity and social justice goals and the number of individuals identified as Familiar Faces who are non-white, several culturally responsive care management teams will be needed. Community-based agencies already providing culturally specific and culturally responsive behavioral health, primary care and reentry support services will be sought to provide these Familiar Faces Care Management Teams (CMTs).

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.

In 2013, King County, in partnership with community stakeholders, developed a plan for an accountable, integrated system of health, human services, and community-based prevention – referred to as the King County Health and Human Services Transformation Plan. 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."

To catalyze improvement in the system's performance for everyone, the plan called for an initial focus on areas where improved performance is most critical – for the individuals and communities experiencing the poorest outcomes. The plan also had to align with and be fundamentally committed to the larger County goal of achieving equity and social justice for county residents. Following preliminary scoping conversations with several internal and community stakeholders during 2014 an initial population of focus emerged: individuals with a mental health and/or substance use disorder who are high utilizers of the criminal justice system – specifically, the King County Jail- the so-called "Familiar Faces". Many of these individuals experience complex chronic health conditions, histories of trauma, substance use, and chronic homelessness or instability in housing and other aspects of their lives and are familiar to these various systems; hence the term Familiar Faces.

The following table (Table 1) is from Familiar Faces, data, demonstrating the racial disproportionality and make-up in the Familiar Faces population.

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/U	5	0.4%	7	0.6%	12	0.5%	0.6%		2.3%
	1273	100.0%	1252	100.0%	2525	100.0%			

Table 1: Familiar Faces by Race

3. <u>How would your concept address the need</u>?
Please be specific.

The Familiar Faces Future State Vision centers the Familiar Face in a Care Management Team (CMT), the core team providing services and "golden thread" support and connection for the Familiar Face. This Flexible CMT includes the flexibility to accommodate the level of care and specific needs the individual has at the time of enrollment and over time, regardless of payer. The care team is one that uses a trauma informed approach, motivational interviewing methods and is evidence-based. Some of the other general areas for improvement that were identified to make progress towards the Familiar Face future state vision, and are important to the success of the Flexible CMT, include:

- 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, based motivational interviewing approaches aligned with harm reduction
- Development of outreach and quick response processes
- Unconditional and flexible funds regardless of payor
- 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
- Definition and development of a community support team

4. <u>Who would benefit</u>? Please describe potential program participants.

Familiar Faces, who are coming into contact with first responders or being booked into a King County jail, who are African American, Native American or Latino/a. These three groups are over-represented in the Familiar Faces population as compared to the King County census data and there is a great need to provide culturally specific and responsive service to the many people of color and marginalized ethnicities, who are in our local jails, often because they lack to the access to the resources needed to become and remain stable in the community – housing, financial entitlements, jobs, education, behavioral health treatment, primary care, transportation, and basic needs.

5. <u>What would be the results of successful implementation of program</u>?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

The overarching outcomes, based on a Results-Based Accountability framework, of the Familiar Faces initiative are:

1. Improved Health
2. Improved Housing Stability
3. Reduced Emergency Department Usage
4. Reduced Criminal Justice Involvement
5. Improved Client Satisfaction

These culturally specific and culturally responsive Familiar Faces Care Management Teams would have specific outcomes focused on:

• A reduction in the annual number of Familiar Faces of color, who are cycling through our jails in King County
• Increased access and penetration of Familiar Faces of color, to behavioral health services
• Increased access of Familiar Faces served to primary care and Apple health enrollment
• Reduced deaths of Familiar Faces enrolled in these CMTs due to behavioral health conditions, chronic medical issues and/or chronic homelessness
• Increased diversion access and system response for criminal justice stakeholders, thus reducing the number of people with behavioral health conditions in our King County jails.

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?

There are long-standing, widely known issues with the lack of culturally responsive and culturally specific services and reentry opportunities offered from a racial justice perspective King County for individuals from nonwhite race and ethnic groups, who are overrepresented in our local criminal justice system. An anti-oppressive practice lens is critical to the behavioral health services provided to our nonwhite Familiar Faces, and this will provide ample service delivery learning and education to providing culturally responsive and culturally specific services to and other individuals (non-Familiar Faces) residing in King County who can or do utilize publicly-funded behavioral health and primary care services. Many people of color in our jails are also living in extreme poverty and are also experiencing homelessness. Often, when these individuals come into contact with law enforcement because of these very issues (living on the street, experiencing behavioral health crises, engaging in survival economies) they are taken to jail in lieu of addressing the root cause of the matter: access. Indeed, access to treatment, housing, jobs, support, healing and recovery and access to community of people who care and value them as people, is critical to stop the cycle of incarceration.

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.

The leadership and design teams of the Familiar Faces initiative provide a large, cross-sector partnership, already in place, that is necessary for the alignment and oversight of these Care Management Teams. In addition, lean continuous improvement and evaluation resources will be needed in order to practice ongoing and swift Plan, Do, Study, Act (PDSA) cycles to ensure program implementation is in viewed from a continuous improvement standpoint by both the providers of the CMTs as well as the oversight/funding body. New partnerships are needed that leverage existing collaborative relationship 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.

The current cross-sector table for Familiar Faces has behavioral health (ETS, DESC, SMH, VCCC, HMC, CPC); primary care (Neighborcare, HMC); Public Health- Healthcare for the Homeless Network and Jail Health Services, Emergency Response and Community Heatlh Clinic;, all five Managed Care Organizations, King County Department of Adult and Juvenile Detention, Seallt Police Department, King County Sheriff's Office, Seattle Municpal Court, King County District Court, King County Superior Court, Pioneer Human Services housing, Plymouth Housing Group, King County DCHS-DRS staff, King County Department of Public Defense, King County Exectuve's Office, Mayor Ed Murray's Policy staff, and many more across human services and criminal justice.

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: $ $375,000 per year, serving 25 people per year
Partial Implementation: $ $750,000 per year, serving 50 people per year
Full Implementation: $ # of dollars here **per year, serving** # of people here **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*, 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*.