MIDD Briefing Paper

BP 84 Existing MIDD Program/Strategy or New Concept Name: Clinical Capacity for Coordinated Entry for All Regional HUBs

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept x (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This new MIDD concept would establish Behavioral Health Teams which include Behavioral Health experts, at Coordinated Entry For ALL (CEA) Regional HUBS which would have the capacity to identify people needing Mental Health / Chemical Dependency services, and provide service linkages and crisis intervention as needed.

Collaborators:

Name	**Department**
Kira Zylstra	All Home

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

Name	***Role***	***Organization***
Amanda Thompkins	*CEA Design Team*	*DCHS Data and Evaluation*
Kate Speltz	*CEA Design Team*	*DCHS HCD*
Scott Mingus	*CEA Design Team*	*DCHS HCD*

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?**

All Home (previously the Committee to End Homelessness) has recently released a new strategic plan to address homelessness in King County. This new plan outlines an array of strategies, including advocating for more state and federal funding, increasing the stock of affordable housing and adding shelter capacity while, at the same time, ensuring there is a coordinated entry system that is equipped to assist in appropriately identifying and prioritizing candidates for the right housing and services intervention by using a progressive engagement approach and diverting people from shelter where possible.

Coordinated entry connects homeless individuals to available housing and appropriate service options by streamlining and reducing intensive assessment and screening as much as possible and shorten the amount of time spent navigating resources and eligibility. The Coordinated Entry for All (CEA) approach works to apply coordinated entry system-wide and ensure the strengths and benefits of the system are felt by all so that there is fair and equitable access for all people experiencing homelessness.

In preparation for the launch of CEA, the Department of Community and Human Services (DCHS) is planning to launch eight CEA Regional HUBs. The Regional HUBs are the intake and assessment sites for families and individuals experiencing homelessness and are responsible for ensuring that all households have prompt access to *the Housing Intervention and Eligibility Triage Tool* which is administered in a safe, welcoming environment.

The Goals of CEA Regional HUBS are to:

- Allow anyone experiencing homelessness to know where to go to get assistance, to be assessed in a standard and consistent way, and to connect with the housing/services that best meet their needs;
- Ensure clarity, transparency, consistency and accountability for homeless clients, referral sources and homeless service providers throughout the assessment and referral process;
- Facilitate exits from homelessness to stable housing in the most rapid manner possible given available resources;
- Ensure that clients gain access as efficiently and effectively as possible to the type of intervention most appropriate to their immediate and long-term housing needs;
- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing resources.

Based on the Seattle / King County Continuum of Care's experience with Youth Housing Connection (YHC) and Family Housing Connection (FHC), the CEA Design Team, made up of experts from All Home and DCHS, has identified a need for clinical support and service linkages to people with behavioral health conditions as a key component needed at the Regional HUBs. The experience of the YHC and FHC systems has been that many families and young adults accessing coordinated entry have behavioral health needs that are not currently being met and, due to a lack of sufficient housing resources, are not often met once referred to housing. Having behavioral health teams connected to Regional HUBS will enable people experiencing homelessness to be supported in their immediate crisis, but also connect them to services immediately upon requesting housing instead of having to wait until a housing placement occurs, which is the current way of accessing behavior health services.

This new MIDD concept would establish Behavioral Health Teams which include Behavioral Health experts, at CEA Regional HUBS which would have the capacity to identify people needing Mental Health / Chemical Dependency services, and provide service linkages and crisis intervention as needed. The CEA Housing Triage Tool does include behavior health questions which would flag the need for a more in depth assessment by a clinical expert. Based on the assessment, the Behavior Health Teams would develop a behavior health plan, and immediately link people experiencing homelessness to services which would follow them to housing once placed.

Some of the proposed Regional HUBs are at existing or planned locations that already have behavioral health capacity and service linkages such as the Sobering Center, Meridian, Navos, and South King County Crisis Center.

This Briefing Paper is requesting funds for a team at locations that do not have behavioral health on site services or linkages and for funding to support housing providers to work more effectively with residents that have behavioral health needs. Proposed sites which would require these additional resources include WorkSource Renton and non-profit, multi-service agencies requesting to operate a Regional HUB (TBD).

This model would enable people experiencing homelessness to get behavioral health support early without needing to wait until they have been connected with a housing resource in order to access these critical services and increase the capacity of housing providers to serve this population well.

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).

The CEA Regional HUBs allow anyone experiencing homelessness and needing assistance to know where to go to get that assistance, serving as a clear entry point to access homeless services. Providing clinical support and service linkages to address behavioral health needs at this location supports people's health and well-being by preventing problems from escalating and providing the opportunity to assist people who are in crisis or at risk of crisis to get help they need. In addition, this approach will allow people experiencing homelessness to access services quickly and get linked to mental health and chemical dependency services before accessing housing supports and while on the streets or unstably housed. By building the capacity of housing providers to support clients with behavioral health needs we will improve the services provided to people experiencing homelessness in housing.

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.**

Homelessness creates new health problems and exacerbates existing ones. Behavioral health issues such as depression or alcoholism often develop or are made worse in such difficult situations, especially if there is no solution in sight. ***- National Health Care for the Homeless Council***

The 35th annual One Night Count (ONC) of homeless people in King County took place in the early hours of Friday, January 23, 2015. The Coalition organized more than 1100 volunteers who fanned out across the county to count the number of men, women and children who were homeless and sleeping outdoors without shelter between 2:00 and 5:00 a.m. They counted people trying to survive in cars and tents, riding late night buses, or curled up in blankets under bridges or in doorways. That same night, staff at agencies that operate shelters and transitional housing programs recorded select information about the people staying in their programs. Staff at the Homeless Housing Program of King County's Community Services Division compile these data.

The ONC identified at least 10,047 people experiencing homelessness in King County, including at least 3,772 men, women, and children were without shelter during the three hour street count. This number is an increase of 21% over those found without shelter last year. This number is always assumed to be an undercount, because we do not count everywhere, and because many people take great care not to be visible. The ONC also identified individuals with known disabilities and selected health conditions by program type. See the below chart.

Table 6: Number of individuals with known disabilities and selected health conditions by program type on the night of the Count.

	OVERNIGHT SHELTER	TRANSITIONAL HOUSING	COMBINED TOTAL
Mental illness	529	539	**1,068**
(serious mental illness: a subset of above)	(344)	(251)	**(595)**
Alcohol or substance abuse	434	445	**879**
(chronic substance abuse: a subset of above)	(242)	(178)	**(420)**
Physical disability	330	359	**689**

SOURCE: King County Department of Community and Human Services

Among young adults, the consequences of homelessness take a significant toll on the young person and society as a whole. Studies show that homeless youth overall are exposed to risks at higher rates than their stably housed peers, which can negatively affect developmental outcomes.[1]

When compared to their stably housed peers, homeless youth and young adults:

- Are more likely to engage in unsafe sexual behaviors and are more vulnerable to sexual exploitation;[2]
- Experience higher rates of substance and alcohol use;[3]
- Have higher rates of mental health symptoms including anxiety, post-traumatic stress disorder, and depression resulting in elevated risk for suicide attempts; Are 2.5 times more likely to be arrested as adults; and
- Are 50% less likely to have a GED or high school diploma.[4]

The Seattle / King County CoC's experience with homeless families and individuals that are presenting for Coordinated Entry (CE) Housing Assessments, shelter, or other crisis response systems, is that they have levels of behavioral health needs that CE Housing Assessors and housing case management staff are not equipped to address. Typology analysis using data from our current Coordinated Entry Systems, Youth Housing Connection (YHC) and Family Housing Connection (FHC), indicates that many people requesting housing have significant service needs, based on their stated interest in substance abuse and mental health services and self-reported mental health diagnoses. Historical data shows that young adults and families wait on the YHC / FHC placement rosters for housing their levels of behavioral health needs only increase, especially if they are living in a place not meant for human habitation.

Coordinated Entry has successfully provided homeless families and individuals with more equitable access to housing, but providers are more likely to serve people with whom they did not have case

[1] National Alliance to End Homelessness, 2011
[2] Toro, 2007
[3] U.S. Department of Health and Human Services, 2007
[4] The National Network for Youth

management or other relationship prior to referral to housing and are often not equipped to address the mental health and substance abuse needs that present after housing placement. As a result, one of the unintended consequences of a coordinated system is that housing providers are often less aware of mental health and substance abuse needs of people being placed in housing because they are less involved in the selection and referral process. Increasing the training capacity of providers will enhance their ability to effectively serve this population.

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

All Coordinated Entry access points will utilize the CEA Housing Triage Tool to match the individual or family with the resource most appropriate for them based on their strengths and needs. The VI-SPDAT is theCEA Housing Triage Tool selected for veterans and single adults. Families and young adults will each use standardized assessments that will vary slightly from the VI-SPDAT to include questions tailored to the needs of families and young adults. Assessments will be administered in a culturally competent manner. The common assessment methods will prioritize those with the highest needs based on vulnerability, protect the privacy of participants, and match the household need with resources most appropriate for them. The VI-SPDAT assess for the presence of a number of issues outlined in the below chart, including behavior health needs.

VI-SPDAT in a Nutshell / Score Accumulation

Domain	Explanation (based on self report)	Points
Age	Age 60+	1
Housing/Homelessness	24+ cumulative months, and/or 4+ episodes	1
Risks		
# of interactions in past 6 mo with emergency / expensive systems:	4 or more interactions/visit to: ER, interactions with police, ambulance rides to hospitals, in-patient hospitalization, calls/interactions with crisis centers/suicide	1
Vulnerability	Single occurrence of either: Attacked or Beaten Up on the streets, Harmed (or threatened to) self or others	1
Legal issues	Warrants or fines that could lead to jail	1
"vulnerable/risky" behavior	Being tricked by others, trading sex/sharing needles, living rough	1
Socialization / Daily Function		
$$ / Resources	Owing Money or lack of minimum resources to meet daily needs	1
Daily Activity	Focused only on daily survival	1
Relationships	Lack of fulfilling relationships, or those present are 'predatory'	1
Hygiene/Daily Life Skills	Observation: poor hygiene, or poor self-care	1
Wellness		
Healthcare	Does not access any healthcare	1
Significant Health Concerns	1 point ea: Kidney, Liver Disease, HIV/AIDS, history of Frostbite / Hypothermia	4 (up to)
Other Health Needs	Presence or History of: Stroke, heart disease, emphysema, diabetes, asthma, cancer, Hepatitis C, Tuberculosis	X
Substance Abuse	EVER problematic use; CURRENT daily use, PAST 6 MO: injection drugs, substitute alcohol products; PAST 1 MO: black out from SA	1
Mental Health	EVER Hospitalized for MH against will, ER visit for MH reasons, TBI, learning disability or DD; PAST 6 MO: MH svcs; CURRENT: trouble concentrating or remembering [or observation of above]	1
Tri-Morbidity	Presence of Substance Abuse + Mental Health + Medical Condition	1
Prescriptions	Rx not filled/taken or sold/stolen/lost	1
Adverse Experiences	Past experience of abuse or trauma untreated or cause of HLN	1

Providing clinical support and service linkages at the CEA Regional HUB locations would keep people healthier by identifying and potentially preventing problems from escalating and providing the opportunity to assist people who are in crisis or at risk of crisis to get help they need as early as possible. In addition, it would allow people experiencing homelessness to be linked to services quickly and have access to crisis supports before accessing housing supports and while on the streets or unstably housed. One key component of improving the health and well-being of people experiencing homelessness is housing. Housing and health care work together and are essential components to preventing and ending homelessness. Health care services works better when a patient is housed, and in turn, maintaining housing is more likely if proper health care is available.[5] The inclusion of Behavioral Health Teams at CEA Regional HUBs allows for a connection to needed services even before an individual is connected with housing, adding to the benefits of linking housing and health care.

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.

[5] http://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf

Decentralized assessments at CEA Regional HUBs for families and individuals experiencing homelessness was a recommendation from Focus Strategies, National experts in ending homelessness hired to consult with King County in 2014 to improve the efficiency and effectiveness of Family Housing Connection (FHC)[6]. The Regional HUB concept was also part of the Interagency Council's (IAC) approved System Vision, and is a best practice in communities with a similar scale of populations experiencing homelessness.

The Department of Housing and Urban Development (HUD) released a policy brief on coordinated entry which emphasized the importance of including mental health and mainstream resources in the design of the system. The brief states "Affordable housing and mainstream services are crucial tools for ending homelessness and should be involved in the coordinated entry process…The more mainstream programs and resources that are connected to your coordinated entry process through the coordination of referral, application and eligibility determination processes, the more effectively your community can consistently connect homeless individuals with housing resources and the community-based supports that they need to maintain that housing."[7]

See above mentioned need for mental health and substance abuse supports for people experiencing homelessness.

3. **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.**

Linking Behavioral Health Teams to CEA Regional HUBs is a new concept, but the need for behavioral health services at the "front doors" to homeless services is well known.

4. **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?**

The new model for CEA will ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, and connected to housing and homeless assistance based on their strengths and needs. It uses standardized tools and practices, incorporates a system-wide housing first approach, and coordinates assistance so that those with the most severe service needs are prioritized, specifically those needing mental health and substance abuse services.

Desired outcomes of implementation of Behavioral Health Teams at the CEA Regional HUBs include:

- When people experiencing homelessness arrive for a housing assessment at CEA Regional HUBs, they will receive timely MH / CD support without needing to wait for housing placement in order to access services. Support includes crisis intervention, assessment, development of a service plan, and linkage to next day appointments as needed.

[6] Focus Strategies - Family Homelessness Coordinated Entry System Analysis and Refinement Project 2014.
[7] https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

- More people will be linked to needed behavioral health treatment prior to housing placement supporting greater housing stability once connected with housing resources.

- Fewer people experiencing homelessness will experience mental health crises while in housing programs because they will already be connected to a Mental Health provider.

- Increased capacity for providers to serve clients with behavior health needs.

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.

The target population for CEA is individuals and families, including veterans, and young adults, who are literally homeless according to the HUD definition of homelessness as well as young adults who are imminently at risk of homelessness (within 14 days). This includes people exiting detention, foster care, and/or transitioning from psychiatric facilities. The Behavioral Health Teams will specifically work to identify and provide service linkages to the target population for CEA that needs behavior health services.

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

Coordinated Entry for All will be implemented county-wide with regionally-based access through CEA Regional HUBs. CEA Regional HUBS are located in non-profit agencies and have services on site for seamless connection, consistent marketing, forms, and approach to serving people experiencing homelessness, and are accessible and welcoming to all populations. Pending a response to a competitive funding process, pending locations would be:

- North /East King County
- Seattle (3 locations)
- Kent
- Auburn / Federal Way
- South East King County

The Behavioral Health Teams would be located at the Regional HUBS partnering with CEA Housing Assessors and Housing Navigator staff.

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 redesign of Coordinated Entry creates regionally based assessment locations which will implement a CEA Housing Triage Tool and integrate the coordinated entry process into services that rapidly re-house and divert individuals and families from homelessness whenever possible. The Triage Tool includes mental health questions that will support Housing Assessors completing the Triage Tool to immediate link those needing services to the Behavioral Health Team.

All Home and King County will work closely with community partners selected to run the Regional HUBs to assure that the Behavioral Health Team are integrated into the model. The success of this concept will also rely on strong collaboration with the existing crisis response system, as well as mental health and substance abuse providers, particularly those that are already part of the homeless system.

In addition, the Sobering Center, Meridian, Navos, and South King County Crisis Center could be part of this approach, serving as, or coordinating with, a regional hub in South County to connect individuals experiencing homeless to needed resources

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?**

By moving access to behavioral health services to the front door of the homeless system instead of being accessed once people who are experiencing homelessness are housed may reduce the enrollment in behavioral health services at housing locations.

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?**

Barriers to implementing Behavior Health Teams as part of the regional HUBs include:

- lack of trained qualified staff available to provided clinical linkages, (workforce shortage).
- the reticence of homeless individuals to become involved (or re involved) with the behavioral health system.
- Integration of the Behavioral Health Teams into the staff at the CEA Regional HUBs

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?**

Providing these services at the CEA Regional HUBs at the initial point of seeking housing supports may also highlight other service gaps not currently addressed with existing funding or housing resources. The housing resources connected with coordinated entry vary widely in their service models, staffing structure, and specialized programming. In adding Behavioral Health supports to the Regional HUBs, there could be challenges in ensuring sustained connections to these resources as service gaps are highlighted in the process.

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?**

This is a new concept / intervention, so if not implemented the consequences are known. Without the inclusion of behavioral health teams at the CEA Regional HUBs, there will continue to be a high level of crisis for those experiencing homelessness without services to respond to crisis or prevent crisis from occurring. CEA Regional HUBs staff and staff providing services connected with the HUBs will not have the capacity and/or the skills to fully address the MH/CD needs of people accessing services through the HUBs.

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?**

The Seattle / King County CoC continue to provide mental health and substance abuse services to people experiencing homelessness through the current services and approaches to care. Behavioral Health Teams have the ability to expand those services and approaches but our communities challenge of having a clear place to access homeless services and linking people to the MH/CD services they need while accessing these services will continue.

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?**

All Home is the Continuum of Care lead and the new Strategic Plan outlines an array of strategies, including advocating for more state and federal funding, increasing the stock of subsidized housing and adding shelter capacity while, at the same time, ensuring there is a coordinated entry system that is equipped to assist in appropriately identifying and prioritizing candidates for the right housing and

services intervention by using a progressive engagement approach and diverting people from shelter where possible.[8]

In 2014, King County approved legislation calling for the development of a Youth Action Plan (YAP) to set King County's priorities for serving its young people, from infants through young adults. As required in the legislation, King County's Youth Action Plan was developed by an appointed Task Force The Task Force identified 9 recommendation areas reflective of the intensive work of the Task Force in reviewing data, barriers and solutions generated from the community conversations and the youth survey. Creating Behavioral Health Teams within CEA regional HUBs has the ability to fit within

- Recommendation Area 2 – Strengthen and Stabilize Families, and Children, Youth and Young Adults
- Recommendation Area 4 – Bust Siloes/We're Better Together
- Recommendation Area 5 – Get Smart About Data

The Best Starts for Kids Initiative dedicates a portion of the first year's levy funds for youth and family homelessness prevention and diversion. During the implementation of CEA Regional HUBs, All Home staff will participate in the Best Starts for Kids Advisory Boards to coordinate the homelessness prevention resources with CEA and the All Home Strategic Plan.

The Five Year Plan to End Homelessness among Veterans in King County was developed at the direction of the Funders Group of the Committee to End Homelessness in King County (now All Home), in alignment with each of the federal, state and local five year plans to end veteran homelessness recently developed by the U.S. Department of Veterans Affairs (VA), United States Interagency Council on Homelessness (USICH), VA-Puget Sound Healthcare System (VA-Puget Sound), and Washington State Department of Veteran Affairs (WDVA). The advisory group of the Five Year Plan to End Homelessness among Veterans in King County recommended priorities and system enhancements. A number of those enhancements, listed below, align with the need for additional clinical capacity at CEA Regional HUBS.

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

The Behavioral Health Teams would be trained in the principles of recovery, resiliency, and trauma informed care in their roles as experts in the field.

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

Homelessness may be caused by a variety of circumstances, but tends to disproportionately impact people of color as evidenced by the fact that people of color are overrepresented in our homeless system. One of the primary goals of coordinated entry is to ensure equitable access to housing resources. King County's Equity and Social Justice Initiative highlights that race and place can predict whether someone has the opportunity to thrive. The determinants of equity (conditions that King County identified as what people need to thrive) are more readily accessible in some neighborhoods

[8] Committee to End Homelessness in King County Strategic Plan July 2015 – June 2019. "A Regional, Aligned, Community Plan to End the Experience of Homelessness among Residents of Seattle/King County"

than in others.[9] The CEA Regional HUBs and the establishment of Behavioral Health Teams at the HUBs will ensure equitable regional access to housing resources and behavioral supports.

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.)**?**

Once CEA Regional HUBS are set up, the resources need to add Behavior Health Teams are financial in that staff would need to be hired.

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

Behavior Health Team at Worksource is $250,000 per year, serving 120 people with 3 FTEs

$100,000 to increase the capacity of homeless housing providers by providing training.

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

A number of revenue sources have been identified for the CEA regional HUBs to pay for assessment and shelter diversion services, but would not cover the cost of behavioral health staffing. The only sources identified for the Behavior Health Teams is MIDD II and Medicaid based on client eligibility.

4. **TIME to implementation: Currently underway**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

As the selected CEA Coordinating Entity, King County is responsible for the referral function, administration and oversight of coordinated entry, assessment and access.
The All Home Coordinating Board Executive Committee has assumed the role of decision-maker and CEA governance throughout implementation. As decision-maker, the Executive Committee will provide guidance and accountability of the transition of the current system and the design and implementation of CEA to ensure the new design reflects a system that will address the needs of the most vulnerable members of the community. Input and recommendations are provided to the Executive Committee from King County and All Home staff teams, advisory and subcommittee members, and community members and consumers an d input from all of these groups has included a priority to address the mental health and behavioral health needs of people experiencing homelessness. Upon completion of the transition and implementation phase, the Executive Committee will ensure continuing accountability and system alignment.
King County will manage the planning and implementation of CEA. The implementation will be complete by June 30th, 2016.
Key efforts and anticipated dates for the full implementation of CEA include:

[9] http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/2014/ESJ-Infographic-Feb-2014.ashx?la=en

CEA Regional HUBs will be selected through competitive process by March 2016, fully transitioning coordinated entry for homeless families and individuals from a centralized to a decentralized assessment model and incorporating Behavioral Health Teams by June 2016.
Analysis of current assessment locations for young adults, single adults, and veterans will continue through June 2016 ensuring that by July of 2016, all assessment locations will offer equitable access to housing assessments using standards tools and methods for ensuring resources are prioritized for the most vulnerable families and individuals.
Common assessment tools for homeless families and young adults will be selected by December 31st, 2016 and integrated into the HMIS for all assessment locations to use by June 2016. Training on the new assessment tool will be conducted in the 1st quarter of 2016 and will be used consistently no later than June 2016 within a fully integrated HMIS system.
CEA will be fully integrated with HMIS to support effective prioritization, best match and placement in appropriate housing and services, evaluation, and reporting. The CEA Housing Triage Tool will be integrated in the HMIS which will hold the centralized referral function and tracking of housing resources.

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?

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.

Working Title of Concept: Clinical Capacity for CEA Regional HUBS

Name of Person Submitting Concept: Hedda McLendon and Kira Zylstar
Organization(s), if any: King County and All Home
Phone: Phone Number Here
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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 preparation for the launch of Coordinated Entry for All Populations (CEA) All Home and King County are jointly proposing clinical support and service linkages be a component of the five CEA Regional HUBs to be developed in 2016. Decentralized assessments at Regional HUBs for families and individuals experiencing homelessness was a recommendation from Focus Strategies to improve the efficiency and effectiveness of Family Housing Connection (FHC), was part of the Interagency Council's (IAC) approved System Vision, and

is a best practice in communities with a similar scale of populations experiencing homelessness.

Clinincal support and service linkages teams at CEA Regional HUBS have the clinincal capacity to identify people needing MH / CD services, and make connections to services including crisis intervention as needed. This model would enable people experiencing homelessness to get behavior health support early without needing to wait until they have been connected with a housing resource in order to access services.

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.

Our experience with homeless families and individuals that are presenting for Coordinated Entry (CE) Housing Assessments, shelter, or other crisis response, is that they have levels of behavioral health needs that CE Housing Assessors and housing case management staff are not equipped to address. Typology analysis using data from our current Coordinated Entry Systems, Youth Housing Connection (YHC) and Family Housing Connection (FHC), indicates that 70% of people requesting housing can be considered high risk, based on their stated interest in substance abuse and mental health services and self-reported mental health diagnoses. We also know that as YYA and Families wait on the YHC / FHC placement rosters for housing their levels of behavioral health needs only increase, especially if they are living in a place not menat for human habitation.

In addition, one of the unintended consequences of a coordinated system is that providers are often less aware of mental health and substance abuse needs of people being placed in housing than they were before the implementation of YHC and FHC. Coordinated Entry has successfully provided homeless families and individuals with more equitable access to housing, but providers are more likely to serve people with whom they did not have case management or other relationship prior to referral to housing and are often not equipped to address the mental health and substance abuse needs that present after housing placement.

3. How would your concept address the need?
Please be specific.

By providing clnincal support and service linakage at the CEA Regional HUBs we will be able to intervene early and prevent further development of mental health needs while people experiencing homelessness wait for a housing placement. Providers will be more aware of the mental health and substance abuse needs of people being placed in housing, and more people experiencing homelessness will arrive to housing already connected to behavior health services.

The CEA Regional HUBs, to be developed in 2016, will build upon the existing Coordinated Entry Systems while creating decentralized, regionally-based resource centers at which families and individuals experiencing homelessness can connect with housing assessments for placement into housing resources that match their individual needs. The benefit of utilizing a Regional HUB model is the ability to co-locate critical services that support safety and housing stability including emergency shelter, employment and income generation, and through implementation of this concept proposal, a clinical support team to address mental health and substance use needs.

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

This concept will benefit young people, single adults, and families that are homeless or at risk of

homelessness that arrive at one of the CEA Regional HUBs. The HUBs would have the clinincal capacity to immediately make connections to behavioral health services including crisis intervention services.

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.

Desired outcomes of implementation of this program include:

- When people experiencing homelessness arrive for a housing assessment at CEA Regional HUBs, they will receive timely MH / CD support without needing to wait for housing placement in order to access services.

- More people will be connected to needed ongoing behavioral health treatment prior to housing placement supporting greater housing stability once connected with housing resources.

- Fewer people experiencing homelessness will experience mental health crises while in housing programs.

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?

Homelessness is among the most negative social justice outcomes for people living with mental illness and substance use disorders. This concept addresses that issue directly, by supporting the success of young people, families, single adults, and veterans with mental health and substance abuse needs seeking housing supports, supporting a quick exit from homelessness while obtaining needed services, and a reduction in repeated episodes of homelessness.

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.

All Home and King County will work closely with the CEA Oversight Group to assure that clinical capacity is part of the CEA Regional HUBs. The success of this concept will also rely on strong collaboration with the existing crisis response system, as well as mental health and substance abuse providers, particularly those that are already part of the homeless system.

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: $ 150,000 per year, serving 80 people per year

Partial Implementation:	**$ 300,000 per year, serving 160 people per year**
Full Implementation:	**$ 750,000 per year, serving 250 people per year**