

Final Report

September 2016 – August 2019

Proposed Outcomes

An increase in provider staff understanding of Evidence Based Practices (EBP), increase in EBP model fidelity scores, improvement in capacity building outcome metrics as determined through individual agency assessments, and community stakeholder understanding and participation in system integration.

Design and complete an “Affordable Housing Inventory” on raw land, vacant and in-use properties. Create recommendations and next steps based on information to strategically increase availability of affordable housing – particularly for hardest to serve clients.

Outcomes Achieved – Housing and Employment Best Practices

- Staff increased knowledge understanding of the Evidence Based Practices through training and mentoring but this process took a longer period of time due to a key leader at Coastal Community Action Program (CCAP) retiring and acclimating a new staff.
 - **Key staff from CCAP and community partners were provided training** on (all materials are readily available on the County’s website www.healthygh.org/directory/housing) :
 - Getting started with PSH and SE
 - PSH and SE Core Elements
 - Effective Services and Supports
 - Doing it right! PSH and SE Fidelity
 - PSH Toolkit
 - Supported Employment Toolkit
- The County with assistance from Advocates for Human Potential has outlined a technical assistance plan with staff from Coastal Community Action Program (CCAP) focused on client assessment, strengths-based housing stability planning, client file documentation, and updating relevant policies and procedures. The County, with support from Advocates for Human Potential meets with CCAP leadership and support staff at least monthly to implement the technical assistance plan and verify progress.
 - **All areas of work were reviewed and verified to be considered “closed” by the County in June 2019**
- **Coastal Community Action Program successfully became a contractor of Medicaid-billable services under the Foundational Community Supports program for Housing and Employment as well as through Pathways Care Coordination**
 - CCAP has enrolled nearly 500 clients in FCS Housing services since launch in June 2018
- Coastal Community Action Program voluntarily participated in a **Fidelity Review** through the Health Care Authority for their Medicaid Foundational Community Supports Supportive Housing program in June 2019. This was an original action-item from our grant proposal to measure system capacity and alignment with fidelity of the Evidence Based Practices. Informal exit interviews from the review indicated HCA and reviewers were impressed with CCAP’s

understanding of the fidelity framework and strong internal infrastructure to support systems that align with the EBPs.

- The informal review debrief also highlighted power of several client stories of transformation utilizing CCAP's Supportive Housing Services to transform from living in a tent by the river, pregnant, and struggling with addiction to graduating the Community Court program five months ahead of schedule, employed, and in recovery with custody of her child. This would not have been possible without strong partnerships and interagency case staffing on behalf of the client for a shared stability plan.
- Designed and implemented a **"Pilot Project" to identify up to 10 case studies** of the hardest to serve clients with co-occurring complex challenges to implement and strengthen training and new practices in Housing, Employment, and Affordable Housing Best Practices
 - Membership included leadership from Grays Harbor County Public Health and Social Services, CCAP Housing and Employment, Behavioral Health providers – Behavioral Health Resources, Catholic Community Services Adult Behavioral Health, and Columbia Wellness as well as consultant/facilitator from Advocates for Human Potential
- **Implemented, evaluated, and refined new Coordinated Entry assessment and prioritization tool** in HMIS (Homelessness Management Information System) that focuses on facilitating meaningful referrals and is integrated to identify, assess, and refer clients to other supportive services such as FCS Housing and Employment supports and "Pathways" case management support
- The County and CCAP drafted and submitted an application for **\$180,000 in annual McKinney Vento (HUD Continuum of Care) funds for Permanent Supportive Housing** that received nearly a perfect score for capacity and readiness – which was directly attributed to the USDA RCDI capacity building work. The application was successful and launched July 1st, 2019 to add 16 PSH program "slots" for the most in-need in our community. This pilot project has laid the ground work for CCAP and community partners to successfully implement the work proposed in the grant with positive performance outcomes.
- **Formation and participation of "Commissioner's Committee for Low Barrier Shelter" to examine shared challenge of addressing unsheltered homelessness for individuals with complex challenges who cannot access current shelter options.** Group membership currently includes Mayors, city administration, police chiefs, fire chiefs, and code enforcement from Aberdeen and Hoquiam, faith-based shelter providers, Homeless Housing/Coordinated Entry provider, leadership from the Behavioral Health Organization, County Commissioner Raines, and Public Health and Social Services staff.
 - Group received information and discussed County homeless housing funds – State requirements, best practices, and limitations for use
 - Group organized discussion into "scenarios" where current shelter capacity would not meet need and specific considerations for each scenario
 - Group received information and discussed implications of current case law impacting unsheltered homelessness with goal to create joint understanding
 - Group gathered preliminary data to scope the need from various perspectives

Outcomes Achieved – Affordable Housing

- Work was completed on the Affordable Housing Inventory with the partnership of NeighborWorks of Grays Harbor and Steinhauer Consulting. Drafting and updating interactive maps that capture vacant properties – both raw land and dwellings in in process. Map can be viewed [here](#).
 - Analysis and data were used to categorize properties into three Tiers – low, medium, high investment need to bring property online
 - Partnership was established with City of Hoquiam where the inventory was done to complete the inventory and analysis, as well as use the City logo in the mailings to add credibility and demonstrate partnership
 - Postcard was drafted to mail to property owners in Tier 1 to invite discussion and partnership with housing program with goal to increase number of available, accessible units for housing program clients
- Met with local developer to discuss needs and resources of affordable housing and available programs to support serving low income clients
- Integrated Landlord Mitigation Fund (statewide fund/tool) into landlord relationship building and first partner landlord successfully applied for and drew on the fund to reimburse \$5,000 in damages to unit – this will preserve the relationship moving forward and offer a tool to this landlord and others when serving higher needs clients
- Created a DRAFT Affordable Housing Pipeline to leverage local affordable housing funds to obtain State and Federal dollars to develop affordable housing in our community with tentative launch date early 2020
- Designed and scheduled educational workshop for City and County stakeholders on House Bill 1406 – State sales tax retention opportunity to fund affordable housing projects
- **Demonstrated a decrease of number of days between enrollment in a homeless housing program and when a client moves into permanent housing**
 - **From 48 days in July 2018 to 13 days by July 2019**

Value of Pilot Project

- Interagency case staffing
 - Brainstorm methods, interventions, questions, etc.
 - Coordinate services with agencies who are already serving that client (everyone has the same information and it is updated accordingly)
 - Developed confidentiality procedures to give client informed consent for case staffing to occur, and drafted additional confidentiality “pledges” all team members sign and have on file to commit all information is used for case staffing only and does not leave the table or expand into other areas of service with the client
 - Developed and implemented clear roles/responsibilities for “lead” vs. “non-lead” case managers working with client
 - **Finalized a flow chart to outline current process for housing to engage Behavioral Health when additional supports are needed and determine system gaps**

- Accountability/Check in
 - A designated entity is getting regular updates and can problem-solve when things stall
 - A designated structure to report out on progress each agency has made with the client
 - Establishes a lead case manager to coordinate
- Culture shift – away from agencies feeling like one agency had to do be everything to every client to - a model where agencies could effectively partner to provide wrap-around services based on their unique capacity and services
- Allows for challenges to go to next level of leadership if needed (can address system barriers directly) – i.e. funding and coding challenges
- Developed and distributed educational materials to Coordinated Entry and housing case manager staff on the benefits of Supported Employment and answers to FAQ from clients who are concerned about access to benefits

Summary of Barriers to Serving Pilot Project clients

Housing

- Housing program funds
 - Client is qualified but wait list was months long for rental subsidy
 - System can serve 1 in 4 literally homeless clients who present for services
- Lack of physical units available to rent
 - Particularly in price range accessible to low income clients
- Long turnaround times in filling out rental applications, approving and sending payment before unit is rented to someone else
- Balance of rehousing more challenging clients who have been evicted with housing enrolled clients who are currently homeless

Services/Supports

- Cyclical detox and relapse
 - More intensive intervention needed
 - Coordination of care needed
- Traditional case management/partnership is ineffective
 - More intensive intervention is needed
 - Challenge of navigating relationship and confidentiality expectations between programs (i.e. client will share with housing case manager but does not want information shared with community court or mental health case manager)
 - For enrolled pilot project clients engagement with housing case managers and other services is “hit or miss” and difficult to build momentum and make progress on client-driven stability plan
 - Cyclical intervention cycle has been identified where housing staff are working with very hard to serve clients through pilot project and others and it becomes apparent additional behavioral health supports are needed. Client is referred to behavioral health

but all services are considered voluntary so they either don't engage or engage and then no-show to several appointments causing client to be discharged from behavioral health services.

▪ *See Flow Chart*

- Clients need skill building on setting healthy boundaries
- Need for curriculum to serve clients who are very recently housed – client is housed now what?
- “Selling” Supported Employment to clients who are wary and do not want to risk access or continuation of benefits

System Recommendations

- The Selection Committee were able to address the following significant system barriers:
 - Lack of informal referral process/pipeline for clients from Behavioral Health to housing
 - Engaging the most vulnerable clients through the complex system
 - Information sharing between agencies
- Increased funding is needed for housing and supportive services – particularly for high intensity clients who will likely need very long-term subsidies and supports
- Higher intensity wrap-around services are needed for high acuity clients to coordinate intensive behavioral health, medical health, and social services
 - Whenever possible these services should be delivered in a way that meets the client where they are – in their home, short but frequent meetings, etc.
- Additional planning and implementation supports are needed to help high acuity clients to navigate the cyclical intervention cycle where housing staff are working with very hard to serve clients through pilot project and others and it becomes apparent additional behavioral health supports are needed. Client is referred to behavioral health but all services are considered voluntary so they either don't engage or engage and then no-show to several appointments causing client to be discharged from behavioral health services.
- Need for training and curriculum to implement to serve high needs clients who have very recently been housed – client is housed, now what?
- More training and supports are needed to “market” Supported Employment to clients who are wary and do not want to risk access to or continuation of benefits

Plan for Sustainability

- Grays Harbor County Public Health and Social Services has committed to continue facilitating once a month leadership meetings (the Selection Committee) with system partners to engage and discuss system-level barriers
 - The Selection Committee will have to develop goals to keep the committee on track and determine their role in Grays Harbor County where there are a number of other committees addressing the homelessness issue
 - The Selection Committee may need to expand by adding physical health, substance abuse treatment, and behavioral health crisis providers to add critical perspectives in planning and navigating systems



Grays Harbor County
Capacity Building Initiative

- Coastal Community Action Program and other partners are designing a process to receive feedback from staff on potential system barriers that could be rolled up to the leadership team agenda
- Grays Harbor Public Health and Social Services has committed to continue facilitating ongoing affordable housing stakeholder meetings to discuss the development and refinement of the Affordable Housing pipeline
- Grays Harbor County Public Health and Social Services will continue to identify opportunities for technical assistance and training with CCAP and other community partners to improve understanding and application of housing best practices
- CCAP will continue implementation and evaluation of Medicaid-billable housing and employment services