INTEGRATIVE SERVICES: UNDERSTANDING AND ADDRESSING OUR REGION'S HOMELESSNESS CRISIS

Behavioral Health Advisory Board

November 7, 2019

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO VISION

LIVE WELL SAN DIEGO

Building Better Health

Living Safely

Thriving

INTEGRATIVE SERVICES

To enable every San Diegan to live well and with dignity

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Integrating across the County: A person-centered approach

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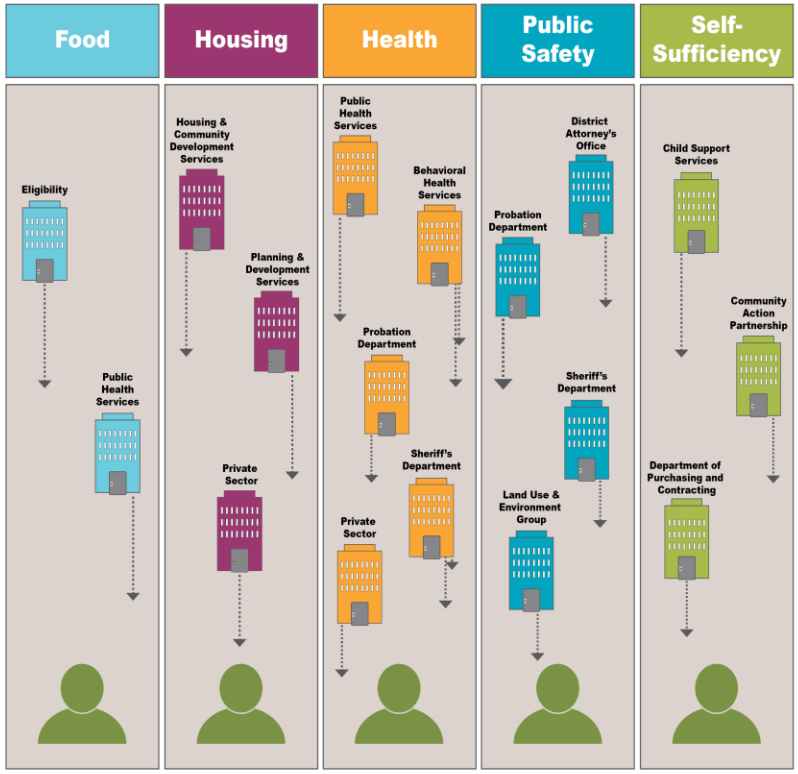
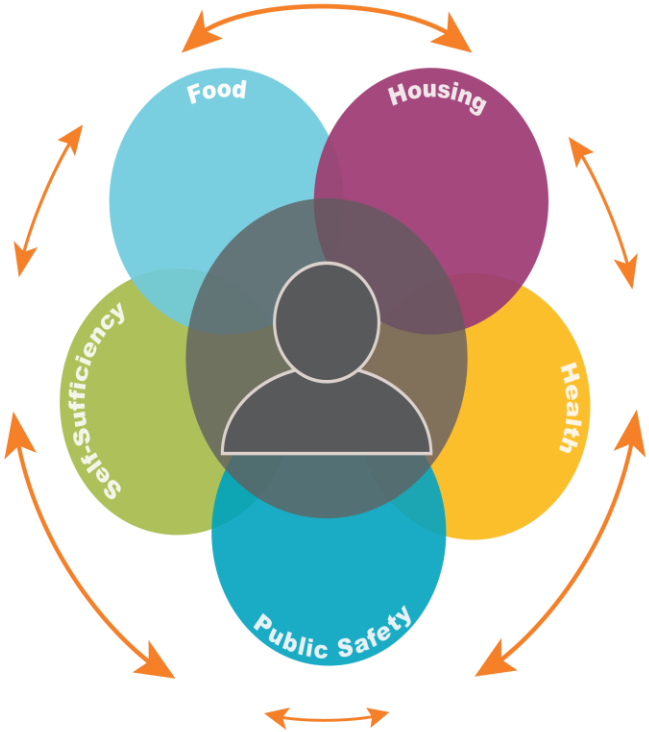
Current: Some Cooperation, Some Silos



Integrative Services: Person-Centered Solutions



ROADMAP

WHAT WE'LL COVER

- Big Picture on Homelessness: Role of Integrative Services
- Housing: Specific Areas of Focus
- Health & Homelessness Team: 10 staff focused on homelessness work
  - Justice & Livability
  - Strategy & Care Coordination
- Health & Homelessness Team: Specific Examples
  - East County Outreach
  - Whole Person Wellness
  - C-3
- Opportunities for BHAB

BIG PICTURE ON HOMELESSNESS

THE BIG PICTURE

- COORDINATING COUNTY ROLE
- How many people experience homelessness?
- Understanding and evaluating the county's role
- Making sense of the more than 70 programs & supports
- Integrating Behavioral Health, Housing, Community
- Data and Performance
- Upstream Homelessness Prevention
- Testing Programs & Regional Leadership
  - Individual Pilots
  - Collaborating across the region (cities/other public entities, non-profits, etc.)

INTEGRATIVE SERVICES AREAS

UNDERSTANDING THE RANGE OF WORK

- Housing Team
- Health & Homelessness Team
- Economic Inclusion Team
- Multi-Generational Support Team

Create More Opportunities to Build Homes

Creative Partnerships:

Working across jurisdictions to create new housing opportunities

Revisiting Land:

Assessing existing county land for affordable homes

Scaling Projects:

Re-examining yield for more housing

HOUSING

Integrating Health and Housing: ***Healthy improvements to the built environment and the context of a person's home to drive healthy outcomes.***

HEALTH & HOMELESSNESS

HEALTH & HOMELESSNESS: EAST COUNTY HOMELESS OUTREACH

Increase in visible homelessness in the unincorporated areas of East County

- County's intensive, coordinated response to identify, connect and support homeless residents
- Ensure public amenities are safe, clean and widely available to residents
- Focus on parks, libraries and encampments in Lakeside, Spring Valley, unincorporated El Cajon, and Oro Valley

HEALTH & HOMELESSNESS: INTEGRATING OUTREACH

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COUNTY PARTNERS

- HHSA Regional Homeless Outreach Workers
- Department of Parks & Recreation
- Department of Public Works
- Planning and Development Services (Code Compliance)
- Sheriff's H.A.R.T. Team Deputies

TIMELINE

- Beginning Monday September 30 through November 30
- Direct and repeat outreach three days a week, 6 a.m. to 2 p.m.
- Data collection to inform evaluation of efforts, collaboration with other service providers, and to test new collection platforms

SERVICES AND SUPPORTS

- Self-Sufficiency program enrollment
- Public Entitlements and Benefits
- Substance Use and Mental Health Treatment linkages
- Project One for All (POFA)
- Whole Person Wellness

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HEALTH & HOMELESSNESS: EAST COUNTY OUTREACH - INITIAL OUTCOMES

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- **82 individual contacts (over 11 days of outreach)**
  - Collaboration with law enforcement: 82 individuals reached*
  - One family in riverbed housed – referred for permanent homes
  - A runaway minor was re-connected with their family and is back home
  - 10 individuals were referred to housing assistance
  - 31 individuals supported with service connection**

WHOLE PERSON WELLNESS

INITIATED LOCALLY IN 2018 TO SERVE OUR COMMUNITY'S MOST IN NEED

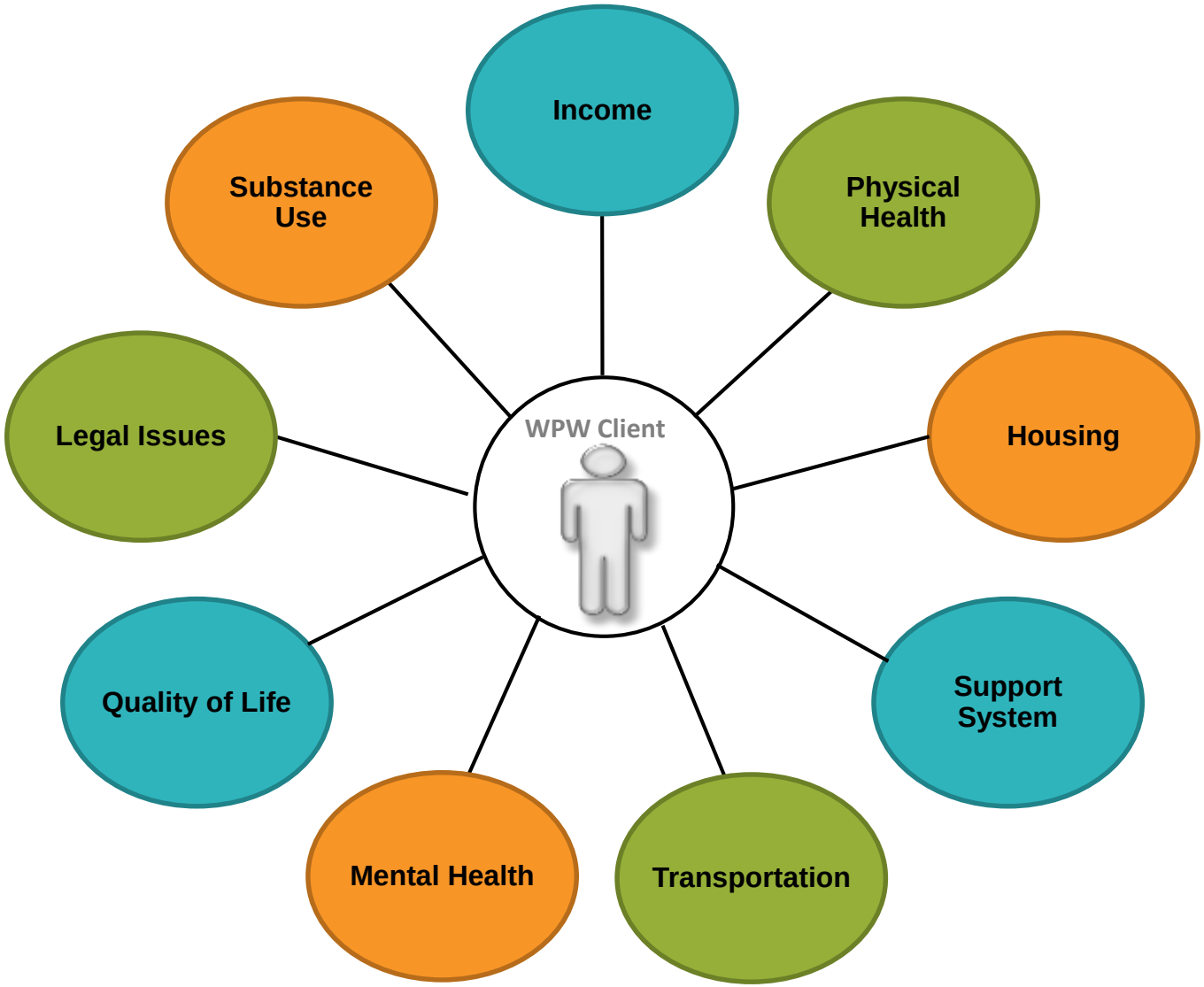
- FUNDED THROUGH A MEDICAID 1115(A) WAIVER THROUGH DECEMBER 2020
- 25 PILOTS STATEWIDE
- STATEWIDE EVALUATION FROM UCLA

TARGET POPULATION

People who are **high utilizers** of health services **AND** experiencing **homelessness, or are at-risk of homelessness AND** have one or more of the following:

- Serious Mental Illness
- Substance Use Disorder
- Chronic Physical Health Conditions

WHOLE PERSON WELLNESS



WPW SPECIFIC ELEMENTS: SERVICES PROVIDED

- **Range of Critical Connections**
  - **Intensive Outreach and Engagement**
  - **System Navigation**
  - **Tenancy Supports**
  - **Technology**

SITs – SERVICE INTEGRATION TEAMs

- 17 teams: Case Manager and Peer Support Specialist, with support from a Licensed Clinician, Housing Navigator, and RN
- High Acuity Teams to work with extremely high-need individuals for 60-day increments
- Regional distribution of teams, going where the needs are

OVERARCHING GOALS FOR WPW

- Provide comprehensive system navigation
- Comprehensive care coordination across multiple systems
- Integrated IT infrastructure
- Provide 800 people with these services

COMMUNICATE ⟷ **COORDINATE** ⟷ **ADVOCATE**

OUTCOMES

HOUSING: PROJECT HAS HOUSED 47% OF PARTICIPANTS, WITH 32% PERMANENTLY HOUSED

*WPW'S HOUSING STABILITY RATE IS AN ASTOUNDING 88%

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ADDITIONAL OUTCOMES

PERFORMANCE METRICS & LESSONS LEARNED

- Enhanced coordination with PERT & EMS Resource Assistance Program
- 66% of enrollees had a PCP visit within 30 days of enrollment, a 14% increase over 2018
- 35% decrease in incarcerations since 2018
- 25% increase in ED visits and 12% increase in inpatient days
  - Removing outliers changes outcomes to reduce ED visits by 24% and inpatient days by 21%
  - Across the State, there was a 17% increase in ED visits during the first year of implementation, followed by a 13% decrease in the next year*

NEW ADDITIONS TO WPW!

ONE-TIME HOUSING FUNDS

- Flexible, regional rental assistance
- Shared housing component
  - Roommate matching
  - Landlord Outreach and Incentives
  - Conflict Mediation
  - Structured, detailed tenancy agreements

HEP A IMMUNIZATION INCENTIVE

- Coordination with Public Health to ensure saturation of Hep A vaccines in the homeless population
- Allows WPW contractors to prioritize vaccination for their program participants and get paid for that work
- Builds on relationships with regional Public Health nurses and FQHC's

C3: COMMUNITY CARE COORDINATION

What is C3? Comprehensive care coordination, system navigation and housing assistance through teams consisting of a Case Manager and Peer Support Specialists.

Who will be helped? Justice-involved individuals with a serious mental illness who are homeless or at-risk of being homeless.

How is it done? Build trust while in custody, navigate to a home upon release with services, engage for 12 months.

C3 FOR VETERANS

EXPANDED C3 SERVICES…COMING FALL 2020

Who will be helped? Veterans in the Veterans Moving Forward program in the Vista Detention Facility.

Core components

1. **In-reach and engagement**
2. **Care Coordination and System Navigation:**
3. **Housing Assistance and Placement**
4. **Financial Stability**

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LET'S STAY IN TOUCH!

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