HOPES Team Model
Mental Health Advisory Board Meeting

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Director
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HOPES Team Model Goal

What We Do

- Stabilize the community's most vulnerable
  - Primarily homeless
  - Mental illness and/or substance use disorder
  - Frequent contact with law enforcement, the public or local businesses
  - Those having difficulty engaging in services

How We Do It

- Early and open referral
- Intensive monitoring and engagement
- Triage and coordinated access to existing programs and services

Where We Do It

- Funded jointly by the City and the County, the HOPES model is county-wide, but with an emphasis on most impacted areas, such as downtown

The HOPES Team Model Design

Multidisciplinary Team (MDT) Approach

- Optimizes existing county and contract provider resources with an integrated MDT. HOPES core MDT Members are:
  - Homeless Persons Health Project (HPHP)
  - County Behavioral Health
    - Adult Mental Health Services
    - Substance Use Disorder Services
  - Downtown Outreach Workers (DOW)
  - Mobile Emergency Response Team (MERT)
  - Veterans Advocate
  - Behavioral Health Court Liaison
  - Homeless Policy Steering Committee
  - Human Services Department

Underlying Principles in Developing the HOPES Model…

- Prior to HOPES, there were several homeless serving organizations in Santa Cruz County, but were operating independently of each other.
- The services an individual would have access to were often dependent on which homeless serving organization had initial contact with the client.
- The HOPES model seeks to integrate care, and ensure a coordinated response to services, that are based on the needs of the client and not how they enter into services.

Underlying Principles in Developing the HOPES Model…continued

- The HOPES model is intended to be responsive and supportive to the community as and equal partner and customer.
- The HOPES program was established to utilize existing funding (no new funding), to operate primarily M-F, 8-5, with the availability of some evening and weekend hours as well.
- HOPES supports a **no wrong door model** to care- if an individual referred is determined not to be homeless, the team will still support the individual in connecting to them to services.

Implementation of HOPES

*The HOPES Team began operations on March 12, 2018

Jasmine Najera is the HOPES Team Manager. Jasmine is a Behavioral Health Manager with extensive experience working with this population, and reports to the Director of Adult Services, Pam Rogers-Wyman.

Referral Process

Current:

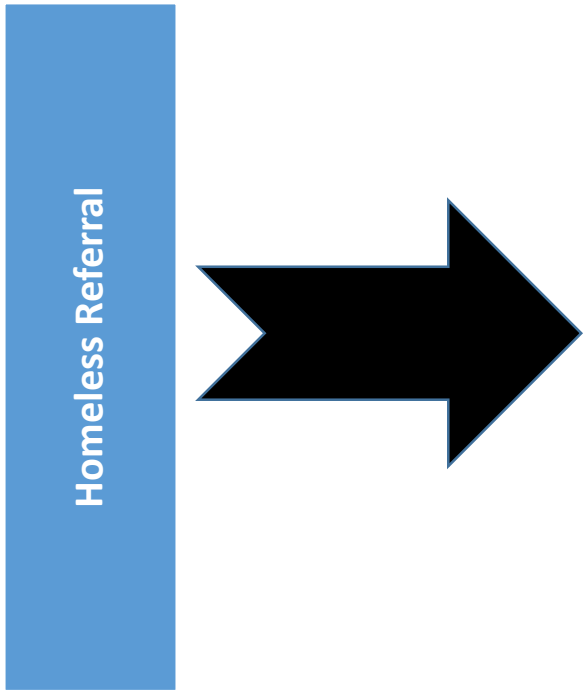
- MDT members case conference 3X week on all individuals in partner systems being monitored and targeted for engagement.
- Community referrals are made through a dedicated and confidential email portal HopesTeam@santacruzcounty.us which is available to any member of the community.
  - The referring individual will receive an automated response acknowledging receipt of the referral, and outlining next steps and crisis services available.
- HOPES Team members coordinates with law enforcement activity, jail staff, and community partners

Next Steps:

- The Homeless Person's Health Project (HPHP) is recruiting for a public health nurse who will take referrals and provide medical triage.

HOPES Model

HOPES Referral, and Assessment Model

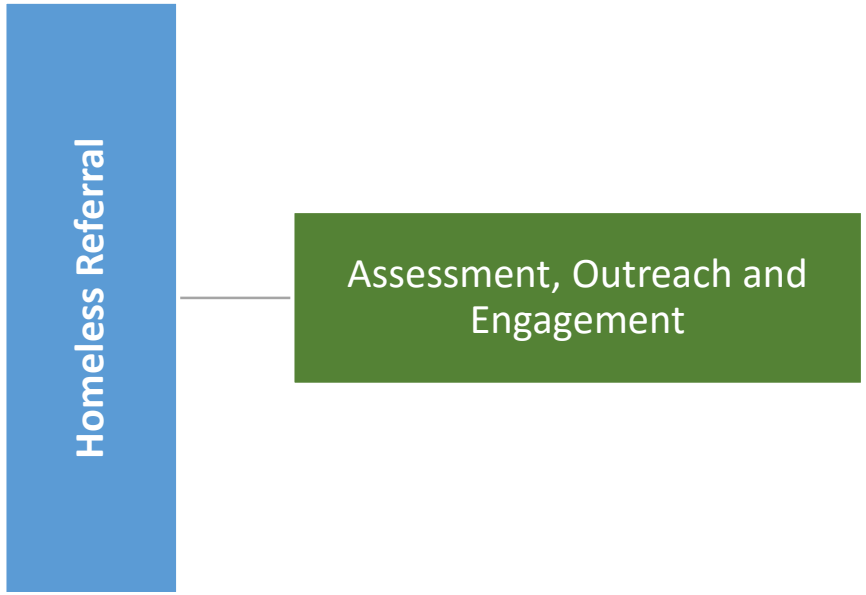


Step1

Initial Triage:

1. By HOPES Team member
2. Determine response level- immediate crisis response vs. referral to the team

HOPES Referral, and Assessment Model



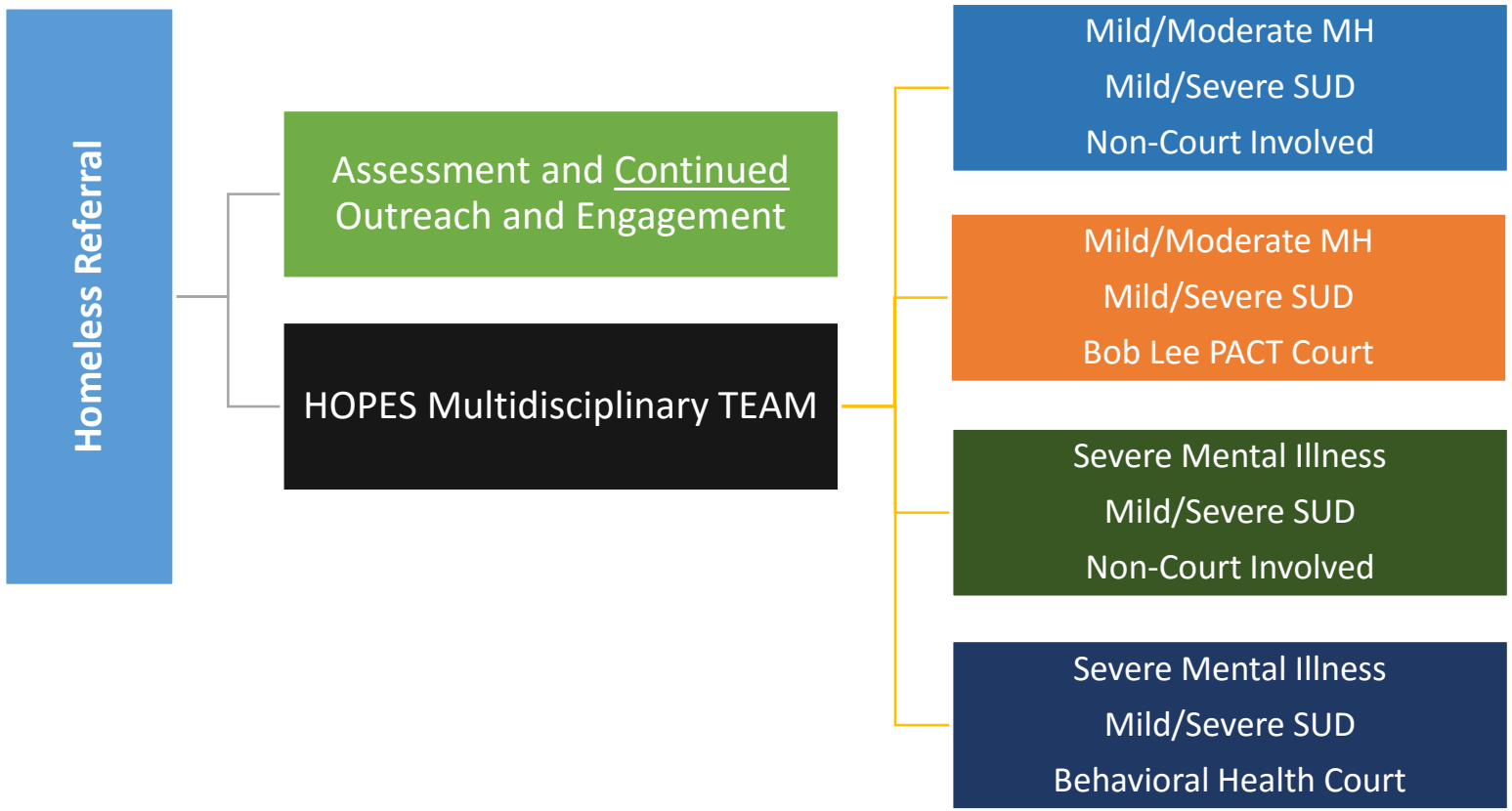
Step 1 **Step 2**

Assessment:

1. **Triage by HOPES staff** with a referral to the team to develop a referral path
2. Inclusive of: health, mental health, substance use disorder, need for hospitalization and/or shelter services

1. Based on a Stages of Change Model
2. Introduce Harm Reduction approach
3. Treatment readiness
4. Engage to support action to treatment or for difficult to engage individuals, continued assessment and outreach

HOPES Referral, and Assessment Model



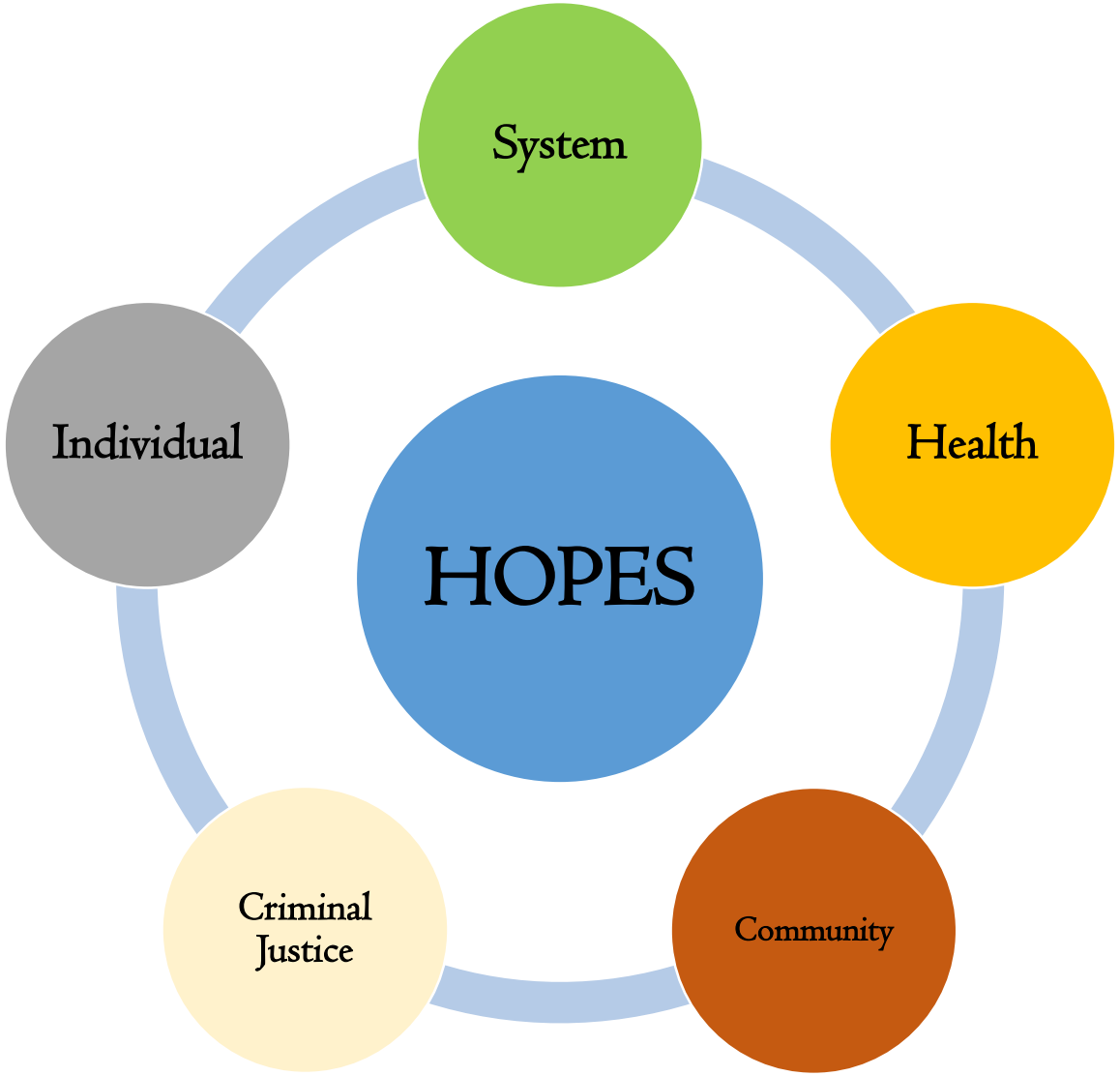
Step 1 **Step 2** **Step 3**

Program Assignment:

1. Engagement with HOPES team MDT.
2. HOPES Team, based on severity of mental illness or Substance Use Disorder, and Court Involvement, refers and connects the individual to the appropriate program.
3. Individuals not ready for treatment are assigned to HOPES and continued work in the community with the case manager with review at 3X week team meetings.

Proposed Performance Measures

Performance Measures Across **Five Domains**



5 Domains Inform 5 Outcome Areas *

1. Housing Status and Stability
2. Public Service Use and Cost
3. Substance Use
4. Mental Health
5. Quality of Life (inclusive of Community Impact)

* Outcome evaluation plan to be developed through contract with outside evaluator

PHASE I – Establish Baseline Data, through December 2018

- Challenge: client data is located in multiple sources; inability to link different databases,
- Solution: use of a client registry to run individual reports off each database.
- The registry will note the location of the client for report generation by geographical area:
  - Emeline
  - Downtown Santa Cruz
  - Harvey West
  - Watsonville
  - Live Oak
  - Aptos
  - Other areas as needed
- Establish baseline data

PHASE II – Develop Outcome Evaluation Plan, Projected start January 2019

- CrossTx Platform, a patient dashboard of data from patient health records and any CrossTx partner, including HOPES.
- CrossTx a necessary tool for reporting measures and indicators towards 5 Outcomes areas
- Establish targets towards outcome areas using baseline data

Performance Measures

1. System Measures: 7 proposed measures
2. Individual: 8 proposed measures
3. Health: 8 proposed measures
4. Criminal Justice: 8 proposed measures
5. Community: 2 proposed measures

Performance Measures- **Individual**

Phase 1:

1. % of individuals who came into services with no benefits and subsequently began receiving benefits
2. % of individuals who experienced an increase/decrease in arrests/or citations
3. % of individuals whose housing condition was upgraded (or downgraded) during the past month
4. Length of stay for individuals in permanent housing as a % of days
5. % of individuals reunited with their home support system (ex. Homeward Bound Program)
6. # of 5150 evaluations performed
7. Jail Days (pre and post) intervention (annual count)

Performance Measures- **Individual,** continued

Phase 2:

1. % of clients who came into services without employment and subsequently began employment including volunteer work

Performance Measures- **Health**

Phase 1:

1. % of individuals who had a minimum of at least 1 primary care visit for preventative care during the year
2. % of individuals who had a recommended vaccination during the year
3. % of individuals referred to mental health treatment who engaged (or withdrew) in treatment
4. % of individuals referred to substance use disorder treatment who engaged (or withdrew) in treatment

Performance Measures- **Health**, continued

Phase 2:

1. % of individuals who have no health home and % of individuals who had no health home but added a health home
2. Psychiatric Hospital bed days: 6-months prior and 6-months post
3. Medical Inpatient Hospital bed days: 6-months prior and 6-months post
4. ED Visits: 6-months prior and 6-months post

Performance Measures- **Criminal Justice**

Phase 1:

1. # of individuals referred to the PACT Court
2. % of individuals accepted into the PACT Court
3. # of individuals referred to the BH Court
4. % of individuals accepted in the BH Court
5. % of individuals who completed the PACT treatment recommendations and have graduated (or withdrew) from the PACT Court
6. % of individuals who have completed the BH Court recommendations and who have graduated (or withdrew) from the BH Court

Performance Measures- **Criminal Justice**, continued

Phase 2:

1. Jail days: 6-months prior and 6-months post- running average
2. Arrests and Citations: 6-months prior and 6-months post- running average

Performance Measures- **Community**

Phase 1:

1. Downtown business satisfaction survey

Phase 2:

1. GIS Hotspot map by homeless contact

Key Statistics to Date: 1rst 8-weeks of operation

113 referrals

-62% of those referrals engaged in services or accepting of outreach.

-other 38% are unwilling to have continued contact, in an unknown location, but are continued to be outreached when they are located.

Next Steps

- HSA returning to the Board of Supervisors to provide a cost estimate on an evaluation component for the proposed outcomes measures in October.