# Integrated Services Delivery for Homeless Individuals and Families



Prepared for 4ᵗʰ Annual Homeless Summit
by:

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# Presentation Overview

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- Integrated Supportive Services Team (ISST)
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- Project 50 Replications
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- Questions

# Project 50 Overview

Project 50:

- Immediate access to permanent housing for most vulnerable and chronically homeless individuals

- Intensive Integrated Supportive Services Team (ISST) aimed at maintaining individuals in housing by meeting their service needs

- Project 50 recently moved into the newly constructed Cobb Apartments and expanded to provide permanent supportive housing with services to an additional 24 participants

# Engagement Team

- Maintain regular contact with identified individuals in efforts of establishing rapport and the goal of engaging these individuals in the services including permanent housing

- Establish a trusting therapeutic relationship with identified individuals

- Assess needs, define service goals, and reach agreement with the individual on a plan for service delivery

- Connect and/or reconnect individuals to appropriate services and supports

# Engagement Team

Registry Creation:

# Integrated Supportive Services Team

Components:

- Services are provided by an integrated team either on site, in a mobile manner or within a community clinic (depending on housing/services model)

- Interagency collaboration for comprehensive care and services

- Multi-disciplinary team to provide integrated health, mental health, and substance abuse services

- Level of service based on each individual's need

# Integrated Supportive Services Team

## Services:

- Healthcare provided by a Federally Qualified Health Center (FQHC)
- Mental health provided by a Medi-Cal certified outpatient mental health clinic
- Substance abuse treatment services
- Money management
- 24 hour/7 day crisis services
- Recovery-based self-help and support groups
- Employment services
- Transportation services
- Educational opportunities
- Medication management
- Benefit (re)establishment
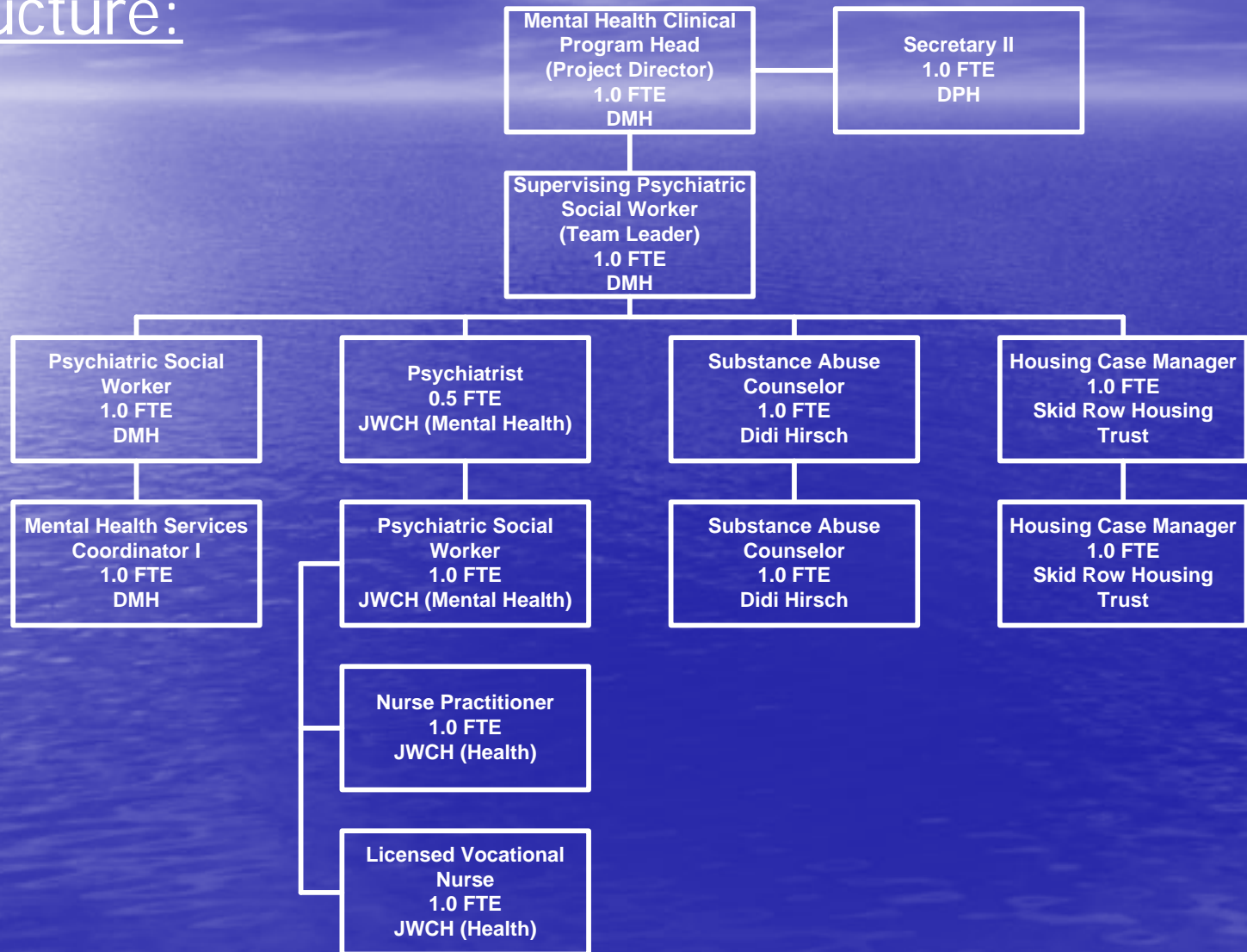
# Integrated Supportive Services Team

Structure:

No matter which agency administers any element of the ISST, all ISST staff work as an integrated team (could be multiple agencies):

- One record
- Daily team meetings
- Regular consultation
- Visits conducted together
- Shared office space
- Non-traditional contacts

# Integrated Supportive Services Team

## Structure:

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┌─────────────────────────┐         ┌─────────────────────┐
│ Mental Health Clinical  │         │    Secretary II     │
│   Program Head          │─────────│     1.0 FTE         │
│ (Project Director)      │         │      DPH            │
│   1.0 FTE               │         └─────────────────────┘
│    DMH                  │
└─────────────────────────┘
             │
┌─────────────────────────┐
│ Supervising Psychiatric │
│   Social Worker         │
│  (Team Leader)          │
│   1.0 FTE               │
│    DMH                  │
└─────────────────────────┘
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| Psychiatric Social Worker 1.0 FTE DMH | Psychiatrist 0.5 FTE JWCH (Mental Health) | Substance Abuse Counselor 1.0 FTE Didi Hirsch | Housing Case Manager 1.0 FTE Skid Row Housing Trust |

| Mental Health Services Coordinator I 1.0 FTE DMH | Psychiatric Social Worker 1.0 FTE JWCH (Mental Health) | Substance Abuse Counselor 1.0 FTE Didi Hirsch | Housing Case Manager 1.0 FTE Skid Row Housing Trust |

**Nurse Practitioner**
1.0 FTE
JWCH (Health)

**Licensed Vocational Nurse**
1.0 FTE
JWCH (Health)

# Financial Sustainability

- It is critical for project sustainability to establish benefits, including Supplemental Security Income (SSI) and Medi-Cal as soon as possible

- Healthcare provided by FQHC can be billed to Medi-Cal at an enhanced reimbursement rate

- Mental health provider can bill DMH for Medi-Cal covered services

- Substance abuse provider can bill Medi-Cal if they are certified Drug Medi-Cal provider

- It is anticipated that the program will require start-up and gap funding during the first 2 years, after which the program will be financially sustainable

# Project 50 Outcome Data

- 91% diagnosed with mental illness
- 84% report history/current substance abuse
- 100% of those offered housing accepted
- 67 individuals housed – only 5 have left voluntarily (87% retention rate)
- 750 hospital days one year prior to housing – 100 hospital days one year after housing
- 750 jail days one year prior to housing – 150 jail days one year after housing
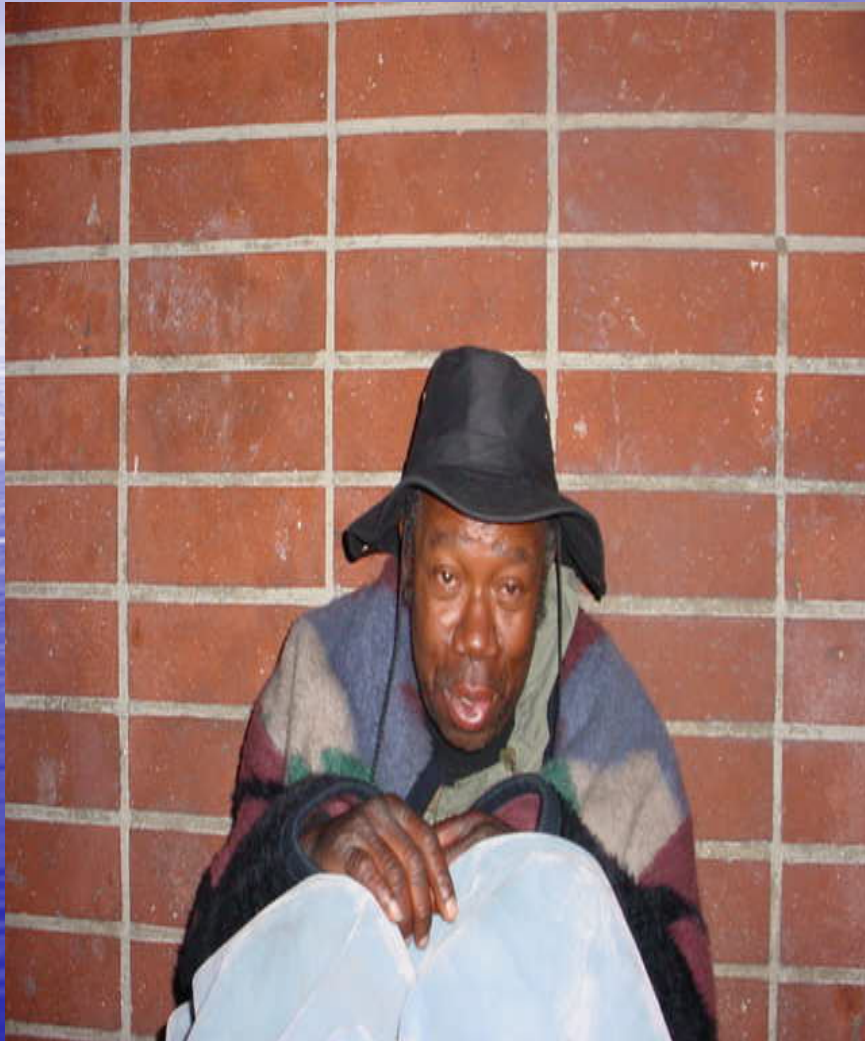
# Project 50

**Before:**

**After:**

# Project 50

**Before:**

**After:**

# Project 50 Replications

Housing for Vulnerable Individuals and Populations:

- **Venice – Project 40**
  - Registry in 2009
  - Scattered site housing

- **Santa Monica – Project 130**
  - Registry in 2009
  - Scattered site housing

- **San Fernando Valley – Project 30**
  - Registry in 2009
  - Scattered site and transitional housing

# Project 50 Replications

Housing for Vulnerable Individuals and Populations:

*In Development:*

- **Hollywood – Project 40**
  - Registry in May 2010
  - Project based and scattered site housing

- **Pasadena – Project Housed**
  - Registry scheduled for October 2010
  - Project based and scattered site housing

- **Veterans Administration – Project 60**
  - Registry being conducted from current caseload
  - Project based housing in West Los Angeles and San Fernando Valley

# Innovations

- Innovations is the final Mental Health Services Act (MHSA) plan to be implemented in Los Angeles County.

- The plan is focused on identifying new practices for the primary goal of learning and increasing the array of creative and effective approaches that can be applied to mental health services for specified populations.

- 4 Models of the Innovations Plan:
    1) Integrated Clinic Model
    2) Integrated Mobile Team Model
    3) Community-Designed Integrated Services Management Model
    4) Integrated Peer-Run Model

# Innovations

Integrated Clinic Model:

- Combines physical health, mental health, and substance abuse services in a community-based site, such as a primary care clinic or mental health clinic, targets homeless, uninsured, Underrepresented Ethnic Populations (UREP)

- Coordinates care across practices, utilizes existing infrastructure and the leveraging of other programs, promotes interagency collaboration

# Innovations

## Integrated Mobile Team Model:

- Deployment of mobile, enhanced, integrated, multidisciplinary teams that includes physical and mental health and substance abuse professionals and peers managed under one agency/point of supervision, uses housing first approach with individualized care plans

- Access to services through multiple points of entry

- Provides Project-Based Service Vouchers to developers to support the development of more housing units for consumers

# Questions?