King County

Department of
Community and Human Services

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IMPLEMENTATION PLAN
2012 – 2017 Veterans and Human Services Levy:
Activity 3.6: Client Care Coordination

1. Goal

Prevent and reduce homelessness.

2. Strategy

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of "Improving Health".

3. Activity 3.6 Client Care Coordination

The Client Care Coordination activity described below is one of six activities funded under Strategy 3: Improving Health.

4. Service Needs, Populations to be Served, and Promotion of Equity and Social Justice

a) Service Needs

The Levy's Service Improvement Plan (SIP) describes the need to support the implementation of the high utilizer integrated database as part of a coordinated effort to identify, engage, house and care for the most vulnerable and highest utilizers of costly public systems. Analysis has shown remarkable reductions in system use for individuals identified as high utilizers prior to placement in permanent supportive housing. The SIP also describes the need to continue to support a Privacy Officer to coordinate data sharing agreements between the County and other entities.

a) Populations to be Served

Chronically homeless single adults, both veterans and non-veterans, who experience mental illness and/or substance abuse, and who are either high users of public systems, such as, jail, emergency departments, community psychiatric hospitals, shelter and/or detox center, or meet requirements for high vulnerability.

b) Promotion of Equity and Social Justice

The Equity and Social Justice Ordinance requires King County to consider the impacts of its policies and activities on its efforts to achieve fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency. The King County Equity Impact Review Tool available online at: http://www.kingcounty.gov/exec/equity/toolsandresources.aspx provides a list of the determinants of equity that may be affected by your activity. Evaluate your activity's impact by responding to the following questions:

i) Will your activity have an impact on equity?

Yes. Client Care Coordination collaborates with referral sources and housing programs to make the most efficient use of housing and service resources by identifying and placing individuals into housing that is appropriate for their needs.

ii) What population groups are likely to be affected by the proposal? How will communities of color, low-income communities or limited English proficiency communities be impacted?

The low-income communities are impacted by this program. Although income information is not maintained in the high utilizer integrated database, the permanent supportive housing programs are required to house individuals with extremely low (30 percent) or low (50 percent) area median income.

iii) What actions will be taken to enhance likely positive impacts on these communities and mitigate possible negative impacts?

Client Care Coordination collaborates with referral sources and housing programs to place individuals who have high use of public safety systems, or high vulnerability into permanent supportive housing.

Activity Description

Client Care Coordination, or targeted recruitment for chronically homeless single adults, continues implementation through the high utilizer integrated database project. This centralized repository integrates data from several sources including the King County mental health data system, state and community psychiatric hospitals, the Dutch Shisler Service Center, King County Correctional facility, shelters and medical emergency services. This service utilization information allows for the identification of homeless individuals who are frequent users of these high cost services. Data is analyzed and system utilization scores assigned using the weighted scoring system developed by the integrated data project manager. Scores are based on the number of times an individual used a service in a given time period and/or the number of days the service was used, compared to overall use of that service by others in the population.

Additionally, scores of those who are assessed as being highly vulnerable, based on a standardized validated assessment tool, the Vulnerability Assessment Tool (VAT) are incorporated into the data base, so that the database will display both client utilization and client VAT scores in client candidate lists. These scores are maintained and

considered separately from the service utilization score. The inclusion of the VAT scores is an important means of assuring that those *most at risk* are those who are identified for service-enriched housing.

From community referral sources, such as REACH, Harborview high utilizers program, Adult Day Center, and shelters, individuals are screened for the system utilization scores and VAT score, creating a triaged list that serves as candidate lists for filling client care designated units in permanent supported housing vacancies in new and existing programs. This process is intended to assure that individuals in greatest need of the limited housing resources available are those who are prioritized for entry.

5. Funds Available

The 2012 Service Improvement Plan identified the following allocations for this activity.

	2012	2013	2014	2015	2016	2017
Veterans Levy	**$ 40,000**	**$ 40,000**	**$ 40,000**	**$ 40,000**	**$ 40,000**	**$ 40,000**
Human Services Levy	**$ 100,000**	**$ 100,000**	**$ 100,000**	**$ 100,000**	**$ 100,000**	**$ 100,000**
Total	**$ 140,000**	**$ 140,000**	**$ 140,000**	**$ 140,000**	**$ 140,000**	**$ 140,000**

A total of $140,000 is available in 2012 to implement this activity. Additional funds will be available annually through 2017 based on the activity's performance.

6. Evidence-based or Promising Practices

Identification and tracking of individuals from the target population will facilitate referrals to several existing and developing evidence-based or best practice models of housing and service provision. The following represent some of those evidence-based or best practice models in King County:

- DESC 1811 Housing First program
- City of Seattle Housing First (several sites)
- Outreach and engagement programs for homeless individuals (HOST, PATH, REACH, etc.)

7. Service Partnerships

The continued implementation of Client Care Coordination, through the high utilizer integrated database, includes the following partners:

- King County Department of Community and Human Services, Directors' Office and Mental Health, Chemical Abuse and Dependency Services Division
- Public Health of Seattle/King County, HealthCare for the Homeless
- Committee to End Homelessness
- King County Department of Adult and Juvenile Detention
- City of Seattle, Human Services Division and Office of Housing
- King County Housing Authority
- Seattle Housing Authority
- United Way of King County

- Safe Harbors Homeless Management Information System (HMIS)
- Harborview Medical Center
- Community –based housing service providers

8. Performance Measures

The following outcomes and targets were identified by the Levy's Evaluation Team. Performance will be evaluated annually and targets will be adjusted accordingly as needed for the following year.

Outcome Indicator	Target(s)	Data Source
Percentage of clients who moved into permanent supportive housing with a high system utilization or high vulnerability score (for Outcome 1)	90%	HU data base
Annual reduction in utilization by successfully housed HU referred clients	No Target Required	Criminal justice and hospital records Data to be provided with submittal of the Levy Annual Progress and Evaluation Report.

The following performance measures and targets were identified by the Levy's Evaluation Team. Performance will be evaluated annually and targets will be adjusted accordingly as needed for the following year.

Performance Indicator	Target(s)	Data Source
Number of persons assessed for system utilization and represented in the data base	15,000	HU data base
Number of persons in the data base meeting system utilization/vulnerability requirements	1,000	Report Card – Services
Number of potential housing referrals screened for possible tenancy	500	Report Card – Services
Number and percentage of clients with system utilization / vulnerability meeting criteria and referred for possible tenancy	225	Report Card – Services