Housing Outreach Partners (HOP) – A behavioral health and medical outreach team for Housing Authority residents

Background

People with serious behavioral health issues are often at risk of housing instability. When they are in crisis, it occurs where they are, not necessarily at a clinic. Taking the time to do outreach to individuals who do not readily come to clinic-based appointments is key. Some of the county's most vulnerable individuals are often not readily able to attend regular clinic appointments. Such individuals often *do* respond positively to tenacious, caring individuals who show an investment in them.

A portion of King County's Mental Illness and Drug Dependency (MIDD) funds have been set aside to support a switch in the model of behavioral healthcare so that treatment can go to the person, with an initial test of a model of outreach to individuals unstably housed in Seattle Housing Authority (SHA) and King County Housing Authority (KCHA) buildings (HA Residents).

The King County Department of Community and Human Services (DCHS) is seeking to identify behavioral health agency partners to launch regionally-positioned behavioral health/medical outreach teams for the Housing Outreach Partner pilot program. These teams will, as further described below, engage HA Residents to provide:

- Limited acute response to HA Residents
- Assertive outreach, engagement, stabilization and linkage to care for HA Residents to:
    - Decrease the number of HA Residents who have need for behavioral health and/or health care, who are either not in treatment or enrolled but not in regular contact
    - Improve housing stability, functioning and quality of life for individuals served – and decrease building problems, including lost occupancy that result from challenging behaviors

This document provides an overview of the planned RFP to procure HOP services.

Funding

There is $2.2 million available in 2019-20 for HOP; half of which cannot be renewed beyond 2020. Each team will be funded at a rate of $400,000 annually. Payment will be provided in monthly installments of 1/12th of the annualized budget with quarterly cost reconciliation. Ten percent of the budget will be held back to be provided as performance incentives. In subsequent years, MIDD is expected to continue to provide partial funding, and contract renewal is anticipated either at a reduced level or with braided funds. During 2020, the HOP team and stakeholders will determine a financial sustainability plan which may include Medicaid billable services and/or leveraging Foundational Community Supports.

Focus Population (50 points)

RFP Respondents can apply to provide two or more HOP teams to SHA/KCHA buildings, which range in size from 20-280 units. Each HOP team will be expected to provide:

- Limited Acute Response (see description below) to a broad pool of buildings serving up to 1500 HA Residents, and
- Assertive Outreach and Engagement (see description below) to an average caseload of 75 individuals within 3-5 targeted HA buildings at a time (minimum of 100 served per year), transitioning to subsequent targeted HA buildings once engagement opportunities at initial buildings begin to be exhausted, retaining residual contact with previous building(s).

RFP respondents will be asked to describe their experience with, and plan for working with diverse populations, including high proportions of seniors, individuals with disabilities, and people of color. Many native languages are spoken by HA residents including Cantonese, Vietnamese, Mandarin, Spanish, and Amharic.

RFP respondents will be asked to describe their experience with, and plan for working with the issues that put HA Residents at risk of housing instability in HA buildings including:

- Poorly controlled or troubling substance use issues
- Attention-seeking (e.g., excessive noise, repeated requests, numerous guests, control of pets/service animals); creating disturbances (e.g., verbal/physical conflicts or exploitation, or damaging property), or poor life skills and self-care (e.g., poor apartment hygiene, smoking violations, self-harm, financial instability)
- Poorly-managed medical conditions - exploratory analysis of residents in two buildings found that 72% were experiencing one or more chronic medical conditions - the most common being conditions associated with medications to treat behavioral health issues including: hypertension, diabetes and hyperlipidemia

Services to be Provided (80 points)

RFP respondents will be asked to describe their experience with, and plan for the following services:

Limited Acute Response

- Providing response for acute behavioral health/medical situations in HA buildings:
  - upon request from Crisis Connections when their triage has determined that other crisis response options are not warranted OR
  - when the HOP team is on-site at given building and is directly contacted by HA staff and HOP staff determine that they can safely and effectively provide such services.
- Providing linkage to care and warm hand-off to services of the HA Resident's need and choice.

Assertive Outreach and Engagement

- Working collaboratively, with each behavioral health team member serving as a member of a given HA building's service team, establishing a building presence, fielding referrals, coordinating care, and leveraging existing resources (e.g., ADS, HHOT nurses, FCS, HCHN, etc.)
- Conducting assessment, assertive outreach and time-limited stabilization (<3 months) to identified HA Residents that effectively addresses issues that compromise housing stability (as described in 'Focus Population' above) using a variety of strategies including, but not limited to, cold-calling, door-knocking, and repeat visits to establish trusting relationships.
- Brokering and coordinating services to (re)-establish linkages to services to meet needs and choice – including coordinating with BHRD and MCO care coordinators to facilitate linkages to care

Staffing (50 points)

RFP respondents will be asked to describe their experience with, and plan for:

- Rapidly hiring, training and supervising HOP behavioral health/medical team staff including:
  - 3.0 FTE community-based behavioral health outreach specialists with at least one CDP
  - 1.0 FTE nurse
  - 0.5 FTE Supervisor
  - Availability of as-needed psychiatric prescribing consultation

- Providing:
    - Assertive Outreach and Engagement to an average caseload of 75 individuals (each behavioral health specialist carrying a 20-30 person caseload) , while maintaining capacity for Limited Acute Response to a broader population as described above
    - Services during regular business hours (7 hours/day, 5 days/week), rotating from site-to-site and services beyond normal business hours

Program Evaluation and Performance Measurement (20 points)

RFP respondents will be asked to describe their experience with, and plan for:

- Providing data transactions into BHRD's electronic management information system that underly performance metrics including demographic, encounter, and referral data transactions
- Participating in the MIDD evaluation plan and other evaluation activities including surveys of:
    - HA building management perception of responsivity to acute events, reductions in challenging resident behaviors, relationships with the HOP team, and HOP team effectiveness
    - Participant perspectives regarding improved housing stability, functioning and quality of life and program satisfaction
- Making timely adjustments to service model based on continuous improvement, stakeholder feedback, program evaluation, and contract monitoring and performance metrics as describe below.

Contract monitoring

The following are basic contract expectations, that if not met would result in quality improvement and/or contract discussions:

- # of individuals enrolled (with an average of 25 individuals *per BH specialist* as measured on a quarterly basis)
- # of new enrollments (with at least 25 individuals *per team* per quarter)

Performance metrics for incentive payment

Incentive payments will be provided for high performance anticipated to be as follows:

Target	Target Deadline	Description
Full Staffing	October 1, 2019	All roles described in the "Staffing" section have been hired and are performing HOP services
Linkage to Care	December 31, 2019 (and quarterly thereafter)	Of those discharged in quarter, confirmed linkage of 75% of those who needed connection (or reconnection) to mainstream behavioral health services and/or medical care
Housing Loss Rate	December 31, 2019 (and quarterly thereafter)	Of those enrolled during a quarter, a rate of loss of housing among enrollees that does not exceed the rate for the building as a whole

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