

Volunteers of America Eastern Washington

An Integrated CCBHC Health and Human Services Provider

CROSSWALK



Our Focus

Volunteers of America Eastern WA is an integrated health and human services provider. For over 125 years, we have been supporting people on their journey out of homelessness. We understand the direct connection with behavioral health, housing stability, physical health and social issues and provide integrated supports for people to rebuild their lives.

For people to thrive, the whole person needs to be supported. We achieve this through a model of support that can assess, provide, coordinate with partners and intervene to find solutions for the whole person so that they may live a meaningful life and contribute to a healthy community.



In Spokane we are experiencing:



INSUFFIENT CAPACITY TO ADDRESS NEEDS OF HOMELESS

- Insufficient and diminishing emergency shelter capacity
- A Lack of step-down or respite capacity
- A Lack of community-based crisis stabilization capacity in Spokane.
- An inability to access clinic-based care due to long wait lists, transportation - and stigma
- Lack of transitional housing and supportive services to prepare individuals with complex needs for independent living

RISING ACUITY AMONG INDIVIDUALS SEEKING SHELTER

- Individuals presenting in shelter in psychiatric crisis and/or experiencing withdrawal symptoms
- Untreated medical needs including wounds, infections, and lapses in chronic condition management and MAT
- Discharges from EDs or Hospitals directly to our shelters without connection to aftercare (11% of discharges according to WHA!)
- Rising number of homeless seniors unable to live independently
- Rising number of homeless Young Adults unprepared to live independently





At VOA Eastern Washington we are solving for both sides of the health and housing equation.



SHELTER, TRANSITIONAL, AND SUPPORTED HOUSING





TREATMENT AND RECOVERY SUPPORT



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We provide Integrated Health and Housing Services to our Shelter and Housing Participants



A Housing First Behavioral Health Home

- Integrated Behavioral Health Care within Permanent Supported Housing
- Integrated Team of clinicians, nurse, case workers and peers
- SAMHSA-funded Certified Community Behavioral Health Center



Crisis Intervention & Nursing in the Shelter

- Crisis assessment and intervention to respond to needs right in the shelter
- Nursing services for basic medical care, triage, and harm reduction
- SAMHSA-funded Treatment for Individuals Experiencing Homelessness



Respite Within Shelter

- For those requiring more around the clock support
- Supporting medically frail individuals accessing shelter, including seniors
- Grant Funding for 8 Respite Beds



Our Whole Person Health Approach

Integrated

Care

Team

- Certified Community Behavioral Health Center
- Crisis Stabilization Services
- Integrated Behavioral Health and Primary Care in Shelters and Housing

Community-Based Behavioral Health Care

Housing

- Shelter (Youth, Young Adult, Women)
- Permanent Supported Housing (single individuals)
- Transitional Housing (Veterans, Foster Youth, Young Adults)
- Respite

- Drop-in Centers

Peer Support Services

- Day Programs
- Transportation

Social and Community Connection Education and Employment Services

- GED Completion Program
- Adult Education Pathway with Community College
- Soft Skill Employment Readiness
- Job Search Support



Innovation in Shelter Services

Crosswalk Teen Shelter (Licensed 13-17 year old)

Crosswalk is a licensed shelter for teens experiencing homelessness.

Age appropriate behavioral health, GED completion program, recreation, skill building, family reunification and housing placement

Young Adult Shelter (18-24 year old)

Age-appropriate services and supports are provided to unhoused elderly women. Includes integrated behavioral health and focusses on education and employment for skill building that leads to livable wage employment.

Hope House Women's Shelter (Over 18 years old)

Women's shelter integrating behavioral health and primary care for crisis stabilization. Includes clinical behavioral health, skill building and housing case management and placement.



Innovation in Housing



Permanent Supportive Housing

175 units supporting chronic homeless with disabilities into housing

- Integrated Behavioral Health interventions
- Peer Support Service
- Primary Care Nursing
- Housing Skill Building

Transitional Housing

(For Homeless Veterans, Young Adults and Foster Youth)

Housing for Young Adults age 18-24. Age-appropriate services and supports including:

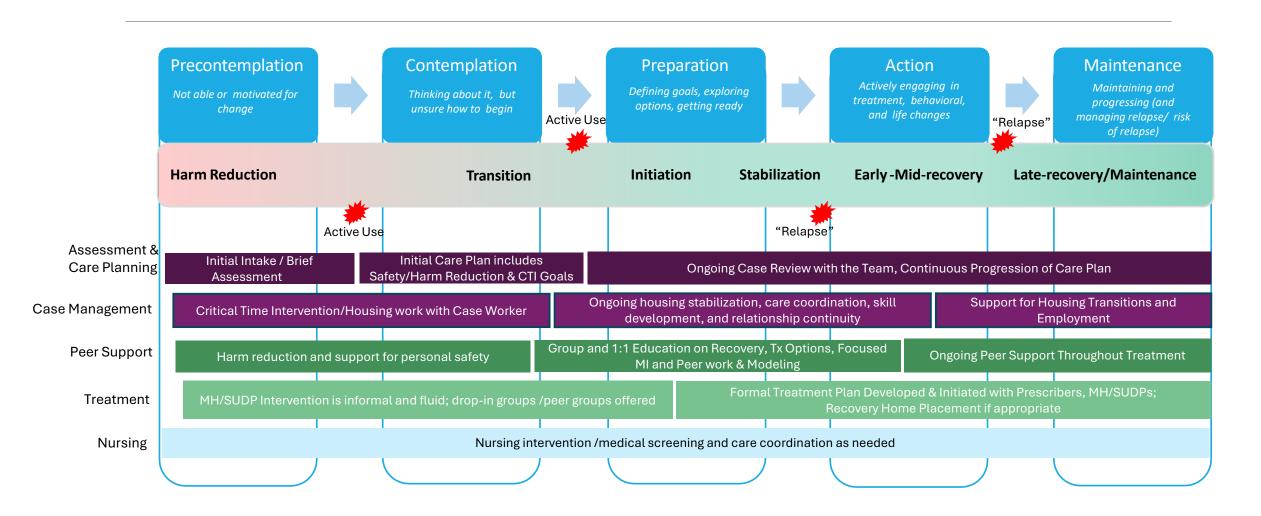
- Educational pathways
- Pathways to permanent Housing
- Employment support
- Integrated Behavioral Health interventions

Group Home – Pregnant & Parenting Teens

Congregate living for young mothers and their baby. Age-appropriate services and supports including:

- Parenting skill building
- ng Employment support
- Attachment and Bonding
- Integrated Behavioral Health interventions
- Educational pathways
- Pathways to permanent Housing

VOA's Vision for the Participant Journey Thru a Stages of Change Lens: *Adaptation of Care Delivery and Interventions to Needs and Readiness*



VOA's CCBHC Integra ted Health and Housing Model



24/7 Safe, Supported Congregate Living Environment

On-site and On-call Behavioral Health Services





Onsite and On-Call Medical Services

Medication Management and Access to Prescribers





On-site Housing Assistance Services

Intensive Case Management for Health and Social Care Needs





Life Skills Support and Habilitation Services

- 24/7/365 Direct Care Supervision and Staffing
- In-house Facilities Maintenance and Security
- Daily Meal Services
- Space for personal storage
- On-site Crisis Intervention Specialist
- Mental Health and Substance Use Disorder Counseling
- Trauma-Informed, Evidence-Based Interventions
- On-site Peer Support Specialist
- On-site Street Outreach Medical Team through FQHC Partner
- Management of acute and chronic conditions
- On-call Physician and telehealth consultation
- Referral to specialty care
- Medication reconciliation and management
- Post-acute aftercare
- Access to psychiatry and MAT through FQHC partner
- Safe medication storage
- Housing Needs Assessment and Planning
- Benefits Eligibility and Coordination, including for Veterans
- Housing Search, Subsidy, and Placement services
- Support for transition and tenancy preservation
- Whole-person assessment and comprehensive care planning
- Clinical care coordination and referral management
- Social service navigation to address health-related social needs
- Transportation services
- Life skills training and development
- Access to job readiness and vocational support services
- Access to educational services
- Wellness and recovery groups and community-building activities

A Range of Flexible Housing Options that are More Responsive to Individual Needs Will Create More Successful Paths to Long-term Housing Stability

Stabilize **Transition** Sustain Prepare Clinical Short-Term **Permanent Affordable** Stabilization and Clinically **Transitional** Outreach, Referrals, **Supported Housing in** Diversions & Discharges Recuperative Integrated Housing Community Housing Care Housing Medical Respite and Short-term Congregate Short-term Independent Long-term Supported Housing Vouchers with Whole-person Clinical Stabilization Living with Intensive Living with Intensive Housing with On-Ongoing Access to Assessment and Initial Treatment and Housing Supports (Group Home & Services site/Mobile Integrated **Integrated Care Services** Integrated Health & **Placement Services** Scattered Site Models) Care Services as Needed Housing Plan

REPLACE Emergency Shelter with Stabilization and Respite to Respond to Complex Care Needs

PROVIDE Service-Rich Shortterm Housing to Support Early Recovery and Preparation for Independent Living INTEGRATE Care into
Community Housing to
Sustain Recovery and
Preserve Tenancy

Tracing the Participant Journey: Framework Used for Observing Integrated Care In Action

Initiation – the "front door"

- How do individuals access care?
- How are needs assessed?
- How is care planning initiated?
- How do you triage and manage risk?

Engagement – building "rapport"

- How do staff develop trust with individuals seeking shelter and housing?
- How does engagement happen in different places? At different paces?

Intervention – delivering services

- How is intervention defined?
- How do we work with "precontemplative" individuals?
- What is meaningful interaction?
 What is "Behavioral Health"?
- What are the barriers to personcentered care?

The 4 S's – Staffing, Skills, Systems, Structure

- How seamless as the stages of the journey? How well "integrated" are services along the journey?
- What changes to the 4 S's could help improve the participant journey *and/or the workforce* experience?

Lessons Learned and Next Steps – Integrated Care 2.0

Initiation – the "front door"

- Close the gap between initial intake, bio-psycho-social needs assessment and BH diagnostic evaluation
- Provide Risk Screening and Harm Reduction right away
- Address basic needs first using critical time intervention practices
- Create welcoming environment and culture of participant-led community

Engagement – building "rapport"

- Connect to case management & housing services immediately
- Create person-centered care plan assigning care team, roles, and tasks
- Formalize the role and development of peer specialists and/or CHWs
- Grow peer & participant-led programming
- Implement relentless outreach

Intervention – delivering services

- Float clinicians in every setting to build trust and provide continuous access to low-barrier interventions
- Cross-train staff in core evidencebased interventions (TIC, Harm Reduction, CTI, MI, CBT) and crisis response protocols
- Add SUD Counselors
- More on-site/mobile CHAS services

The 4 S's – Staffing, Skills, Systems, Structure

Systems: Revise assessment, workflows/ warm hand-offs to open cases for billing upon intake or within 12 hours of initiation Systems: Leverage Lease-Up to intake PSH residents for Integrated Care and promote the value of services to support tenancy Systems: Use Credible features to automate more of intake, care planning, case assignment and panel management workflows Skills: Train all staff in evidence-based interventions, using OTJ training, shadowing and mentoring by onsite clinical supervisors Skills: Develop career pathways for support/CM staff to become more skilled non-MHP counselors, CHWs, or peer certified Staffing: Revisit shifts to match clinical coverage to highest intake hours in shelter; dedicate consistent clinical presence to PSH Staffing: Revisit CHAS agreement to ensure nursing coverage in PSH, rapid prescriber access, & MH crisis / withdrawal protocols Structure: Allocate clinical supervisors to programs to reduce time in transit, increase on-site access, and OTJ staff development Structure: Create matrixed clinical leadership model to oversee quality and consistency of implementation across all programs

The Clinical resources through our Integrated Care Model, a collaboration with CHAS.

VOA BEHAVIORAL HEALTH AND HOUSING STABILIZATION TEAM:

Clinical Supervisor

Behavioral Health Crisis Intervention Specialist

Co-Occurring Disorders Specialist

Peer Specialist

Mental Health Counselor

Case Managers for Housing and Care Coordination

24/7 Direct Care Staffing



Medical Direction

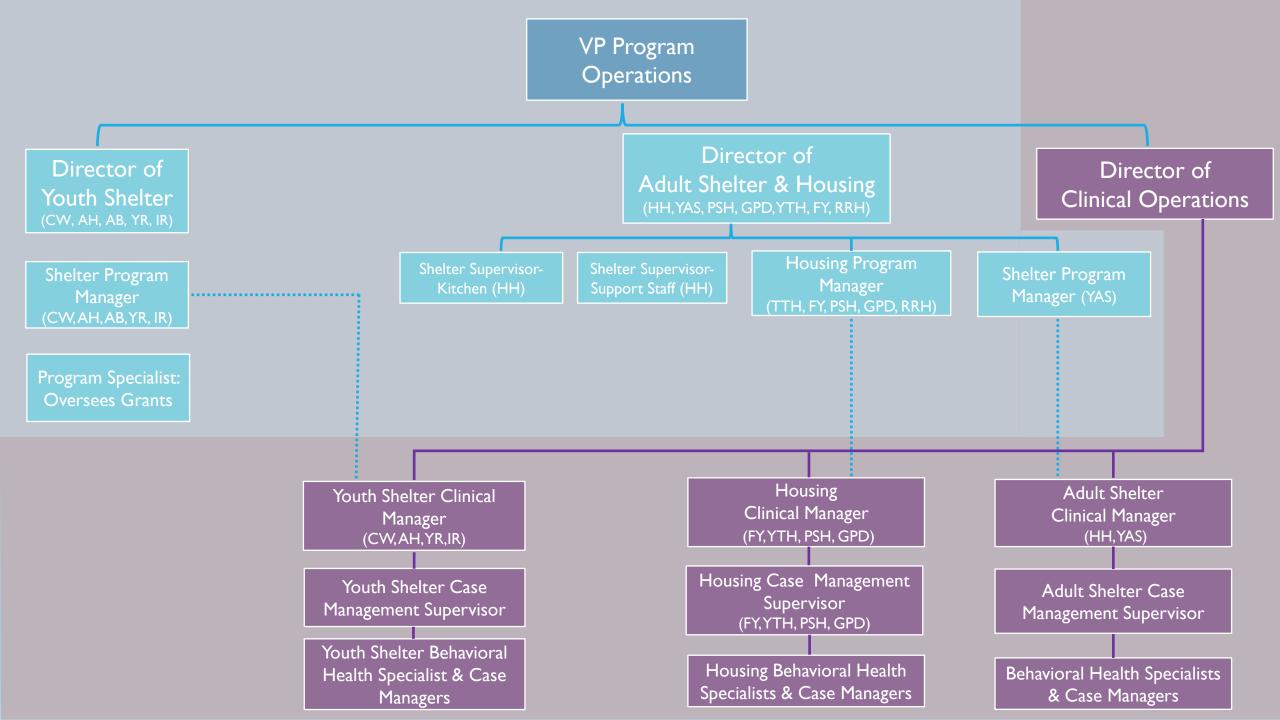
On-Site Community Nursing provided by the CHAS Street Outreach Team

On-Call Physician Consultation

Access to Psychiatric prescribing

Access to Medications for Opioid and Alcohol Use Disorders (MOUD/MAUD)







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