

38. Accept and file final grant reports on Healing the Streets and Building Hope and Safety-Santa Cruz, and a report on mobile community crisis response activities and Community Response Initiative to Strengthen Emergency Systems (C.R.I.S.E.S.) Grant Pilot Program ()



## **County of Santa Cruz Board of Supervisors**

### **Agenda Item Submittal**

**From:** Health Services Agency

**Subject:** Report on Various Behavioral Health Grants

**Meeting Date:** February 11, 2025

**Formal Title:** Accept and file final grant reports on Healing the Streets and Building Hope and Safety-Santa Cruz, and a report on mobile community crisis response activities and Community Response Initiative to Strengthen Emergency Systems (C.R.I.S.E.S.) Grant Pilot Program

### **Recommended Actions**

1. Accept and file the final grant report on Healing the Streets, as awarded by Substance Abuse and Mental Health Services Administration (SAMHSA);
2. Accept and file the final grant report on Building Hope and Safety-Santa Cruz, as awarded by SAMHSA; and
3. Accept and file a report detailing progress on mobile community crisis response activities and the Community Response Initiative to Strengthen Emergency Systems (C.R.I.S.E.S.) Grant Pilot Program, administered by the California Department of Health Care Services.

### **Executive Summary**

The Health Services Agency (HSA) requests the Board to accept and file this written report for two concluded grant-funded programs, including any activities, outcomes, outputs, and any implementation barriers that may have occurred. Both grant programs were funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) to further treatment, prevention and education goals of the Health Services Agency Behavioral Health Division (BHD). HSA also requests the Board to accept and file a report on mobile community crisis response activities and the C.R.I.S.E.S. Grant Pilot Program, administered by the California Department of Social Services (CDSS).

### **Discussion**

On November 16, 2021, the Board accepted four separate multi-year grants to support expansion of Behavioral Health programs, including two from SAMHSA, the Healing the Streets grant in the amount of \$3,000,000, and the Building Hope and Safety-Santa Cruz grant in the amount of \$799,632. HSA has provided a total of five subsequent grant updates to the Board, and on February 28, 2023, the Board directed HSA to submit a final report at the conclusion of each grant.

On October 17, 2023, the Board accepted a multi-year award in the amount of \$2,480,855 from CDSS for the C.R.I.S.E.S. Grant Pilot Program, and authorized BHD to negotiate an agreement with Family Services Agency of the Central Coast (FSA) to provide mobile crisis response services, as per the grant application, which was later approved on January 9, 2024 and amended on April 9, 2024. The Board also requested ongoing reporting to keep informed of BHD's progress on mobile crisis response activities associated with the C.R.I.S.E.S. Grant, which was deferred to February 11, 2025.

## ***Healing the Streets Grant***

The SAMHSA Healing the Streets grant was awarded September 2021 and concluded December 2023. When BHD completed a data review on participant care and impacts of COVID-19 in late 2020, it was discovered that the most significant gap in care was the loss of services to people experiencing homelessness who were enrolled in BHD services and active prior to March of 2020 but with whom BHD lost contact. The grant proposal was a joint effort between BHD, the Housing for Health Division (H4H) in the County Human Services Department (HSD), and the Homeless Persons Health Project (HPPH), drawing from cross-departmental data and experience in working with people experiencing homelessness and serious mental illness.

The Healing the Streets grant had two aims:

1. Provide direct services to people experiencing serious mental illness or co-occurring disorders and homelessness using the Critical Time Intervention Model.
2. Develop an integrated and coordinated system of care for people experiencing serious mental illness or co-occurring disorder and homelessness.

A full evaluation of the Healing the Streets grant is attached. A summary of grant activities and findings follows.

### Process and Outcome Evaluation

The evaluators, at Research Development Associates (RDA), asked three questions to determine process outcomes of the grant:

1. In what way is the Critical Time Intervention Model effectively meeting the needs of participants experiencing homelessness and/or co-occurring disorders?

The evaluation found that based on participant characteristics, the program successfully connected with the intended population. The field-based behavioral health and case management services had the biggest impact in meeting participant needs. By partnering with the HPPH Street Medicine team and expanding street-level services to include medication, case management, and therapy support in the field, staff engaged and treated individuals in the community. Staff met participants' needs by providing thousands of individual services and using skills grounded in multiple evidence-based modalities. The evaluation found that high caseloads and limited housing availability, along with challenges coordinating with the H4H Coordinated Entry system, exposed the misalignment of the Critical Time Intervention model. The team subsequently shifted to a Strengths-Based Case Management Model, also an evidence-based practice. Staff implemented workflows with varying success, challenged by resource restraints and initial model misalignment, but still saw significant individual successes.

2. What is the nature and extent of collaboration and coordination between Healing the Streets and partner agencies?

Overall, most partners reported positive relationships with Healing the Streets or positive perceptions of Healing the Streets in the community. As the program established itself within the landscape of social service providers, program

partners reported having a better understanding of their role in coordinating services to people experiencing homelessness. Regular huddles between services providers allowed for individual care planning and sharing. One of the identified gaps is the challenge with communication and non-duplication of services with shared participants. While the grant aim included developing a shared platform for data on participant activities and information, challenges with data-sharing strategies and siloed systems created barriers to achieving housing goals in particular.

### 3. Are program services improving outcomes for individuals experiencing homelessness with mental health and/or co-occurring disorders?

Overall, participants reported being better off as a result of participating in the program. Participants reported that the program helped them stay connected to or get connected to health care providers, including behavioral health providers and Medication Assisted Treatment (MAT) providers. Data shows an improvement in mental health conditions, a reduction in homelessness, and an increase in social connectedness.

A total of 359 unique individuals out of 648 referrals (55%) engaged with program staff and formally enrolled in services to meet their needs, which were varied. Participants self-reported demographic information and were able to choose what they wanted to work on with their case manager. Of the enrolled participants, 55% identified as male, 32% identified as Hispanic, 70% identified as heterosexual, and 68% experienced street homelessness in the past month.

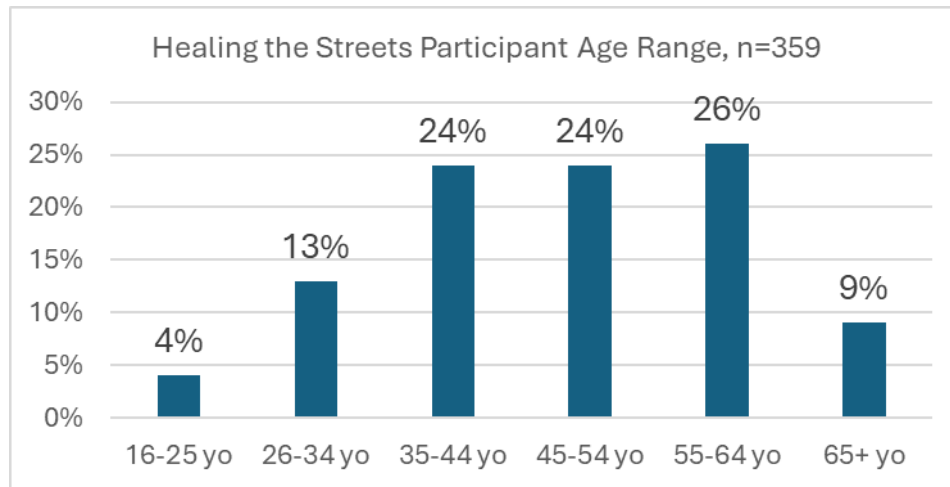
Key outputs and outcomes include:

- 3,492 individual direct services were provided to 346 unduplicated participants.
- 59% of participants were initially engaged in Santa Cruz, and 41% in Watsonville.
- The average length of service was 168 days (5-6 months).
- 11% of participants received 288 individual therapy sessions.
- 46% of participants showed a decrease in psychological distress.
- Homelessness among participants decreased by 6%.

Figure 1 – Referrals to Healing the Streets (n=648)



Figure 2 - Age of Healing the Streets Participants 2021-2023 (n=359)



### Sustaining Gains and Integrating Learning

The BHD Adult Mental Health Services Branch convened a workgroup made up of staff in direct service and supervisory roles to ensure that learnings from the grant were integrated into service delivery of Full-Service Partnership (FSP) teams and that strategies were put in place to mitigate barriers to care for people in the community experiencing homelessness and serious mental illness. This workgroup determined that developing a FSP team with homelessness as a population of focus and including close coordination with the H4H Continuum of Care will improve outcomes and best support a recovery path. Without housing, treatment gains of symptom reduction and improvement in functioning are almost impossible to sustain. The Integrated Housing and Recovery Team (IHART) was developed by redirecting current County staff from other teams along with the associated client caseloads where current clients also experienced homelessness. BHD is working with H4H to ensure coordination with housing services and enrollment into Coordinated Entry.

### ***Building Hope and Safety-Santa Cruz Grant***

In 2018, the community formed the Santa Cruz County's Suicide Prevention Task Force (SPTF) to gain a better understanding of local experience with suicide, to gather and understand data, review best practices, and create a Suicide Prevention Strategic Plan. The Task Force was comprised of a wide array of community members including community-based health care employees and faith-based organizations, school officials, law enforcement, hospice personnel, behavioral health and public health staff, veterans' advocates, and other stakeholders. This represents the County's first formal suicide prevention plan, which was formally adopted by the Board on June 11, 2019. BHD staff submitted the Building Hope and Safety grant proposal to SAMHSA to support some of the work on the Suicide Prevention Plan and initially received a denial. BHD was notified in September 2021 that the application status changed and was awarded the grant.

A full evaluation of the Building Hope and Safety-Santa Cruz grant is attached. A summary of grant activities and findings follows.

Building Hope and Safety-Santa Cruz consisted of the following activities:

Rapid Follow-up: BHD operated a program called "Rapid Connect" for persons who

attempted suicide or were at risk of a suicidal crisis. The program provided case management and linkage for youth and adults who were treated in local emergency departments and hospitals or received at the Crisis Stabilization Program.

Screening and Assessment: BHD, in partnership with Applied Crisis Training and Consulting, Inc. (ACT), hosted training on the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning. The training was offered to BHD Clinicians, contracted provider agencies, and other community clinicians by The Columbia Lighthouse Project and ACT.

Training: ACT provided workshops on these evidence-based practice (EBP) trainings: Applied Suicide Intervention Skills Training (ASIST), safeTALK, Mental Health First Aid (MHFA), and Counseling on Access to Lethal Means (CALM) for service providers in Santa Cruz.

Community Recovery Supports: ACT partnered with BHD to implement Community-Based Supportive Services (CBSS) including a system mapping, creation of a pocket guide for services, universal and selective public education campaigns, postvention services, and expansion of supportive services for victims of domestic violence.

Enhanced Services for Victims of Domestic Violence: These services were provided in partnership with Monarch Services and ACT. Monarch advocates and therapists actively worked on addressing the increased need for mental health services for survivors resulting from the COVID-19 shelter-in-place (SIP) order through counseling services and collaboration with community partners.

Access to Telehealth Services: Throughout the COVID-19 pandemic, BHD, ACT, and Monarch have offered services through telehealth and, once safe, in person. Telehealth services included telephone only and video telehealth appointments. In addition to standard telehealth visits, telehealth rooms were available on-site in two BHD locations (North and South County) to provide participants without access to technological means the availability of services. ACT partnered with Monarch to develop or update a list of local resources to provide to participants needing suicide crisis support, including the suicide crisis line 24/7/365, which offers access to language interpretation in 140 languages. Monarch, Behavioral Health, and partners provided follow-up calls to individuals at risk of suicide, offering three-way calls to connect participants with other sources of support as needed. ACT also partnered with local organizations to connect survivors of loss with audio-visual telehealth support group meetings. Monarch has continued to fully serve participants since the beginning of the COVID-19 pandemic and Santa Cruz County's SIP order. Cell phones and laptops were provided to participants and staff as needed. In addition to this, all Monarch staff were thoroughly trained in responding to the 24-hour crisis line, making them uniquely prepared to offer teleservices to participants during this time. As a result, advocates and therapists continued to work with survivors to provide counseling support and safety planning as necessary.

Applied Survey Research (ASR) performed the evaluation for this grant. Key findings include:

- More than half (58% to 93%) of service providers reported increased awareness of, or familiarity with, other system partners and their services/role.
- Over 800 service providers and community members received at least one evidence-based training, and tailored training and technical assistance plans

were developed for and provided to 13 local organizations.

- A majority (63% to 98%) of service providers reported improved skills or increased abilities to identify, evaluate, and/or manage risk of suicide in clients, and more than half (57% to 97%) reported increased comfort or competence in using screening, assessment, and/or safety planning tools.
- One hundred percent (100%) of CALM training participants reported that the training was effective or highly effective in helping them provide support to clients at risk of suicide.
- Monarch Services provided housing support to over 100 individuals and screened all for suicide risk, in addition to referring for crisis services.
- Nearly three-quarters (73%) of service providers reported increased knowledge of resources for those affected by suicide death. Program staff distributed materials and referrals for support to individuals exposed to a suicide death, conducted grief support calls, and offered suicide loss group support.

### ***C.R.I.S.E.S. Grant Pilot Program***

On October 17, 2023, the Board accepted the C.R.I.S.E.S. grant, a pilot program from the CDSS Civil Rights, Accessibility and Resource Equity (CARE) Branch. The grant term is October 1, 2023, through August 31, 2026. The grant pairs BHD with a community-based organization, Family Services Agency (FSA). CDSS believes that the complexities of emergency issues surrounding crises in mental health, intimate partner violence, community violence, substance use, and natural disasters can, at times, be addressed more safely, with greater impact, and more cost effectively and efficiently by community-based organizations, which often have deeper knowledge and understanding of the issues, trusted relationships with the people and communities involved, and specific knowledge and relationships surrounding the emergency.

The C.R.I.S.E.S. grant enables BHD to further the goals of implementing a 24/7/365 Mobile Crisis Response Team response to the community by augmenting existing services and providing after-hours crisis response with a focus on the cities of Santa Cruz and Watsonville, without involving law enforcement unless there is a safety concern. The city-centric approach is in response to field data and identified needs of at-risk and marginalized individuals.

The California Department of Health Care Services (DHCS) issued a mandate for 24/7/365 mobile crisis response via BHIN 23-025 on July 19, 2023, requiring all County BHDs to provide mobile crisis response around the clock for Medi-Cal beneficiaries by January 1, 2024. BHD will continue to support crisis response needs in the community regardless of payor. BHD was out of compliance with this mandate for 11 months and worked with the DHCS on a Corrective Action Plan. The main barrier to implementation was FSA's challenges in hiring qualified staff as well as BHD and FSA restructuring of existing resources.

BHD and FSA reached full 24/7/365 implementation on December 5, 2024. Shifts came online to seven (7) days a week as follows:

- FSA fully implemented the swing shift from 4:30pm to 12:30am in July 2024.
- BHD expanded day shift services from 8:00am to 6:00pm in September 2024, moving from five (5) days a week to seven (7) days a week.
- Full implementation was brought by FSA with the night shift, operating from 12:00 midnight to 8:00am seven (7) days a week on December 5, 2024.

The FSA teams will respond to behavioral health crises and will engage, assess, de-escalate, safety-plan, and link individuals to appropriate community services and supports. In compliance with BHIN 23-025, BHD has additional clinical staff available on call 24 hours a day to provide clinical consultation and Telehealth services. Both teams are capable of transporting individuals to services needed to further stabilize the crisis being faced.

The next phase of the grant is to convene regular, quarterly meetings with a minimum of two impacted member groups, with a focus on at-risk, underrepresented populations, by partnering with agencies that have existing relationships with community members. These include National Alliance on Mental Illness (NAMI) - Santa Cruz Chapter, Pajaro Valley Prevention and Student Assistance (PVPSA), and the Diversity Center. BHD and FSA staff will ask for feedback regarding services during follow up contact, and BHD will utilize RDA, an independent third-party evaluator, to review the community feedback and effect on the overall Pilot Program. CDSS will also perform evaluation on grant deliverables.

### **Financial Impact**

The programs detailed in this memo are funded by the grants under which they are listed - the Healing the Streets and the Building Hope and Safety-Santa Cruz grants from SAMHSA, and the C.R.I.S.E.S. grant from CDSS. The Healing the Streets and Building Hope and Safety-Santa Cruz grant awards were accepted through Board action on November 16, 2021, the C.R.I.S.E.S. grant was accepted through Board action on October 17, 2023, and funding for all three grants has been budgeted appropriately. No new County General Funds are needed or requested.

### **Strategic Initiatives**

Operational Plan - Operational Excellence

### **Submitted By:**

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### **Recommended By:**

Carlos J. Palacios, County Administrative Officer

### **Artificial Intelligence Acknowledgment:**

Artificial Intelligence (AI) did not significantly contribute to the development of this agenda item.





# Healing the Streets

## Cumulative Evaluation

March 2022 – December 2023



# Healing the Streets

## Cumulative Evaluation Report: March 2022 – December 2023

This report was developed by RDA Consulting, SPC under contract with Santa Cruz County Behavioral Health.

RDA Consulting, SPC, 2023







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## Introduction

**In December 2021, Santa Cruz County Behavioral Health Division (SCC BHD) contracted with RDA Consulting, SPC (RDA) to conduct an evaluation of the Healing the Streets (HTS) program.** HTS is an innovative program designed to meet the needs of people experiencing homelessness (PEH) with serious mental illness (SMI) and possible co-occurring substance use disorders (SUDs) with field-based behavioral health services and other critical supportive services.

**This report is a cumulative evaluation and includes data from the program's beginning in March 2021 through September 2023.** The background section sets the context for HTS program operations with information about the homelessness and social safety net system in Santa Cruz County. The HTS overview provides a description of the services provided, program goals, program timeline, and the future of the program. Following this is an overview of the evaluation approach and methods, as well as key learnings from the Plan Do Study Act (PDSA) quality improvement cycles. Next is the evaluation findings, organized by evaluation question. The final section provides recommendations for future programming. Attached at the end of this report are a series of 21 appendices, which includes a more detailed descriptions of the program context and funding source, in-depth descriptions of the program design, descriptions of the evaluation approach and methods, all four PDSA reports, and full client case studies. These appendices include additional details intended to enable a deeper understanding of the HTS program and the evaluation findings.



## Background

**California has recorded the largest homeless population in the U.S. for over a decade.**<sup>1</sup> Santa Cruz County experiences unique challenges concerning homelessness, mental health support, and treatment of SUDs.<sup>2</sup> More people experience homelessness per capita in Santa Cruz County than anywhere else in California, with a high rate of individuals also contending with an SUD.<sup>3</sup> Individuals residing in Santa Cruz are burdened by an extremely high cost of living and lack of access to affordable housing (see **Appendix A** for more information).

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<sup>1</sup> <https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/>

<sup>2</sup> <https://www.ppic.org/blog/homeless-populations-are-rising-around-california/>

<sup>3</sup> [https://www.co.santa-cruz.ca.us/Portals/0/County/GrandJury/GJ2023\\_final/2023-6\\_BHD\\_Report.pdf](https://www.co.santa-cruz.ca.us/Portals/0/County/GrandJury/GJ2023_final/2023-6_BHD_Report.pdf)

**At the height of the COVID-19 pandemic in 2020, approximately 2,000 people in Santa Cruz County were experiencing homelessness**, with 32% reporting psychiatric or emotional problems, 30% reporting drug or alcohol use, and 30% reporting PTSD.<sup>4</sup> During this time, in part because of the pandemic, access to behavioral health services fell precipitously for this population. This is supported by outcomes from the 2022 Santa Cruz County Homeless Point-in-Time Count and Survey in which the prevalence of substance use disorders more than doubled since 2019.<sup>5</sup>

**Unfortunately, this increased need for supportive services has coincided with reduced access to services.** SCC BHD serves as the County's safety net for behavioral health services and aims to address the most critical mental health needs of its County low income residents, with a particular focus on serving high-risk individuals (e.g., PEH, justice-impacted). The County is eager to meet the needs of their clients. However, in recent years, they have been chronically understaffed. As a result, they have been unable to fully meet the needs of the population they serve, resulting in disruptions in access to care and poorer quality of treatment across services.

**Other service providers in the County face similar barriers to meeting the needs of their clients.** Providers are further impacted by external circumstances (e.g., encampment sweeps and closures) that have complicated their efforts to conduct outreach and maintain contact with individuals in need of services.

**In September 2021, Substance Abuse and Mental Health Services Administration (SAMHSA) awarded SCC BHD with a \$3,000,000 block grant for Community Mental Health Services.** These funds were awarded to support HTS. The County contracted with a local behavioral health provider, Front Street Inc., to provide case management and peer support. These conditions compelled and inspired the County to design HTS to reach PEH more effectively with services. See **Appendix B** for more information about the funding source.



## Overview of Healing the Streets

HTS integrates interdisciplinary services that are low-barrier, field-based, and self-directed to meet the needs of PEH who have SMI and may also have a co-occurring SUD(s). HTS's delivery team includes case managers, a peer, a nurse practitioner, and therapist who provide field-based care in both North and South County (learn more about the HTS staffing model in **Appendix C**). Via outreach and engagement efforts, HTS links clients with access to medical, behavioral health, and housing services. HTS collaborates with county programs, Homeless Person's Health Project's (HPHP) street medicine, Housing for Health, and local services providers (see **Appendix D**). Core to the methodology of HTS is

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<sup>4</sup> <https://housingmatterssc.org/wp-content/uploads/2019/08/2019-PIT-Count-Full-Report.pdf>

<sup>5</sup> <https://www.housingforhealthpartnership.org/Portals/29/HAP/Providers/Data/2022PITFullReport.pdf>

that all service delivery is field-based, low-barrier, and self-directed. To learn more about the program design and logic model, see **Appendix E** and **Appendix F**.

## Services Provided

HTS works in partnership with other providers to offer the following services to PEH:

COVID-19 Services	Medical Services	Food	Benefits Services
Clothing	Housing	Mental Health Services	Substance Support Services
Dental Services	Mailbox Services	Pet Services	Cellphone Services

See **Appendix G** for the HTS “HTS Needs and Referral Chart” used to engage clients in determining their self-selected needs

## Program Goals

1. **Provide integrated services and establish stable ongoing connections** to health, behavioral health, and housing providers for people experiencing homelessness who also have serious mental illness and possible co-occurring disorders.
2. **Strengthen safety net infrastructure** and develop seamless, universal pathways into care through care collaboration and coordination that reduces duplication of services.
3. **Incorporate harm reduction and trauma-informed practices** that promote wellness, stability, and recovery for people experiencing homelessness and behavioral health challenges.
4. **Vet the Critical Time Intervention (CTI) model as best practice** for people experiencing homelessness with mental health needs in Santa Cruz County.
5. **Ensure that people receive access to behavioral health support** in the community without the barrier and stigma associated with brick-and-mortar services.
6. **Improve client quality of life** through supporting people experiencing homelessness in reaching their self-identified goals.

# Program Timeline

Figure 1. Program Implementation Timeline



The seed for HTS was planted with a grant application submitted to SAMHSA. The grant was awarded, and the funding period began in October 2021. The HTS program was announced locally in a virtual community meeting in January 2022. Due to staff requisitioning and capacity issues, COVID-19, and the typical challenges of program implementation, HTS began serving clients in March 2022. Over the next year and a half, HTS provided thousands of units of service to clients, with 360 individuals fully enrolled in the HTS program by September 2023. HTS was awarded a no-cost extension by SAMHSA in October 2023 to help them reach their goal of enrolling 600 clients. That shifted the program end date from September 30, 2023 to December 31, 2023.

## Future of HTS

Efforts to shift the funding and program model began in fall 2023, and the current iteration of the HTS program sunset on December 31, 2023, with the end of the extended SAMHSA funding period. The successor program will be called Integrated Housing and Recovery Team (IHRT). The County will continue to use this evaluation and other learnings from HTS to inform a Specialty Mental Health service team for PEH that integrates the housing continuum of care services through Housing for Health, an HTS partner agency.



## Evaluation Overview

In December 2021, the County contracted with RDA to conduct a multi-year evaluation of their HTS program. RDA has a 40-year history of providing equity and social impact driven consulting services in the San Francisco Bay Area and beyond. RDA's objective was to evaluate the implementation and outcomes of the HTS program, support continuous quality improvement efforts, and comply with SAMHSA requirements as they pertained to evaluative and quality improvement efforts. This cumulative evaluation of the HTS program includes data from the outset of the program in March 2021 through September 2023.

## Evaluation Questions

This evaluation addresses three questions, each of which guided all data collection activities and analyses, reporting, presentation of findings, and learning conversations.

1. In what ways is the **HTS model** (specifically, Critical Time Intervention [CTI]) effectively meeting the needs of clients experiencing homelessness with mental health and possible co-occurring substance use disorders?
2. What is the nature and extent of **collaboration and coordination of care** between HTS and partner programs?<sup>6</sup>
3. Is HTS **improving outcomes for individuals** experiencing homelessness with mental health and possible co-occurring substance use disorders?

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<sup>6</sup> This evaluation question was changed from the original question. The original question was, "How does collaboration and coordination of care enhance/support: (a) the model in developing an integrated system of care for people with mental illness experiencing homelessness and (b) continuity and quality of care for individual clients?" Due to the County not adopting the Unite Us closed loop referral platform or a shared instance of the care coordination platform Activate Care, the scale of this question is no longer aligned with the activities of HTS.



# Approach

As part of the multi-year evaluation of the HTS program, RDA completed a process evaluation in fall 2022. In winter 2023, RDA completed a cumulative process and outcome evaluation, the results of which are detailed in this report.<sup>7</sup> The process evaluation assessed whether the program was implemented as intended, while the outcome evaluation assesses the results and accomplishments of the program and participants (see **Appendix H** and **Appendix I**). Both process and outcome evaluations provide information to help support program improvement over time.

**RDA took a developmental evaluation approach to this project.**<sup>8</sup> Developmental evaluation provides a dynamic and responsive approach to evaluation and is typically best suited to complex environments and new and emergent social innovation. Central to developmental evaluation is responsiveness to a rapidly changing landscape through real time learning, reflection, and adaptation. As applied to the HTS evaluation, real time feedback and learning is provided through a monthly dashboard and ongoing quality improvement cycles (see the section below called Quality Improvement Synopsis & Learnings). The developmental evaluation approach engages the evaluator as an integrated member of the program implementation team. To this end, RDA's staff has been involved in providing evaluation support, administering National Outcome Measures (NOMs) interviews to HTS clients, and engaging with ongoing quality improvement cycles. Due to our numerous roles in the project, RDA had frequent access to information as well as awareness of programmatic processes, successes, and challenges.

## Positionality Statement

The four members of this evaluation team are located outside of Santa Cruz County, and are White, female, and have considerable education and experience in social research, evaluation, and homeless services. We are committed to addressing our biases and do so in part by relying on insight from those with lived experience through our qualitative data collection efforts. The RDA sub-contractor who administered NOMs interviews directly to clients lives in Santa Cruz County, has a background in trauma-informed community engagement, is Latino/x, and Spanish speaking.

<sup>7</sup> HTS has taken an iterative approach to program implementation, therefore as evaluators we saw value in including process data alongside outcome data as it continued to hold relevance throughout the lifespan of the program.

<sup>8</sup> <https://www.betterevaluation.org/methods-approaches/approaches/developmental-evaluation>



## Methods

### Data Collection Methods & Sources

**RDA employed a mixed-method approach that used primary qualitative and secondary quantitative data sources to evaluate the implementation and outcomes of the HTS program, support continuous quality improvement efforts, and comply with SAMHSA requirements.** This cumulative evaluation report includes information about HTS program processes and implementation as well as client characteristics, services received, experiences, and outcomes between March 2022 through September 2023. To address the evaluation questions presented earlier, RDA used quantitative and qualitative data sources described below. Additional information regarding the evaluation questions, domains, and data sources may be found in **Appendix H**, **Appendix I**, and **Appendix J**.

### Quantitative Data Sources

This evaluation used six sources of quantitative (i.e., numerical) data, each of which are described in Table 1 below. This data was collected between March 2022 and September 2023 and was provided to and/or retrieved by RDA for analysis in October 2023 via Microsoft Teams.

**Table 1. Quantitative Data Collection Sources and Metrics<sup>9</sup>**

Data Source	Data Population/ Unit	Key Data Metrics
HTS Outreach Tracking	HTS Clients	<ul style="list-style-type: none"><li>• Number of all HTS outreaches</li><li>• Dates of all HTS outreaches</li></ul>
HTS Referral Tracking	HTS Clients	<ul style="list-style-type: none"><li>• Number of Incoming HTS Referrals</li><li>• Agencies Referral Sources</li></ul>
HTS Master Spreadsheet	HTS Clients	<ul style="list-style-type: none"><li>• Number of Clients Enrolled</li><li>• Program Entry &amp; Exit dates</li><li>• ROI Completion dates</li></ul>
Quarterly IPP Reports	HTS Program	<ul style="list-style-type: none"><li>• Type &amp; Description of Staff Trainings</li><li>• Number of Staff Training Recipients</li></ul>
Activate Care (AC) Platform	HTS Clients & Program	<ul style="list-style-type: none"><li>• Number of Clients Enrolled</li><li>• Location of first Outreach among Clients Enrolled</li><li>• Outreach Notes for all Clients Enrolled</li><li>• Program Implementation/Usage of AC</li></ul>

<sup>9</sup> Other data sources were reviewed for consideration in this evaluation, including behavioral health data from EPIC systems and "Section H" services data from NOMs data retrieved from SPARS; however, results were not ultimately presented in this report and are therefore not included in this table (see Limitations for additional details).

Data Source	Data Population/ Unit	Key Data Metrics
National Outcomes Measures (NOMs) Interviews	HTS Clients & Program	<ul style="list-style-type: none"> <li>Client NOMs Interviews Completed</li> <li>Client Demographics</li> <li>Client Outcomes (psychological distress, homelessness, emergency service utilization, social connectedness, legal system involvement, program satisfaction)</li> <li>Client program discharge type</li> <li>Implementation of NOMs process</li> </ul>

## Qualitative Data Sources

The evaluation also used five sources of qualitative (i.e., narrative) data, each of which are described in Table 2 below. Data from meeting notes, Activate Care Case Notes, and Monthly SAMHSA Reports were collected between March 2022 and September 2023. RDA collected all cumulative evaluation data from focus groups and interviews in August 2023. To learn more about qualitative data collection methods see **Appendix K**. To view the interview and focus group protocols RDA utilized to gather data, see **Appendix L**.

**Table 2. Qualitative Data Collection Sources and Metrics**

Data Source	Data Population & Quantity	Key Data Metrics
Focus Groups & Interviews	1 focus group & 6 interviews with 10 total HTS Staff	<ul style="list-style-type: none"> <li>Outgoing referral sources</li> <li>Collaboration and joint service provision with partners</li> <li>Perceptions of program workflow, adherence, and effective practices</li> <li>Changes in perceptions of HTS role, collaboration quality, and resource adequacy</li> <li>Partner successes &amp; challenges experienced</li> <li>Services and outcomes experienced by clients</li> </ul>
	4 focus groups & 3 interviews with 16 total HTS Partner Staff	
	16 interviews with 16 total HTS Clients	
Case Study Interviews	2 interviews with 2 total HTS Staff	<ul style="list-style-type: none"> <li>Number of Incoming HTS Referrals</li> <li>Agencies Referral Sources</li> </ul>
Activate Care Case Notes	Case Notes for 2 total HTS Clients	<ul style="list-style-type: none"> <li>Services provided to HTS clients during enrollment</li> </ul>
HTS & RDA Meeting Notes	Meeting notes from 19 months of HTS Program Implementation	<ul style="list-style-type: none"> <li>Implementation updates, processes, &amp; progress</li> <li>Extent of fidelity &amp; adherence to HTS model and program elements</li> <li>Staff trainings received</li> </ul>
Monthly SAMHSA Reports	Reports from 19 months of HTS Program Implementation	

## Data Analysis

Upon collection of each data source, **RDA first organized and cleaned the qualitative and quantitative data.** Transcripts were edited for clarity, and quantitative data were reformatted for analysis. **RDA analyzed the quantitative data sources using Stata and Microsoft Excel** software to perform descriptive (e.g., calculation of frequencies, averages) and pre/post analysis to describe the clients enrolled and served in HTS, completion of program activities, and HTS client outcomes.

**RDA analyzed the qualitative data sources using NVivo** software to perform thematic analysis of all focus groups and interview responses, as well as data from meeting notes and SAMHSA reports. After developing a codebook with anticipated themes, RDA used NVivo to identify recurring themes within the data related to program implementation processes and perceptions, perceived effectiveness of program strategies, successes and challenges experienced, inter-agency collaboration among HTS staff and partners, as well as client services, experiences, and outcomes. RDA used Microsoft Excel software to perform thematic analysis of Activate Care case notes for two HTS clients to identify themes related to service provision to support client case studies.

## Limitations

### Databases and Data Management Limitations

- **Care coordination through shared data platforms:** A key high-level goal of HTS was to create a more coordinated system of care for the target population.
  - **Unite Us:** The original vision was to use a closed loop referral platform known as “Unite Us.” This shared application would allow service providers to refer and follow up on referrals for shared and new clients alike. Local use of the platform launched in December 2020. Santa Cruz Health Information Organization (SCHIO) announced a pause on platform implementation in July 2022. The County and Front Street gained access to Unite Us in August of 2023; however, this development did not align with the evaluation timeline and, consequently, could not be represented in this report.
  - **Activate Care:** HTS’s data management platform, Activate Care, was initially intended to be used by providers throughout the County. However, as of April 2023, Santa Cruz County is no longer pursuing county-wide adoption. Because staff experienced challenges adopting and utilizing the Activate Care platform (to be described later in this report), quantitative data presented may not represent a comprehensive view of services rendered by the program.
- **Access to Behavioral Health data:** Although the team had access to behavioral health service records in the County’s Avatar system, pulling records for HTS clients was considered unduly labor intensive due to the need for individual queries for each HTS client. The team instead sought behavioral health data from sources including the Epic electronic health record system (i.e., nurse practitioner services), Activate Care (i.e., individual therapy services), and SPARS (i.e., Section

H services requested by SAMHSA); however, resulting data from most of these sources was limited and not an accurate representation of behavioral health service connection among HTS clients. Therefore, the presentation of services in this report is limited to outreach services provided by HTS staff directly.

- **Unique client identifiers:** There is no universal unique identifier for every client served by HTS. There are, however, unique identifiers for every HTS client entered into SPARS. Some clients did not possess a unique identifier in the quantitative data sources, either because it did not exist or it was missing. Therefore, clients could not be matched across multiple databases (e.g., clients in the Activate Care data could not be fully matched to clients in the NOMs data). Therefore, some data used for the current evaluation only exists for certain sub-groups of HTS clients.

## Methodological Limitations

- **Self-report:** Because this evaluation relies heavily on self-reported data, it is possible that HTS clients, staff, and/or partners were not able to recall their experiences or responded in ways viewed as socially desirable. As shown in the quantitative and qualitative data collection sources (Table 1 and Table 2), RDA triangulated multiple data sources to maximize validity of the information for each evaluation question.
- **Selection bias:** Partners and clients who agreed to take part in an interview or focus group may have been those with more positive experiences or more long-term interactions with the HTS program. The small number of interviewees also means that these data cannot be assumed to be representative of all HTS clients or partners.



## Quality Improvement Synopsis & Learnings

In service to the iterative nature of the developmental evaluation approach, RDA facilitated a series of rapid improvement cycles to support continuous quality improvement within HTS. RDA utilized the Plan Do Study Act (PDSA) framework in partnership with HTS staff to identify a program need, test program improvement activities, use data to evaluate whether these changes reach desired outcomes, and collaboratively adapt or adopt methods that improve the program. In individual PDSA cycles, staff worked with real-time data to inform quality program delivery. RDA and HTS integrated a total of four PDSA cycles<sup>10</sup> throughout the larger evaluation process with the intention to have the first two cycles focused on implementation and the second two cycles focused on improving outcomes. Below are synopses and learnings from each of the four cycles.

### PDSA Cycle 1: Eligibility & Activate Care (May - July 2022)

In this cycle the team identified and implemented two separate change practices to improve programming.

**Change Practice 1: Defining and Improving our Screening Process and Eligibility Criteria for HTS Clients.** The team wanted more clarity on the target populations and how to screen for eligibility. As a result of this improvement cycle, HTS staff better defined their target population, and with a clearer definition, updated the online referral form. Staff created an outreach script to assist with screening for eligibility criteria. While studying the change, RDA did not observe a statistically significant difference in the extent to which enrolled consumers met program eligibility indicators before and after the PDSA cycle.<sup>11</sup> However, the change practice had the benefit of providing a clear process for intake of eligible clients which was ultimately adopted.

**Change Practice 2: Shifting from paper record keeping to electronic data management in Activate Care.** Traditionally, PDSAs function to improve an already existing program process. The second Change Practice was focused on improving implementation of Activate Care. As a result of this tested practice, HTS trained staff on Activate Care usage, RDA explored data sources that could be retrieved from Activate Care for evaluative purposes, and staff input paper files into Activate Care. The adoption was slow but led to a focused effort in digitizing program records and case notes. There was still work to

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<sup>10</sup> There is a variance in how many months cycles ran for as well as the time between cycles. This was related to HTS staff availability, and the nature of the changes being implemented, and the identified time needed to do so.

<sup>11</sup> A chi-square test of independence was used to examine the bivariate relationship between consumer program eligibility status using indicators of homelessness and mental health challenges (0=did not meet eligibility criteria, 1=met eligibility criteria) and enrollment period (0=March 29-July 6, 2022, 1=July 7-September 30, 2022). No significant association was observed,  $\chi^2(1, N=91) = .002, p=.96$ . The window of observation was only a few months so it may not have been enough time to observe a change.

be done around data entry roles, and consistency in data entry practices for case managers. See the full PDSA Cycle 1 Report in **Appendix M**.

## **PDSA Cycle 2: Developing a Disenrollment Process (August - November 2023)**

**Change Practice: Enact a process to disenroll clients who are no longer engaged in the HTS program.** A lack of clarity among case managers in terms of who was active on their caseload caused uncertainty around caseload capacity. In response, the team developed clear criteria around disenrollment due to scenarios including disengagement, successful graduation, or step down of care. Additionally, as part of continuous quality improvement efforts, RDA developed and refined a workflow for both disenrollment in Activate Care and clear guidance on the discharge process from Activate Care. These process improvements enabled the program to effectively clean up the client list and capture 35 disenrollments from Activate Care, but there remains a need for clarification and role responsibility in terms of discharges from SPARS. See the full PDSA Cycle 2 Report in **Appendix N**.

## **PDSA Cycle 3: Tracking Enrollment (January - April 2023)**

**Change Practice: Implement and iterate on a weekly data dashboard to track and review program enrollments.** To help bolster staff awareness of enrollment targets and successful enrollments, HTS administrative staff created a data dashboard and emailed it to case managers and leadership staff weekly. This effort successfully generated more conversation around enrollment targets and prompted the sharing of referral assignments and follow up, client goals met, and workflow refinement. While this practice provided greater data clarity, there was no corresponding uptick in program enrollment. See the full PDSA Cycle 3 Report in **Appendix O**.

## **PDSA Cycle 4: Bolstering Enrollment (July - November 2023)**

BHD leadership requested that the final PDSA cycle focus on improving program enrollment numbers. Rather than have the full staff engage in this PDSA cycle, RDA focused this cycle on leadership and administrative staff. RDA facilitated a learning session with direct service staff to better understand their experiences providing services and the client journey through HTS.

**Change Practice: Have clinical staff support HTS enrollment.** Previously, case management staff oversaw supporting client enrollment. Leadership recognized that clients visiting the nurse practitioner were not being enrolled in HTS and clinical staff performing a field-based service could better support enrollment. HTS assigned case managers to support clinicians in enrolling clients. This intervention was unsuccessful as many clients served by the nurse practitioner were not interested in receiving HTS services, and many did not show up for their appointments with case managers. Furthermore, RDA's contract for conducting NOMs interviews with clients ended with the original end date of the program on September 30, 2023. Therefore, RDA trained HTS staff to conduct



NOMs interviews themselves. This transition took out a layer of complexity from the enrollment process and became the more meaningful change practice. See the full PDSA Cycle 4 Report in **Appendix P**.

## Lessons Learned

Each cycle created an opportunity for staff to envision future improvements and work together using real time data to inform program practices. Some practices were adopted with adaptations while others were abandoned because they did not effectively solve the issue at hand. While PDSA 1 and 2 were heavily focused on implementation practices, PDSAs 3 and 4 were dedicated to addressing one of the main programmatic cruxes of HTS: reaching more clients. Originally, the plan was to focus on improving program outcomes rather than outputs, yet the issue of low enrollment was critical to maintaining program funding. Therefore, it made the most sense to utilize the collective effort engendered by PDSA cycles to work towards practices that would improve enrollment. The process of program improvement through PDSAs can be a powerful way of leveraging a team. RDA supported the creation of tools for HTS/IHRT so that the team can carry on internal PDSA efforts to create space and a shared language and process for enacting continuous quality improvement.



## Evaluation Findings




Utilizing the above sources, data collection methods, and analysis approach, RDA triangulated the quantitative and qualitative data to derive HTS program findings. These findings are organized according to the three evaluation questions detailed in the **Evaluation Questions** section. These findings are intended to inform future programming that supports individuals with serious mental illness and possible co-occurring substance use disorders who are also experiencing homelessness.



# 1. In what ways is the HTS model effectively meeting the needs of clients experiencing homelessness with mental health and possible co-occurring substance use disorders?

Findings in the following sections collectively address the first evaluation question by detailing (1) **the nature and extent of client needs for HTS to address**, including the volume of individuals engaged and enrolled by the program, demographics and characteristics of clients enrolled, and clients' presenting service needs at enrollment; (2) **the types of program practices that HTS employed to meet client needs**, including trainings received in program model components and services provided to clients; and (3) **the implementation of program practices that HTS employed to meet client needs**, including how well HTS implemented program elements, as well as key successes and challenges experienced in their efforts to do so.

## Evaluation Question 1 Key Findings

-  **The need for HTS services in Santa Cruz County is significant, with most clients expressing a need for housing, behavioral health, and basic needs services.** HTS outreach efforts allowed the team to reach many community members in need of services in the County. HTS client population characteristics were generally aligned with characteristics of PEH in the County, suggesting that HTS was successfully targeting their intended population.
-  **HTS staff employed several methods, including outreach and evidence-based treatment modalities, to meet the varied needs of clients.** Staff met client needs by providing thousands of individual services, which clients shared were easily accessible. Staff worked to meet client needs by employing their background, skills, expertise, and training in multiple evidence-based program modalities.
-  **In working to meet client needs through multiple program practices and services, staff reported that workflows were implemented with varying levels of success.** Many internal and external factors complicated implementation of key HTS program practices to meet client needs, including resource constraints, model misalignment, and several community-level contextual challenges.

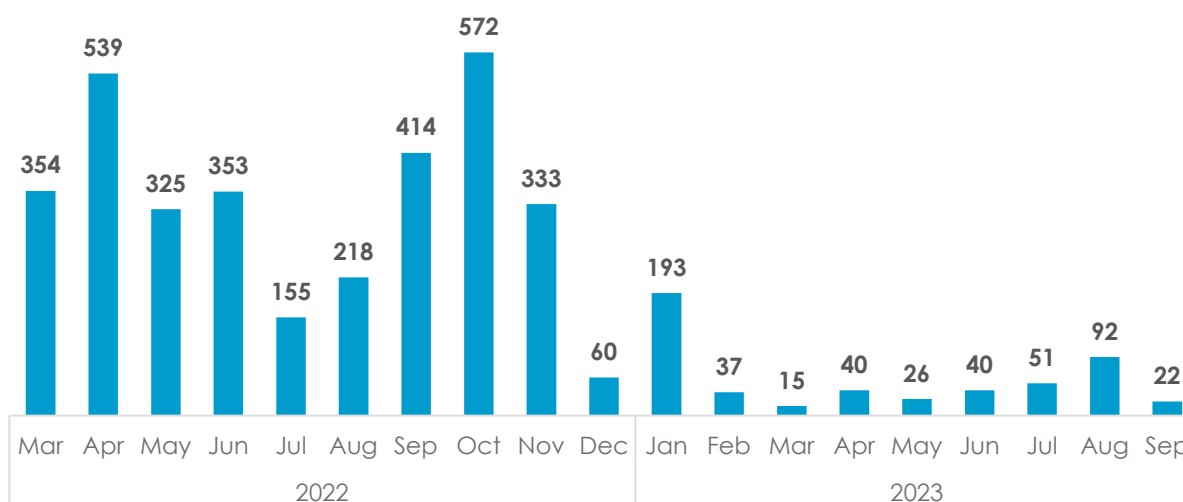
## Nature and Extent of Client Needs

The following section describes the nature and extent of existing needs HTS sought to address in order to provide context about ways in which the HTS model effectively met client needs. The scope of client service needs is demonstrated through understanding of the volume of individuals engaged and enrolled by the program, demographics and characteristics of clients enrolled, and clients' presenting service needs at enrollment. For more information about the overall needs of people experiencing homelessness in the County, see **Background**.

### Volume of Clients Served

During the first 18 months of program operation (from March 1, 2022 to September 30, 2023), **HTS staff conducted nearly 4,000 outreaches with individuals in potential need of services within Santa Cruz County**, with 93% (3,568) of outreaches taking place during the first full year of program operation<sup>12</sup> (see Figure 2).

**Figure 2. HTS Program Outreaches by Month, N=3,839**



**The HTS program received over 600 incoming client referrals for services from over 30 partner agencies during the reporting period.** Over a third of incoming referrals came from community service providers, such as Front Street, Housing Matters, Encompass, and the Salvation Army, among others<sup>13</sup> (see Figure 3). Other incoming referrals came from Health Services Agency (HSA)-Behavioral Health (BH)<sup>14</sup> (16%, 104) or other HSA agencies<sup>15</sup>

<sup>12</sup> A total of 61% (2,358) of outreaches took place in FY1 (10/1/21-9/30/22), and 39% (1,481) of outreaches took place in FY2 (10/1/22-9/30/23).

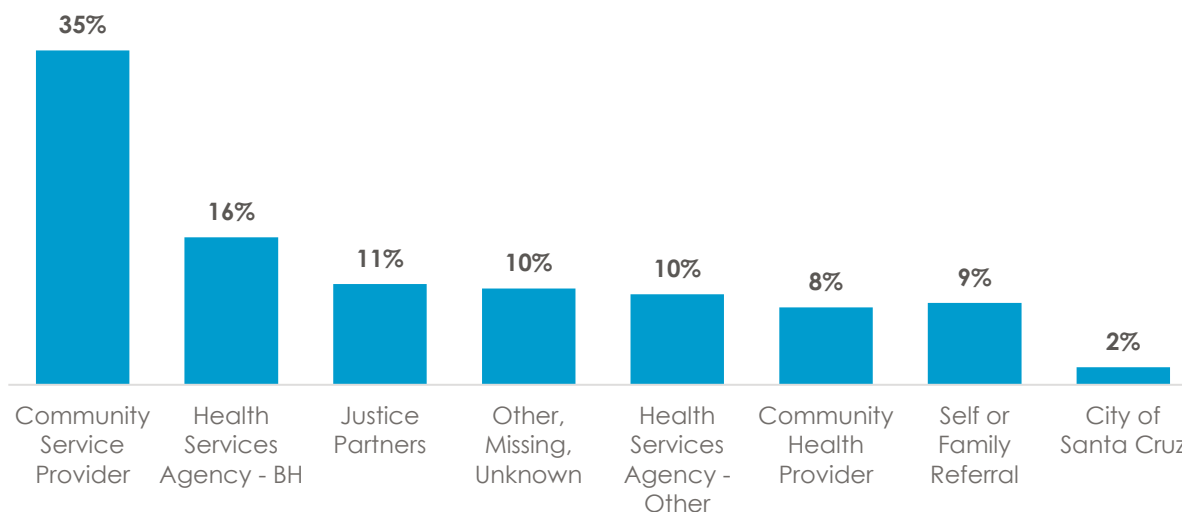
<sup>13</sup> Community service provider agencies included: Abode, Downtown Outreach Workers (DOW), Encompass, Front Street, Housing Matters, Janus, National Alliance on Mental Illness (NAMI) SC, Salvation Army, and Volunteer Center of SC.

<sup>14</sup> HSA-BH agencies included: Access, Adult BH, Community Reentry Services Team (Crest), Psychiatry, Mental Health Liaison (MHL), Older Adult Services (OAS) team, Recovery team, and SUDS.

<sup>15</sup> Other HSA agencies included: CARE team, HPHP, Children's MH, Nurse Family Partnership, and SCC Health Center.

(10%, 65), Justice partners<sup>16</sup> (11%, 71), Community Health providers<sup>17</sup> (8%, 52), the City of Santa Cruz (2%, 13), or via a self or family referral (9%, 58).

**Figure 3. HTS Incoming Program Referrals, N=648**



**A total of 359 unique individuals were formally enrolled in HTS and reported to SAMHSA for services to address their needs.**<sup>18</sup> As of September 2023, the HTS team enrolled 60% of their overall SAMHSA enrollment goal (359/600), including 46% during FY1 (92/200) and 67% during FY2 (267/400).

### **Characteristics of Clients Served**

**Comparing HTS client data to data about PEH in the County indicates that HTS may be targeting the key demographics of the larger population of PEH in the County.**<sup>19</sup> Of the 359 clients enrolled in HTS, about half identified as White or multiracial (50%, 180) and not Hispanic (49%, 176). Additionally, most enrolled clients identified as male (55%, 197), heterosexual (70%, 253), and between 35 and 64 years old<sup>20</sup> (74%, 298) (see Table 3). For reference, a 2022 randomized sample of 333 PEH in the County also indicated that most identified as White (74%, 246), not Hispanic (61%, 203), male (72%, 240), and heterosexual (82%, 273).

<sup>16</sup> Justice partner agencies included Blaine St, Jail, Maintaining Ongoing Stability through Treatment (MOST), Partners for Justice, SCC police, probation, public defender, and superior courts.

<sup>17</sup> Community health provider agencies included: Dominican Hospital, Palo Alto Medical Foundation (PAMF), Telecare, Tuolumne Me-Wuk Health Clinic, and Watsonville Community Hospital.

<sup>18</sup> Of this group, 96% (346) were captured in the program's case management database, Activate Care, and 91% (327) had completed ROIs upon program enrollment. Of those that were enrolled into the program (359), 25% (90) had completed reassessment SPARS entries, and 60% (216) had completed discharge SPARS entries. SPARS entries include those with and without a completed reassessment or discharge interview.

<sup>19</sup> Source: <https://www.housingforhealthpartnership.org/Portals/29/HAP/Providers/Data/2022PITFullReport.pdf>

<sup>20</sup> The average age among enrolled clients with available information was 48 years old (SD=12.7, Range=19-80, N=278).

**Table 3. HTS Enrolled Client Demographics, N=359**

Category	Count	Percent
<b>Age Group</b>		
16-25	16	4%
26-34	45	13%
35-44	92	26%
45-54	86	24%
55-64	89	25%
65+	31	9%
<b>Gender</b>		
Male	197	55%
Female	111	31%
Other or Unknown	51	14%
<b>Race</b>		
White (not multiracial)	155	43%
Unknown	132	37%
Other Race (not multiracial)	29	8%
Multiracial/2+ Races	25	7%
American Indian (not multiracial)	18	5%
<b>Ethnicity</b>		
Not Hispanic	176	49%
Hispanic-Mexican	96	27%
Other Hispanic <sup>21</sup>	19	5%
Unknown	68	19%
<b>Sexual Orientation</b>		
Heterosexual	253	70%
Gay, Lesbian, Bisexual, or Other	27	8%
Unknown	79	22%

**Needs of Clients Served**

**The needs of HTS clients mirror the needs of PEH in the County, suggesting that HTS may be targeting the key needs of the larger population of PEH in the County.** HTS clients presented to the program with a variety of needs at the time of their enrollment. Of the 359 clients enrolled in HTS, most were unemployed (66%, 237), had graduated from high school or had college education (54%, 194), and had no military service (73%, 261). Most clients self-reported having experienced homelessness in the past month (68%, 244),<sup>22</sup> no legal involvement in the past month (71%, 255), and endorsed one or more indicators of psychological distress in the past month (65%, 235) (see Table 4). The previously cited 2022 report of 333 PEH in the County indicated that most were unemployed (80%, 266), had not been incarcerated in the past 12 months (66%, 220), and many experienced psychiatric or emotional conditions or a substance use disorder (39%-67%, 130-223).

<sup>21</sup> This category includes clients who identified as Central American, Puerto Rican, or Another Unspecified Hispanic Ethnicity.

<sup>22</sup> Due to the number of clients with missing data (23%), this percentage is likely to be an underestimate of the true proportion of HTS clients experiencing past-month homelessness at enrollment.

Additionally, 86% (286) of this study's Point in Time (PIT) count of PEH in the County were non-veterans.<sup>23</sup>

**Table 4. HTS Enrolled Client Needs at Enrollment, N=359**

Category	Count	Percent
<b>Employment Status</b>		
Employed full/part time	28	8%
Unemployed & looking	110	31%
Unemployed & disabled	60	17%
Unemployed & retired	15	4%
Unemployed & not looking	52	14%
Other or Unknown	94	26%
<b>Education Status</b>		
Less than 12 <sup>th</sup> grade	79	22%
HS Diploma/GED or Vocational	91	25%
Some College	83	23%
College or Graduate Degree	21	6%
Unknown	85	24%
<b>Veteran Status</b>		
Served in Military	12	3%
No Military Service	261	73%
Unknown	86	24%
<b>Recent Legal Involvement</b>		
1+ arrest or jail in past month	20	6%
No arrest or jail in past month	255	71%
Unknown	84	23%
<b>Recent Homelessness</b>		
Homeless in past month	244	68%
Not homeless in past month	34	9%
Unknown	81	23%
<b>Recent Psychological Distress<sup>24</sup></b>		
0 indicators in past month	22	6%
1 indicator in past month	19	5%
2 indicators in past month	24	7%
3 indicators in past month	33	9%
4 indicators in past month	36	10%
5 indicators in past month	39	11%
6 indicators in past month	84	23%
Unknown	102	28%

<sup>23</sup> Source: <https://www.housingforhealthpartnership.org/Portals/29/HAP/Providers/Data/2022PITFullReport.pdf>

<sup>24</sup> Indicators of Psychological Distress include feelings of nervousness, hopelessness, restlessness, depression, worthlessness, and feeling that everything was an effort. The average number of psychological distress indicators among the 257 clients with available baseline data was 3.90 out of 6.

Despite concerns regarding client behavioral health, **direct service providers reported that HTS clients usually expressed priority interest in support for basic and other key needs in favor of support related to behavioral health.** Among these included housing, food, medication, income, transportation, and legal and social support.

## Program Practices Employed to Meet Client Needs

To understand ways in which the HTS model effectively met client needs, the following section describes information about HTS program practices employed to do so, including the nature and extent of staff trainings received in evidence-based modalities central to the HTS model, as well as the type and extent of services provided to clients by HTS staff to meet their service needs.

### Training

**HTS staff collectively received a total of 41 trainings in key evidence-based practice modalities during the reporting period to meet client needs.** To support proper implementation of approaches central to the HTS model and meet client needs, staff received regular trainings in key evidence-based practice modalities, such as Critical Time Intervention (CTI), Motivational Interviewing (MI), Trauma-Informed Care (TIC), and Strengths-Based Case Management. Staff participated in 16 trainings in CTI, 16 trainings in MI, and nine trainings in TIC (see Figure 4). To support proper entry and tracking of client outreaches and engagements, all HTS staff also completed training in Activate Care during the implementation period. In addition, staff also received training in CPR, first-aid, and sexual harassment.

**Figure 4. HTS Staff Trainings Received by Type, N=41**



### Service Provision

**To support client needs, HTS staff provided 3,492 individual direct services for 346 clients during the program period,** including outreach and engagement, case management, care coordination, CTI, MI, trauma-informed services, as well as support with shelter, housing, benefits, transportation, and referrals to other services. Additionally, within this service provision, 11% of HTS clients (40) received 288 individual therapy services by the HTS therapist. The 359 clients enrolled in HTS were enrolled for an average of 168 days, or approximately five to six months.<sup>25</sup>

<sup>25</sup> The start of HTS client enrollment was defined as the date of a client's first HTS service, as reported to SAMHSA in SPARS; the end of HTS client enrollment was defined as the date of discharge, as reported to SAMHSA in SPARS. Client enrollment lengths ranged from one day to over a year.

**Clients identified a variety of services that HTS case managers provided, in addition to receiving referrals to other service providers.** Some clients shared that HTS connected them to behavioral health services, including medication for their mental health or referrals to substance use services. Staff explained that they often provide referrals to SUD treatment programs, sober living environments, methadone clinics, Medication-Assisted Treatment (MAT) services, psychiatrists, therapists, and peer support linkages. Although clients were not always clear regarding the services available or offered to them by HTS versus other providers, they acknowledged the ease of connecting with their HTS case manager to receive assistance with a variety of service needs.

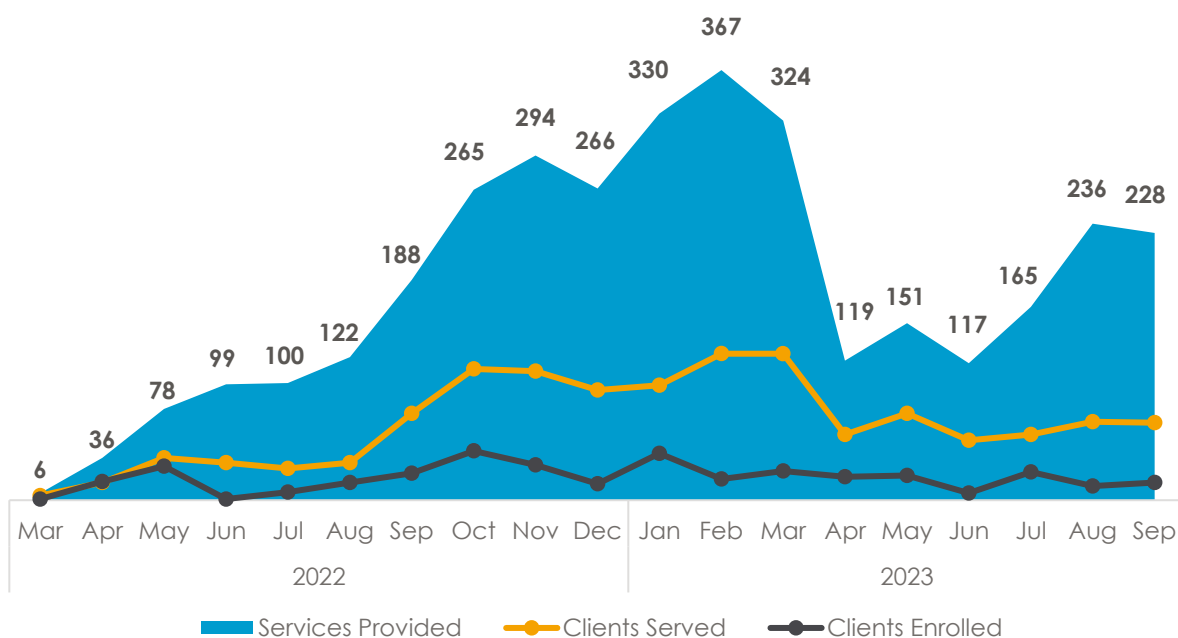
## Implementation of Program Elements

To understand ways in which the HTS model effectively met client needs, the following section describes information about HTS implementation of program practices employed and key challenges faced in doing so, as well as program successes.

### ***Outreach, Enrollment, and Case Management Implementation***

**In their efforts to effectively meet client needs, HTS direct services staff viewed the service model as incompatible with enrollment requirements from their federal funder.** Staff found that as caseloads increased, their provision of high intensity case management services to existing clients complicated efforts to continue enrolling new clients at the rate needed to meet SAMHSA requirements. As further demonstrated in Figure 5, staffs' service provision grew precipitously through the spring of 2023, even as the number of unique clients served, and the number of new clients enrolled, remained relatively steady throughout the reporting period. Staff reported that a diligent focus on enrolling new clients left little time for effective case management and engagement with existing clients, as well as for fulfilling administrative tasks, such as proper documentation of case notes.

**Figure 5. HTS Direct Service Provision by Monthly Clients Served and Enrolled**



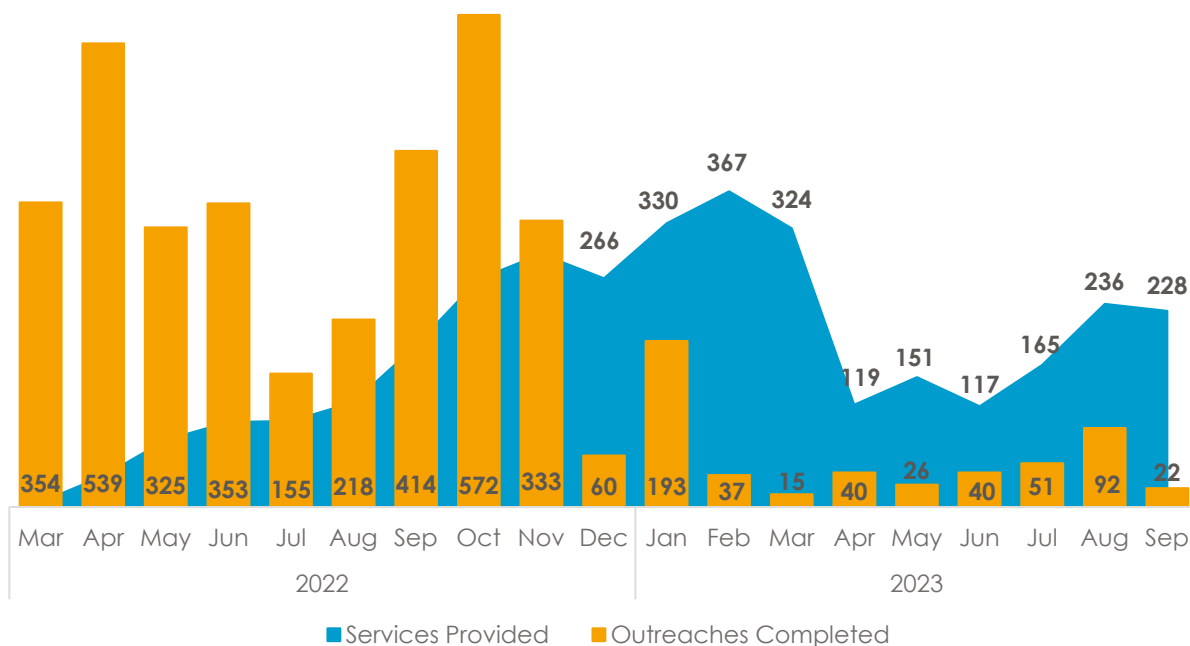
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*"There is pressure to sign up as many clients as you can, but that creates an immediate problem. We're digging a giant hole if we keep signing up clients. We're already behind." - HTS Delivery Staff*

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Outside of the tension between their service model and funding requirements, **staff and partners identified several other internal and external factors that impacted outreach, enrollment, and service efforts to meet client needs**. Staff believe that a six-month delay in launching their program services contributed to challenges with enrollment. Additionally, as with other agencies across the community, HTS experienced persistent challenges with staffing shortages, turnover, and retention, often attributed to the high cost of housing, as well as a prolonged period without peer support staff. Further, several key external forces experienced during the HTS implementation period, including multiple encampment clearings and closures described further in **Appendix B**, as well as historic winter storms and flooding in 2023, all of which displaced many existing and prospective clients. As further demonstrated in Figure 6, outreach efforts saw a decline in 2023 relative to direct services provided to enrolled clients, which grew during this period.

**Figure 6. HTS Direct Service Provision and Outreaches by Month**



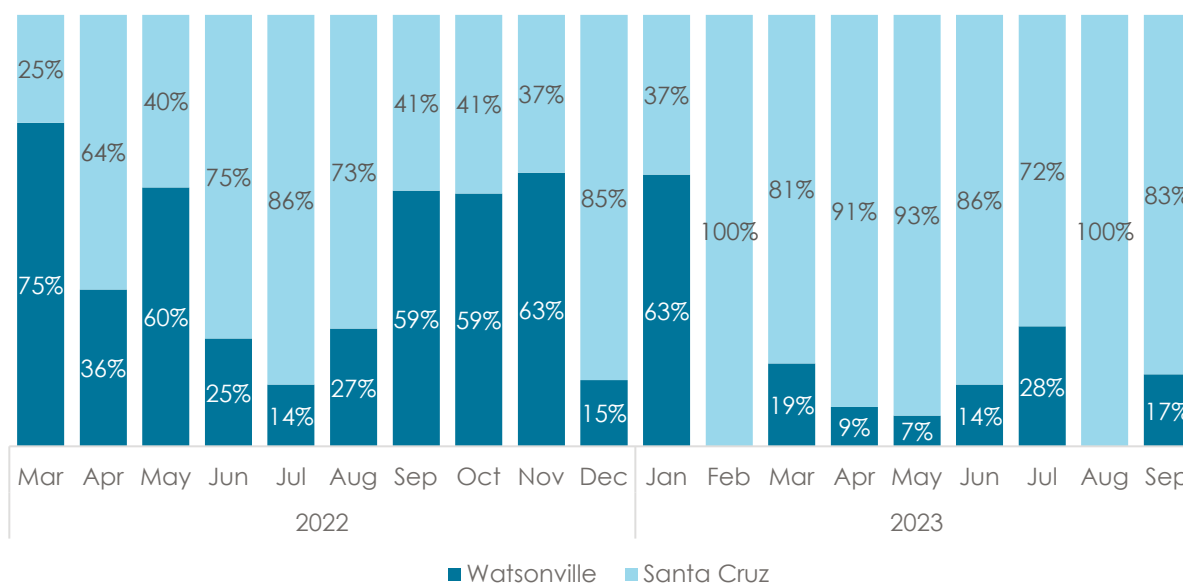
**Despite these challenges, the HTS team made ongoing, diligent efforts to increase enrollment during the program period.** Staff leveraged new partnerships with community organizations that allowed case managers to establish designated days and locations in which to engage new clients. Staff tried out new enrollment strategies, such as having



their NOMs interviewer complete client enrollment interviews in new locations and having their nurse practitioner recruit new clients. Additionally, in fall 2022, HTS staff collaborated to organize and host an enrollment fair in the community with food and resources that boosted enrollment over the course of a single day. Staff also collaborated with their evaluator, RDA, to engage in two PDSA quality improvement cycles oriented towards increasing program enrollment.

**In addition to challenges and strategies to increase enrollment, HTS staff observed differences in their outreach presence across the community.** Overall, more clients who enrolled in HTS were initially engaged in Santa Cruz (59%, 197) relative to Watsonville (41%, 138). However, this fluctuated over time, with a more even distribution of outreach locations among enrolled clients in 2022 compared to 2023 (see Figure 7).

**Figure 7. Initial Outreach Location Among Enrolled HTS Clients by Month of Enrollment, N=335**



**HTS staff attributed key differences in needs and resources between North and South County as influential to their outreach presence in each community.** Staff saw higher visible client need and openness to engagement in North County, as well as greater resources and options for staff to conduct outreach and engagement. In contrast, a more highly dispersed clientele, fewer resources, a smaller number of designated outreach locations, and the departure of two bilingual Spanish-speaking staff complicated efforts to reach potential clients in Watsonville, which has a higher proportion of Latinx and Spanish-speaking individuals relative to Santa Cruz. Although staff viewed most of their efforts focused on Santa Cruz, they believed that the type and quality of services they provided were equal in both communities.

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*"I have held [an] eye on maintaining equity of capacity in both North and South County. With the encampment changes and loss of bilingual staff, it's been tricky to maintain the same level. But we have been physically present in both communities and maintaining [service provision]." - HTS Leadership*

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### **Critical Time Intervention (CTI) Implementation**

Although CTI was central to HTS's original model, **staff cited a fundamental misalignment between the CTI model and what HTS could realistically achieve in practice.** Staff noted that HTS clients often needed support in meeting their self-determined goals for a longer period than the nine-month total enrollment length offered by the CTI model. According to staff, the "chaotic life rhythms" of clients often meant they could not be consistently located or reached, which interrupted continuity and service brokerage. Further, staff and partners attributed a severe lack of low-barrier housing and on-demand shelter beds within the County as complicating the program's efforts to adhere to the CTI model and effectively meet client housing needs since locating appropriate housing frequently exceeded the nine-month period of a CTI cycle.

HTS staff and leadership identified several other challenges to effectively implementing CTI to meet client needs. As previously mentioned, encampment closures and historic weather events that impacted outreach and enrollment also hampered efforts to reach clients and adhere to the CTI model. In addition, HTS staff felt a lack of community-wide support for the program, and in some cases experienced resistance within the community toward their homeless outreach efforts. In addition, the previously mentioned challenges with hiring staff often created feelings of being overwhelmed and burnt out among existing staff, complicating efforts to maintain fidelity to CTI model components.

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*"HTS has a CTI short-term model design. We underestimated the challenge of getting the housing piece because we don't have shelter here. The goal was we'd get it, but in the interim, [we experienced many] County problems—like NIMBYism, community adversity...so the model maybe didn't match what we can do." - HTS Leadership*

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In acknowledgement that the CTI model was an inappropriate fit for the program and community context, **leadership decided to change the program's case management model to a Strengths-Based approach in July of 2023.** In taking an approach that intentionally uplifts a client's existing skills, case managers leverage and build upon client strengths to help them meet their individual care and service goals. Training on the Strengths-Based Case Management model began in February 2023 and the HTS team has been working toward fidelity to that model.

### **Data Entry Development and Workflow Implementation**

**HTS faced significant challenges implementing a coordinated data management system, which impacted their ability to coordinate care between providers.** A key goal

of HTS was to take part in and promote additional efforts in building a coordinated system of care for PEH to address lack of coordination between providers and duplication of services. One such intervention included a closed-loop referral platform called “Unite Us” and the other, a care coordination system called Activate Care. The Unite Us platform was intended to allow service providers to refer and follow up on referrals for shared and new clients alike. Local use of the platform launched in December 2020, before SCHIO announced a pause on further implementation of the platform in July 2022. Approximately one year later, the HTS program launched Unite Us in August of 2023; however, the team has experienced challenges with full adoption.

During the first year of program implementation, HTS proceeded with a full adoption of Activate Care as the central data management platform. Activate Care was originally intended to be used by providers throughout the County to provide real-time communication on a client-level basis. However, county-wide adoption did not materialize as intended, which inhibited collaborative care across behavioral health and other service providers serving PEH. Continued existing data silos and a lack of database infrastructure in the County further complicated client care coordination. Although HTS worked diligently with their partners at SCHIO to develop and configure Activate Care to accurately track program practices and client-level information, staff ultimately felt that the complexity of the HTS program (e.g., the number of systems and workflows involved, the split team across the County and Front Street) did not lend itself to accurate data capture of client touchpoints by staff and rendered staff oversight, accountability, and quality assurance efforts challenging. Consequently, program staff believe they provided many more services than what Activate Care could capture.

**HTS staff reported that they implemented data entry workflow procedures with varying levels of success during the program period.** Specifically, adoption of Activate Care was slower than expected, with a lower-than-anticipated volume of clients entered into the system. Case managers experienced challenges inputting case notes into the system for each client interaction, as well as noting the evidence-based practice modalities used in each instance. In addition, staff admitted having difficulty following workflows for completion of NOMs interviews as part of the client enrollment process.

**Despite staff efforts to improve Activate Care and SPARS workflows, numerous factors made full adoption challenging.** Leadership conceded that workflows were complex and sometimes unclear, affecting fidelity to best practices among staff. Likewise, case management staff expressed a lack of understanding of procedures, contributing to difficulties implementing workflows for data collection and entry into multiple systems. Technical challenges with the Activate Care system also complicated case manager efforts to input client information into the system in an accurate and timely fashion, especially in the context of larger program challenges with staffing. Leadership staff also believed that general burnout among staff contributed to challenges with effective implementation of data collection workflows.

### **Key Implementation Successes**

**HTS found success in behavioral health street medicine and intends to use this in future program iterations.** Although limited long-term outcomes are observed for this population, care delivery has been seen as a success.

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*“Overall, we served a lot of people, touched a lot of people's lives, we showed a lot of compassion, we got people back on track. That's the street medicine component, I feel like that is important. You don't need to do anything, just be where you are and we'll come to you.” - HTS Leadership*

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Beyond street medicine, **HTS sees the background, skill, and expertise of their staff members as a key program success.** Staff are recognized for their ability to build rapport with clients and encourage them to engage in services. New staff hirings that occurred after program launch, including a nurse practitioner, licensed mental health clinician, and peer support specialist, have further supported the program's ability to provide comprehensive services to meet client needs. In addition, HTS staff view their overall approach to client engagement as a key success, described as flexible, low-barrier, and cohesive.

#### **Recommendations from Stakeholders**

- Improve staff recruitment and retention efforts (*HTS Staff recommendation*)
- Adopt a shared data management platform to facilitate collaborative client care across behavioral health and other service providers (*HTS Staff recommendation*)
- Adopt a program model that is better suited to program goals with consideration to community resources/capacity (i.e., housing) and staffing capacity (*HTS Staff recommendation*)
- Continue providing field-based behavioral health services (*HTS Leadership recommendation*)

## 2. What is the nature and extent of collaboration and coordination of care between HTS and partner programs?

Drawing on HTS and partner feedback from interviews and focus groups, this section describes how HTS and program partners collaborate to serve individuals in the community, as well as successes and challenges partners experience collaboratively participating in integrated services with HTS.

### Evaluation Question 2 Key Findings



**Overall, most partners reported positive relationships with HTS or positive perceptions of HTS in the community.** When HTS initially launched, program partners were naturally unfamiliar with the program. HTS efforts to establish itself within the landscape of social service providers in the County provided program partners with an understanding of what HTS does and their role in service provision. This familiarity has enabled partners to provide more explicit recommendations for ways HTS can improve. Collaboration and coordination of care looks different for each partner in terms of the level and frequency of communication. Specifically, partners expressed a desire for stronger communication with HTS and the use of a shared data platform to improve client care and coordinate efforts to support the population of individuals they collectively serve.

## Collaboration

HTS leadership and staff reported regularly meeting with certain partners and indicated regularly communicating with others (see **Appendix D** for a complete list of partners). Some partners supported these statements, indicating that their organization and HTS worked collaboratively (e.g., conducted outreach together) and attended regular integrated team meetings. Communication occurred in a variety of forms, including in-person case conferencing, over the phone or via email, at larger collaborative meetings with multiple agencies, at trainings, and through online referrals to HTS.

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*"[Our partner collaboration] has changed for many partners from an awareness that we exist to a lovely collaborative interactive trusting level of sharing care for some clients." - HTS Leadership*

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**Staff at partner agencies noted their preexisting relationships with HTS delivery staff facilitated their ability to communicate informally with HTS, but they still desired stronger communication with HTS for more effective collaboration.** HTS delivery staff acknowledged partners' descriptions of collaboration, indicating that this type of partnership is the most effective way to provide efficient services to clients. Both HTS and partners serve the broader homeless population of Santa Cruz County and may share clients and coordinate services and care. However, not all partners expressed having strong relationships or consistent collaboration with HTS. HTS staff and leadership feedback supported these findings.

HTS leadership recognized that, **while partnerships have grown, not all partnerships are fully leveraged or realized.** These collaborative efforts have been hindered by external system challenges, delays, and other uncontrollable factors. In particular, County-wide system coordination (i.e., failure to adopt Activate Care throughout the County and the Unite Us platform failing to provide closed loop referrals) has negatively impacted the ability for HTS to coordinate care with partners.

Ultimately, **awareness of the HTS program and services has grown within the community, according to staff, which has strengthened collaborations.** Although HTS staff see improvements in streamlining their approach to sharing care with other agencies, there is still room for improvement.

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*"We're sharing space with new agencies, but no one knows what anyone else is doing. We need to reconcile that space, balance our system relationship, make [a culture of communication] ... The job moves so fast we cannot communicate day to day. It's dynamic, neat, creative, and [HTS] case managers are wonderful and have lots of experience, but whenever we sign up to work with anyone, these are complex people who don't have a history of success, and it's not within the safe container of mental health services." - HTS Delivery Staff*

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## Collaborative Successes

In addition to working collaboratively with HTS to conduct outreach and locate individuals in need of services, **partners observed HTS delivery staff engage positively with clients and other individuals in the target population.** Partners emphasized the unique ability of HTS case managers to establish strong client rapport.

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*"They're very supportive and hand things off nicely. There's not a lot of hurried stress. That's noteworthy to me. They never seem frazzled or at the end of their rope." - Program Partner*

*"I've seen them interact with clients and it's always handled expertly and delicately." - Program Partner*

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Additionally, **partners recognized specific bilingual HTS case managers as an asset to client engagement.** However, due to staff turnover within HTS, there is an ongoing need for multilingual HTS case managers to continue to equitably serve individuals in the community.

While not all partners identified strengthened or improved relationships with HTS, overall, **most partners reported largely positive relationships with HTS or positive perceptions of HTS in the community.** At an administrative level, partners identified improvements in their work with HTS. Specific examples of these collaborations include working with HTS on grant applications and re-envisioning the service landscape in the wake of the CalAIM restructuring.

**Collaboration—both internally amongst HTS staff and externally with community partners—was identified as a key component of HTS's success.** The nature and impact of collaboration with internal and external partner agencies was noted by HTS leadership and delivery staff as well, with the HTS team citing these partnerships as key ingredients in the functionality and efficacy of HTS. Partners expressed that the HTS program works to fill a gap in service provision for people experiencing homelessness, and they view HTS staff as communicative, trustworthy, and effective in their roles. Specific elements of HTS program delivery that stood out to clients, staff, and partners included the program's flexible approach in meeting current and prospective clients where they are, providing case management not tied to other services (e.g., shelter), and establishing a collaborative system to help address client needs in a timely manner. Relatedly, partners shared that HTS's use of vehicles from the Front Street fleet as a core component of HTS's flexibility and agile response to clients. HTS leadership intentionally set up flexible use of a vehicle fleet as part of program infrastructure, having identified access to immediate transportation as a key component of effective outreach and service delivery. Partners also shared that the ability to receive standalone case management that is not tied to other services like shelters, many of which have long waitlists, greatly increased accessibility of services.



## Collaborative Barriers

**Both HTS and partners recognize that the use of different data management platforms remains a barrier to partnering.** As highlighted in RDA's Process Evaluation, HTS's data management platform, Activate Care, was identified as a challenge because other providers throughout the County do not utilize the platform or if they do, it is not a compatible instance of the platform. As a result, other providers do not have access to HTS client data, further inhibiting collaborative care across behavioral health and other service providers.

Both partners and HTS commented on the **lack of adequate resources and challenges of providing services in Santa Cruz County**, reflecting that this was a systemic issue for providers in the County. In particular, HTS and partners identified a structural challenge with City-run shelters and their process surrounding how they prioritize shelter eligibility. HTS leadership and staff emphasized these relationships with specific partners presented an ongoing challenge due to limited service capacity of these key providers in the community.

Partners identified that **HTS staff turnover contributed to weakened partnerships with HTS**. Staff departure was particularly noticeable for partners when another HTS case manager was unable to "replace" the consistent HTS presence partners and clients had become accustomed to. Partners noted that the loss of staff could have negative ramifications for client care. For example, staff from two partners noted that some clients reported negative feelings when they did not receive advanced notice of their case manager's departure. Partner staff commonly communicate informally with HTS delivery staff, thus more formal communication channels with HTS will enable partners to communicate with HTS regardless of staffing changes and HTS can inform partners of staffing changes in advance to limit disruptions to client care.

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*"[I] used to work closely with [former HTS case manager]. After he left, nobody was coming back to where we did the outreach, we lost a lot of that connection...HTS started joining us and bringing resources there. [Former HTS staff name] was doing an amazing job helping with resources, if we had questions or needed something, we would contact [former HTS staff name] but then he left HTS and nobody showed up to continue." - Program Partner*

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**Partners expressed a need for improved communication to allow for greater case coordination with HTS.** Specifically, partners noted that some clients are provided duplicative services by both their organization and HTS. Through more structured collaboration and coordination of client care, HTS and partners may better meet the needs of clients without overburdening them with duplicative services. For example, some partners expressed a desire for follow-up communication from HTS about a client they referred. By updating partners about services HTS provided clients, as well as referrals to other services, both HTS and partners can reduce their service intensity for individual clients who may already be connected with services as a result of these collaborative efforts.



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*"I know we did almost the same tasks sometimes, so we could have two people doing the same thing, so how will we help them versus HTS help them to avoid duplication while the client gets what they need? That's important to talk about." - Program Partner*

*"[We need a] way to communicate better. There's a lot of staff. If someone takes the lead with a patient, I don't know what vehicle it would be with, but with all the technology we have, it would be an easy way to figure out how to communicate with folks. It would help to not duplicate efforts or to just have things run parallel to what HTS does." - Program Partner*

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**However, consistent referral follow up may be challenging for HTS to implement in practice, particularly given the program's "no wrong door" approach in combination with limited staffing capacity.** HTS works to connect all referred individuals to services, while continuing to service existing clients. This limits staff's ability to follow up with each referral made to HTS (see **Appendix Q** for an overview of a case manager time study.) In the absence of a County-wide data infrastructure to communicate with providers more seamlessly, it will be difficult for HTS to be responsive to partners about referrals received.

#### **Recommendations from Stakeholders**

- Adopt a shared data management platform to facilitate collaborative client care across behavioral health and other service providers (*Partner recommendation*)
- Increase communication and structured collaboration with partners (*Partner recommendation*)
  - ◆ This includes scheduling and/or attending regular meetings with multiple program providers, embedding HTS staff at consistent outreach sites, notifying partners about the status of clients referred to HTS, and communicating about service delivery plans to reduce duplicative client services.
  - ◆ Administratively, HTS can collaborate with partners in submitting grant applications and addressing service provision in compliance with CalAIM requirements.
- Develop distributable program materials that partners can provide to prospective clients or other service providers. This may improve awareness and knowledge of HTS's purpose and services, and when referrals to HTS are appropriate (*Partner recommendation*)
- Address limited staff capacity (*HTS Staff & Partner recommendation*)
  - ◆ Frequent staff turnover can weaken collaboration and negatively impact client care. HTS should focus on hiring and retaining case managers, particularly multilingual staff. HTS should communicate to partners when staffing changes occur, particularly if the client is receiving coordinated care from HTS and partners.

### 3. Is HTS improving outcomes for individuals experiencing homelessness with mental health and possible co-occurring substance use disorders?

The final evaluation question seeks to examine the impact that the HTS program has on clients. This question was answered using baseline and reassessment NOMs data, interviews, and focus groups. The impacts investigated include physical health, mental health, housing, social connectedness, service utilization, legal system involvement, satisfaction, discharge from the program, among others.

#### Evaluation Question 3 Key Findings



**Overall, clients report being better off as a result of participating in the program.**

Both clients and direct service staff shared that HTS helped clients stay connected to existing healthcare providers as well as get them connected to new providers. Clients generally experienced improvements to their mental health, most often attributed to the relationship with their case manager, with whom they feel very connected. Emergency service utilization dropped slightly, while legal system involvement increased slightly. The vast majority of clients were very satisfied with the services they received at HTS. However, most clients remain unhoused.

## Physical Health

**Clients shared varied experiences with physical health outcomes.** A few clients expressed their overall health improved. Clients shared experiences gaining weight, having a better attitude, and getting back on medication. Most clients indicated that their physical health stayed the same since being involved with HTS.

**Both clients and direct service staff shared that HTS helped clients stay connected to existing healthcare providers as well as get connected to new providers.** Clients expressed that because of assistance with HTS staff, they were able to stay connected to their medical providers through rides to appointments and pharmacies. One client reported they were able to get a knee brace because their HTS case manager helped them make and attend multiple appointments. Other clients shared experiences of getting connected to new providers such as primary care providers, physical therapists, optometrists, and dentists.

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*"[I'm feeling] quite well because [HTS] recommended me to another person for the operation that I was undergoing. I felt very bad and right now, physically, I feel very well. I don't feel what I felt before the operation and I am very satisfied." - HTS Client*

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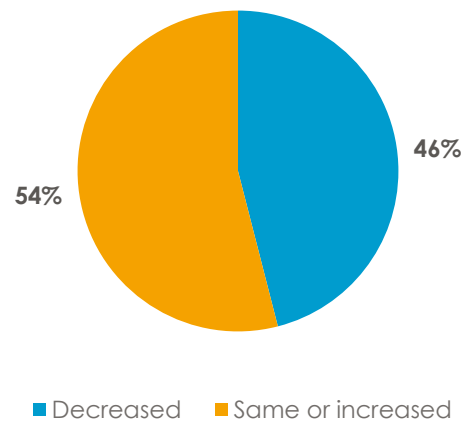
## Mental Health

Overall, **the HTS program has a positive impact on client mental health.** Several clients shared that the program increased their self-esteem, put them in an overall better state of mind, improved their resilience, and helped them calm down emotionally.

A few clients reported feeling the same or worse, with some clients expressing frustration with their current situation and its impact on their mental health. Clients who described negative mental health impacts expressed feeling frustrated that they were still on the streets and did not receive the services they expected from HTS. As a result, they felt a lack of trust and overall feelings of depression.

NOMs assessment data show that, on average, clients' **psychological distress symptoms decreased since enrolling in the program.** As part of baseline and reassessment NOMs, clients are asked to share how many psychological distress symptoms they experienced in the past month. These symptoms include feeling nervous, hopeless, restless or fidgety, so depressed that nothing could cheer them up, that everything was an effort, or worthless. Among 24 HTS clients with both baseline and reassessment data, nearly half saw their psychological distress score decrease (46%, 11), while slightly more than half saw their scores stay the same or increase (54%, 13).

**Figure 8. Psychological Distress NOMs Scores, N=24**



**Many clients shared that the relationship with their case managers was a main driver for improvements to mental health.** Clients shared that having somebody to talk to “helps you stay stronger” and it makes it feel like there’s someone out there who cares.

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*“I didn’t kill myself when I wanted to because [my HTS case manager] was there to help me step back and take a good look at what was going on.” - HTS Client*

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*“Just talking to her and seeing her was helpful.” - HTS Client*

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**Several clients expressed improved mental health due to basic needs being met by HTS.** Staff shared that basic needs are often easier to meet than mental health or substance use needs due to stigma and reluctance to engage in treatment. Additionally, staff indicated that clients are less likely to prioritize their mental health needs when their basic needs are not being met, yet their clients’ mental health is often tied to the extent to which their basic needs are being met (see additional context in Needs of Clients Served).

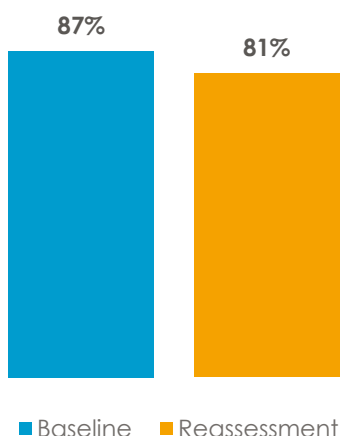
**Staff reported that they are seeing better adherence to medication and increased engagement in field-based services.** Clients are much more likely to engage with services that are out in the field compared to in a provider’s office. For example, one client experienced a mental health crisis as they were adjusting to a new housing situation. Staff were able to stabilize the situation in the client’s home, which likely helped the client avoid losing their housing placement.

## Housing

NOMs assessment data show that **more clients are housed since enrolling in the program compared to pre-program enrollment.** As part of baseline and reassessment NOMs, clients are asked about the number of nights in the past 30 days that they have experienced homelessness. Among 31 HTS clients with both baseline and reassessment

data, the endorsements of homelessness in the past month decreased slightly from 87% (27) to 81% (25). Among all 278 HTS clients with baseline interviews who responded to this question, 88% (245) endorsed experiencing homelessness in the past month.

**Figure 9. Homelessness NOMs Scores, N=31**



**Clients shared that HTS supports connections to housing related services and supports.**

Several clients reported that their case managers provided them with referrals to agencies who could connect them to long-term housing. Some clients have been connected to temporary housing like a shelter or hotel, while others have been connected to permanent housing. Others shared experiences of HTS staff helping them gather the necessary documentation to apply for housing, like a driver's license and birth certificate.

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*"I've got a Section 8 voucher because of my case manager from HTS. She hooked me up with Pathways and through Pathways I got a housing voucher." – HTS Client*

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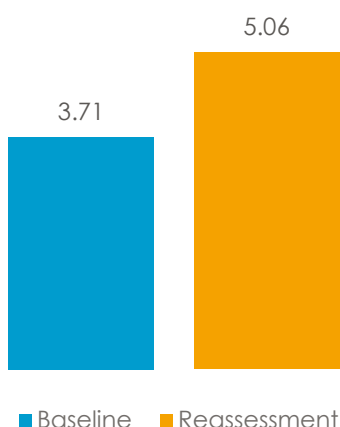
**However, most clients remain unhoused.** A few clients shared frustration with their current housing situation and did not feel like HTS has been able to help them get into housing. Community partners expressed a lack of clarity around who gets housed after participating in HTS, which is in line with their overall feedback about not hearing updates on clients they have referred to the program. Staff explained that they have been able to support some clients in securing housing, but the housing shortage in Santa Cruz County has made this extremely difficult. Staff reported feeling "powerless" when it comes to housing their clients. Future IHRT programming is slated to have some designated housing units for eligible participants.

## **Social Connectedness**

NOMs assessment data show that, on average, clients' **feelings of social connectedness increased since enrolling in HTS**. As part of baseline and reassessment NOMs, clients are asked to share how many feelings of social connectedness they experienced in the past

month. These feelings can include happiness with the friendships they have, having people with whom they can do enjoyable things, feeling like they belong in their community, and feeling like, in a crisis, they would have the support they need from family and friends. This is then calculated on a scale ranging from 0 to 4. Among 22 HTS clients with both baseline and reassessment data, the average past-month feelings of social connectedness increased from 2.68 to 3.45. The average social connectedness score among all 227 HTS clients who responded to this question during baseline interviews was 2.85.

**Figure 10. Social Connectedness NOMs Scores, N=22**



**A few clients indicated that they feel more connection to their community as a result of their involvement in the program.** One client shared that because they are no longer on the streets, they feel more part of the community. Another client described reconnecting with friends they had not seen in years.

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*"I came back to the community. I got back into the community which I wasn't before so like I feel part of the community now. I'm not on the streets anymore." - HTS Client*

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**Most clients shared that they feel connected to their case managers and other providers, but do not feel more or less connected to other people in the community.** Clients described the impact that seeing their case manager regularly has on their feelings of connection. **Staff and leadership described experiences of building strong relationships and trust in the community**, particularly with the peer support specialist role. They explained the humanizing effect of recognizing and acknowledging clients out in the community, and that community members trust HTS out in the encampments. The original goal of having clients enrolled for nine months from the CTI model, staff shared, did not fit well with the need to build deep relationships with clients, which often takes longer than nine months.

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*"People experiencing homelessness may feel invisible or undesirable, so when someone engages you, it helps people feel seen to us and to the community. I feel like we've done that." - HTS Leadership*

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## Service Utilization

NOMs assessment data show that **client emergency service utilization dropped slightly since enrolling in HTS**. As part of baseline and reassessment NOMs, clients are asked about the number of nights they have stayed in a hospital for mental health, detox/inpatient or residential SUD treatment, or an emergency room for a psychiatric or emotional problem in the past month. Among 31 HTS clients with both baseline and reassessment data, use of these services decreased slightly or stayed the same (n<11). Among all 278 HTS clients with baseline interviews who responded to these questions, 5-7% (14-19) endorsed using these services in the past month.

## Criminal Justice System Involvement

NOMs assessment data also show that **client criminal justice system involvement increased slightly since enrolling in the program**. However, this was not found to be statistically significant. As part of baseline and reassessment NOMs, clients are asked about the number of times they have been arrested in the past month. Among 29 HTS clients with both baseline and reassessment data, legal system involvement increased slightly (n<11). Among all 275 HTS clients with baseline interviews who responded to these questions, 7% (19) endorsed experiencing an arrest or jail stay in the past month.

## Other Client Outcomes

**Most clients say that they are better off as a result of participating in HTS**. Clients shared multiple additional outcomes that they experienced because of their participation in the program, including their ability to complete daily tasks, their follow through with things, their ability to take care of their pets, and getting on the path to securing a job or other sources of income.

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*"I can't tell you how immeasurable it is because for me to actually follow through is just like it's an immeasurable step to actually follow through and then keep going because it's so easy for me to keep constantly falling off the path to get well." -HTS Client*

*"For some clients, seeing that someone cares gives them the motivation to keep going. Playing that coach is an unmeasurable thing that makes a difference. [...] We're helping out a lot of individuals in measurable and holistic ways, and that makes a difference." -HTS Staff*

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## Satisfaction

**The vast majority of clients were very satisfied with the services they received at HTS, with many expressing gratitude for their case manager.** When asked about their experience in the program, a common refrain from clients was feeling blessed, supported, and grateful. Clients described HTS as a “wonderful program” with staff going “above and beyond” to help. Multiple clients described their case manager as a “good friend.” One client said that their case manager treated them “better than I’ve had family members treat me.”

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*“They’re just very compassionate about helping me get back on my feet and showing me the ropes of what I needed to do and guiding me.” - HTS Client*

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*“When I need a hug, they are there to hug me.” - HTS Client*

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NOMs assessment data reflects the high levels of satisfaction. On reassessment, clients rated general satisfaction an average of 2.8 out of 3, treatment participation an average of 1.9 out of 2, and quality and appropriateness of service an average of 8.25 out of 9. Below are the NOMs satisfaction data of clients with reassessment interviews.



**Figure 11. Satisfaction NOMs Scores**

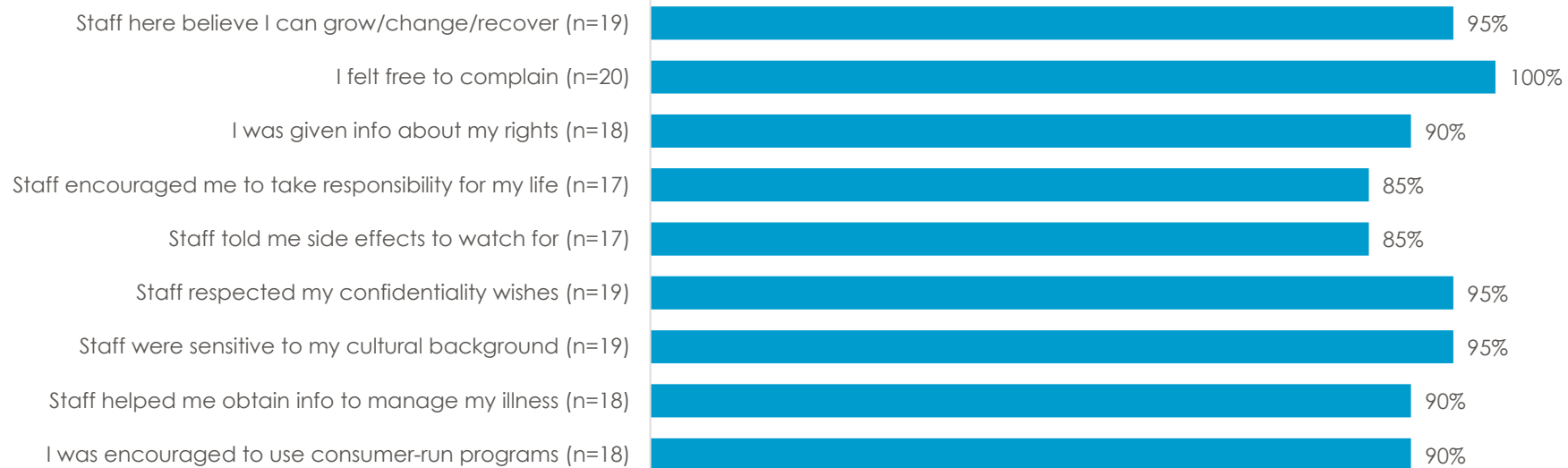
### General Satisfaction



### Treatment Participation



### Service Quality and Appropriateness



**Some clients expressed a desire to meet more frequently with their case manager.** A few clients shared experiences of being unable to get in contact with their case manager or of varied frequency in contact. Staff explained that, in some cases, clients with high mental health needs contact their case managers multiple times a day and express frustration when unable to reach them each time. Multiple clients specifically mentioned their case manager's high caseload as a possible reason why they were unable to receive the time and attention they needed.

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*"I wish that there were more employees and more case managers because they seem so overworked." - HTS Client*

*"The one thing a lot of people complain about including me is having too many people on one caseload [...] it's a lot and one person can only do so much." - HTS Client*

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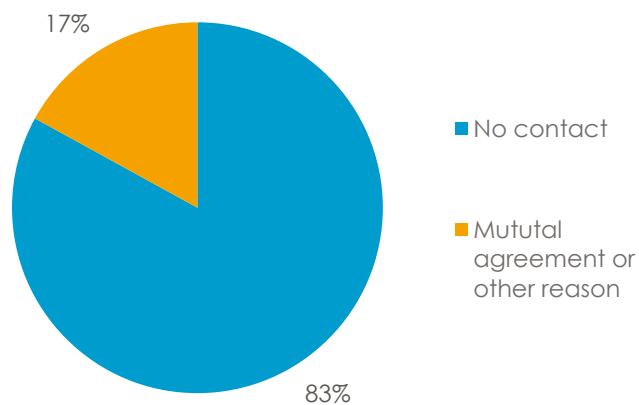
A few clients who were frustrated with their housing situation shared that they wished that HTS could do more to help them get housed. As previously mentioned, staff feel that their abilities to house clients are limited and that more communication with clients about what falls within HTS's power regarding housing is needed.

**Clients shared a diversity of experiences with the program,** with one person sharing a very different experience than most others. This client expressed extreme dissatisfaction, feeling like HTS had not helped them, but negatively impacted them by not providing promised services. Despite reporting their experience to the administrative office, the client indicated that nothing was done to remediate the poor service quality they encountered.

## **Discharge from Program**

According to data from SPARS, **216 unique clients were discharged from the program.** The majority of clients were discharged due to lack of contact for 90 days after their previous encounter with their case manager (83%, 180). The remaining clients were discharged after mutual agreement upon cessation of treatment or for another circumstance (17%, 36).

**Figure 12. Client Discharge Reasons, N=216**



**Most former clients shared that their case manager told them that they would no longer be working with them.** Some clients said that their case manager told them that they would be leaving and that they would get connected to a new case manager, but they were never connected. Other clients explained that they fell out of contact with the program and were unable to be found by HTS staff. This is in line with the SPARS data shown above.

#### **Recommendations from Stakeholders**

- Reduce the caseload size for case managers so staff can provide the depth and intensity of care that clients need and are asking for (*Client recommendation*)
- Increase the quality and quantity of contacts between case managers and clients (*Client recommendation*)
- Offer more resources to meet clients' basic needs (*Client recommendation*)
- Define the caseload size for case managers to meet community need and avoid staff burnout (*Staff recommendation*)
- Clearly communicate to clients, staff, and community partners what services are offered around housing and what services are outside the scope of the program (*Staff recommendation*)
- Provide more housing support (*Client recommendation*)

### **Dana's<sup>26</sup> Story**

Dana was living on the streets in Santa Cruz when she was connected to a shelter and a case manager at HTS. The team worked quickly to connect Dana to a housing navigator at Encompass, set up benefits appointments, take her to doctor's appointments, refer her to a women's health center, and buy her clothing and other necessities. In March of 2023, Dana was able to secure an apartment.

However, due to a recent relapse and medication changes, Dana has been experiencing difficult mental health symptoms like paranoia and self-doubt. Her case manager, Lauren, is continuing to meet with her to help her with her job search, but fear and self-doubt has stopped her from engaging in full-time work.

Throughout Dana's time in HTS, Lauren has been able to provide the needed space for Dana to vent her emotions. With the help of HTS staff and other community partners, Dana has built a support system of people who care about her and do not judge her when she experiences setbacks. Dana has built up her ability to reach out for help when she needs it, particularly for her mental health and medical needs.

Currently, Lauren is working with Dana to build up her self-confidence and secure a stable job. While there is still work to be done, the progress Dana has made shows the potential for a bright future.

### **Ethan's<sup>27</sup> Story**

Before Ethan enrolled in HTS, he had been cycling through behavioral health providers and was on a waitlist for services. Once connected with HTS, Ethan faced ongoing challenges with engagement and connection to services. His case manager, Rebecca, advocated tirelessly to get Ethan assigned to a coordinator. All the while, HTS ensured he had his basic needs met, like water, a tent, and a blanket. Ethan was eventually assigned to a specialty mental health coordinator. With the help of HTS and his legal team, his court cases were also resolved.

Despite these positive developments, winter's arrival in Santa Cruz posed significant challenges for Ethan. He lost a dear friend to an overdose, began living in a wooded encampment, and struggled with worsening mental health. At this point, HTS and Ethan's specialty mental health coordinator placed him on a list for dual-diagnosis treatment through Casa-Pacific.

Ethan entered Casa-Pacific in April 2023 for treatment and has been sober ever since. He loves the structure and safety of the program and is now studying for his GED. Ethan dreams of going to welding school and getting his own living space.

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<sup>26</sup> Name has been changed to protect client confidentiality. Interviews were provided by case managers with consent from their client. To read Dana's full story, see **Appendix S**.

<sup>27</sup> Name has been changed to protect client confidentiality. Interviews were provided by case managers with consent from their client. To read Ethan's full story, see **Appendix T**.



## Recommendations for the Future

The following recommendations were shared by staff, clients, and partners in their respective interviews or focus groups. RDA added recommendations from best practice research and observation as the HTS learning and evaluation partner. These recommendations can guide program design decisions for future programming.

### Program Infrastructure Recommendations

**Conduct a planning process based on the findings from this cumulative evaluation prior to program implementation to inform continued and new programming (i.e., IHRT or similar program offshoots).**

**Consider planning marketing and socialization of the updated model.** Identifying the program as an offshoot or different iteration of HTS may be beneficial given HTS's positive reputation and name recognition in the community. The new team should make clear distinctions about what this new program offers to reduce the conflation between services provided under the new model.

**Adopt a shared data management platform and standardized data processes to facilitate collaborative client care across behavioral health and other service providers.**

In-house coordination may be improved by adopting Avatar, the County's electronic health record. There is also a benefit in utilizing the Homeless Management Information System (HMIS) to coordinate care with other homeless services providers. Overall, the development of a standardized data collection and reporting process could help to capture data more effectively. This could entail developing a data capture/documentation process that is standardized and consistent.

**Improve program guidance documentation and training materials to establish clear workflows for staff.** Example scenarios and how to correctly document what to do in these situations will benefit delivery program staff and reduce the burden on administrative staff completing quality assurance checks. Adequate time for documentation should be allotted for delivery staff to complete these administrative tasks.

**Adopt a set of formal process improvement practices to ensure ongoing effectiveness and improvement.** Review, integrate and adopt ongoing quality improvement processes as well as opportunities to adapt program practices based on client feedback to ensure trauma-informed and culturally responsive programming. To track program impact, determine key metrics and ensure the ability to capture and reflect on impact, and create specific venues for reviewing this data. As with the PDSA cycles, reviewing real time data will provide a shared understanding of what is working as well as areas that need improvement.

**Ensure program activities are supported by the funding model.** Future program iterations must be supported by a funding model that aligns with program activities and creates sustainable services with realistic outputs. For example, HTS's use of a CTI case management model was an inappropriate match given the lack of dedicated housing resources in the County and case managers' high volume of clients on their caseloads, resulting in an inability to maintain fidelity to the model. Future iterations of the program would benefit from utilizing a case management model that works well in parallel with caseload sizes. Setting balanced caseloads and workloads based on staffing capacity, the acuity of client needs, and programmatic level of service will support identification of these aligned funding streams.

**Address limited staff capacity.** Frequent staff turnover can weaken collaboration and negatively impact client care. Continue to focus on hiring and retaining case managers, particularly bilingual and/or multilingual staff to communicate with and meet the needs of individuals in the community more effectively. In the instance of staff turnover, the program could proactively communicate to partners and clients when staffing changes occur, particularly if the client is receiving coordinated care from multiple agencies.

Due to the high acuity of client needs, more case managers are needed to reduce staff caseload. This will enable staff to provide the depth and intensity of care that clients need while simultaneously avoiding overworking staff and reducing staff burnout. Continuing to hire peer support staff and provide peer support to clients is recommended, in addition to designating or hiring a housing expert so that at least one staff member has a strong knowledge of housing options available in the community and can facilitate housing navigation for clients.

## Service Provision Recommendations

**Increase frequency of case manager communication and in-person contacts with clients.** For clients, this would look like seeing their case manager more often during the week and may translate into feeling more supported by their case manager. Having a strong relationship with a case manager led to self-reported improvements in mental health for HTS clients, so it is imperative that case managers develop strong relationships with their clients.

**Continue to provide connections, coordination, and support to clients.** Connections and coordination with health care providers and support and care through case management were key components of successful ongoing care coordination for HTS clients.

**Provide more information on resources, more direct support with basic needs, and additional services.** With the changing landscape of services and the dynamic needs of clients, it is important that clients are kept up to date on what services and resources are available in the community. Case managers can help clients with health appointment scheduling to further support clients' wellness and continuity of care. When possible, clients can be provided with monetary support (e.g., gift cards) as well as food and hygiene kits to meet their basic needs.

**Offer clear communication about service offerings to clients and partners.** Providing clear explanation regarding what services are offered around housing can reduce client frustration with program capabilities, and clarifying what services fall outside the scope of the program may help reduce confusion among partners.

**Simplify program offerings to two key components: field-based behavioral health and case management.** These specific components of HTS were identified as core program strengths. Future program iterations should continue field-based access to services because this brought behavioral health care to a population that is underserved, filling a critical gap in the continuum of behavioral health care. Transportation remains a critical barrier and provision of transportation remains a crucial program element to continue HTS clients' successful access to medical care and pharmacy prescriptions. Additionally, by operating with flexibility, case managers were able to quickly address client needs and connect clients expediently to providers not tied to other services.

**Pursue additional ways to procure flexible funding.** This type of funding would enable case managers to provide clients with immediate assistance to meet their basic needs without cumbersome administrative barriers.

**Continue efforts to secure dedicated housing units and shelter resources for clients.** Housing and shelter remain core needs of the target population to reach well-being and stability. Additional to procuring housing, staff should ensure temporary shelter options are available to clients by advocating for a more collaborative shelter system. Currently, the shelter system in the County is highly restricted and prioritizes some people over others. It is important to increase access to the shelter for program clients.

## Collaboration Recommendations

**Increase communication and structured collaboration with partners to strengthen relationships.** This includes scheduling and/or attending regular meetings with multiple program providers, embedding program staff at consistent outreach sites, notifying partners about the status of clients referred to the program, and communicating about service delivery plans to reduce duplicative client services. Additional clarifications should be made concerning when partners should refer to the program and for which specific set of services. Coordination efforts would be made easier by a shared technology platform, which would need to be adopted on a county-level.

**Increase program visibility among service providers and individuals in the program's target population through marketing materials.** Doing so can improve key stakeholders' knowledge of the program which may increase collaborations and partnerships. Materials should include clear and professional branding that accurately and succinctly describes services offered as well as contact information. These materials should be routinely updated distributed to partners. The County's public health marketing department should be consulted regarding these advertising efforts.

**Services and collaborative efforts should be aligned with future CalAIM changes.** CalAIM is one of the largest state-wide investments in serving the program's target population. There will be many opportunities to align services and collaborate to support clients in their health and well-being. The program should proactively address



how services may evolve under CalAIM and how partnerships can be developed and strengthened during this systemwide shift.



## Acknowledgments



*Photo Credit: This photo was provided by Santa Cruz County. It depicts a mural at a recently expanded behavioral health site in Watsonville.*

From HTS: Thank you to the HTS staff for your collaboration, support, and participation in this evaluation, Karen Kern, Shelly Barker, Kayla Gray, Clayton Conrad, Lindsey Pilkington, and the incredible direct service staff. We appreciate the many community partners for providing your insights and recommendations for HTS's continued growth. We'd like to give a special thank you to HTS clients who went out of their way to share their experiences to help inform this evaluation.

From RDA: We would like to express appreciation to all who have contributed to the evaluation of Healing the Streets. Thank you to the RDA Consulting project team, Alison Farringer (Lead Quantitative Analyst), Caroline Calonge (Lead Qualitative Analyst), Dina de Veer (Project Director), Julia Lang (Project Manager), and Taylor Kidd (Analyst), as well as Hector Borjas (field interviewer) for conducting the evaluation and

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## Appendices

### Appendix A. Landscape/Context

The United States has been grappling with a mental health crisis which has only worsened as a result of the COVID-19 pandemic.<sup>28</sup> In 2020, one in five adults in the U.S. experienced a mental health condition.<sup>29</sup> Similarly, nearly one in six Californians experience a mental illness<sup>30</sup> and one in 24 Californians have a serious mental illness that impacts their ability to function.<sup>31</sup> Further, a third of adults with serious mental illnesses who received county-provided mental health services in California had a co-occurring substance use disorder. The co-occurrence of homelessness, mental illness, and/or substance use disorders is a complex issue affecting a significant number of individuals in the US.

On a national level, California has had the largest homeless population for over a decade. In 2022, 30% of all people in the U.S. experiencing homelessness lived in California.<sup>32</sup> In particular, Santa Cruz County experiences unique challenges concerning homelessness, mental health support, and treatment of substance use disorders. Santa Cruz has more people experiencing homelessness per capita than anywhere else in California, with a high rate of individuals also dealing with a substance use disorder.<sup>33</sup> Additionally, individuals residing in Santa Cruz are burdened by an extremely high cost of living and lack of access to affordable housing. In 2023, Santa Cruz County was found to have the most expensive rental market in the country.<sup>34</sup> Eviction became the leading cause of homelessness for individuals surveyed during the 2022 Point-In-Time Count.<sup>35</sup> *For a more detailed picture of homelessness in Santa Cruz, see data and reports located on Santa Cruz County Housing for Health Partnership website.*<sup>36</sup>

Santa Cruz County's Behavioral Health Department (BHD) serves as the primary mental health care provider for low income individuals and aims to address the most critical mental health needs of its County residents, with a particular focus on serving high-risk individuals (e.g., people experiencing homelessness, justice-impacted).<sup>37</sup> Over 35% of BHD's low-income clients are people experiencing homelessness, with nearly 70% of individuals experiencing a chronic substance use disorder. However, the recent Grand

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<sup>28</sup> <https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide>

<sup>29</sup> <https://www.samhsa.gov/mental-health/myths-and-facts>

<sup>30</sup> <https://www.chcf.org/wp-content/uploads/2018/12/MentalHealthCA2018.pdf>

<sup>31</sup> <https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained/>

<sup>32</sup> <https://www.ppic.org/blog/homeless-populations-are-rising-around-california/>

<sup>33</sup> [https://www.co.santa-cruz.ca.us/Portals/0/County/GrandJury/GJ2023\\_final/2023-6\\_BHD\\_Report.pdf](https://www.co.santa-cruz.ca.us/Portals/0/County/GrandJury/GJ2023_final/2023-6_BHD_Report.pdf)

<sup>34</sup> <https://www.sfchronicle.com/realestate/article/most-expensive-rent-california-18167616.php>

<sup>35</sup> <https://www.santacruzsentinel.com/2022/09/16/larger-picture-revealed-for-santa-cruz-county-homelessness/>

<sup>36</sup> <https://housingforhealthpartnership.org/LearningCenter/DataandReports.aspx> and

<https://housingforhealthpartnership.org/Portals/29/HAP/Providers/Data/2023PITExecutiveSummary.pdf>

<sup>37</sup> [https://www.co.santa-cruz.ca.us/Portals/0/County/GrandJury/GJ2023\\_final/2023-6\\_BHD\\_Report.pdf](https://www.co.santa-cruz.ca.us/Portals/0/County/GrandJury/GJ2023_final/2023-6_BHD_Report.pdf)

Jury investigation uncovered that BHD did not sufficiently meet its service goals. Specifically, the investigation found BHD to be seriously understaffed. This lack of adequate staffing has strongly contributed to BHD's inability to meet the needs of the population they serve resulting in disruptions in access to care and poorer quality of treatment across services. This reduced access to services coincides with an increased need for supportive services. This is supported by outcomes from the 2022 Santa Cruz County Homeless Point-in-Time Count and Survey in which the prevalence of substance use disorders more than doubled since 2019.<sup>38</sup>

While other service providers seek to offer supportive services to individuals experiencing homelessness, mental health conditions, and/or substance use disorders, many face similar barriers to BHD (i.e., understaffed, limited access to resources). Street medicine and outreach teams are further impacted by environmental and social circumstances that have complicated providers' efforts to conduct outreach and maintain contact with individuals in need of services.

For example, the presence of encampments enabled providers to consistently locate clients to provide treatment and services. The County has made efforts to eliminate encampments that were previously allowed during the height of the pandemic. In 2022, the most notable closure in Santa Cruz occurred at the Benchlands encampment in San Lorenzo Park resulting in the displacement of individuals given the lack of shelter beds and housing in the County.<sup>39</sup> Other encampment closures have occurred in Sycamore Grove and Pogonip.<sup>40</sup>

Between December 2022 and January 2023, Santa Cruz County was severely impacted by winter weather and storms, resulting in flooding, landslides, and significant structural damage.<sup>41</sup> Federal aid and other disaster funds and resources were made available to organizations which enabled providers to assist community members in need.<sup>42</sup> Despite the increased availability of flexible funding, service providers were unable to offer clients consistent care as they shifted their work to emergency aid while also navigating the structural impacts of the storms on their work (e.g., road closures and flooding disrupting outreach).

Ultimately, the Grand Jury recommended increasing staffing to support individuals with mental health issues in need of services, increasing the capacity of crisis stabilization programming - including expanding service availability - and improving services available to individuals with unique needs and barriers to care (i.e., people experiencing homelessness, justice-impacted, racial and ethnic minorities). While these recommendations were aimed at the County's BHD, they remain applicable to service providers throughout Santa Cruz who support individuals experiencing homelessness, mental health issues, and/or substance use disorders.

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<sup>38</sup> <https://www.housingforhealthpartnership.org/Portals/29/HAP/Providers/Data/2022PITFullReport.pdf>

<sup>39</sup> <https://lookout.co/santacruz/civic-life/story/2022-11-18/unsheltered-in-santa-cruz-a-deep-dive-into-outreach-at-the-benchlands>

<sup>40</sup> <https://www.newsbreak.com/santa-cruz-ca/3033661335602-after-very-public-benchlands-clearing-santa-cruz-taking-quieter-approach-with-pogonip-homeless-encampment>

<sup>41</sup> <https://www.cbsnews.com/sanfrancisco/news/winter-storms-santa-cruz-county-crews-busy-summer-repairing-damage/>

<sup>42</sup> <https://www.santacruzcountyca.gov/OR3/Emergency.aspx#:~:text=On%20April%203%2C%202023%2C%20President,menu%20below%20for%20more%20information>

## Key Informant Interview Program Context

The following program context is the summary analysis from a series of project discovery interviews with key stakeholders, conducted in spring of 2022.

### ***Community Resources: Strengths***

Numerous programs and services in Santa Cruz County address critical needs for PEH, including for those experiencing SMI and co-occurring SUDs. Existing programs offer medical and behavioral health services (e.g., Salud Para La Gente, Santa Cruz County Mental Health, ACCESS team, Janus of Santa Cruz), harm reduction and MAT (e.g., Santa Cruz County Harm Reduction Coalition, Watsonville Health Center), housing navigation and shelter services, (e.g., Front Street, Housing Matters, Salvation Army, City of Santa Cruz, County of Santa Cruz, Salvation Army) and other basic needs (e.g., Second Harvest Food Bank, Loaves and Fishes, Community Action Board). Some staff have reported recent growth in inter-agency collaboration within the County, noting that the relatively smaller size of Santa Cruz allows agencies to better familiarize and communicate with each other. Staff agree that there is room for improvement in collaboration and coordination across physical and behavioral health, human services, and housing service agencies (and in streamlining referral processes) to effectively meet clients where they are at while avoiding service duplication. HTS and partners praise their dedicated staff who build trust with and serve PEH, bringing valuable lived experience and sensitivity to their roles.

### ***Community Resources: Gaps and Barriers***

There are disparities in resource availability and access between North and South County, and there is a call for scaling up existing resources to meet current needs. South County is described as having fewer resources and investment compared to North County, evidenced in part by fewer existing programs and services for basic needs, substance use, and harm reduction. More generally, availability of and access to behavioral health services is lacking across the County, with limited detoxification services and lengthy treatment waiting periods creating gaps in care for PEH with behavioral health needs. Difficulty obtaining appointments, limited-service hours, acquiring transportation, and social stigma present challenges for accessing Santa Cruz County's mental health services. The COVID-19 pandemic exacerbated existing accessibility challenges, with limited in-person outreach and a transition to telehealth further complicating community efforts to connect with PEH.

The current housing crisis has significantly impacted the landscape of services within Santa Cruz County. Shelter closures, a limited housing stock, and unaffordable rent rates have resulted in fewer opportunities for short-term and crisis placements, in addition to creating limited diversity in housing opportunities for individuals at different phases of their physical and behavioral health rehabilitation process. Staff also describe political will and a pervading "not in my backyard" mentality as further complicating efforts to expand services, evidenced in part by a lack of local resource investment, coordinated community movements against outreach efforts, and closure of encampments and shelters. County-wide barriers present even greater challenges for people who are undocumented to obtain needed assistance.

Despite these barriers, HTS seeks to leverage the community's strengths to address and navigate around the County's most pervasive challenges.

## Appendix B. Funding Source

In September 2021 Substance Abuse Mental Health Services Administration (SAMHSA) awarded The County of Santa Cruz (SCC) Behavioral Health Division (BHD) with **\$3,000,000** from Block Grants for Community Mental Health Services to support an innovative new program called Healing the Streets (HTS).<sup>43</sup>

As an agency within U.S. Department of Health and Human Services, SAMHSA leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Community Mental Health Block Grant Program's (MHBG) objective is to support the grantees in carrying out plans for providing comprehensive community mental health services. Grantees can be flexible in the use of funds for both new and unique programs or to supplement their current activities. Grantees use the block grant programs for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services.<sup>44</sup>

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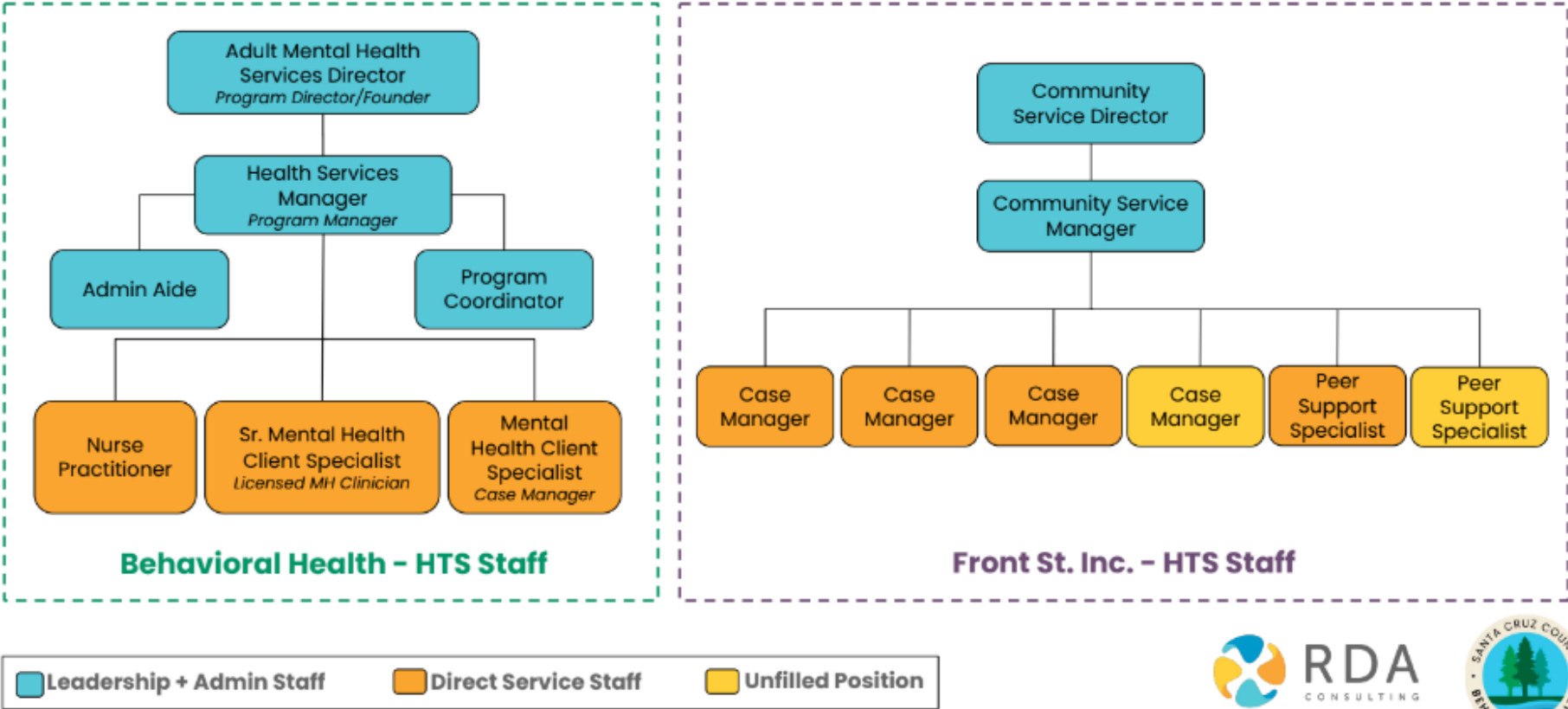
<sup>43</sup> Source: Notice of funding awarded

<sup>44</sup> Source: <https://www.samhsa.gov/grants/block-grants/mhbg>. The purpose of MHBG funds is to provide priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; Fund treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance; Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.



Appendix C. HTS Staffing Diagram

Healing the Streets (HTS) Staffing Chart  
2023 Snapshot



## Appendix D. HTS Partner Map

The below map was created from referral data gathered from Spring of 2022 through Fall of 2023. The map captures partners who provided referrals to HTS and does not indicate which partners HTS staff engaged with outgoing referrals.

## Community Health Providers

- Dominican Hospital
- Tuolumne Me-Wuk Health Clinic
- Palo Alto Medical Foundation (PAMF)
- Watsonville Community Hospital

### What services are available?

Hospitals and clinics help support clients in getting their healthcare needs met. Their role has primarily been one of utilizing HTS as a resource to clients who fit eligibility criteria. For any outgoing referrals to medical care, utilization of hospitals and clinics is specific to location and health care insurance coverage.

## Community Service Providers

- Abode
- Downtown Outreach Workers (DOW)
- Encompass
- Front Street
- Housing Matters
- Janus
- NAMI Santa Cruz
- Salvation Army
- Telecare
- Volunteer Center of Santa Cruz (Community Connections)

### What services are available?

Community Service providers are other non-county community providers supporting clients in meeting their needs. Incoming referrals to HTS were from homeless service providers who provide (shelter, housing navigation, outreach) and behavioral health providers who provide (mental health and substance use disorder supports). *There are many additional service providers in which HTS staff sent outgoing referrals that are not represented here.*

## Healing the Streets (HTS) Community Partnerships

Total Self (50) or Family (6) Referrals = 56

**53**  
referrals

**229**  
referrals

**163**  
referrals

**69**  
referrals

## Health Services Agency Service Providers

- Behavioral Health
- Care Team
- Crest
- Health Center
- Homeless Persons Health Project (HPPH)
- HOPES
- Housing 4 Health
- HSA Access
- Maintaining Ongoing Stability through Treatment (MOST)
- MHL
- Nurse Family Partnership
- Older Adult Services (OAS) Team

### What services are available?

Each of the County Behavioral Health and Public Health programs partnered with HTS, a program of Behavioral Health, to access care for mutual clients. These County provided services center around mental health, substance use disorder, access to medical care, and access to housing services. HTS both received incoming referrals and created outgoing referrals to these providers.

- Public Health
- Recovery North / South
- Substance Use Disorder Services (SUDS)

## Justice System Partner Providers

- Jails
- Jail Discharge Planners
- Probation
- Public Defender
- Superior Courts
- Watsonville Police Department (WPD)
- Mental Health Liaison
- WellPath (county contracted)

### What services are available?

Justice systems providers encounter individuals in need of services in criminal justice settings and connect eligible persons with HTS. HTS does not send outgoing referrals to these providers.

**Project Timeframe: March 2022 - September 2023**

# Appendix E. Program Design

## Program Design

### Services Provided

HTS is a field-based program that starts with outreach. Case managers meet clients where they are at, providing enrollment and services in the field at encampments and fixed locations on specific days of the week. Once enrolled, clients determine their own goals which are entered into Activate Care, a care coordination database. Case managers can provide a host of services; housing navigation, housing problem solving, access to housing flex funds for those who are eligible, connection to resources such as benefits (Supplemental Security Income [SSI]), Supplemental Nutrition Assistance Program (SNAP), Medi-Cal) and basic needs (food, clothing, shelter referrals, COVID-19 resources, and more), linkages to mental health services, substance use resources like MAT, inpatient and outpatient services, and street level medical care, including the option to see a practitioner using telehealth. The HTS team also passes out supplies such as Narcan to reduce overdoses in the community.

### Program Components

- Critical Time Intervention (initially): CTI is a time-limited, evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods. CTI has been applied with veterans, people with mental illness, people who have been homeless or in prison, and many other groups. The model has been widely used on four continents.<sup>45</sup> CTI is the case management method that the HTS team is using that provides a phased approach: pre-CTI, which can be any length of time, and phase one, two and three which are 3 months each, totaling in 9 months of case management services. The goal of CTI is developing long term supports and greater self-efficacy within the client's life.
- Strength Based Case Management (SBCM) (starting in summer of 2023): In summer of 2023, HTS switched from CTI to SBCM as the case management model. SBCM encourages the client to build and nurture informal support networks while also identifying and accessing formal community services and institutional resources. The model encourages the client to take the lead in identifying their own needs, take ownership of the search for resources and services to address those needs, and view the community as a resource rather than a barrier. SBCM involves outreach, clinical services, advocacy, and robust coordination between case managers and clients.
- Peer support: Peer support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with mental

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<sup>45</sup> Source: <https://www.criticaltime.org/cti-model/>

health conditions, SUDs, or both. This mutuality—often called “peerness”—between a peer support worker and person in or seeking recovery promotes connection and inspires hope. Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships.<sup>46</sup> By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves.<sup>47</sup>

- Outreach: Outreach is the process of bringing individuals into treatment who do not access traditional services. Effective outreach utilizes strategies aimed at engaging persons into the needed array of services, including identification of individuals in need, screening, development of rapport, offering support while assisting with immediate and basic needs, and referral to appropriate resources. Outreach results in increased access to and utilization of community services by people who are homeless and have mental illnesses. Active outreach is defined as face-to-face interaction with literally homeless people in streets, shelters, under bridges, and in other nontraditional settings. In active outreach, workers seek out homeless individuals. Outreach may include methods such as distribution of flyers and other written information, public service announcements, and other indirect methods. Outreach may also include “in reach,” defined as when outreach staff are placed in a service site frequented by homeless people, such as a shelter or community resource center, and direct, face to face interactions occur at that site. In this form of outreach, homeless individuals seek out outreach workers.<sup>48</sup>
- Field-based services: This refers to the act of providing services where people are at in encampments, public parks, etc. In working with those experiencing homelessness, it is critical to bring services to them in the field. There are barriers to transportation, accessing phones, scheduling, and more that stand in the way of the target population accessing services. Field-based services means bringing behavioral health services to people experiencing homelessness where they are at. The HTS team accomplishes this piece through the nurse practitioner and therapist, setting up appointments with ACCESS, the County's Behavioral Health screening service, and through telehealth appointments on tablets.

### **Program Delivery Methods**

- Low barrier: Refers to programming with a minimal level of expectations and requirements to attain services.<sup>49</sup>

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<sup>46</sup> Mead, S., & McNeil, C. (2006). Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation*, 10(2), 29-37.

<sup>47</sup> Source: [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/brss\\_tacs/value-of-peers-2017.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf)

<sup>48</sup> Source: <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr08-02Enclosure10.pdf>

<sup>49</sup> Source: <https://www.springsrescuemission.org/what-it-means-to-be-a-low-barrier-homeless-shelter/>

- Client-centered (or person-centered<sup>50</sup>) care: This approach is grounded in an understanding of individual's specific strengths and challenges and providing them with options that fit their preferences and lifestyle. This approach puts the client at the center of their care because they are the expert on their own life and needs.
- Trauma-informed care: An approach to care that acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation, past and present, in order to provide effective health care services with a healing orientation. Trauma-informed care shifts the focus from "What's wrong with you?" to "What happened to you?"<sup>51</sup>
- Harm reduction: Harm reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing SUD treatment and other health care services.<sup>52</sup>

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<sup>50</sup> Source: <https://www.usich.gov/news/people-experience-homelessness-they-arent-defined-by-it/>

<sup>51</sup> Source: <https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/>

<sup>52</sup> Source: <https://www.samhsa.gov/find-help/harm-reduction>

## Appendix F. Logic Model

### Logic Model

To help conceptualize HTS program components, processes, and goals in preparation for the evaluation, RDA developed an integrated logic model representing HTS as a whole. The logic model includes a description of the HTS program intervention and evaluation questions, as well as a higher-level outline of program inputs (i.e., resources), activities, 6-month and 1.5-year outcomes, and expected long-term contributions. The logic model also includes brief descriptions of conditioning factors, including program strengths, assumptions, and external challenges.



**Figure 7. Santa Cruz County Healing the Streets Logic Model**

**Intervention:** HTS is creating an integrated service model using collaboration and coordination of multiple providers across systems, Critical Time Intervention (CTI), peer support, and field-based services to foster access to health, behavioral health, and housing navigation services for people experiencing homelessness with Severe Mental Illness in Santa Cruz and Watsonville.

**Evaluation Questions:**

1. In what ways is the <b>HTS model:</b> (Critical Time Intervention (CTI) case management + field-based clinical services + street outreach + peer support) effectively meeting the needs of people experiencing homelessness (PEH) with Severe Mental Illness (SMI) with possible Co-occurring Disorders (COD)?
2. How does <b>collaboration &amp; coordination</b> of care enhance/ support (a) the model in developing an integrated system of care for people with mental illness experiencing homelessness? (b) continuity and quality of care or individual clients?
3. Is Healing the Streets <b>improving outcomes for individuals</b> experiencing homelessness with SMI?

Process □		Goals to Monitor □		Long-term Contribution
Inputs & Resources <i>What do we contribute to accomplish our activities?</i>	Activities <i>What do we undertake to accomplish our goals?</i>	6 Month Outputs & Outcomes <i>What do we expect to achieve by 6 months?</i>	1.5 Year Outputs & Outcomes <i>What do we expect to achieve by 1.5 years?</i>	<i>What is the long-term social change our program area is trying to achieve?</i>
<ul style="list-style-type: none"> <li>→ Office space</li> <li>→ Tablets</li> <li>→ Mobile Health Van</li> <li>→ Staffing (County staff, Case Managers, Peer Specialists)</li> <li>→ Evaluation (Contract with RDA)</li> </ul>	<ul style="list-style-type: none"> <li>→ Provide outreach, engagement, connection, and referral to services</li> <li>→ Offer and provide Telehealth visits</li> <li>→ Develop an ROI and referral process using Unite Us</li> </ul>	<ul style="list-style-type: none"> <li>→ At least 200 clients have been engaged and enrolled</li> <li>→ All staff are trained in CTI</li> <li>→ All hired Peer Specialists are trained in IPS</li> <li>→ All clients are entered into</li> </ul>	<ul style="list-style-type: none"> <li>→ At least 600 clients have been engaged and enrolled</li> <li>→ 75% of clients are established in a health and behavioral health home</li> <li>→ 75% of clients are enrolled or re-</li> </ul>	<ul style="list-style-type: none"> <li>→ Provide integrated services and establish stable ongoing connection to health, BH, and housing providers for PEH who have SED, SMI, and COD.</li> <li>→ Strengthen safety net infrastructure and develop seamless, universal pathways into care through care collaboration and coordination that reduces duplication of services.</li> </ul>

	<ul style="list-style-type: none"> <li>→ Conduct NOMs interviews</li> <li>→ Enroll all clients in Activate Care</li> <li>→ Train all staff in <i>Critical Time Intervention</i></li> <li>→ Train all Peer Specialists in <i>Intentional Peer Support (IPS)</i></li> <li>→ Create collaborative meetings with providers</li> <li>→ Promote Activate Care to providers</li> <li>→ Use PDSA cycles to promote CQI</li> </ul>	<p>Activate Care</p> <ul style="list-style-type: none"> <li>→ HTS staff are coordinating with BH, Health, and homeless service providers</li> <li>→ Telehealth has been piloted</li> <li>→ Referrals are being made to additional services and followed up on</li> <li>→ Clients are progressing toward their self-identified goals</li> </ul>	<p>enrolled in benefits</p> <ul style="list-style-type: none"> <li>→ 50% of clients are connected to housing navigation services</li> <li>→ Staff have offered 100% of participants access to remote services via telehealth devices at least weekly</li> <li>→ Multiple partners have successfully adopted Activate Care</li> <li>→ 80% of providers have adopted the ROI and referral process</li> </ul>	<ul style="list-style-type: none"> <li>→ Incorporate harm reduction and trauma-informed practices that promote wellness, stability, and recovery for PEH and behavioral health challenges.</li> <li>→ CTI is vetted as a best practice for people experiencing homelessness with SMI needs in Santa Cruz County.</li> <li>→ People receive access to behavioral health support in the community without the barrier and stigma associated with brick-and-mortar services.</li> <li>→ Client quality of life is improved through reaching their self-identified goals.</li> </ul>
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## Appendix G. HTS Needs and Referrals Chart

# HTS Needs and Referrals

CROSS OFF  
THE SERVICES YOU NEED!

<p>Covid 19 Services</p> 	<p>Medical Services</p> 	<p>Food</p> 
<p>Benefits Services</p> 	<p>Clothing</p> 	<p>Housing</p> 
<p>Mental Health Services</p> 	<p>Substance Support Services</p> 	<p>Dental Services</p> 
<p>Mailbox- Service</p> 	<p>Pet Service</p> 	<p>Cellphone Service</p> 

FOR MORE INFORMATION CALL:  
831-454-4352



# HTS Necesidades Y Referencias

¡MARQUE LOS SERVICIOS QUE NECESITA!

Servicios De  
Covid 19



Servicios  
Medical



Servicios de  
comida



Servicios de  
Beneficios



Ropa



Servicios de  
vivienda



Servicios de  
Salud Mental



Servicios de  
apoyo a  
sustancias



Servicios  
dentales



Servicio de  
Buzón



Servicio de  
mascotas



Servicio de  
telefonía celular



PARA MÁS INFORMACIÓN LLAME AL:  
831-454-4352



## Appendix H. Process and Outcome Evaluation Sub-Question Matrix & Domains

This matrix presents the process and outcome evaluation questions, evaluation domains, and data sources used to measure each domain. Detailed descriptions of each domain follow. Although data collection and analysis were guided by these evaluation questions and domains, cumulative report findings were further condensed and integrated to directly respond to the three core evaluation questions.

### Process and Outcome Evaluation Questions, Domains, and Data Sources

Core Evaluation Questions			Sub-Questions, Domains, and Sources		
Q1. In what ways is the HTS model (specifically CTI) effectively meeting the needs of clients?					
Q2.* What is the nature and extent of collaboration and coordination of care between HTS and partner programs?					
Q3. Is HTS improving outcomes for clients?					
Q1	Q2	Q3	Sub-Evaluation Questions	Evaluation Domain	Data Sources
x	x	x	1. Who is being served by the program (i.e., who is connecting to services)?	Clients Served	<ul style="list-style-type: none"><li>HTS Master Spreadsheet</li><li>HTS Outreach Tracking</li><li>Activate Care Platform</li><li>NOMs Interviews</li><li>HTS Referral Tracking</li></ul>
x	x		2. How is the model being implemented? To what extent has implementation followed the original program model? What are successes and challenges?	Engagement in Intended Program Practices	<ul style="list-style-type: none"><li>Activate Care Platform</li><li>Focus Groups &amp; Interviews</li><li>Monthly SAMHSA Reports</li><li>HTS &amp; RDA Meeting Notes</li></ul>
				Implementation Mode and Quality of Intended Program Practices	<ul style="list-style-type: none"><li>Activate Care Platform</li><li>Focus Groups &amp; Interviews</li><li>Monthly SAMHSA Reports</li><li>NOMs Interviews</li></ul>
x	x		3. What methods/strategies for service delivery are effective? What strategies are supporting the target population?	Perceived Effectiveness of Intended Program Practices	<ul style="list-style-type: none"><li>Focus Groups &amp; Interviews with HTS staff, clients, and partners</li></ul>

x		<b>4. What successes and challenges</b> have local partners experienced participating in integrated services with HTS?	Program Partner Successes and Challenges	<ul style="list-style-type: none"> <li>Focus groups &amp; Interviews with HTS staff and partners</li> </ul>
x	x	<b>5. Is engagement with HTS associated with improved client physical and mental health?</b>	Client Physical and Mental Health	<ul style="list-style-type: none"> <li>NOMs Interviews</li> <li>Interviews with HTS clients</li> </ul>
x	x	<b>6. Is engagement with HTS associated with improved client housing?</b>	Client Homelessness Experience	<ul style="list-style-type: none"> <li>NOMs Interviews</li> <li>Interviews with HTS clients</li> </ul>
x	x	<b>7. Is engagement with HTS associated with changes in client service utilization?</b>	Client Service Utilization	<ul style="list-style-type: none"> <li>NOMs Interviews</li> </ul>
x	x	<b>8. Is engagement with HTS associated with improved client social connectedness?</b>	Client Social Connectedness	<ul style="list-style-type: none"> <li>NOMs Interviews</li> <li>Interviews with HTS clients</li> </ul>
x	x	<b>8. Is engagement with HTS associated with changes in client legal system involvement?</b>	Client Legal System Involvement	<ul style="list-style-type: none"> <li>NOMs Interviews</li> </ul>
x	x	<b>9. What is the level of client satisfaction with the HTS program?</b>	Client Program Satisfaction	<ul style="list-style-type: none"> <li>NOMs Interviews</li> <li>Interviews with HTS clients</li> </ul>
x	x	<b>10. What type of discharge did clients have</b> upon exit from HTS?	Client Discharge	<ul style="list-style-type: none"> <li>NOMs Interviews</li> </ul>



# Appendix I. Process and Outcome Evaluation Domain Descriptions

Note that although data collection and analysis were guided by the evaluation domains described below, cumulative report findings were further condensed and integrated to directly respond to the three core evaluation questions.

- **Clients Served:** The volume, needs, and characteristics (including demographics) of clients engaged and served in the program, as well as incoming client referrals to HTS.
- **Engagement in Intended Program Practices:** HTS staff engagement in intended HTS program practices, including staff training and provision of services to HTS clients.
- **Implementation Mode and Quality of Intended Program Practices:** HTS staff perceptions of how and how well HTS program elements were implemented, including: outreach, enrollment, and case management services; the Critical Time Intervention (CTI) model; and data entry and program workflows.
- **Staff Perceived Effectiveness of Program Practices:** How HTS staff and partners view the impact and effectiveness of implemented program practices and activities including any practices that are seen as crucial “key ingredients.”
- **Program Partner Successes and Challenges:** Partner agency staff reflections on how they collaborated with HTS, and successes and challenges experienced in doing so.
- **Client Physical and Mental Health:** Changes in client self-reported physical and mental health tied to HTS participation, including level of psychological distress.
- **Client Homelessness Experience:** Changes in client self-reported homelessness.
- **Client Service Utilization:** Changes in client self-reported frequency of recent mental health hospitalizations; detox, inpatient, or residential substance abuse treatment stays; and psychiatric emergency room visits.
- **Client Social Connectedness:** Changes in client self-reported social connectedness (e.g., feelings of belongingness in one’s community, feeling supported by others).
- **Client Legal System Involvement:** Changes in client self-reported arrests and jail incarcerations.
- **Client Program Satisfaction:** Participant satisfaction with the HTS program after enrollment and service engagement (e.g., liking the services received, comfort with asking questions about treatment).
- **Client Discharge:** The nature and circumstances surrounding clients’ discharge from the program, including whether the discharge involved mutually agreed cessation of treatment, client withdrawal from treatment, clinical referral out of the program, or other discharge circumstance.



## Appendix J. Data Source Descriptions

**HTS Outreach Tracking** tracks the number and date of all HTS outreaches by program staff in the community. HTS service delivery staff updates and maintains this data on a regular basis in Microsoft Teams. HTS shared this tracking with RDA to inform the total number of outreaches performed by HTS staff on a monthly basis during the reporting period.

**HTS Referral Tracking** tracks the number and details of incoming client referrals made to HTS from external agencies and partners. The program's administrative team updates and maintains this database in Microsoft Teams. HTS shared this tracking with RDA to inform the total number of incoming client referrals made to the program, as well as the agency source of each referral.

**HTS Master Spreadsheet** is the program's running record of all active and disenrolled clients served by HTS, as well as dates of ROI and NOMs interview completion. The program's administrative team updates and maintains this database in Microsoft Teams. HTS shared this database with RDA to inform the total number of clients served during the evaluation period and the rate of ROI completion among enrolled clients.

**Quarterly Infrastructure Development, Prevention and Mental Health Promotion (IPP) Reports** are quarterly reports developed by HTS leadership that are shared with SAMHSA as part of ongoing reporting requirements. These reports include the type and description of trainings provided to HTS program staff (i.e., Critical Time Intervention, Motivational Interviewing, trauma-informed care), including the number of staff who underwent the training in the past quarter. HTS shared these reports with RDA to inform the frequency and nature of staff training received during the reporting period.

**Activate Care (AC)** is the program's HIPAA-compliant case management system. HTS staff and/or partners enter client information into Activate Care throughout the duration of program implementation. HTS shared client-level data available from this platform with RDA to inform the location of first outreach among enrolled clients, outreaches provided to enrolled clients, and program adoption and implementation of the Activate Care platform.

**National Outcome Measures (NOMs)** consist of data required by SAMHSA in accordance with the Government Performance and Results Act (GPRA).<sup>53</sup> RDA's subcontractor will collect this data by interviewing each client directly and entering it into SAMHSA's Performance Accountability and Reporting System (SPARS). RDA accessed client-level self-report data collected at baseline, six months post-baseline, and at discharge directly via SPARS to inform HTS program enrollment, client demographics, services, and outcomes, as well as program adoption and implementation of NOMs.

**Focus Groups and Interviews** were used to collect qualitative data from HTS staff, partners, and clients on HTS program implementation, collaboration, and outcomes. RDA conducted one focus group and six interviews with 10 total HTS staff, four focus

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<sup>53</sup> NOMs data reporting was updated and does not include all the same fields. This means it will be usable for some domains but not for others.

groups and three interviews with 16 total partner staff, and 16 interviews with 16 total HTS clients.

**Case Study Interviews** were used to collect qualitative data from HTS staff members to support client case study development, including information about client experiences, services, and outcomes. RDA conducted interviews with two HTS staff members, each of which were focused on one HTS client.

**Activate Care Case Notes** were used to collect qualitative data about services provided to clients by HTS case managers and other community partners during clients' HTS enrollment. This information was used to support client case study development for two HTS clients. HTS staff entered case notes into Activate Care on a routine basis between March 2022 and September 2023; Administrative staff subsequently provided the secondary data to RDA for analysis.

**HTS & RDA Meeting Notes** were used to collect qualitative observational data about HTS program implementation updates, processes, and progress toward goals, as well as the extent of implementation fidelity and adherence to program elements and model. RDA collected and analyzed meeting notes spanning 19 months of HTS program implementation, from March 2022 to September 2023.

**Monthly SAMHSA Reports** were used to further inform HTS program implementation updates, processes, fidelity, and progress toward programmatic objectives, as well as the extent and nature of staff training received. RDA received Monthly SAMHSA Reports compiled by HTS staff for SAMHSA spanning 19 months of HTS program implementation, from March 2022 to September 2023.

## Appendix K. Qualitative Data Collection Methods

**Focus Groups.** RDA conducted focus groups to understand implementation and effectiveness from the perspective of HTS staff, partners, and clients. RDA conducted a 1.5-hour virtual focus group for HTS delivery staff and two 1-hour virtual focus groups for HTS partner agency delivery staff. Additionally, RDA conducted two 1-hour in-person focus groups with clients in both geographic areas of service—one in North County, Santa Cruz and one in South County, Watsonville. Participants were provided with food and a \$40 Visa gift card, which is a best practice that recognizes the time, effort, and contribution of clients in sharing their experiences. Additionally, the focus groups were held in accessible locations and HTS staff provided transportation to those who needed it. Translation services were provided at both focus groups for those clients who speak Spanish.

RDA will replicate these focus groups in the outcome evaluation to understand the program impacts on the target population, the efficacy of the model, and extent and nature of coordination and collaboration of care towards the end of the grant period.

**Interviews.** RDA conducted interviews to further gather qualitative information (one-on-one) from staff and partners regarding program implementation and effectiveness. RDA conducted five 45-minute to one-hour long interviews with HTS administrative staff and five 45-minute to one-hour long interviews with HTS partner agency administrative staff. As with the focus groups, RDA will replicate these interviews in the outcome evaluation.

**Monthly Program Reports.** HTS staff completed monthly reports to the grantor sharing about completion of programmatic objectives. RDA utilized the narrative data from these reports to inform our findings.

# Appendix L. Qualitative Data Collection Protocols

## Interview Protocol for HTS Leadership Staff

Date	
Name	
Title	
Agency/Dept./Org.	
Interviewer	

Hello, my name is \_\_\_\_\_ and this is \_\_\_\_\_ from RDA Consulting.

Thank you for taking the time to talk with us. For this final cumulative evaluation of HTS, we are focusing on the implementation process and outcomes of HTS and collaborations with agency partners since we last spoke. The purpose of this interview is to get your perspective and insights on the program workflow, successes and challenges, client and program outcomes, as well as the extent and nature of HTS collaborations. Feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation should take approximately 45-60 minutes. As we are going through the interview, I will be typing notes, and I'll be recording so that we can use the automated transcript for additional records. Is it okay if I record this interview? We will be using the information from these interviews, as well as upcoming interviews and focus groups with other HTS program partners in this cumulative evaluation of HTS. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the program, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation. Do you have any questions before we begin?

### Introductions

- 1) How long have you been in your role at HTS?
- 2) Can you please describe your main role and responsibilities on the HTS Team?
- 3) Do you feel you understand the intention behind the HTS model? (Probe - briefly explain the HTS model?)

### Implementation

- 4) In what ways has the HTS model been implemented as intended?
  - a) To what extent is HTS currently facilitating Behavioral Health service access in the manner intended?
  - b) Is HTS serving the intended demographic?

- 5) In what ways, if any, has the HTS model *not* been implemented as intended? Why or why not?
  - a) Is there any component of the model that has not been implemented?
  - b) Were there any components added to the model that were not part of the original vision?
- 6) Has implementation of the HTS program varied across different geographies, populations, and/or services? If so, how and why?
  - a) To what extent has this changed over time?
  - b) Is there variance between who is being served in North and South County?
  - c) Are there notable differences as to how services are delivered in North and South County? Are different services offered from HTS in North and South County?
- 7) Thinking about the current workflow procedures of HTS, to what extent do you feel they are effective? To what extent has this changed over time? [Prompt: such as enrollment processes, data tracking, client service tracking, GPRA workflows]
  - a) Is program tracking through Activate Care happening as intended?
  - b) Is getting clients interviewed for GPRAs happening as intended?
  - c) What are some key successes and challenges to program workflows and procedures with HTS implementation?
- 8) To what extent are the available resources adequate to implement HTS as intended?
  - a) To what extent have resources changed over time? [Prompt: Has anything changed in terms of resource availability/adequacy? Any changes in housing/shelter opportunities, changes in staffing capacity?

### **Collaboration with Partners**

- 9) What does your collaboration with other partners and other agencies look like for HTS? How has it changed over time?
  - a) Which agencies/partners is HTS actively partnering/collaborating with?
  - b) How often do you have meetings with partners regarding your joint efforts?
  - c) What is the quality or strength of collaboration?
- 10) What are the main strengths of HTS partnerships?
  - a) How have any partnerships helped foster greater coordination of care for clients?
  - b) How does partnering specifically benefit clients?
  - c) Are there any areas that need additional collaboration or strengthened partnership to best meet client needs?

### **Impact**

- 11) Which methods, strategies, or practices are working to connect and serve clients in the HTS program?
  - a) What are the "key ingredients" contributing to these successes?

- 12) What impacts do you see HTS having...
- a) On client access to services?
  - b) On client outcomes? [Prompts: meeting basic needs, access to BH, wellbeing, daily functioning]
  - c) Within the community?
- 13) What improvements could be made to the program directly that would help support greater client outcomes?

**Other Considerations**

- 14) [If time allows] What else should we know about the implementation or outcomes of HTS that we haven't yet discussed? Is there anything else you would like to share?

Thank you!

## Focus Group Protocol for HTS Delivery Staff

Date	
FG Type/Size	
Location	
Facilitator	

Thanks for taking the time to join us today. My name is \_\_\_\_\_ and this is \_\_\_\_\_ from RDA Consulting. As you know, RDA has partnered with Santa Clara County to support the evaluation of the HTS program.

I will be facilitating our talk today and \_\_\_\_\_ will take notes, but we won't be attaching your names to anything that is said. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there is anything you don't want us to document. We respect your anonymity. Feel free to ask for clarification about any questions I ask or add information you believe is relevant. You are also welcome to put questions or comments in the chat, if you prefer.

For our cumulative evaluation, we are focusing on your experiences with the implementation process and outcomes of HTS since we last spoke. The purpose of this focus group is to understand each of your perspectives and insights on the program workflow, successes and challenges, collaborations with other agencies, program and client-related outcomes, and other thoughts you might have about how things are going with the program.

This conversation will take approximately 60 minutes. As we are going through the focus group, I will be typing notes. Additionally, we are hoping to record our conversation. We will use an automated transcript to support our written notes and make sure we do not miss anything important that was said today. Afterwards, we will delete the recording. Is it okay with you if we record this conversation? Does anyone have any questions before we begin?

### Introductions

- 1) To get started, I'd like to begin with introductions. Please share:
  - a) Your name
  - b) Your role
  - c) How long you have been working with the HTS program

### Roles & Responsibilities

- 2) Who does HTS serve [what demographics]?
- 3) What is HTS's role in serving clients?
  - a) [If another probe is needed: What services do you provide?]



- 4) In what ways have roles, responsibilities, and clients served changed over time, if at all?

### **Program Implementation**

- 5) In what ways has the HTS program and model been implemented as intended? [Prompt: Is HTS currently facilitating behavioral health service access in the manner intended?]
- 6) In what ways, if any, has the HTS model *not* been implemented as intended?  
a) Were there any components added to the model that were not part of the original vision?
- 7) How, if at all, has implementation of the HTS program varied across different geographies, populations, and/or services? [Probe to consider differences between north and south County]
- 8) [If time, and not already answered] To what extent are the current workflow procedures of HTS effective? [Prompt: such as enrollment processes, data tracking, client service tracking, GPRA workflows, Activate Care]
- 9) [If not already answered] To what extent are the available resources (including ongoing training for staff), adequate to implement HTS as intended?
- 10) In what ways has implementation of the HTS model changed over time, if at all?

### **Perceived Effectiveness and Impact of the Model**

- 11) Which methods, strategies, or practices are working to connect and serve clients in the HTS program? What are the “key ingredients” contributing to these successes?
- 12) What impacts do you see HTS having...  
a) On client access to services?  
b) On client outcomes? [Prompts: meeting basic needs, access to BH, wellbeing, daily functioning]  
c) Within the community?
- 13) In what ways has perceived effectiveness and impact of the HTS model changed over time, if at all?

### **Collaboration with Partners**

- 14) What does your collaboration with partners look like for HTS now? [Probe: Consider referral agencies as well] [Rephrasing of question, if needed: How do you work together with other providers to serve clients?]
- 15) What are the main strengths of HTS partnerships?  
a) How have any partnerships helped foster greater coordination of care for clients?

- 16) Are there any areas that need additional collaboration or strengthened partnership to best meet client needs?
- 17) In what ways has collaboration with partners changed over time, if at all? [Probe: nature and quality of collaborations]
- 18) [If Time Allows] What else should we know about the implementation or outcomes of HTS that we haven't yet discussed? Is there anything else you would like to share?

Thank you!

## Interview Protocol for HTS Partner Staff

Date	
Name	
Title	
Agency/Dept./Org.	
Telephone #	
Interviewer	

Hello, my name is \_\_\_\_\_ and this is \_\_\_\_\_ from RDA Consulting. Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called RDA Consulting and we are supporting Santa Cruz County's evaluation of the Healing the Streets Program.

(If a repeat interviewee: You may recall speaking with us previously as a component of our process evaluation of Healing the Streets). The purpose of this conversation is to hear from you, as someone who partners with Healing the Streets in some capacity to serve individuals experiencing homelessness who may also have serious mental illness and or co-occurring disorders. The purpose of this interview is to get your perspective and insights on HTS successes and challenges, as well as the extent and nature of HTS collaborations, particularly if there have been significant changes since we last spoke. Feel free to ask for clarification about any questions I ask, or to add information you believe is relevant.

This conversation should take approximately 45 minutes with the potential to take up to 60 minutes. As we are going through the interview, I will be typing notes. Additionally, we are hoping to record our conversation. We will use the automated transcript to support our written notes and make sure we did not miss anything important that was said today. Afterwards, we will delete the recording. Is it okay with you if we record this conversation?

We will be using the information from these interviews and other data collection efforts to inform an evaluation of HTS. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the program, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any comments you would like removed. Do you have any questions before we begin?

### Introductions

- 1) To begin, please share your name, job title, and agency/organization you work for, as well as how long you have worked in your current position. [Confirm if not already known]
  - a) Name:
  - b) Title:

- c) Agency:
- d) Length of employment:

- 2) What is your role or your organization/agency's role in working with the Healing the Streets program? [prompt: What types of services do you provide?]

### **Program Implementation**

- 3) Since we last spoke, do you feel you have a better understanding of the services HTS offers? *(Prompt: Can you describe the services you have seen HTS offer?)*
  - a) What role does HTS fill in the service landscape? Is this role clear?
  - b) Is there a population you believe HTS is most equipped to serve? *(Probe: SMI, SUD, homeless, co-occurring, etc.)*
- 4) What is your perception of the effectiveness of HTS programming?
  - a) Can you identify/describe any effective methods, strategies, or practices HTS staff use to serve clients?
- 5) *[Only ask Housing for Health and HPHP]* To what extent are the current resources enough to implement HTS as intended? Why?
- 6) Have you seen/heard of any challenges (new or ongoing) that the HTS program has encountered in implementing their program?
  - a) <prompt> What, if any, services did you expect HTS to provide that they do not

### **Collaboration with HTS**

- 7) Could you describe the nature and quality of your organization/agency's partnership with HTS?
  - a) How does your organization collaborate with HTS?
  - b) Do you have a process for HTS staff to refer clients to your organization/agency for services? If yes, how would you characterize this referral process (e.g., formal or informal)?
  - c) How often do you have meetings with the HTS team regarding your joint efforts in supporting the population of individuals your programs serve?
  - d) Since we last spoke, you identified your relationship with HTS as \_\_\_\_\_. [pull from transcript]. Has your relationship changed? *(Probe: weak, growing, or strong relationship with HTS?)*
- 8) Now, thinking about the HTS program within the broader scope of services offered throughout the County, how has HTS contributed to greater service integration among providers (e.g., care coordination, non-duplication of services, gap filling, etc.)?
  - a) If HTS has not provided greater integration of services, are there challenges inhibiting integration of services to support clients (e.g., adequate resources, sufficient staffing)?

9) What are some examples of collaborative successes that your agency/organization has experienced thus far with HTS?

10) Where do you see room for improvement in collaborating with HTS?

**Closing**

11) Do you have any recommendations for how HTS can best serve clients experiencing homelessness with SMI/ SUD in North and South County?

12) [If time Allows] In closing, is there anything else you would like to share regarding HTS?

Thank you!

## Focus Group Protocol for HTS Partner Staff

Date	
Name(s)	
Agency/Department	
Interviewer	

Hello, my name is \_\_\_\_\_ and this is \_\_\_\_\_ from RDA Consulting. Thank you for taking the time to talk with ME/US. I/WE work for a consulting firm called RDA Consulting and we are supporting Santa Cruz County's evaluation of the Healing the Streets Program.

(If previously interviewed: You may recall speaking with us previously as a component of our process evaluation of Healing the Streets). The purpose of this conversation is to hear from you, as someone who partners with Healing the Streets in some capacity to serve individuals experiencing homelessness who may also have serious mental illness and or co-occurring disorders. The purpose of this focus group is to get your perspective and insights on HTS successes and challenges, as well as the extent and nature of HTS collaborations, particularly if there have been significant changes since we last spoke. Feel free to ask for clarification about any questions I ask or add information you believe is relevant. You are also welcome to put questions or comments in the chat, if you prefer.

This conversation will take approximately 60 minutes. As we are going through the focus group, I will be typing notes. Additionally, we are hoping to record our conversation. We will use the automated transcript to support our written notes and make sure we did not miss anything important that was said today. Afterwards, we will delete the recording. Is it okay with you if we record this conversation?

We will be using the information from these interviews and other data collection efforts to inform an evaluation of HTS. While your name will not be attached to the answers you provide in the interview, because of your affiliation in the program, it may be possible to identify you as the source of certain information. We hope you will feel comfortable sharing candidly about your experiences, but please let me know if there are any comments you would like removed. Do you have any questions before we begin?

### Introduction

- 1) To begin, please share your name, job title, and agency/organization you work for, as well as how long you have worked in your current position. [Confirm if not already known]
  - a) Name:
  - b) Title:
  - c) Agency:
  - d) Length of employment:

### Program Implementation

- 2) Since we last spoke, to what extent do you have a better understanding of the services HTS offers? *(Prompt: Can you describe the services you have seen HTS offer?)*
  - a) Is there a population you believe HTS is most equipped to serve? *(Probe: SMI, SUD, homeless, co-occurring, etc.)*
- 3) In what ways is HTS programming effective?
  - a) Can you identify/describe any effective methods, strategies, or practices HTS staff use to serve clients?
  - b) What impact, if any, have you seen for clients served by HTS?

### **Collaboration with HTS**

- 4) Could you describe the nature and quality of your organization/agency's partnership with HTS?
  - a) How do you collaborate with HTS?
  - b) How would you describe the process for you/your organization to make referrals to HTS? *<prompt: clear, confusing, seamless, complex>*
  - c) How would you describe the process for HTS staff to make referrals to your organization's services? *<prompt: clear, confusing, seamless, complex>*
  - d) How often do you have meetings with the HTS team regarding your joint efforts in supporting the population of individuals your programs serve?
  - e) Since we last spoke, has your relationship with HTS changed or remained the same? *(Probe: weak, growing, or strong relationship with HTS?)*
- 5) In what ways, if any, has partnering with HTS contributed to clients receiving better quality of care, seamless service delivery, additional services, etc.?
- 6) [If time allows] What are some examples of collaborative successes that your agency/organization has experienced thus far with HTS?
- 7) Where do you see room for improvement in collaborating with HTS?
- 8) [If time allows] What do you like best about partnering with HTS?

### **Closing**

- 9) Do you have any recommendations to improve the Healing the Streets program moving forward? *< Prompt: How can HTS improve services for clients who have SMI/SUD and are experiencing homelessness?>*
- 10) In closing, is there anything else you would like to share regarding HTS?

Thank you!



## Interview Protocol for HTS Clients

Date	
Location	(North or South County)
Interviewer	
Interviewee	

### Confirmation of Participation

Please confirm that you participated in HTS and met with a Case Manager: *(interviewer note, make sure they know what HTS is and that their case manager was an HTS case manager).*

Are you a current (have worked with your case manager in the past 2 months) or a former client?

### Introduction

Language check in: English or Spanish?

Thanks for taking the time to speak with me today. My name is Hector Borjas and I'm helping Healing the Streets learn from their clients and former clients. I work for RDA Consulting and we are excited to interview you and understand your experience and feedback on the Healing The Streets Program.

In this 30 minute interview, I'll ask you questions about your experiences and will type your answers. Your answers will be part of a report we are creating about Healing the Streets and how it is serving you and others who are experiencing homelessness.

Your name will not be associated with anything you say in the report we create. I hope you feel comfortable sharing your experiences, but please let me know if there is anything you don't want me to write down or maybe you want me to delete something you said as our conversation goes on. We respect your privacy.

This is your opportunity to make your voice heard about what is working well, what isn't working well, and what you feel is needed in the Healing the Streets Program. And remember, there are no "wrong" or "right" answers.

You will receive a \$20 Visa gift card as gratitude for your participation.

If there are any questions that you do not want to answer, just let me know and we can skip. Regardless of what you say during our conversation, you will receive a gift card for your participation. Do you have any questions before we begin?

### Introduction

- 1) To get started, would you mind sharing your name and how long have you participated in Healing the Streets?
- 2) Do you stay in North or South County?
- 3) How did you find out about the program?
  - a) <PROMPT: were you referred by another provider?>

## Program Experience

- 4) Which services did you receive through Healing the Streets?
  - a) <PROMPT: support with application for social security, mental health or substance uses services, housing or shelter resources>
- 5) Did HTS staff refer you to any other service providers to support your needs?
  - a) What type of services?
  - b) What were the names of the service providers?
    - i) <PROMPT: Examples of organizations might be Downtown Outreach or Salvation Army. Examples of services include rental assistance, overnight shelter, etc.>
- 6) On average, how often do you/ did you receive services from your Case Manager at HTS? (e.g., approximately once every two months, once per month, twice per month, etc.)
- 7) How did you feel treated by HTS staff?
  - a) <PROBE: For example, maybe you felt listened to and respected, or maybe you felt like you were not heard because you were offered services that did not fit your needs.>
- 8) How would you rate your overall satisfaction with the HTS program on a scale of 1 to 5 where 5 = very satisfied and 1 = very unsatisfied?
  - a) Why did you choose "[number]"?
- 9) If you no longer receive services from HTS, what was the process like for ending those services?

## Outcomes/Impact

- 10) What, if any, goals did you accomplish as a result of working with your Healing the Streets case manager? <Prompt: Examples of goals include enrolling in benefits, finding housing, reconnecting with family...>
- 11) Would you say you think you are better off, worse off, or the same as a result of participating in Healing the Streets?
- 12) Which changes, if any, did you notice in your physical health as a result of participating in Healing the Streets?
- 13) Which changes, if any, did you notice in your mental health as a result of participating in Healing the Streets?
- 14) Which changes, if any, did you notice in your housing stability as a result of participating in Healing the Streets?
  - a) <Probe: Did HTS staff help connect you to people who assisted you with housing (even if you are still in a temporary setting currently)?>

15) Which changes, if any, did you notice in how connected you feel to other people as a result of participating in Healing the Streets?

16) Are there any other changes or benefits to you and your overall quality of life that you associate with participation in Healing the Streets?

**Recommendations**

17) In what ways do you think the Healing the Streets program could do better or be more helpful?

**Closing**

18) In closing, is there anything else you would like to share about your experience with Healing the Streets?

Thank you!

## Case Study Interview Protocol for HTS Delivery Staff

Date	
RDA Staff	
Interviewee	

Hello, my name is \_\_\_\_\_. Thank you so much for taking the time to talk with me today. I work for RDA Consulting, and we are collaborating with the Santa Cruz County Human Services Agency to evaluate the Healing the Streets program.

The purpose of today's conversation is to generate a "case study," or in-depth story about one of your clients. We would like to understand a typical client journey through the HTS program. We will be including these stories as part of our final cumulative evaluation report. Names and key identifying information will be changed for confidentiality.

We are interested in hearing about a typical client—one whose journey in the program has ups and downs. We hope you will feel comfortable sharing candidly about your client's experience, but please let us know if there were any sensitive comments that you would like us to be especially careful about when writing up the summary of the conversation. As a reminder, this interview will be about 45 minutes long. Do you have any questions for me before we begin?

### Introductions

Let's start with introductions.

- 1) What is your name and your role?

### Client Entry

Tell me a little bit about your client.

- 2) What is their background or "story"?
- 3) How did this client come to be part of the HTS program?
  - a) When did you begin working with this client?
- 4) What specific needs did this client have upon entry into the HTS program?
  - a) *Prompt: housing, mental health, substance use, benefits enrollment*

### Client Service Utilization

- 5) What services did the client engage in as part of their enrollment in HTS?
  - a) *Prompt: care coordination, housing advocacy, benefits enrollment, transportation, referrals, mental health and social support*
  - b) How did they become connected to each service? (e.g., case manager referral to external agency, HTS clinician provided the service directly)

- 6) What successes did this client experience during their enrollment in HTS (if any)?
  - a) How well did this client adhere to/engage with services/treatment (e.g., appointment attendance)?
  - b) Which services (if any) seemed to be the most engaging for this client?
  - c) Did they get connected to housing or other long-term services? Which services?
- 7) What barriers or setbacks did this client experience during their enrollment in HTS (if any)?
  - a) How did they overcome them (if applicable)?

### **Client Experience and Outcomes**

- 8) What is your impression of this client's overall experience in the HTS program?
  - a) What feedback have they shared (if any)?
- 9) How have you seen this client benefit from the services they received through HTS? Please provide specific examples.
  - a) What changes have you seen in this client (if any)?
  - b) To what extent do you see these changes as connected to the services they received as part of HTS? Please explain.

### **Conclusion**

- 10) Is there anything else you'd like to share about this client that we haven't asked you about?

Thank you!

# Appendix M. PDSA Cycle 1 Report

## Santa Cruz County Healing the Streets (HTS)

### PDSA Cycle 1: May 17 - July 30, 2022

#### Final Summary Report | August 2022

HTS staff participated in a two and a half month PDSA CQI cycle facilitated by RDA. This collaborative effort is in place to inform how to rapidly iterate and improve on programming to create greater impact. This process uses data to inform program enhancements. Two “practices” were identified and enacted through this PDSA Cycle 1. The first was to address the challenge of determining eligibility and defining who the program serves. The second practice was to implement a new data platform called Activate Care for greatest data capture, coordination of care, and impact tracking.

**Step 1: PLAN** (Identify action steps to carry out the Change)

**Step 2: DO** (Implement the Change)

#### Practice 1: Defining and Improving our Screening Process and Eligibility Criteria for HTS Clients (Screening and Eligibility)

Action Steps	Who “Change Teams”	Timeline	Progress Status
Better define the target population	Shelly, Lindsey, Julia	June 30	Complete
Define screening process and capture it in case notes/outreach documentation	Karen, Patrice, Sierra, Shelly, Kayla; RDA	July 15	In Progress- (Screening process defined. Observation of SMI/ SUD not yet included in Activate Care)
Mapping (flow chart) what services people who are engaged via outreach but do not do intake, people who do intake and are not eligible, and people who do intake and are eligible.	Sierra, Shelly, Lindsey	July 15	In Progress (This has been discussed but there is not a formal document)
Create a simple script or role play new workflow and screening language	HTS leadership +	July 15	Complete

	direct service staff; Ali, Carl		
Enact the newly defined processes around intake.	All direct service staff	July 22	In Progress (script & eligibility criteria being used - workflow and documentation not in use)
Improve the referral form to improve clarity of eligibility	HTS leadership + RDA	July 22	Complete

#### What do we expect focusing on this practice to result in?

- Getting clarity on target population and enrolling eligible clients.
- Diminished stress for staff.
- Serving clients that HTS has the resources for.

#### What does progress towards this change look like?

- Observe the number of clients engaged and enrolled that meet the target population.
- Use NOMs data to fact check eligibility and serve as a baseline to continue assessing eligibility "accuracy" over time.
- Observe the number of outreaches, enrollments, and those found to be ineligible.



### Check in Points for Practice 1: How will the change team check in, how often?

- Bi-weekly check ins on PDSA “Do” phase at Huddle
- HTS leadership to meet shortly for the documentation piece
- Change teams meet in early June and again in late June

### Practice 2: Implementing Activate Care Intake and Output (Activate Care Adoption)

Action steps	Who “Change Teams”	Timeline	Progress Status
1. Get all shadow files (paper files) into Activate Care	All HTS direct service staff	July 1	In Progress (most shadow files moved, not all)
2. Improving intake data: Documenting any issues, bugs, data fields that do not feel useful or correct, adding missing components, reviewing data accuracy	HTS	Monthly forever	In Progress (This is currently happening and will be ongoing)
3. Further refining what data/ knowledge we can gain from Activate Care - do a demo with SCHIO	RDA & HTS leadership	Monthly through PDSA Cycle 1	In Progress (Refinement is currently occurring and we are scheduling a demo)
4. Make sure activate care NOMs workflow triggers correctly (test that field with 6-month date is being populated, look at client from every sing case manager to make sure workflow is triggered)	Kayla, Shelly, Julia (RDA & HTS)	June 30	Complete

5. Determining what data we can use to answer our evaluation questions & regularly check into program metrics "dashboard"	RDA	June 30	In Progress (The dashboard is a living process to communicate data regularly and will be iterated on)
6. Create a poll for staff to share about Activate Care experience	Taylor (RDA)	July 22	Complete
7. Build Activate Care report that crosswalks to SAMHSA Infrastructure Development, Prevention and Mental Health Promotion (IPP) data	Shelly, Patrice, Julia, Alison (RDA & HTS)	July 15	In Progress (Conversations have been had about this but there is not a crosswalk built)

#### What do we expect focusing on this practice to result in?

- Efficiency for field-based care; use of tablets and minimal paper.
- Ease of communication and collaboration.
- Good enrollment and accurate data collection.
- Producing a smooth process for NOMs reassessments.

#### What does progress towards this change look like?

- Adoption of Activate Care platform and transferring all shadow files into the system.
- Ability to better serve clients, document their progress, needs, and goal attainment.
- Activate Care ease of use for staff in the field; not cumbersome.
- Transparency across the team about successes.
- Greater enrollment numbers due to a smooth and clear process.

### Check in Points for Practice 2: How will the change team check in, how often?

- Check in about Activate Care every other week in the huddle
- HTS leadership will have monthly check-ins about data quality and any changes needed to Activate Care.
- RDA and HTS leadership have Activate Care as a standing agenda item in monthly meetings
- Shelly, Patrice, Julia & Alison meet in June to crosswalk SAMHSA IPP to Activate Care data.

### **Step 3: STUDY - Examine the Change**

#### **Practice 1: Screening & Eligibility**

#### **Practice 2: Activate Care Adoption**

<b>Data Sources Studied for Practices 1 &amp; 2</b>	<b>Information Gathered from Data Sources</b>
<b><i>Monthly meeting and PDSA check-in notes</i></b>	Progress/status for each action step
	Staff experiences/feedback on processes
<b><i>SPARS (SAMHSA's reporting system)</i></b>	Number of NOMs/GPRA interviews completed
	Eligibility indicators of enrolled participants
<b><i>RDA's Activate Care Survey</i></b>	Staff experiences/feedback on Activate Care

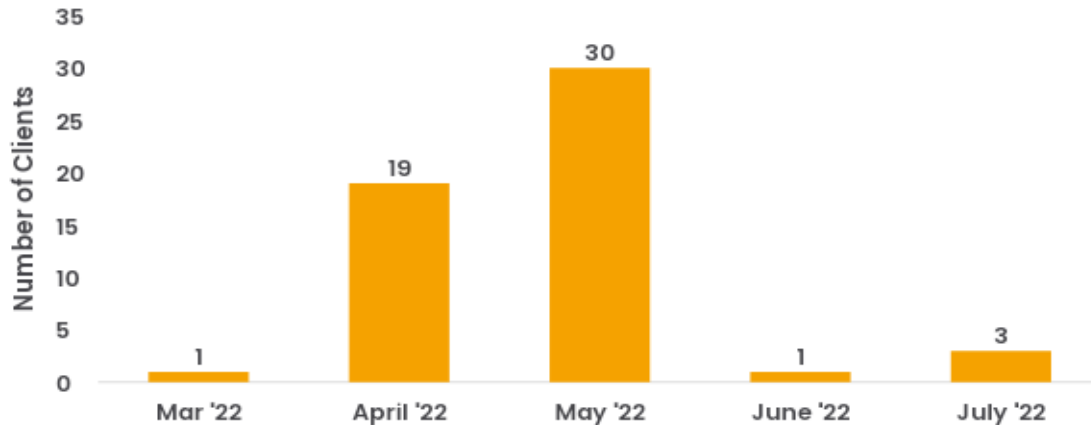
### Practice 1: Action Steps Completed

- ☒ Clarified the target population, and updated the website and referral form
- ☒ Developed outreach script as a guide for engaging potential participants
- ☒ Defined the process for screening potential participants

### Practice 1: Themes and Learnings

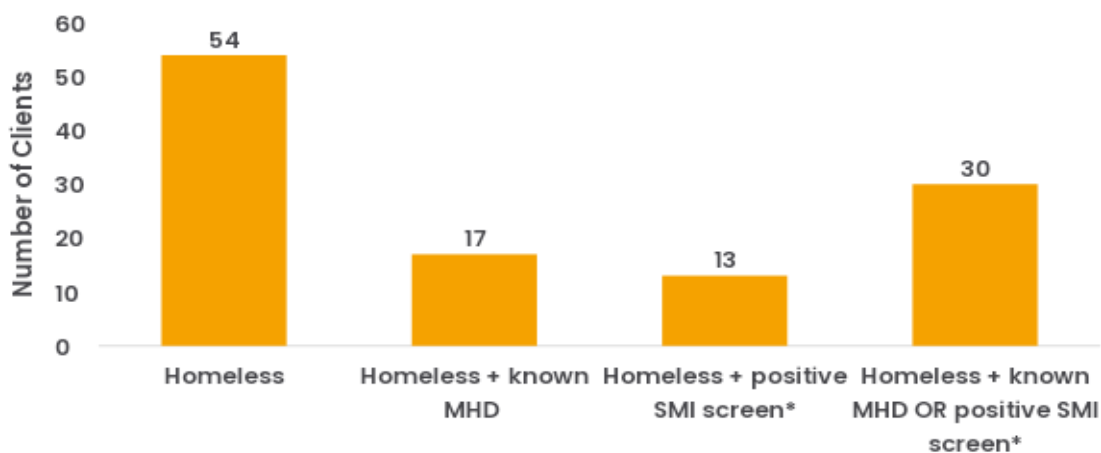
- The outreach script helps guide the engagement approach and is useful for orienting new staff.
- The team uses careful observation and relationship-building as primary mechanisms for screening (versus a formal tool).
- The team offers supplies and referrals to individuals who may not qualify for/desire HTS enrollment.
- Between **March 29 and July 6, 2022**, a total of 54 clients received baseline NOMs interviews, with over half conducted in the month of May (see Figure 8 below).

**Figure 8. NOMs Interviews Completed Monthly**



- When the project got its start in late March, the team coalesced and put together a workflow to do warm handoffs to RDA to provide NOMs interviews. This activity ramped up in April and May. Then with 50 new high need clients, case managers were busy and not sure how to prioritize bringing on new clients vs. tending to their new caseloads. This accounts for a large drop off in NOMs baseline interviews.
- Many of the clients with completed baseline NOMs interviews possessed the eligibility criteria for HTS, including 55% (30) of clients who experienced homelessness and had a known mental health diagnosis (MHD) OR screened positive for potential SMI (see Figure 9 below).

**Figure 9. Eligibility Characteristics Among HTS Participants (N=54)**



\*The NOMs interview includes the validated Kessler-6 (K-6) Psychological Distress scale (under section B. Functioning, items 4A-F). A positive screen for serious mental illness (SMI) on the K-6 tool is a score falling between 13-24. Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3370145/#:~:text=Kessler%20K6,-The%20K6%20asked&text=Responses%20to%20the%20six%20items,greater%20tendency%20towards%20mental%20illness>

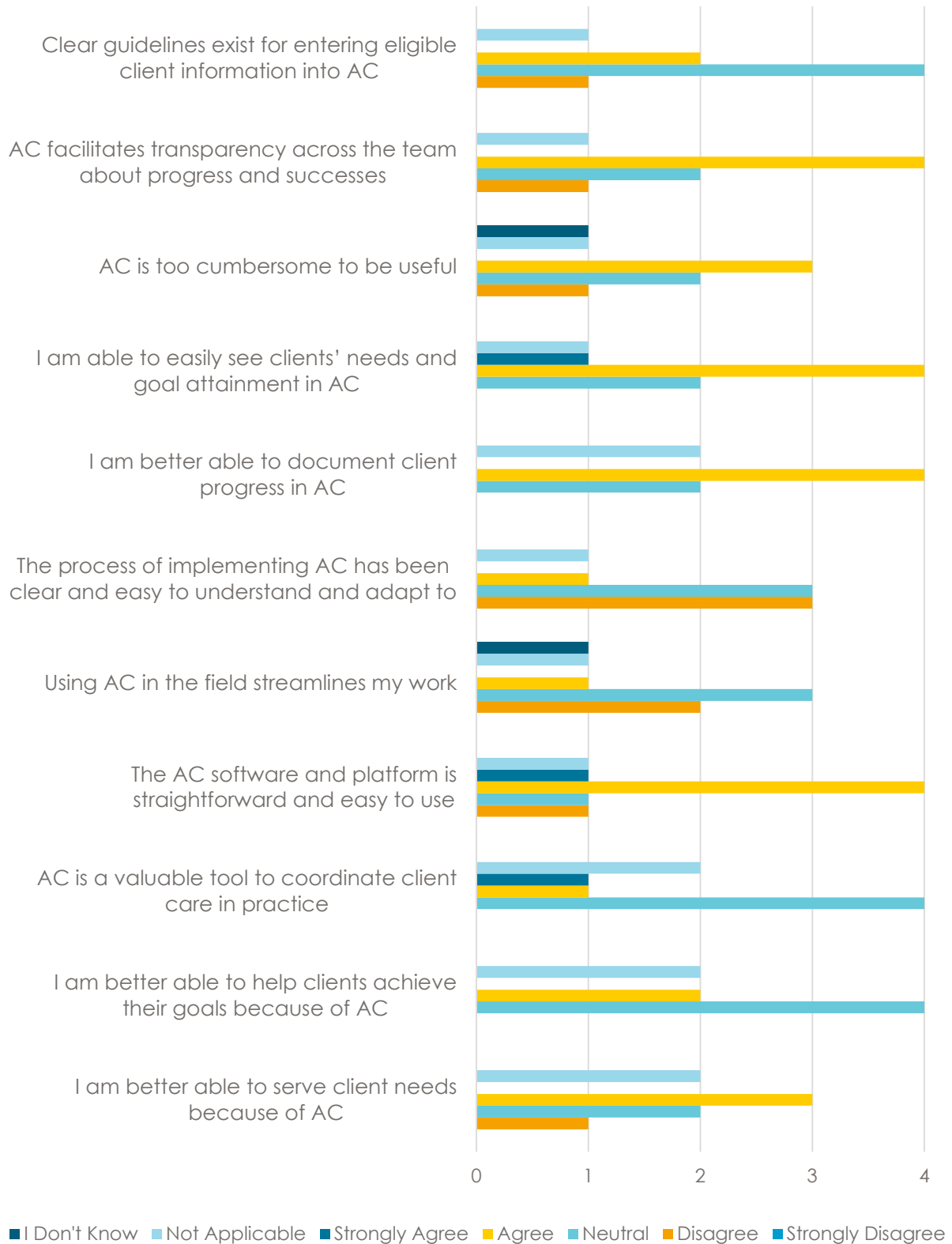
## Practice 2: Action Steps Completed

- ☒ 49 client shadow files have been entered into Activate Care.
- ☒ Initial tests of the NOMs reassessment reminders suggest they are functioning.
- ☒ Eight HTS staff provided thoughtful insight on their experiences with Activate Care thus far.

## Practice 2: Themes and Learnings from the Activate Care Survey

- Staff experienced several successes thus far with Activate Care:
  - Ability to view clients and track their data in the system
  - Ability to access client workflow, plans, and track progress
  - Seven out of eight staff received training on Activate Care
  - Understanding of what is expected when using Activate Care
- Staff also experienced several challenges thus far with Activate Care:
  - Existing learning curve associated with the transition to the system
  - Unclear and/or difficult implementation process
  - Cumbersome system requirements negate usefulness
  - Ongoing technical difficulties and frustrations with reporting requirements
- Staff largely held neutral views about Activate Care as a valuable tool, but most indicated that it is straightforward or easy to use.
- Staff expressed disagreement or neutral views about Activate Care streamlining their work and being clear and easy to adapt to. However, most staff agreed that they can document client progress and view client needs and goals in the system.
- Although Activate Care largely facilitates transparency across the team, staff held neutral views about the existence of clear guidance for entering eligible client information into the system

**Figure 10. Active Care Survey Responses (N=8)**





- Staff provided the following recommendations for improving the use of Activate Care:
  - Clarify guidelines for entering eligible client information into the system
  - Provide routine training (e.g., written instructions, reference guide)
  - Improve user functionality (e.g., identify and eliminate elements that are non-essential or excessive to improve workflow, sustainability)
- The HTS team continues to work on building out Activate Care fields for both practical and evaluative use.
- The SCHIO team has provided multiple training sessions to HTS and RDA staff to better understand Activate Care capabilities.

#### **Step 4: ACT - Adapt, Adopt, or Abandon the Change**

##### **Practice 1: Screening & Eligibility**

##### **Practice 2: Activate Care Adoption**

#### **Practice 1 ACT Decision: Adapt**

- Clarify client assignment to case managers based on (1) current case manager caseload size, and (2) client level of need, to avoid overloading case managers with many high need clients.
- Clarify the protocol for responding to referrals that are ineligible or are not a good fit for HTS (e.g., review client needs, respond with referral to outside services).
- Clarify the protocol for responding to clients that are eligible for HTS but already connected to other services.
- Clarify the protocol for responding to clients that accept HTS services but decline the NOMs interview.
- Clarify the NOMs workflow process (e.g., when and how to engage Hector).

### Practice 2 ACT Decision: Adapt

- Continue to improve clarity and implementation processes for the team surrounding Activate Care and determine what data fields have been built into the system to date.
- Work to redefine the Activate Care workflow to determine who does what, in part to decrease the data entry onus on case managers.
- Determine how to build NOMs items as discrete fields into Activate Care, given the upcoming NOMs revision from SAMHSA taking place next year.

### Remaining Questions to Study

- What is the eligibility “accuracy” of incoming referrals?
- Are changes in the screening process associated with changes in eligibility “accuracy” of enrollments?
- Does Activate Care create improved data management (e.g., understanding, client goal attainment)?

# Appendix N. PDSA Cycle 2 Report

## Santa Cruz County Healing the Streets (HTS)

### PDSA Cycle 2: August 30 - November 30, 2022

#### Final Summary Report | November 2022

Healing The Streets staff participated in the second Plan, Do, Study, Act (PDSA) continuous quality improvement cycle facilitated by RDA Consulting. This cycle was a three-month collaborative effort that rapidly iterated and improved programming in an effort to increase program process and impact. The PDSA process uses data to inform the potential impact of tested program changes or enhancements. The team first identified a programmatic challenge related to a lack of clarity in staff caseload sizes. The team then worked to develop a “change practice” (i.e., solution to the problem), resulting in the creation of a formal client disenrollment process that the team subsequently implemented. RDA and HTS staff studied the results of enacting this disenrollment process, and the HTS team ultimately decided to adopt and adapt this change practice.

#### **Step 1: PLAN** - Identify action steps to carry out the change

##### **Objective:**

- Clarify and streamline the process of formally disenrolling clients with whom we've lost contact.
- Create a workflow of how to notate and actively disenroll people from our systems and caseloads.

##### **Define the problem we are solving:**

Case managers are finding it difficult to know how many clients are actively on their caseloads. There is not a process for disenrolling people who are inactive or that cannot be located.

##### **Which evaluation question or questions does this correlate to?**

**Evaluation Question 1:** In what ways is the HTS model (specifically, Critical Time Intervention [CTI]) effectively meeting the needs of clients experiencing homelessness with mental health and possible co-occurring substance use disorders?

- The CTI framework is based on a small, time-limited caseload; therefore staff need a clear understanding of who is on their caseload and who has

transitioned off of their caseload to effectively use CTI.

**Evaluation Question 3:** Is HTS improving outcomes for individuals experiencing homelessness with mental health and possible co-occurring substance use disorders?

- Understanding who is active on a case manager's caseload will presumably allow case managers to focus attention on new and active clients.

### Change Practice: How we intend to solve the problem?

Enact a process to disenroll clients who are no longer engaged from the HTS program. This is the solution, or change practice, which will be tested in this PDSA cycle.

PLAN Action Steps:	Who	Timeline	Progress Status
1. Review, Edit, and Confirm this PLAN	HTS Staff	9/21/22	Complete
2. Defining: what qualifies as disengagement? (e.g., X amount of outreach attempts; a formal declination such as, "no I do not want services"; X amount of time)	HTS Staff	10/1/22	Complete
3. Look up the SAMHSA standard and work on discharge NOMS workflow	RDA	9/21/22	Complete
4. Create a workflow with standards around discharge processes and steps to discharge a client from a caseload a. Activate Care (AC) Discharge b. SPARS Discharge	HTS Leadership + RDA	10/15/22 (delayed)	Complete
5. Train staff in using the "status" function in AC- disenrolled	HTS Staff	9/14/22	Complete

### Anticipated Outcomes: What do we expect focusing on this practice will result in?

- Clearer caseloads
- Better understanding of who is on case manager caseloads

- Less stress and greater awareness of workload
- Greater efficiency

#### **Data: What data will help us understand if the change is working?**

- List of how many people were disenrolled in Activate Care (quantitative)
- Discharges in SPARS (quantitative)
- Case Manager Survey measuring case manager perceptions on the disenrollment process, knowledge and clarity of caseload size, and disenrollment practices (qualitative)

#### **Check in points: How will the change team check in, and how often?**

- Monthly PDSA check-ins
- HTS staff may use RDA's Google Form to share thoughts/feedback at any time
- Use this shared tracker to update status of activities

### **Step 2: DO - Implement the Change**

#### **Action Steps Completed**

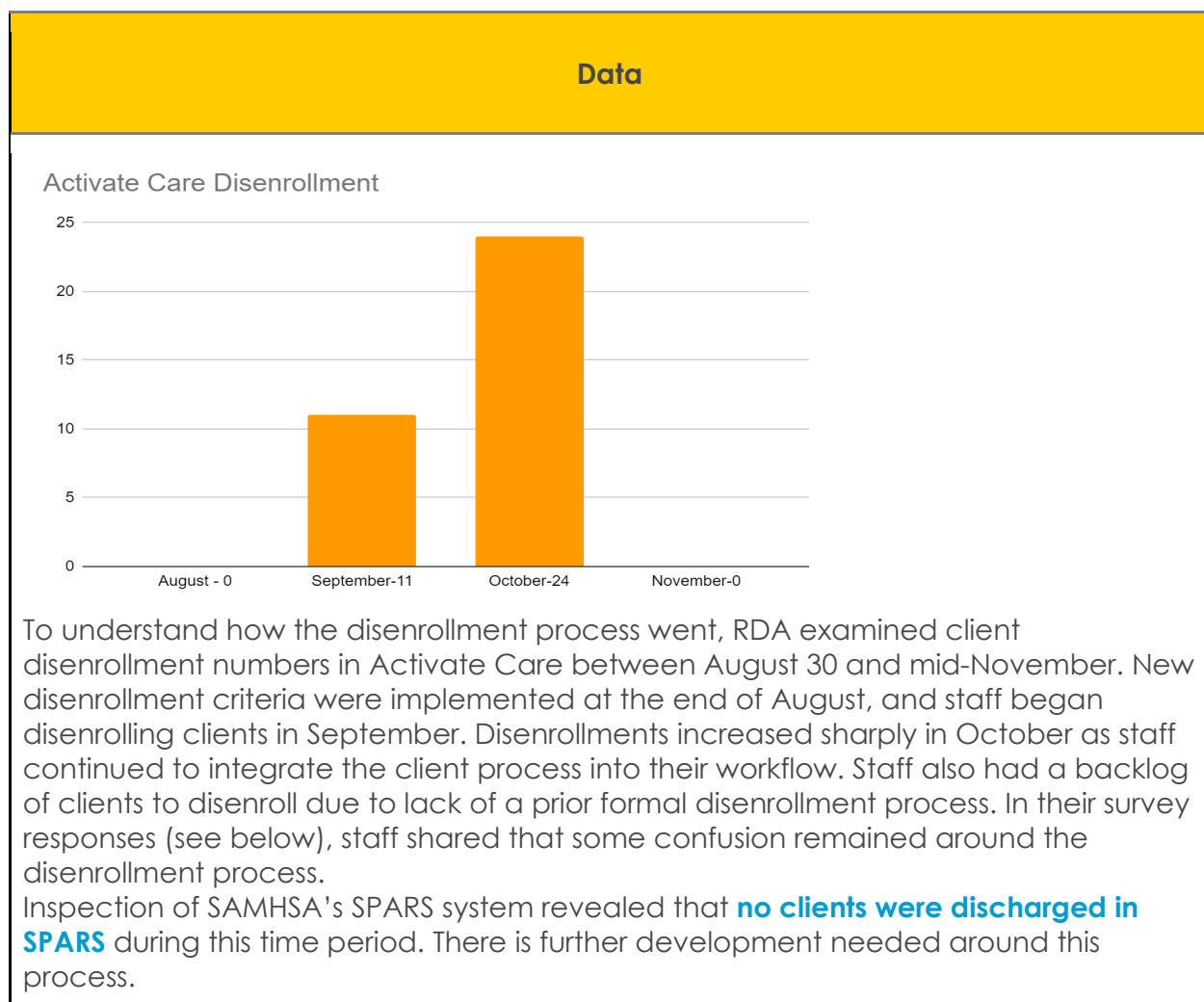
- ☒ Created criteria for disenrollment.
- ☒ Learned SAMHSA SPARS requirements for client discharge.
- ☒ Created a new workflow for Activate Care disenrollment and SPARS Discharge.
- ☒ Bonus: Created a "Section K" workflow for documenting services received by clients for SPARS.
- ☒ Disenrollments from Activate Care.

#### **Incomplete Action Steps**

- ☐ The SPARS discharge process was not enacted.

### Step 3: STUDY - Examine the Change

Data Source	Information Gathered
<i>Activate Care</i>	# of Disenrollments
<b>SPARS</b> (SAMHSA's reporting system)	Number of Discharges
<i>Staff Survey</i>	Participation and experience with disenrollment. Experience of caseload clarity.

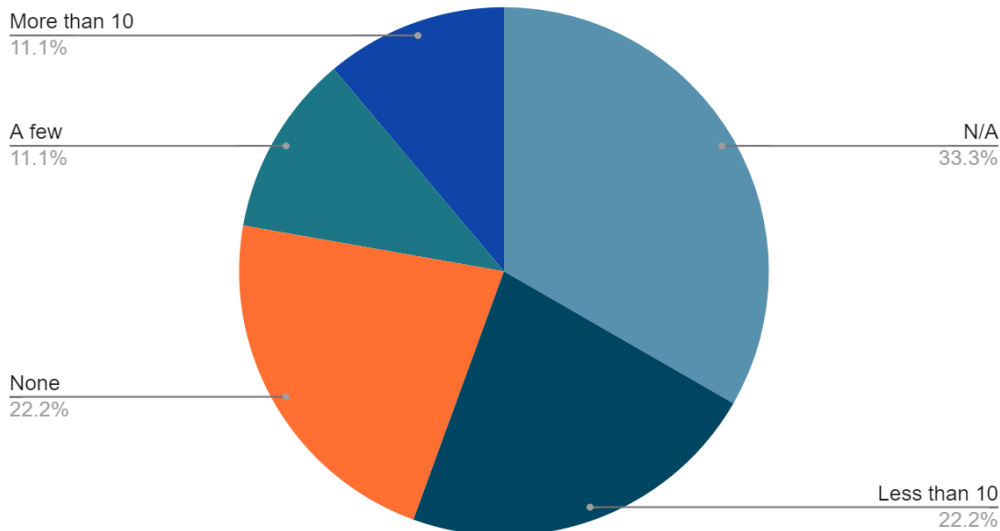


## STAFF SURVEY

RDA conducted a survey of HTS staff as a means of measuring progress on caseload clarity.

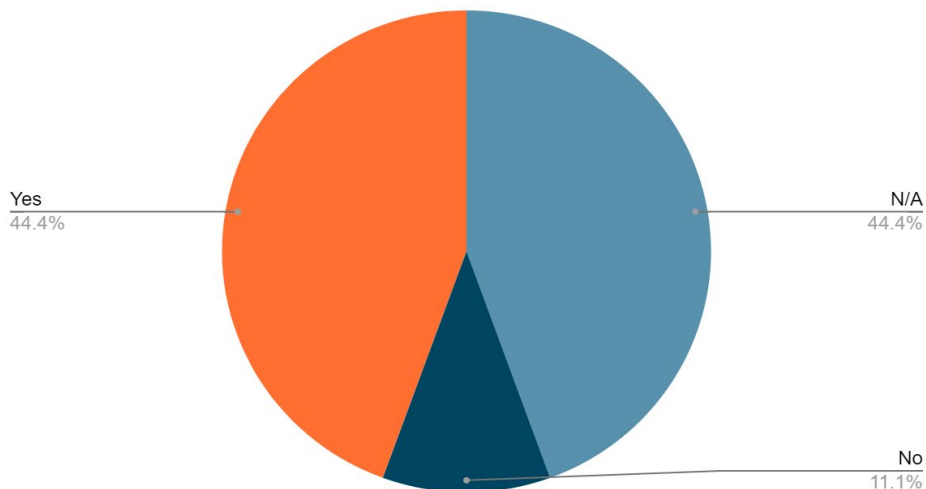
### Quantitative Survey Results

How many people have you disenrolled from Activate Care?



**Four out of six staff tasked with client disenrollment had disenrolled clients from Activate Care.** Showing that the new disenrollment workflow had been adopted by a portion of the staff. Two staff had not yet disenrolled clients. Those that hadn't yet disenrolled clients expressed a need for further clarity regarding the criteria and process for doing so.

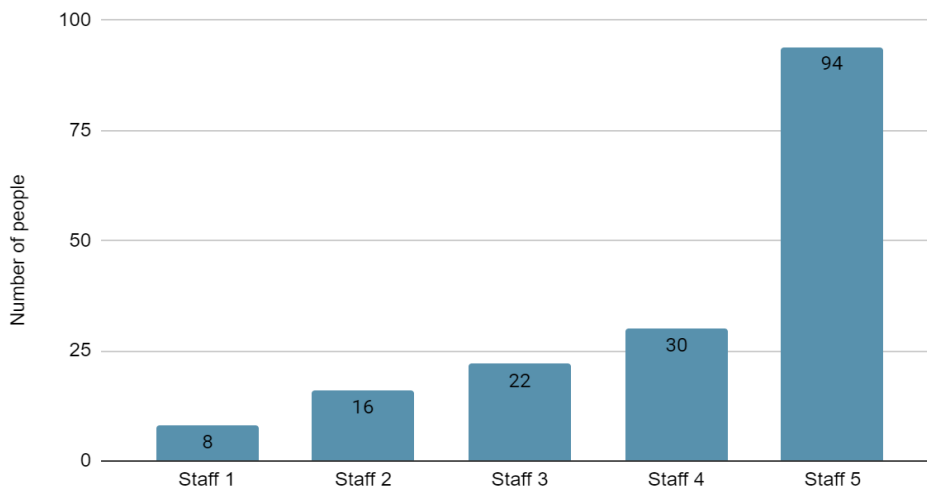
Do you know how many people are on your caseload?





Before the start of the PDSA cycle, case managers did not have clarity on how many clients were actively on their caseload. Upon measuring the impact of this PDSA Cycle 3 on case manager's caseload clarity, **four case managers had clarity about their caseload size, one did not**, and the item was not applicable to four administrative staff members. This marks an increase in clarity of active caseload size with a continued need to train staff and refine the process.

How many people are currently on your caseload?



This survey revealed that **case managers oversee caseloads of varying sizes, displaying that the distribution of service provision is unequal among case managers.**

### Qualitative Staff Survey Results

1. What would better help you know your caseload size?
  - Periodic updates pulled from Activate Care
  - An update on Activate Care to distinguish active clients from inactive/disenrolled clients
  - A private spreadsheet
  - A monthly list
  - I keep track of my own clients to ensure I am tracking everyone with ROIs and people that are missing the NOMS.
2. What would improve the process for disenrolling inactive clients?
  - Activate Care updates
  - Concise written instruction

#### **Step 4: ACT** - Adapt, Adopt, or Abandon the Change

##### **ACT Decision: Adapt**

- Criteria for disenrollment - **Adopt**
  - Adopt: The team decided to adopt the disenrollment criteria determined in this PDSA cycle.
- Activate Care (AC) disenrollment process- **Adapt**
  - Adapt: The team generally adopted this idea with the addition of another step in Activate Care to better display active caseloads.
  - Adapt: There is a need for further documentation of processes. Updates to Activate Care disenrollment need to be documented (as disenrolled clients were still appearing in case manager's caseloads).
  - Adapt: Staff will continue to refine the process for tracking outreach attempts for disengaged clients in Activate Care.
- SPARS discharge process - **Adapt**
  - Adapt: Further structure and training is needed to embed a discharge process into the weekly huddles in order to collect the needed data for SPARS. HTS leadership/administrative staff need to refine a process for maintaining the "Section K" spreadsheet data (i.e., client services received) needed to discharge clients from SPARS.
- Overall disenrollment process - **Adapt**
  - Adapt: Staff agreed with the overall disenrollment process. There is room to improve the process, such as creating an easily accessible document with clear criteria and action steps for disenrolling.

## Appendix O. PDSA Cycle 3 Report

### Santa Cruz County Healing the Streets (HTS)

#### PDSA Cycle 3: January 31 - April 30, 2023

##### Final Summary Report | June 2023

Healing the Streets staff participated in the third Plan, Do, Study, Act (PDSA) continuous quality improvement cycle facilitated by RDA Consulting. This cycle was a three month collaborative effort that rapidly iterated and improved programming in an effort to increase program process and impact. The PDSA process uses data to inform the potential impact of tested program changes or enhancements.

The team first identified a programmatic challenge related to a lack of clarity on client enrollment goals and follow-through to reach the overall program goal of serving 600 individuals. The team then worked to develop a “change practice” (i.e., solution to the problem), resulting in the creation of a weekly data dashboard/ tracker that displays the enrollment goals, how many clients were enrolled by each case manager and the referrals received and acted upon. RDA and HTS staff studied the results of enacting a weekly data dashboard/ tracker and the HTS team ultimately decided to adopt and adapt this change practice.

##### Timeline

PDSA Cycle 3	JAN 23	FEB 23	MAR 23	APR 23
Planning Meeting (RDA & HTS) <i>Determine objectives &amp; action steps</i>	PLAN			
Program Activities (HTS)		DO		
Data Gathering & Documentation (RDA & HTS)		DO		
Data Analysis (RDA)			STUDY	
Learning & Reflection Meeting (RDA & HTS) <i>Decide what changes to make</i>				ACT

## **Step 1: PLAN - Identify action steps to carry out the change**

### **Objective**

Increase awareness and knowledge of individual and collective program enrollment over time. This may serve as one of many steps toward a larger program goal of increasing enrollment.

### **Define the problem we are solving**

Staff may lack awareness of their outreach and enrollment milestones over time. This may be one factor that contributes, in part, to not meeting program enrollment goals.

### **Change Practice: How do we intend to solve the problem?**

Implementing and iterating on data dashboards to track and review program enrollment on a weekly basis.

<b>Which evaluation question(s) does this correlate to?</b>	<b>How does this PDSA cycle relate to the evaluation question</b>
Evaluation Question 1: In what ways is the HTS model (specifically, Critical Time Intervention) effectively meeting the needs of clients experiencing homelessness with mental health and possible co-occurring substance use disorders?	Outreach and engaging a large volume of individuals is intended to be part of the program model or approach.
Evaluation Question 2: What is the nature and extent of collaboration and coordination of care between HTS and partner programs?	Part of the dashboard provides insight into referrals being responded to. Client referrals are a main contributor to new enrollments and a main facet of how HTS partners with other entities.

PLAN - Action Steps	Who
Finalize and Communicate Weekly GPRA Targets to team (e.g., 3 per week per staff member)	HTS Team
Hector start dropping off at a fixed time (Wed by EOD)	Hector/Admin
Clayton maintains Weekly GPRA Targets	Clayton and HTS Team
Start using Weekly GPRA Targets in weekly huddles	HTS Team
RDA creates and shares dashboard of aggregate GPRA data monthly (Monthly Data Dashboard)	RDA
Meeting on data system clarity	HTS Admin + RDA
Clean up data storage (Section H and master spreadsheet re: GPRA data)	HTS Admin + RDA

### Anticipated Outcomes: What do we expect focusing on this practice will result in?

Short term: Increase awareness of both (1) expected enrollment goals and (2) progress towards meeting transparent enrollment goals. A better picture of where we are in real time. Address blind spots in communication between admin and direct service. Better data quality.

Long term: Increase enrollment numbers.

### Data: What data will help us understand if the change is working?

- Weekly GPRA targets for HTS case managers (quantitative)
- Monthly dashboard of aggregate GPRA data (quantitative)
- Staff survey measuring case manager perception of data tracker (qualitative)
- Observational data (qualitative)

### Check in points: How will the change team check in, and how often?

- Monthly PDSA check-ins
- Use shared activity tracker to update status of activities

## Step 2: DO - Implement the Change

### Action Steps Completed - All

- ☒ Finalize and Communicate Weekly GPRA Targets to team using new weekly dashboard/tracker (e.g., 3 per week per staff member)
  - ☒ GPRA Lead start dropping off at a fixed time (Wed by EOD)
  - ☒ Program Admin maintains Weekly GPRA Targets
  - ☒ Start using Weekly GPRA Targets in weekly huddles
- Also added case manager names and goals
- ☒ RDA creates and shares dashboard of aggregate GPRA data monthly- Monthly Data Dashboard
  - ☒ Meeting on data system clarity
  - ☒ Clean up data storage (section H and master spreadsheet re: GPRA data)
  - ☒ Bonus: New weekly email clarifying GPRA/ NOMS Reassessment due dates by Case Manager

## Step 3: STUDY - Examine the Change

Data Source	Information Gathered
Dashboards	Reviewed for trends (both weekly and RDA)

<i>Staff Survey</i>	Qualitative data about how direct service staff viewed the Weekly dashboard (filled out by 3 direct service staff)
<i>Observational Data</i>	We used notes from our check-ins to understand the results of this change practice



## Quantitative Data Sources

### HTS Weekly GPRA Dashboard/ Tracker Example

Each week program administration staff sent out a weekly email with data from the week before. The weekly dashboard includes HTS case manager enrollments, including GPRA's performed, Activate Care profiles created, referrals assigned, referrals acted upon, and goals achieved.

## Healing the Streets Weekly Data

**Week of: Thursday 3/9/2023 to Wednesday 3/15/2023**

Goal of 3 enrollments per person/ per week. Whole team =15.

Enrollment= ROI+enrollment forms, GPRA completed, Activate Care profile

Case Manager	GPRA Performed	Activate Care Profiles Created	Referrals Assigned	Referrals Acted Upon	Goals Achieved
Case Manager 1	6	2	3	0	0
Case Manager 2	0	0	0	0	0
Case Manager 3	0	0	3	1	0
Case Manager 4	0	1	3	1	0
Case Manager 5	2	4	0	0	0
<b>Total</b>	<b>8</b>	<b>7</b>	<b>9</b>	<b>2</b>	<b>0</b>
<b>% of goal reached</b>	<b>53%</b>				

### RDA Monthly Data Dashboard

Since the RDA's monthly data tracking outreach, referrals, GPRA data, Activate Care accounts, goals accomplished, and demographic data.

#### The Monthly RDA Dashboard Includes the Following Data

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Outreach</li> <li>• Referrals</li> <li>• GPRA Data</li> </ul> | <ul style="list-style-type: none"> <li>• AC Accounts</li> <li>• Goals Accomplished</li> <li>• Demographic Data</li> </ul> |
|--|---|

<b>Total SAMHSA Enrollments:</b>	<b>261</b>	<b>Total SAMHSA Reassessments:</b>	<b>37</b>	<b>Total SAMHSA Discharges:</b>	<b>104</b>
<b>% to TOTAL GOAL (600)</b>	<b>43.5%</b>	<b>% to 3/31/23 100% Target (106)</b>	<b>34.9%</b>	<b>% of HTS Clients discharged</b>	<b>39.8%</b>
		<b>% to 3/31/23 80% Target (85)</b>	<b>43.5%</b>		
		<small>(106 total 6-month reassessments are "due" by 3/31/23 based on 106 baselines having been completed 3/1/22-9/30/22)</small>			

### Analysis of HTS Weekly Data Dashboard/ Tracker

RDA examined HTS's new internal weekly GPRA dashboards to get an understanding of the impact of this practice on enrollment numbers.

#### HTS Weekly GPRA Target Tracker: January 16 - April 5, 2023 (11 weeks)

Week of...	GPRA's Performed	AC Profiles Created	Referrals Assigned	Referrals Acted Upon	Goals Achieved
Jan 16-Jan 20	0	0	6	2	N/A
Jan 23-Jan 27	4	11	12	6	N/A
Jan 26-Feb 1*	8	16	17	5	N/A
Jan 30-Feb 3	5	7	9	3	N/A
Feb 2-Feb 8*	1	2	10	3	N/A
Feb 9-Feb 15	13	1	19	8	0
Feb 16-Feb 22	2	7	21	5	1
Feb 23-Mar 1	3	4	10	2	5
Mar 2-Mar 8	3	5	19	7	3
Mar 9-Mar 15	8	7	9	2	0
Mar 16-Mar 22	9	9	12	9	3
Mar 23-Mar 29	3	4	10	1	1
Mar 30-Apr 5	1	1	13	5	0
<b>TOTAL*</b>	<b>60</b>	<b>74</b>	<b>167</b>	<b>58</b>	<b>13</b>

*\*Note: Total numbers are imprecise, and likely an overestimation, because two of the tracking periods included overlapping dates.*

#### Key takeaways about the HTS Weekly Data Dashboard:

In any given week, more Activate Care profiles were generally created than GPRA's were performed. In any given week, an average of 34% of assigned referrals were acted upon. There was not an increase in client goals achieved being entered into Activate Care.

### Analysis of RDA Monthly Data Dashboard/ Tracker

RDA examined our monthly dashboard to get an understanding of the impact of the change practice on enrollment numbers.

### RDA Monthly Data Dashboard for HTS: January 1 – March 31, 2023

Month	Incoming Referrals	GPRA Baselines Completed	GPRA Reassessments Completed	GPRA Discharges Completed	Client Goal Attainment	Clients Enrolled into AC	Clients Disenrolled from AC
Jan 2023	33	8	0	0	3	4	7
Feb 2023	43	18	5	0	12	14	3
Mar 2023	74	25	7	2	3	41	60
<b>TOTAL*</b>	<b>150</b>	<b>51</b>	<b>12</b>	<b>2</b>	<b>18</b>	<b>59</b>	<b>70</b>

*\*Note: Total numbers do not match those in the HTS dashboard due to overlapping tracking periods in the HTS dashboard, and because the total time periods presented are slightly different between the two dashboards.*

Key takeaways from RDA's Monthly Data Dashboard:

All GPRA completions increased between January and March 2023. Client enrollment into AC also increased between January and March 2023.

### Qualitative Data Sources

Staff Survey

- RDA conducted a survey of HTS staff as a means of measuring perceptions of the weekly GPRA tracker and status updates.

## Analysis of Survey Results

### As a result of the Weekly GPRA Tracker and status updates...

<b>I have a better understanding of my weekly enrollment numbers.</b>	Agree (33%)	Neither Agree nor Disagree (67%)
<b>I have more discussions about enrollment and meeting targets with staff and/or leadership.</b>	Agree (100%)	
<b>this information is used in discussions about challenges or barriers to enrollments</b>	Agree (100%)	

*During PDSA check-ins, multiple case managers agreed they have a better understanding of their weekly enrollment numbers because of the Tracker.*

Three staff responded to the survey asking about their perceptions of the weekly data dashboard and status updates. Two of the three staff neither agreed nor disagreed that they had a better understanding of their weekly enrollment numbers as a result of the trackers. All staff agreed that, as a result of the tracker, they had more discussions about enrollment and meeting targets with staff and/or leadership and the information has been used in discussions about challenges or barriers to enrollments. Overall, there was more clarity around the enrollment process as a result of using the weekly GPRA tracker and status updates.

I would like us to continue using the Weekly GPRA Tracker & status updates.		Yes (33%)	Yes, but... (33%)	I'm ambivalent (33%)
Reasons to Continue Using this Tracker:	Recommended Changes to Tracker & Other Feedback:			
<ul style="list-style-type: none"><li>Accountability</li><li>Promotes more conversation</li></ul>	<ul style="list-style-type: none"><li>I'd like to include the total GPRA numbers to have a better idea of progress toward the 600 goal.</li><li>Not sure that the way referrals are being reported accounts for the backlog of referrals some staff have.</li><li>We simply need more case managers. I don't think there's any other way around it.</li></ul>			
During a PDSA check-in, one case manager suggested adding staff names to increase clarity about individual goal progress.				

The three staff respondents were mostly in favor (or neutral) about continuing to use the trackers. Reasons identified for continued use of the tracker include accountability and the promotion of conversation. Suggested changes to the tracker/other feedback included the inclusion of total GPRA numbers to better understand progress toward goals, reporting changes to better address referral backlogs, and hiring more case managers.

#### Step 4: ACT - Adapt, Adopt, or Abandon the Change

##### ACT Decision: Adapt

Sharing weekly referral and GPRA baseline data - Adapt

Adapt: Case manager names were added as an iteration to the change practice - this is a version of "studying" the change and determining that we want to "Adapt" it. Case managers chose this to create more clarity and accountability via adding names.

Adapt: We learned in the process of getting clearer data that the workflow for getting reassessments to the GPRA Lead wasn't working well - for that reason we "Adapted" the weekly data sharing process to include those clients who are up for reassessment.

Adapt: The team generally adopted this idea. They recognized GPRAs will no longer occur after the grant-period ends. There was a recommendation to add the total number of clients who have been fully enrolled and therefore have completed baseline GPRA's to the weekly dashboard. Giving the full GPRA numbers will give a sense of how close they are to the goal enrollment of 600 individuals.

#### *RDA's data dashboard - Adopt*

- Adopt: The team decided to adopt the RDA data dashboard from this PDSA cycle.

#### *Data management practices - Adopt*

- Adopt: The team decided to adopt the data management practices from this PDSA cycle.

#### *Sharing weekly list of who is up for reassessments - Adapt*

- Adapt: Generally, staff reported this list is helpful, but can be outdated. Efforts should be made to discharge clients from this list.

### **Conclusion**

The change practice and associated activities met the short term goals of this PDSA cycle which were to

- Increase awareness of both (1) expected enrollment goals and (2) progress towards meeting transparent enrollment goals.
- A better picture of where we are in real time.
- Address blind spots in communication between admin and direct service.
- Better data quality.

However, this cycle did not meet the long term goal of increasing rates of enrollment to support catching up to the goal of 600 individuals served by HTS.

It was determined that receiving weekly GPRA baseline data, reassessment data, and referral data is a helpful set of practices that creates more data clarity and provides a tool that promotes conversation about enrollment and referral follow through. There was a loss in staff capacity and ultimately the barrier to enrolling more clients is considered to be an issue with case management capacity. PDSA 3 helped the team create more functional and transparent workflows and communication around core program functions and overall was viewed as a positive set of changes.

# Appendix P. PDSA Cycle 4 Report

## Santa Cruz County Healing the Streets (HTS)

### PDSA Cycle 4: July 1 - November, 2023

#### Final Summary Report | November 2023

Healing The Streets staff participated in the fourth and final Plan, Do, Study, Act (PDSA) continuous quality improvement cycle facilitated by RDA Consulting, SPC (RDA). This cycle was a four month collaborative effort that rapidly iterated on programming to improve program processes and impact. The PDSA process uses data to inform the potential impact of tested program changes or enhancements.

In Cycle 4, Behavioral Health leadership requested that the focus of this cycle remain on one of the ongoing core challenges: program enrollment. RDA and HTS determined that HTS leadership would hold this change cycle rather than extending it to full staff participation as had been the case for the previous three cycles.

RDA worked with HTS to identify possible explanations for low program enrollment. HTS leadership shared that the nurse practitioner's work was being provided to many individuals who are not HTS clients. Additionally, it was thought that if the program therapist had support for enrollment of clients, there would be an increase in enrollment. Given these two factors, HTS identified a "change practice" (i.e., solution to the problem) of sending case management staff out with the nurse practitioner and therapist to support enrollment.<sup>54</sup> Part of the enrollment process was dramatically altered during the course of this PDSA and contributed to a full abandonment of change practices piloted in this cycle.

#### Timeline

PDSA Cycle 4	JUL 23	AUG 23	SEPT 23	OCT 23	NOV 23
Planning Meeting <i>Determine objectives &amp; action steps</i>	PLAN				
Program Activities		DO			
Data Gathering & Documentation		DO			

<sup>54</sup> The combination of the NP and therapist will be referred to as "clinical" staff.



Data Analysis

STUDY

Learning & Reflection  
Meeting

ACT

*Decide what changes to maintain or adapt*

## Step 1: PLAN - Identify action steps to carry out the change

### Objective

Have clinical staff (nurse practitioner and therapist) contribute to client enrollment with the support of case managers.

### Define the problem we are solving

HTS is not on track to reach 600 individuals fully enrolled in services (full enrollment meaning they have or have declined a baseline GPRA, they have been enrolled in Activate Care, and have a release of information).

### Root cause of issue:

- Unrealistic enrollment goal
- Staffing capacity not commensurate with goal
- Not all staff contribute to enrollment
- Workflow challenges with GPRA
- GPRA's done by contractor

### Change Practice: How do we intend to solve the problem?

Change Practice 1: Have clinical staff support HTS enrollment by having case managers join nurse practitioner on key days of the week to perform GPRA's and,

Change Practice 2: Update the workflow and have therapist hand off ROIs to get clients connected to a case manager and do a GPRA interview.

### Which evaluation question or questions does this correlate to?

Evaluation Question 1: In what ways is the HTS model (specifically, Critical Time Intervention) effectively meeting the needs of clients experiencing homelessness with mental health and possible co-occurring substance use disorders?

- How does this PDSA relate? - Engaging 600 individuals is an intended target for the program model.

### Tasks and roles

Action needed to implement the solution	Who	Start date	Deadline
Meeting to identify gaps in enrollment workflows	James, Kayla, Shelly	7/26/23	7/31/23
Staff join nurse practitioner on Fridays and on new Wednesday walking outreach in North County to do ROI and new enrollment conversation to provide GPRAs to clients	Hector, James, Case Manager	7/28/23	9/8/23
Therapist to complete ROI with new clients and then email admin team to seek Case Manager assignment	David	7/28/23	8/31/23
Verify Case Managers for David's ROI's and connected them to getting GPRAs	Clayton	7/28/23	8/31/23
Have Case Manager join Therapist on Mondays at Salvation Army to do ROI and new enrollment conversation	James, Rebecca and/or Lauren	8/7/23	9/8/23
Document new workflows	Shelly, Clayton, Kayla	9/5/23	9/30/23

### Anticipated Outcomes: What do we expect focusing on this practice will result in?

Short term: This change solution will allow us to reach clients already being served by the nurse practitioner and therapist in the field.

Long term: This change will capture additional enrollments and show a bigger and clearer picture of our impact to SAMHSA, moving us closer to our enrollment goal of 600 clients (357 clients enrolled as of 8/31/23).

### Data: What data will help us understand if the change is working?

We will look at total new enrollments each month and use the weekly dashboard to subtract out any new enrollments that were generated by Case Manager and Peers. The remainder of new enrollments will be via field-based clinical staff supporting enrollments.

### Check in points: How will the change team check in, and how often?

We are going to use a mix of ad hoc meetings with key change team members and monthly check ins with RDA tagged onto our current leadership meetings.

## Step 2: Do - Implement the Change

Action needed to implement the solution	Start Date	Finish Date	Barriers	Status
Meeting to identify gaps in enrollment process	7/26/23	7/31/23	Underutilizing field-based clinician for programmatic touches	Complete
Staff join nurse practitioner on Fridays and on new Wednesday walking outreach in North County to do ROI and new enrollment	7/28/23	9/8/23	Clients no showing for medical appointment. Cannot provide a Case Manager	Complete

conversation to provide GPRAs to clients			on Friday. HPHP clinic is very small.  County pushback on outreach; street medicine team spending a long time finding people since they've been scattered from encampments	
Field based therapist to complete ROI with new clients and then email admin team to seek CM assignment	7/28/23	8/31/23	No identified barriers – not an ongoing intervention	Complete
Case Manager join therapist on Mondays at Salvation Army to do ROI and new enrollment conversation	8/7/23	9/8/23	Need to optimize the workflow with nurse practitioner's clients that do ROI's	Complete
Case Manager join nurse practitioner on new Wednesday walking outreach in North County to do ROI and new enrollment conversation	8/16/23	9/8/23	Until recently, inadequate CM staffing did not allow for CM presence on Mondays	Incomplete
Verify Case Managers for therapist's ROI's and connected them to getting GPRAs	7/28/23	8/31/23	Successful – but one time intervention	Complete (8 people declined or GPRAd)

Writing/confirming new workflows	9/5/23	9/11/23	Will not be moving forward with any of these workflows	Incomplete
<b>Additional Activities: Program Changes</b>				
During PDSA 4 RDA's support of GPRA enrollment contractually ended 9/30/23. RDA trained case management and peer staff on conducting GPRA interviews and created new workflow documentation that supported what was taught in the virtual trainings as of 9/13/23. This change in workflow substantially impacted PDSA 4, making much of the effort no longer relevant.				

### Step 3: Study - Examine the Change

Data Source	Information Gathered
Monthly GPRA Dashboards	Leadership staff identified through monthly GPRA dashboard data that having the clinical staff contribute to HTS program enrollment was not providing a noticeable change in enrollment numbers. Many of the nurse practitioner's clients did not show up to their given appointments when case management staff were available to support, and many were not interested in signing up for HTS services. As per the therapist's clients, most of them were already signed up as HTS clients and a few were signed up as a result of this PDSA effort.
Staff Feedback	The nurse practitioner offered feedback that many of his clients do not make it to their designated appointments, making it hard to effectively fill a Case Manager's time that joins him to support enrollment. Additionally, many of the therapist's clients were already enrolled. This effort to finish enrollment for any of the therapist's clients who had an ROI but were not fully enrolled was successful, but merely a

	one-time effort. Staff did not see value in continuing the change process, especially given the new GPRA workflow of Case Managers and peers doing GPRA/NOMs interviews themselves.
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## Step 4: Act - Adapt, Adopt, or Abandon the Change

### ACT Decision: Abandon

The original PDSA 4 effort to integrate case management staff in supporting clinical staff in capturing the individuals they reach as HTS clients was viewed not to be worth the effort and therefore was fully abandoned. However, the effort to capture the therapist's clients who had ROI's but did not have full program enrollments was successful, as eight individuals either declined or completed a GPRA interview. This was a one-time activity as the therapist can perform GPRA interviews himself now or reach out to any Case Manager or Peer Support Specialist to do so.

## Conclusion

HTS staff tried tirelessly to find new ways to engage and enroll clients throughout the course of the program. Due to encampments being moved and the nature of people experiencing homelessness not having a fixed location to live in, it has been challenging for staff to have an enrollment process that is spread out between multiple interactions. They meet clients on outreach or providing services, the client signs an ROI, and then Case Managers would schedule with RDA staff to provide the GPRA interview. This extra level of coordination made the workflow clunky and complicated, especially given the specific challenges of connecting to the target population.

Many individuals benefited from services from the nurse practitioner that will not be captured with SAMHSA and their enrollment targets. This effort to capture those individuals as enrolled clients did not make a meaningful enough difference to justify staff time and resources. PDSA 4 efforts were abandoned for this reason. The hope is that a more integrated team in which multiple staff are now able to perform GPRAS and therefore complete enrollments in one interaction is hoped to help bridge the gap in people served and number of enrollments.

## Appendix Q. Case Manager Time Study

30min- 1hr/day	<b>Starting the day</b> Email, check messages, coordinate with coworkers (such as GPRAs) and supervisors, coffee
2.5- 4hrs/week	<b>Rotating meetings</b> Team huddle, Front Street, HMIS, street medicine, supervision and oversight, coaching, case conferencing
4- 8hrs/month	<b>Rotating trainings</b> Strengths model, motivational interviewing, CTI, Activate Care, trauma informed systems, non-violent crisis intervention, NAMI, CPR
2-4hrs/day	<b>Travel throughout Santa Cruz and Watsonville</b> Armory, jail, motels, Building K, doctor's offices, psychiatric facilities, board and care, partners
2-4hrs/day & 6- 9hrs/week	<b>Service provision &amp; outreach</b> <u>Services:</u> transportation, care coordination, advocacy, benefits assistance, resource connection, listening and support <u>Referrals:</u> CalAIM Enhanced Care Management (ECM) & community supports, behavioral health, housing navigation, benefits, medical, phones <u>Outreach:</u> Watsonville, library, the levee, Salvation Army, Depot Park
2hrs/day	<b>Partnership and care coordination</b> Coordinating and following up on referrals to partners like CalAIM ECM & community supports, HPHP, Salvation Army, The Armory, Housing Matters, Pathways
1-2hrs/day	<b>Documentation</b> Notes in Activate Care, outreach tracking and notes, creating profiles, service tracking
30min/day	<b>Wrap up the day</b> Talk with team about how the day went, finish email

# Santa Cruz County Behavioral Health Services Healing the Streets



**Dana's<sup>1</sup> journey with the Healing the Streets (HTS) program has been one of resilience in the face of adversity.** Originally from Portland, OR, Dana has struggled to find stability in her life. Her ongoing substance use and involvement with the wrong crowd escalated to the point of eviction from her apartment and an arrest. Shortly after this, Dana relocated to Santa Cruz where she found employment as a caregiver. However, after continued struggles with substance use and worsening mental health, she found herself living on the streets. She was able to secure a shelter spot at The Armory, at which point she was referred to HTS by the Association of Faith Communities and connected to her case manager, Lauren.

When Dana first entered the program, had a very upbeat personality and was "a delight to be around." **Lauren and the HTS team worked quickly to connect Dana to a housing navigator** at Encompass, set up benefits appointments, take her to doctor appointments, refer her to a women's health center, and buy clothing and other necessities. **Lauren also supported Dana's job search, helping her become an In-Home Supportive Services (IHSS) worker** and assisting with background check requirements.

**Dana's sense of humor and motivation shone through**, even during her addiction struggles. She remained dedicated to her recovery, regularly attending Narcotics Anonymous (NA) meetings and therapy appointments. With Lauren's guidance, **Dana maintained focus on her job and housing searches.**

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*"One thing that I admire about Dana is no matter where she is in her addiction, she can be cracking jokes and making you laugh. She was also really motivated, wanting to work, wanting to get back into caregiving, wanting to maintain her sobriety."*

**– Lauren, Dana's Case Manager**

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**In March of 2023, Dana was able to secure an apartment.** Stable housing, coupled with her consistent involvement in NA and completing her daily steps, offered her the structure she needed to "get out of her head" and work towards recovery and self-improvement.

However, **Dana's path to recovery has not been without setbacks.** Due to a recent relapse and changes to her medication, Dana has been experiencing difficult mental health symptoms like paranoia, self-doubt, and emotional numbness. She also had a challenging relationship with her NA sponsor, whom she felt was judgmental and difficult to trust. Lauren is continuing to meet with Dana to help her with her job search, but fear and self-doubt has stopped her from engaging in full-time work.

Throughout Dana's time in HTS, Lauren has been able to provide the needed space for Dana to vent her frustrations and emotions. With the help of HTS staff and other community partners, **Dana has built a support system** of people who care about her and won't judge her when she experiences setbacks. Dana has built up her ability to reach out for help when she needs it, particularly for her mental health and medical needs.

Currently, Lauren is working with Dana to build up her self-confidence and secure a stable job. While there is still work to be done, **the progress Dana has made shows the potential for a bright future.**

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<sup>1</sup> Name has been changed to protect client confidentiality. Interviews were provided by case managers with consent from their client.





# Santa Cruz County Behavioral Health Services Healing the Streets



**Before Ethan<sup>1</sup> enrolled in Healing the Streets, he was moving in and out of shelters and his car.** He often had trouble getting along with others, in part due to irritability stemming from his substance use and mental illness. Ethan had a longstanding pattern of engaging in unhealthy relationships, and he struggled with employment and legal challenges. His lack of housing contributed to his mental health instability, where he disliked taking his medication because it made him fall asleep in unsafe places and potentially become victimized. He had cycled through treatment providers in the past and was on a waitlist for services when he ran into Rebecca, an HTS case manager whom he had met several years prior. Ethan decided to enroll in HTS with Rebecca as his case manager.

**Once connected with HTS, Ethan faced ongoing challenges with engagement and connection to services.** For months after he was approved for specialty mental health, Rebecca and the HTS team advocated tirelessly to get Ethan assigned to a coordinator. All the while, HTS ensured he had basic needs met, like water, a tent, and a blanket.

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*"It's the ability to do the little things, like reach out with gift card, blanket, or water bottle. So much of the time, [clients must] "hurry up and wait" for the bigger treatment services, placements, and coordinators. It was important to let [Ethan] feel like he could call me for support."*

**– Rebecca, Ethan's HTS Case Manager**

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Rebecca worked to connect him with mental health and supportive housing services, supported his existing skills and desire to obtain a job, reminded him about his probation supervision requirements, as well as transported, accompanied, and advocated for him at court appearances with his public defender. Ethan sought a structured, safe, and harm reduction-based living environment where he could achieve behavioral health stability.

**Through the combination of Ethan's engagement and HTS's advocacy with the County, Ethan was eventually assigned to a specialty mental health coordinator.** With the help of HTS and his legal team, his court cases were also resolved. Though he received a conviction, his mental health status, program engagement, and opportunity for treatment were factors considered in his sentencing (informed by Rebecca and his coordinator), in which he received no jail time.

**Despite these positive developments, winter's arrival in Santa Cruz posed significant challenges for Ethan.**

He lost a dear friend to an overdose, began living in a wooded encampment, and struggled with worsening mental health as he tried to navigate the harsh winter conditions outdoors as an older adult. He lost his phone and became disconnected from Rebecca and his coordinator. Before HTS could reconnect with him, Ethan was placed on a psychiatric hold and sent to treatment in a different town. Upon his return to Santa Cruz, all his possessions were gone, and he sought respite through Second Story. At this point, HTS and Ethan's specialty mental health coordinator successfully reconnected with him and placed him on a list for dual-diagnosis treatment through Casa-Pacific.

**Ethan entered Casa-Pacific in April 2023 for treatment and has been sober ever since.** He loves the structure and safety of the program and is now studying for his GED. Ethan dreams of going to welding school and getting his own living space.

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<sup>1</sup> Name has been changed to protect client confidentiality. Interviews were provided by case managers with consent from their client.



## Appendix T. Acronym Defined

Acronym	Definition
<b>CAB</b>	Community Action Board
<b>CQI</b>	Continuous Quality Improvement
<b>COD</b>	Co-Occurring Disorder
<b>CTI</b>	Critical Time Intervention
<b>DOW</b>	Downtown Outreach Workers
<b>ECM</b>	Enhanced Care Management
<b>GPRA</b>	Government Performance and Results Act
<b>HIP</b>	Health Improvement Partnership
<b>HIPAA</b>	The Health Insurance Portability and Accountability Act
<b>HMIS</b>	Homeless Management Information System
<b>HPHP</b>	Homeless Person's Health Project
<b>HTS</b>	Healing the Streets
<b>IPP</b>	Infrastructure Development, Prevention and Mental Health Promotion
<b>IPS</b>	Intentional Peer Support
<b>MAT</b>	Medication-Assisted Treatment
<b>MI</b>	Motivational Interviewing
<b>NOMs</b>	National Outcome Measures
<b>PDSA</b>	Plan Do Study Act
<b>PEH</b>	People experiencing homelessness
<b>RDA</b>	RDA Consulting
<b>ROI</b>	Release of Information
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SCHIO</b>	Santa Cruz Health Information Organization
<b>SMI</b>	Serious Mental Illness
<b>SNAP</b>	Supplemental Nutrition Assistance Program
<b>SPARS</b>	SAMHSA's Performance Accountability and Reporting System
<b>SSI</b>	Supplemental Security Income
<b>SUD</b>	Substance Use Disorder

# Final Evaluation Report

Building Hope and Safety, Santa Cruz County

June 2023



*Helping People  
Build Better Communities*

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## Project Background

In 2018, the community formed the Santa Cruz County's Suicide Prevention Task Force (SPTF) to gain a better understanding of local experience with suicide, to gather and understand data, review best practices, and create a Suicide Prevention Strategic Plan. The Task Force was comprised of a wide array of community members including community-based health care employees and faith-based organizations; school officials; law enforcement, hospice personnel; behavioral health and public health staff; veterans advocacy; and other stakeholders. This represents the County's first formal suicide prevention plan, which was formally adopted by the County Board of Supervisors on June 11, 2019.

Since January 2022 "Building Hope & Safety-Santa Cruz" consisted of the following activities:

- **Rapid Follow-up:** County Behavioral Health (CBH) operated a program called "Rapid Connect" for persons who attempted suicide or were at risk of a suicidal crisis. The program provided case management and linkage for youth and adults who were treated in local emergency departments and hospitals or received at the Crisis Stabilization Program.
- **Screening & Assessment:** CBH, in partnership with Applied Crisis Training and Consulting, Inc. (ACT), hosted training on the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning. The training was offered to CBH Clinicians, contracted provider agencies, and other community clinicians by The Columbia Lighthouse Project and ACT.
- **Training:** ACT provided workshops on these evidence-based practice (EBP) trainings: Applied Suicide Intervention Skills Training (ASIST), safeTALK, Mental Health First Aid (MHFA), and Counseling on Access to Lethal Means (CALM) for service providers in Santa Cruz.
- **Community Recovery Supports:** ACT partnered with CBH to implement Community-Based Supportive Services (CBSS) including a system mapping, creation of a pocket guide for services, universal and selective public education campaigns, postvention services, and expansion of supportive services for victims of domestic violence.
- **Enhanced Services for Victims of Domestic Violence:** These services were provided in partnership with Monarch Services and ACT. Monarch advocates and therapists actively worked on addressing the increased need of mental health services for survivors as a result of the COVID-19 shelter-in-place (SIP) order through counseling services and collaboration with community partners.
- **Access to Telehealth Services:** Throughout the COVID-19 pandemic, CBH, ACT, and Monarch have offered services through telehealth and, once safe, in person. Telehealth services included telephone only and video telehealth appointments. In addition to standard telehealth visits, telehealth rooms were available on-site in two CBH locations (North & South County) to provide clients without access to technological means the availability of services. ACT partnered with Monarch to develop or update a list of local resources to provide to clients needing suicide crisis support, including the suicide crisis line 24/7/365, which offers access to language interpretation in 140 languages. Monarch, Behavioral Health, and partners provided follow-up calls to individuals at risk of suicide, offering three-way calls to connect clients with other sources of support as needed. ACT also partnered with local organizations to connect survivors of loss with audio-visual telehealth support group meetings. Monarch has continued to fully serve clients since the beginning of the COVID-19 pandemic and Santa Cruz County's SIP order. Cell phones and laptops were provided to clients and staff as needed. In addition to this, all Monarch staff were thoroughly trained in responding to the 24-hour crisis line, making us uniquely prepared to offer teleservices to clients during this time. As a result, advocates and therapists continued to work with survivors to provide counseling support and safety planning as necessary.

## EVENTS IMPACTING PROGRAM IMPLEMENTATION

### UNEXPECTED GRANT AWARD

Although a welcome surprise, the unexpected grant award led to a slower start and a longer-than-planned ramp up. Program partners and County staff had shifted to other programs and priorities after receiving notice that their application was not accepted. When they received notice that their application status had changed, and the program could begin implementation, partners and the County worked quickly to re-engage, adapt and adjust the program activities.

### IMPACTS OF COVID-19

The COVID-19 pandemic had a significant impact on the implementation of the Building Hope & Safety-Santa Cruz program and altered program strategies and activities. Engaging and recruiting a range of community service providers and volunteers for training was complicated by the ongoing state of emergency. Trainer and participant exposure to COVID-19 (and re-assignment due to short staffing) resulted in rescheduling of trainings and necessitated significant adaptations to traditional training methodology.

### STAFF TRANSITIONS

The program team worked with County staff during the transition of several key positions and partners, including positions and staff previously overseeing and implementing strategic planning activities and drafting the Building Hope & Safety grant. In addition, the lead program agency experienced staff turnover and transitions, occasionally causing delays in data collection and program implementation.

### CZU COMPLEX FIRES AND STORMS

In addition to the COVID-19 crisis, the CZU Complex fires in Santa Cruz County caused evacuations in August and September of 2020. This additional disaster caused widespread evacuations and destruction. In the years following the fires, the increased risk of flooding during the rainy season led to subsequent evacuations in areas with long-term fire damage and impacted County staff and services across the county. Additionally, the impact of extreme storm conditions and significant damage to our communities locally (which again necessitated the reassignment of County staff for emergency shelter purposes) provided a further challenge and impacted planned activities at various points throughout the grant implementation.

## PROJECT GOALS, OBJECTIVES AND ACTIVITIES

GOAL	OBJECTIVES	ACTIVITIES
<b>Goal 1: Improve Collaboration Efforts Among Suicide Prevention Agencies and Programs</b>	<ul style="list-style-type: none"> <li>➤ Integrate suicide prevention activities across multiple sectors and settings.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Establish baseline information regarding the trainings, tools, and related policies used by a range of community agencies and programs.</li> <li>➤ Determine workforce education needs by conducting a community assessment survey and key stakeholder interviews.</li> <li>➤ Complete initial resource and system mapping of existing local prevention, intervention, and postvention activities.</li> </ul>



GOAL	OBJECTIVES	ACTIVITIES
		<ul style="list-style-type: none"> <li>➤ Promote consistent training on, and use of, evidence-based tools.</li> </ul>
<b>Goal 2: To Increase Service Provider Awareness of and Ability to Assess for and Manage Risk of Suicidal Behaviors</b>	<ul style="list-style-type: none"> <li>➤ Increase the competency and confidence of clinical and other service providers in evaluating and managing the risk for suicidal behavior.</li> <li>➤ Provide training to the workforce in suicide assessment and intervention.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Develop a training portfolio and materials for clinical providers and workers.</li> <li>➤ Coordinate and provide a range of identified evidence-based trainings to providers and community members.</li> </ul>
<b>Goal 3: Through Partnership with Local Domestic and Sexual Violence Prevention Agencies, Enhance Access to Suicide Intervention and Care for Survivors and their Dependents</b>	<ul style="list-style-type: none"> <li>➤ Promote help seeking for populations disproportionately impacted by suicide, particularly during the COVID-19 pandemic.*</li> <li>➤ Increase number of clients served.*</li> <li>➤ Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery among staff.</li> <li>➤ Generate and disseminate resources related to suicide to media outlets and the general community.</li> </ul> <p><i>*Including, but not limited to, individuals experiencing or recovering from intimate partner or domestic violence and their dependents.</i></p>	<ul style="list-style-type: none"> <li>➤ Provide trauma-informed and culturally-responsive services to target population.</li> <li>➤ Screen individuals for imminent safety concerns and provide emergency shelter vouchers to those whose safety is in jeopardy.</li> <li>➤ Coordinate and conduct trainings for Monarch staff, volunteers, providers, and community members on suicide prevention and intervention. Provide opportunities for follow-up skill building opportunities for staff.</li> <li>➤ Coordinate a broad public education marketing campaign around suicide prevention.</li> </ul>
<b>Goal 4: Provide Care and Support to Individuals Affected by Suicide Deaths by Enhancing the Support Network</b>	<ul style="list-style-type: none"> <li>➤ Enhance system partners' ability to provide support to individuals affected by suicide deaths.</li> <li>➤ Enhance connections amongst service providers to strengthen the ability to refer and partner in helping those at enhanced risk.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Coordinate with relevant stakeholders to map out the existing chain of response following a suicide death.</li> <li>➤ Coordinate with local organizations to identify training and resource needs to provide suicide bereavement support.</li> </ul>

## Evaluation Method and Design

### RESEARCH DESIGN FOR PROCESS AND OUTCOME EVALUATION

As part of the evaluation process, ASR confirmed key outcomes and as needed, developed tools to measure outcomes in accordance with best practices. The program's evaluation employed a mixed-methods design, utilizing quantitative and qualitative data to assess the various overall program measures' progress toward accomplishing outputs and outcomes associated with implementation. Process and outcome measures of the evaluation utilize data from multiple sources and perspectives (assessments, surveys). Data instruments and tools, including data collection tools and pre- and post-training surveys, were used to assess progress towards the following process and outcome measures. ASR utilized a data

collection tracker to collect, monitor and analyze all process and outcome data related to the evaluation plan.

## PROCESS AND OUTCOME INDICATORS

INDICATOR	RESULT
<b>Goal 1: Improve Collaboration Efforts Among Suicide Prevention Agencies and Programs</b>	
<b>PROCESS MEASURES (HOW MUCH AND HOW WELL)</b>	
# of agencies participating in agency assessment and/or key informant interviews (KIs) and system mapping (Goal of 20)	8
<b>OUTCOME MEASURES (IS ANYONE BETTER OFF)</b>	
% of partners reporting increased awareness of other system partners and their services/role (Goal of 90%)	58%-93%
<b>Goal 2: To Increase Service Provider Awareness of and Ability to Assess for and Manage Risk of Suicidal Behaviors</b>	
<b>PROCESS MEASURES (HOW MUCH AND HOW WELL)</b>	
# of CBO service providers and clinical staff trained (Goal of 400)	869
# and types of trainings held: <ul style="list-style-type: none"> <li>• Applied Suicide Intervention Skills Training (ASIST) Workshops (Goal of 8)</li> <li>• safeTALK (Suicide Awareness for Everyone) Workshops (Goal of 8)</li> <li>• Counseling on Access to Lethal Means (CALM) Workshops (Goal of 6)</li> <li>• Mental Health First Aid (MHFA) Trainings (Goal of 3)</li> <li>• Trainings on the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Plan tools for the Santa Cruz Behavioral Health workforce (Goal of 3)</li> <li>• Training and Technical Assistance (TA): Tailored training and technical assistance plans developed for and provided specifically to local organizations (Goal of 10 organizations)</li> </ul>	<b>44 trainings</b> <b>ASIST: 10</b> <b>safeTALK: 8</b> <b>CALM: 6</b> <b>MHFA: 3</b> <b>C-SSRS: 4</b> <b>TA: 13 organizations</b>
<b>OUTCOME MEASURES (IS ANYONE BETTER OFF)</b>	
% of service providers reporting improved ability to identify, evaluate, and/or manage risk of suicide in clients (Goal of 90%)	63%-98%
% of service providers reporting increased comfort and/or competence in using screening, assessment, and/or safety planning tools (Goal of 75%)	57%-97%
<b>Goal 3: Through Partnership with Local Domestic and Sexual Violence Prevention Agencies, Enhance Access to Suicide Intervention and Care for Survivors and their Dependents</b>	
<b>PROCESS MEASURES (HOW MUCH AND HOW WELL)</b>	
% of at risk individuals screened for suicide risk (Goal of 95%)	100%
# of at risk individuals screened for suicide risk	141



# of individuals receiving shelter support (Goal of 150 individuals)	23 served (total of 2,301 bed nights)
# of emergency vouchers provided (Goal of 511 emergency vouchers)	118 served (total of 566 voucher nights)
# of trainings provided to service providers and CBO staff (Goal of 4)	3
<b>OUTCOME MEASURES (IS ANYONE BETTER OFF)</b>	
% of service providers who report that trainings were effective or highly effective in helping them provide support to clients at risk for suicide (Goal of 90%)	98%-100%
% of service providers reporting referrals of suicidal clients for crisis services (Goal of 100%)	100%
<b>Goal 4: Provide Care and Support to Individuals Affected by Suicide Deaths by Enhancing the Support Network</b>	
<b>PROCESS MEASURES (HOW MUCH AND HOW WELL)</b>	
% of providers who report increased knowledge of resources for those affected by suicide death (Goal of 100%)	73%
<b>OUTCOME MEASURES (IS ANYONE BETTER OFF)</b>	
% of individuals exposed to a suicide death who receive materials and referrals for support <i>Note: The percentage of individuals exposed to a suicide death who received materials and referrals for support could not be calculated for this report.</i>	30 individuals
% of providers who reported that they felt prepared to connect those affected by suicide death with appropriate resources or care (Goal of 95%)	70%

## Evaluation Results

### DATA DISCUSSION BY GOAL AREA

#### GOAL 1: IMPROVE COLLABORATION EFFORTS AMONG SUICIDE PREVENTION AGENCIES AND PROGRAMS

##### Number of agencies participating in agency assessment and/or key informant interviews (KIIs) and system mapping

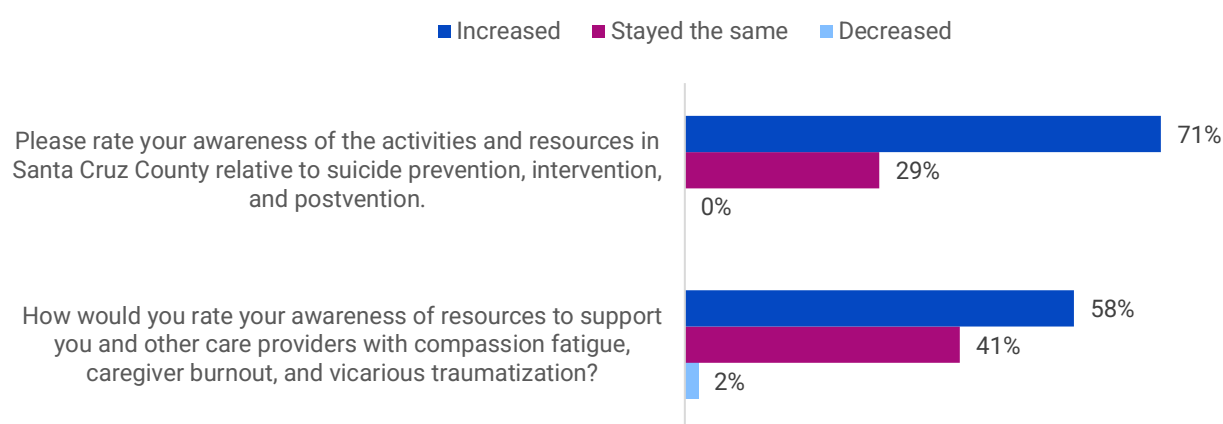
Eight (8) agencies participated in an agency assessment or a key informant interview (KII) and system mapping. This is less than the goal of having 20 agencies participate in these activities.

## Percentage of partners reporting increased awareness of other system partners and their services/role

As a result of the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Plan Tools training, 71% of participants reported increased awareness of activities and resources in the county relative to suicide prevention, intervention and postvention. In addition, over half (58%) of participants reported increased awareness of resources related to support for compassion fatigue, caregiver burnout, and vicarious traumatization. This is below the goal of achieving a 90% increase in awareness among partners/agencies.

After participating in the Mental Health First Aid (MHFA) training, 93% of service providers reported increased awareness of or familiarity with other local service providers and their role. This is more than the goal of 90% of service providers reporting increased awareness.

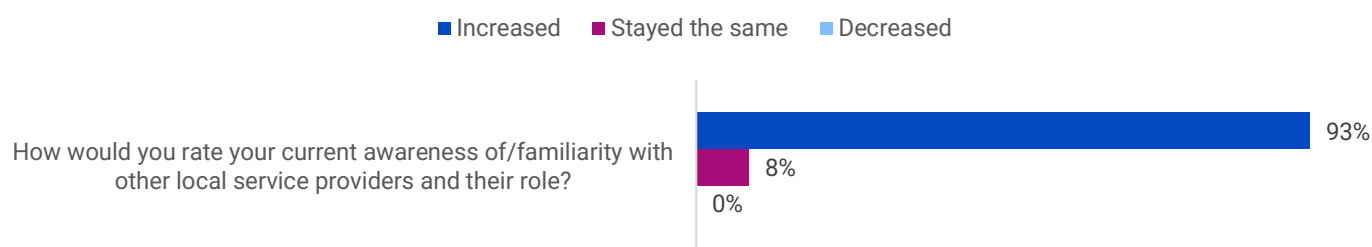
### Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning



N=132

Note: Percentages may not equal to 100% due to rounding.

### Mental Health First Aid (MHFA)



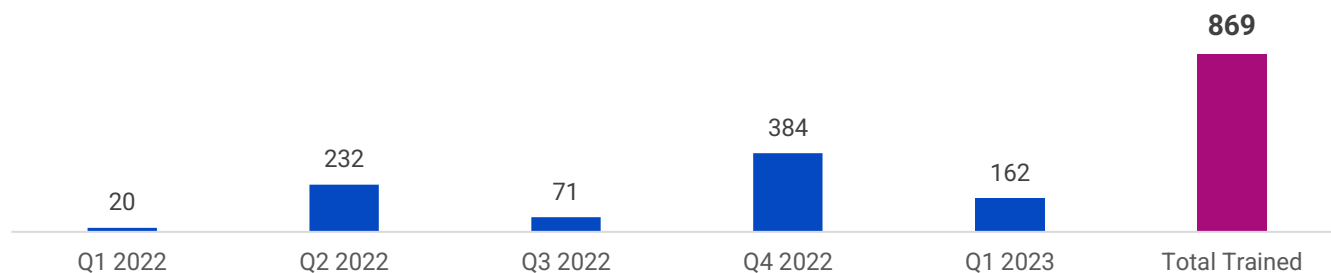
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Note: Percentages do not equal to 100% due to rounding.

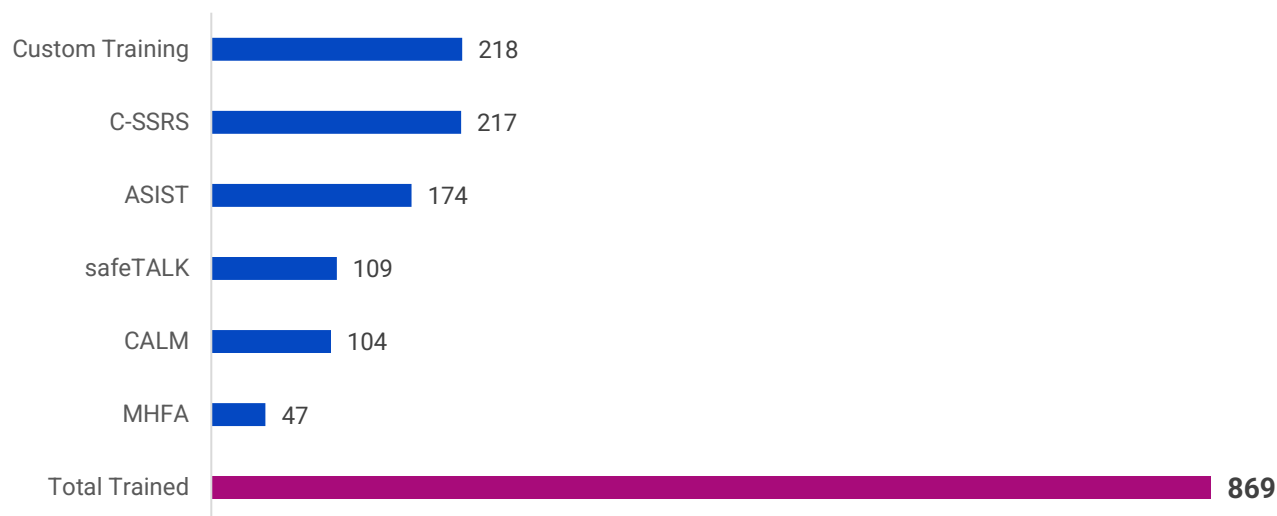
## GOAL 2: TO INCREASE SERVICE PROVIDER AWARENESS OF AND ABILITY TO ASSESS FOR AND MANAGE RISK OF SUICIDAL BEHAVIORS

### Number of Community-Based Organization (CBO) service providers and clinical staff trained, by quarter

While the goal was to reach 400 providers and clinicians with training, the program surpassed that goal and reached 869.

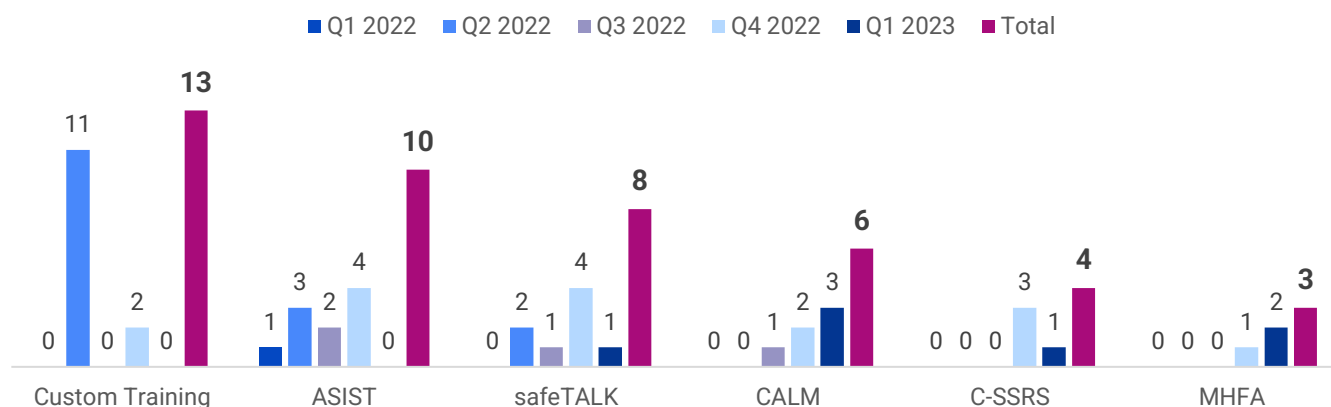


### Total number of participants, by training type



### Number and types of trainings held, by quarter

In addition, the program was able to provide more Applied Suicide Intervention Skills (ASIST) and Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Plan Tools training than planned and reached more organizations with tailored training and technical assistance than planned.



## Training and technical assistance

Customized staff training and/or technical assistance was provided to the following 13 organizations:

- American Medical Response
- Ceiba College Preparatory Academy
- Encompass Community Services
- Healing the Streets
- Housing Matters
- Janus of Santa Cruz
- Monarch Services
- National Alliance on Mental Illness – Santa Cruz Chapter
- Pajaro Valley Prevention and Student Assistance
- Santa Cruz City Schools
- Santa Cruz Community Healthcare
- Scotts Valley Unified School District
- Walnut Avenue Family and Women’s Center

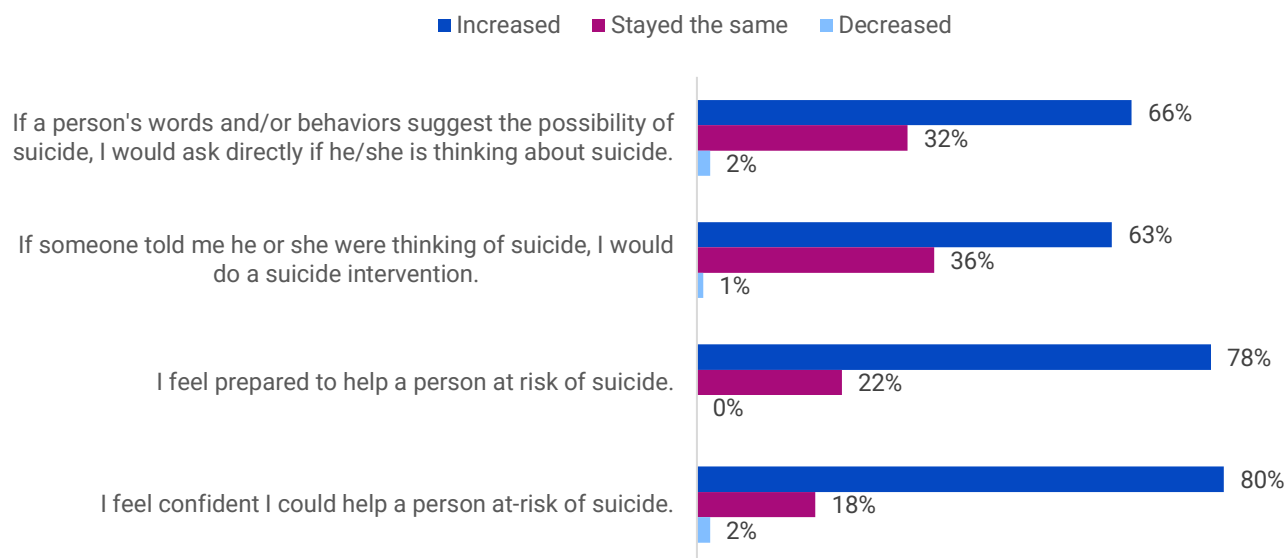
## Goals versus actual, number of training participants and types of trainings

PROVIDERS TRAINED	GOAL	ACTUAL
Number of CBO providers and clinical staff trained	400	869
TRAINING TYPE	GOAL	ACTUAL
Applied Suicide Intervention Skills Training (ASIST) Workshops	8	10
safeTALK (Suicide Awareness for Everyone) Workshops	8	8
Counseling on Access to Lethal Means (CALM) Workshops	6	6
Mental Health First Aid (MHFA) Trainings	3	3
Trainings on the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Plan tools for the Santa Cruz Behavioral Health workforce	3	4
Training and Technical Assistance: Tailored training and technical assistance plans developed for and provided specifically to local organizations	10	13

## Percentage of service providers reporting improved ability to identify, evaluate, and/or manage risk of suicide in clients, by training type

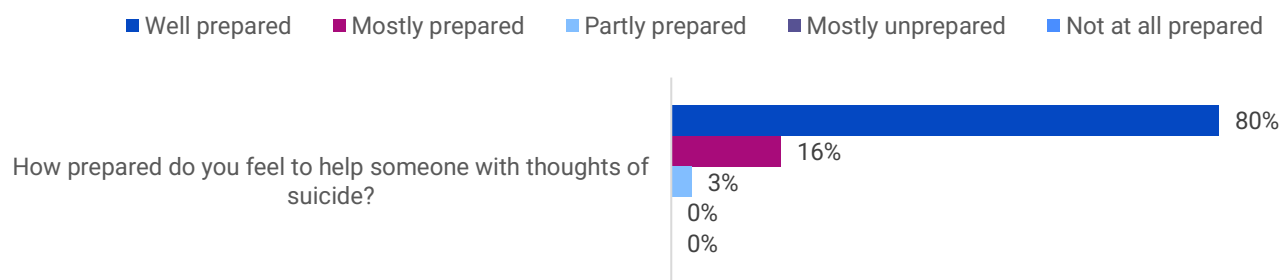
The percentage of service providers reporting improved skills or increased abilities ranged from 63% to 98% depending on the training type. This is below the goal of 90% of service providers reporting improvement or increased ability.

## Applied Suicide Intervention Skills (ASIST)



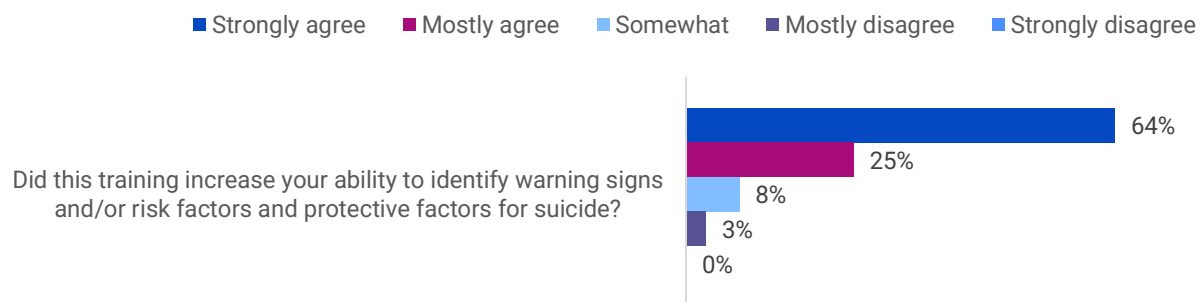
N=152

## Counseling on Access to Lethal Means (CALM)



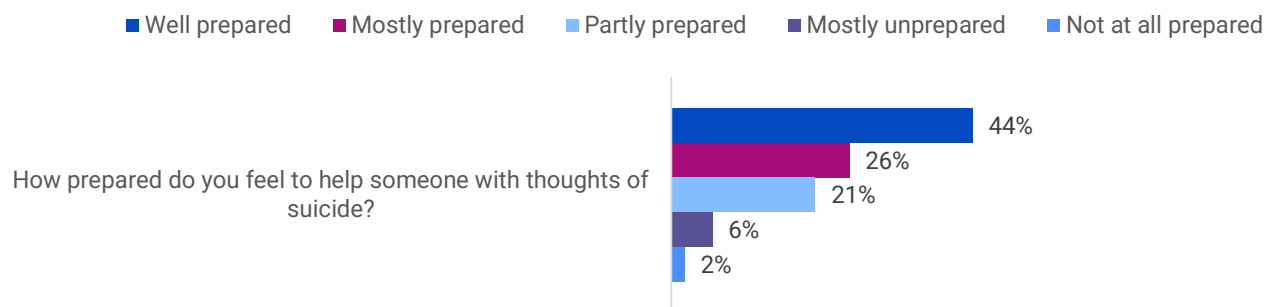
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Note: Percentages do not add up to 100% due to rounding.



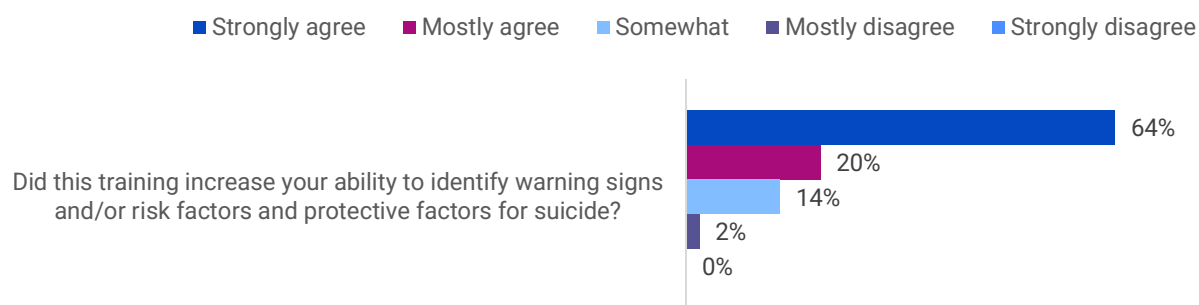
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## Custom Trainings



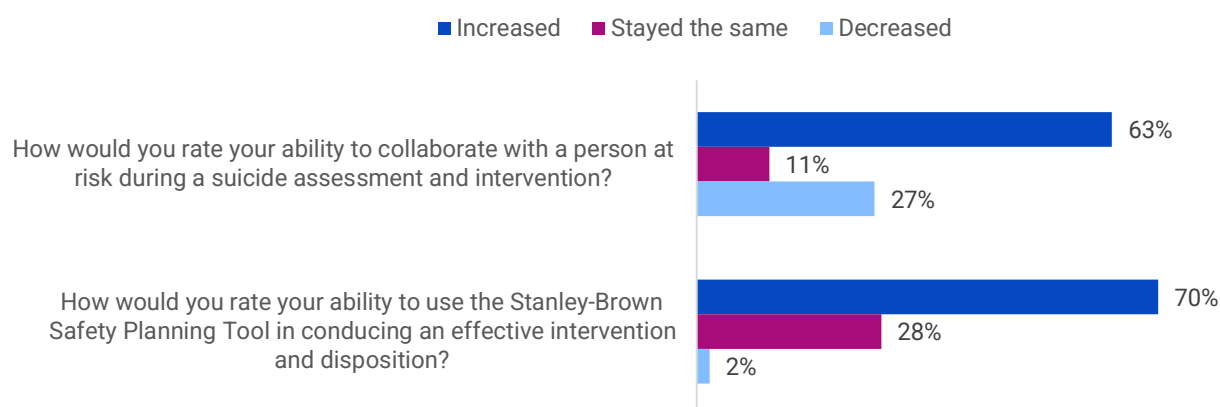
N=177

Note: Percentages do not add up to 100% due to rounding.



N=175

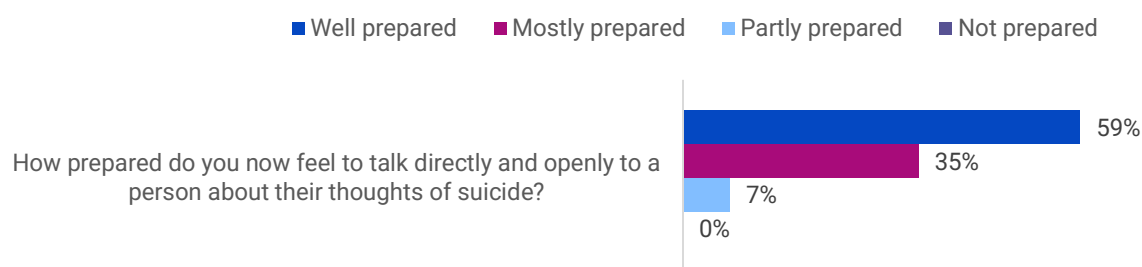
## Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning



N=132

Note: Percentages may not add up to 100% due to rounding.

## Suicide Awareness for Everyone (safeTALK)



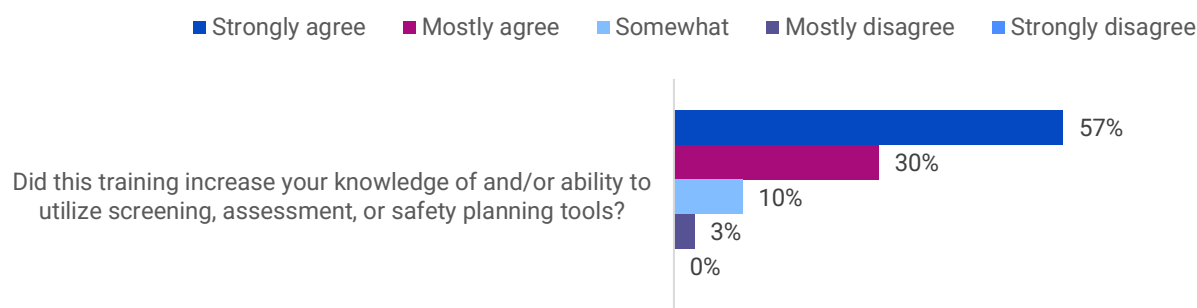
N=107

Note: Percentages do not add up to 100% due to rounding.

## Percentage of service providers reporting increased comfort and/or competence in using screening, assessment, and/or safety planning tools, by training type

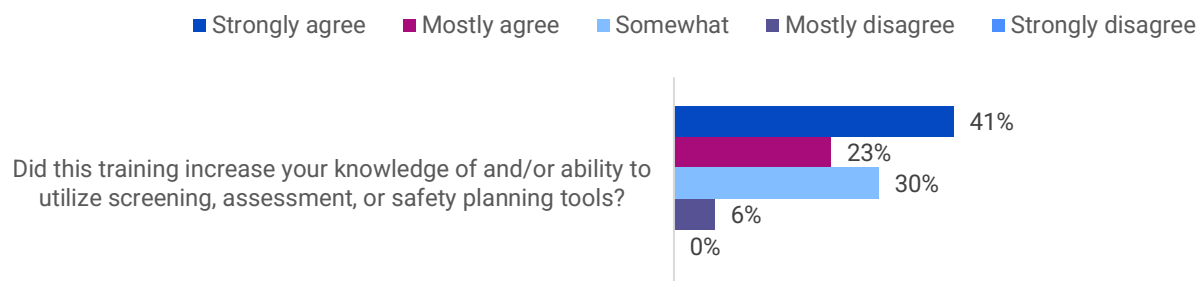
The percentage of service providers reporting increased comfort or competence ranged from 57% to 97% depending on the training type. This is below the goal of 90% of service providers reporting increased comfort or competence.

### Counseling on Access to Lethal Means (CALM)



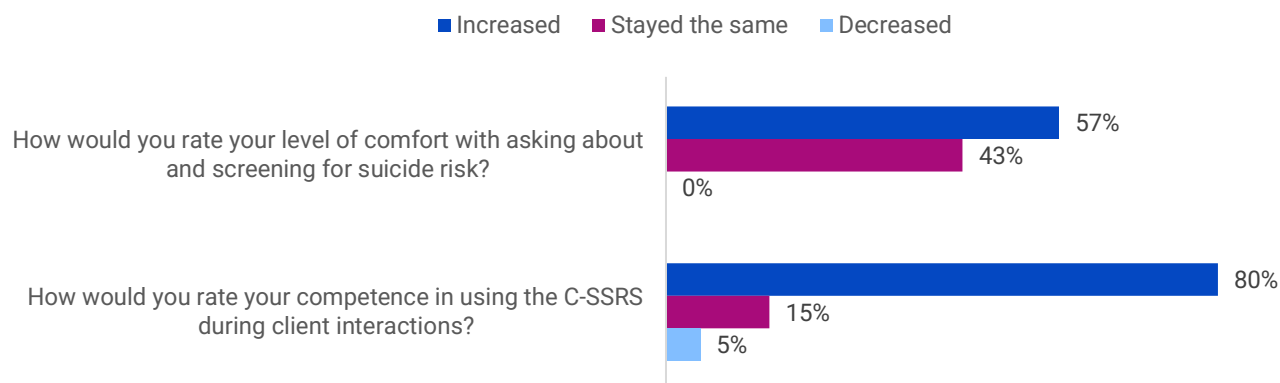
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### Custom Trainings



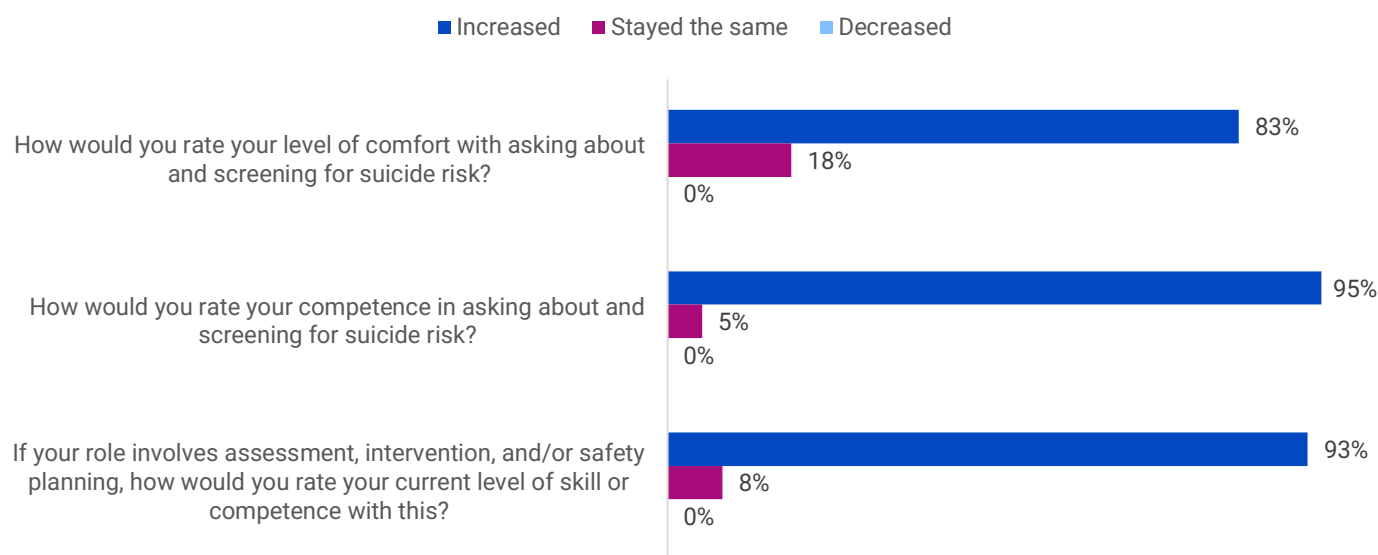
N=168

### Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning



N=132

### Mental Health First Aid (MHFA)



N=40

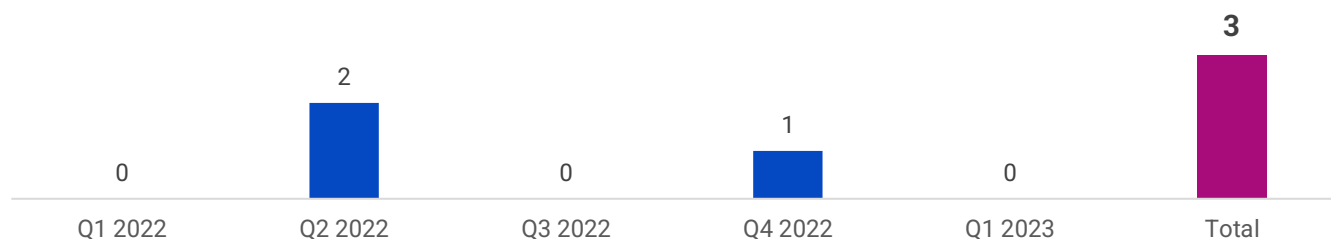
Note: Percentages may not add up to 100% due to rounding.

### GOAL 3: THROUGH PARTNERSHIP WITH LOCAL DOMESTIC AND SEXUAL VIOLENCE PREVENTION AGENCIES, ENHANCE ACCESS TO SUICIDE INTERVENTION AND CARE FOR SURVIVORS AND THEIR DEPENDENTS

#### Number of trainings provided to service providers and CBO staff, by quarter

Three (3) customized trainings were provided to Monarch Services and other domestic violence and sexual prevention staff. This is less than the goal of providing four (4) trainings to service providers and CBO staff.





### Goals versus actual

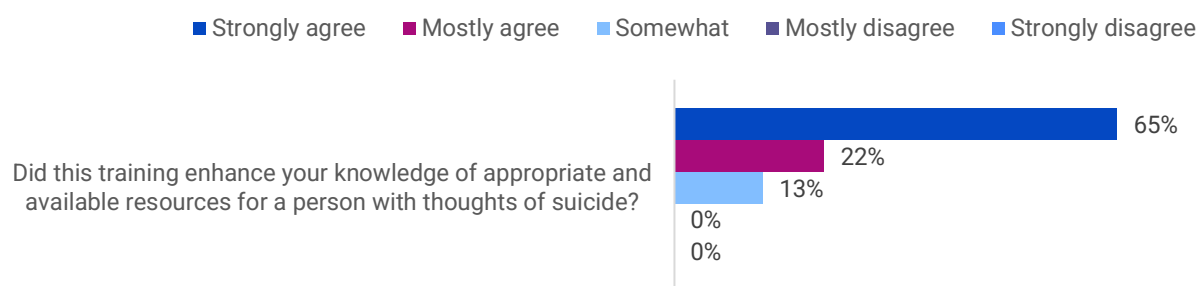
During the program period, all 141 individuals who received shelter support from Monarch Services were screened for suicide risk. Twenty-three (23) adult clients received emergency confidential shelter support for a total of 2,301 bed nights. One hundred and eighteen (118) emergency motel vouchers were provided for a total of 566 bed nights. These are less than the goals of providing shelter support to 150 individuals and distributing 511 emergency vouchers.

	GOAL	ACTUAL
Percentage of at-risk individuals screened for suicide risk	95%	100%
Number of individuals receiving shelter support	150	23 served (total of 2,301 bed nights)
Number of emergency vouchers provided	511	118 served (total of 566 voucher nights)
Number of trainings provided to service providers and CBO staff	4	3

### Percentage of service providers who report that trainings were effective or highly effective in helping them provide support to clients at risk for suicide

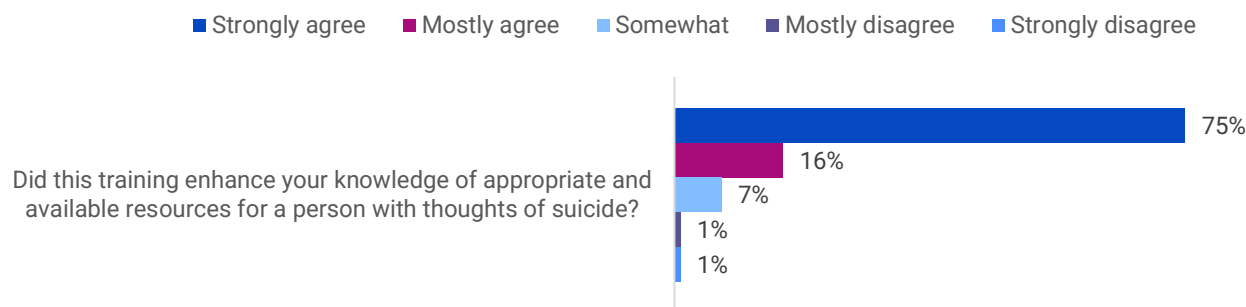
The percentage of service providers reporting that the trainings were effective or highly effective in helping them provide support to clients at risk for suicide ranged from 98% to 100% depending on the training type. This is above the goal of 90% of service providers reporting that trainings were effective or highly effective.

#### Counseling on Access to Lethal Means (CALM)



N=60

## Custom Trainings



N=176

### Percentage of service providers reporting referrals of suicidal clients for crisis services

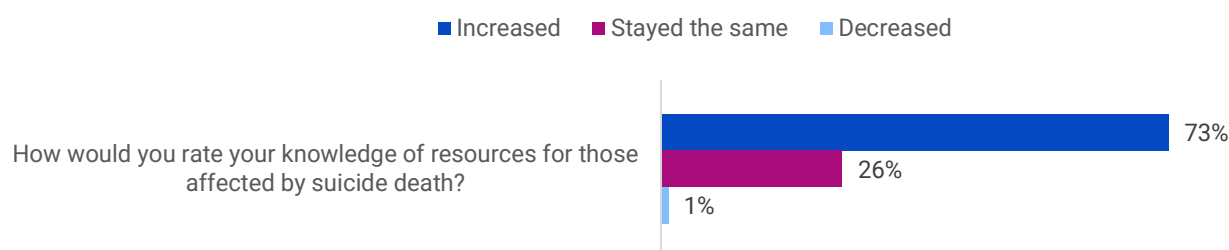
For this program, Monarch Services was the only provider asked to report on referrals of suicidal clients for crisis services. Crisis support was provided to all 31 (100%) referrals received by Monarch during the program period.

## GOAL 4: PROVIDE CARE AND SUPPORT TO INDIVIDUALS AFFECTED BY SUICIDE DEATHS BY ENHANCING THE SUPPORT NETWORK

After receiving the C-SSRS and Safety Plan Tools training, 73% of providers reported increased knowledge of resources for those affected by suicide death, and 70% reported feeling prepared to connect those affected to resources or care, less than the targets of 100% and 95%, respectively.

### Percentage of providers who report increased knowledge of resources for those affected by suicide death

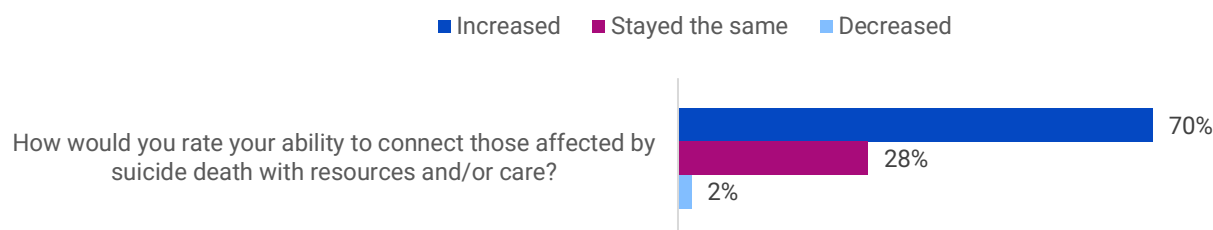
#### Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning



N=132

## Percentage of providers who reported that they felt prepared to connect those affected by suicide death with appropriate resources or care

### Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning



N=132

## Percentage of individuals exposed to a suicide death who receive materials and referrals for support

The percentage of individuals exposed to a suicide death who received materials and referrals for support could not be calculated for this report. However, the following data related to the fourth goal of this program shows the types of support offered during the program period:

Number of individuals exposed to a suicide death who receive materials and referrals for support	30
Number of grief support calls	39
Number of suicide loss support group sessions	30

## Conclusions and Recommendations

Since January 2022, Building Hope & Safety-Santa Cruz program partners worked together to improve collaboration efforts, increase service provider awareness and competency, and enhance access to suicide intervention and care, with the overarching shared goal of enhancing the support network for survivors and their dependents.

Despite the series of events that impacted program implementation including COVID-19 and local wildfires and storms, Building Hope & Safety-Santa Cruz proved to be effective in determining workforce education needs, providing a range of evidence-based trainings to providers and community members, screening individuals for imminent safety concerns and providing them with appropriate services/support, and providing suicide bereavement support to individuals affected by suicide death.

Specifically:

- More than half (58% to 93%) of service providers reported increased awareness of or familiarity with other system partners and their services/role.
- Over 800 service providers and community members received at least one evidence-based training, and tailored training and technical assistance plans were developed for and provided to 13 local organizations.
- A majority (63% to 98%) of service providers reported improved skills or increased abilities to identify, evaluate, and/or manage risk of suicide in clients, and more than half (57% to 97%) reported increased comfort or competence in using screening, assessment, and/or safety planning tools.

- One hundred percent (100%) of CALM training participants reported that the training was effective or highly effective in helping them provide support to clients at risk of suicide.
- Monarch Services provided housing support to over 100 individuals and screened all for suicide risk, in addition to screening all suicidal clients referred for crisis services.
- Nearly three-quarters (73%) of service providers reported increased knowledge of resources for those affected by suicide death. Program staff distributed materials and referrals for support to individuals exposed to a suicide death, conducted grief support calls, and offered suicide loss group support.

The Building Hope & Safety-Santa Cruz program built a solid foundation for continuing to provide education to local service providers and community members whose knowledge of suicide assessment and intervention varies. By meeting with leadership to get buy in for trainings and working with individuals and organizations to curate the training process, the program created new partnerships while meeting the enhanced need for trainings amongst a wide range of service providers. Hundreds of participants engaged in trainings, and customized staff training/technical assistance was provided to over a dozen organizations.

Program partners can build on this momentum, and specifically, can continue to:

- Coordinate and provide evidence-based trainings to service providers and community members,
- Utilize pre- and post-survey tools to measure training impact and to document learnings,
- Meet with organizational leadership to get buy in from management and staff in conveying to team members that training opportunities are important and a worthwhile use of staff time,
- Gauge the best timing, location and support needed to make trainings as accessible to attendees and inclusive of individual needs as possible,
- Work with organizations to curate the training process and ensure that individuals and teams attend the trainings that will be most useful for them personally and professionally, and
- Tailor the resource information provided to attendees based on the training module, attendee background/demographics, populations served, etc.

As a result of the Building Hope & Safety-Santa Cruz program, community members, service providers, and the overall system grew their capacity to provide care and support to individuals at risk of suicidal behavior, as well as individuals affected by suicide death.

## Logic Model

INPUTS	ACTIVITIES	SHORT-TERM OUTCOMES	LONG-TERM OUTCOMES
Applied Training	<b>Goal 1: Improve Collaboration Efforts Among Suicide Prevention Agencies and Programs</b>		
	<ul style="list-style-type: none"> <li>Establish baseline information regarding the trainings, tools, and related policies used by a range of community agencies and programs.</li> <li>Determine workforce education needs by conducting a community assessment survey and key stakeholder interviews.</li> <li>Complete initial Resource and System Mapping of existing local prevention, intervention, and postvention activities.</li> <li>Promote consistent training on, and use of, evidence-based tools.</li> </ul>	<ul style="list-style-type: none"> <li>Increase in service providers reporting increased collaboration among service providers and suicide prevention agencies and programs.</li> <li>Increase in partners reporting increased awareness of other system partners and their services/role</li> <li>Increase in service providers reporting increased comfort and/or competence with screening tools.</li> </ul>	<ul style="list-style-type: none"> <li>Increased capacity of service providers to serve individuals considering suicide or at risk of committing suicide.</li> </ul>
	<b>Goal 2: To Increase Service Provider Awareness of and Ability to Assess for and Manage Risk of Suicidal Behaviors</b>		
	<ul style="list-style-type: none"> <li>Develop a training portfolio and materials for clinical providers and workers.</li> <li>Coordinate and provide a range of identified evidence-based trainings to providers and community members.</li> </ul>	<ul style="list-style-type: none"> <li>Increase in percentage of clients who are screened for suicidal risk factors.</li> <li>Increase in staff reporting increased ability to accurately assess and manage the risk of suicide in clients.</li> <li>Increase in service providers reporting increased comfort and/or competence in using screening, assessment, and/or safety planning tools.</li> </ul>	<ul style="list-style-type: none"> <li>Improved identification of risk factors for suicide for service providers.</li> </ul>
	<b>Goal 3: Through Partnership with local domestic and sexual violence prevention agencies, enhance access to suicide intervention and care for survivors and their dependents</b>		
	<ul style="list-style-type: none"> <li>Provide trauma-informed and culturally-responsive services to target population.</li> <li>Screen individuals for imminent safety concerns and provide emergency shelter vouchers to those whose safety is in jeopardy.</li> <li>Coordinate and conduct trainings for Monarch staff, volunteers, providers, and community members on suicide prevention and intervention. Provide opportunities for follow-up skill building opportunities for staff.</li> <li>Coordinate a broad public education marketing campaign around suicide prevention.</li> </ul>	<ul style="list-style-type: none"> <li>Increase in number of at risk individuals screened for suicide risk.</li> <li>Increase in providers reporting that trainings were effective or highly effective in helping them be prepared to provide support to clients at risk for suicide.</li> <li>Increase in providers reporting referrals of suicidal clients for crisis services.</li> <li>Increase in providers reporting increased help-seeking behaviors among disproportionately impacted clients.</li> </ul>	<ul style="list-style-type: none"> <li>Reduced access to lethal means.</li> <li>Improved access to mental healthcare.</li> </ul>

	<b>Goal 4: Provide Care and Support to Individuals Affected by Suicide Deaths by Enhancing the Support Network</b>		
	<ul style="list-style-type: none"> <li>• Coordinate with relevant stakeholders to map out the existing chain of response following a suicide death.</li> <li>• Coordinate with local organizations to identify training and resource needs to provide suicide bereavement support.</li> </ul>	<ul style="list-style-type: none"> <li>• Survivors/family members receiving support after suicide death of a loved one.</li> <li>• Resources distributed to survivors/family members following the suicide death of a loved one.</li> </ul>	<ul style="list-style-type: none"> <li>• Increased social support for survivors/family members after suicide death of a loved one across the system.</li> </ul>

## **Appendix A – Building Hope & Safety Community Agency Survey Summary Report**

# Results from Building Hope & Safety Community Agency Survey – November 2022

## INTRODUCTION

In 2018, the community formed the Santa Cruz County's Suicide Prevention Task Force (SPTF) to gain a better understanding of local experience with suicide, gather and understand data, review best practices, and create a Suicide Prevention Strategic Plan. The Task Force was comprised of a wide array of community members including community-based health care employees and faith-based organizations; school officials; law enforcement, hospice personnel; behavioral health and public health staff; veterans advocacy; and other stakeholders. This represents the County's first formal suicide prevention plan, which was formally adopted by the County Board of Supervisors on June 11, 2019.

In January 2022 "Building Hope & Safety-Santa Cruz" was launched with the following activities:

**Rapid Follow-up:** County Behavioral Health (CBH) operates a program called "Rapid Connect" for persons who have attempted suicide or are at risk of a suicidal crisis.

**Screening & Assessment:** CBH, in partnership with Applied Crisis Training and Consulting, Inc. (ACT), will host training on the Columbia Suicide Severity Rating Scale (C-SSRS) and Safety Planning.

**Training:** ACT will provide workshops on these evidence-based practice (EBP) trainings: Applied Suicide Intervention Skills Training (ASIST), safeTALK, Mental Health First Aid, and Counseling on Access to Lethal Means (CALM) for service providers in Santa Cruz.

**Community Recovery Supports:** ACT will partner with CBH to implement Community-Based Supportive Services (CBSS) including a system mapping, creation of a pocket guide for services, universal and selective public education campaigns, postvention services, and expansion of supportive services for victims of domestic violence.

**Enhanced Services for Victims of Domestic Violence:** These services will be provided in partnership with Monarch Services and ACT.

**Access to Telehealth Services:** Throughout the COVID-19 pandemic, CBH, ACT, and Monarch have offered services through telehealth and, once safe, in person. ACT will partner with Monarch to develop or update a list of local resources to provide to clients needing suicide crisis support, including the suicide crisis line 24/7/365, which offers access to language interpretation in 140 languages. Monarch, Behavioral Health, and partners will provide follow-up calls to individuals at risk of suicide, offering three-way calls to connect clients with other sources of support as needed. ACT will also partner with local organizations to connect survivors of loss with audio-visual telehealth support group meetings.

## METHODOLOGY

In October 2022, 83 leaders and staff within Santa Cruz County agencies and non-profits providing mental health services completed a survey aimed at gathering information on training programs, tools, or materials for suicide assessment, prevention, intervention, or postvention. Applied Survey Research (ASR), Building Hope & Safety's evaluation partner, developed the survey and analyzed the results.



Respondents were asked to describe their use and training needs related to five specific training programs, tools and/or materials:

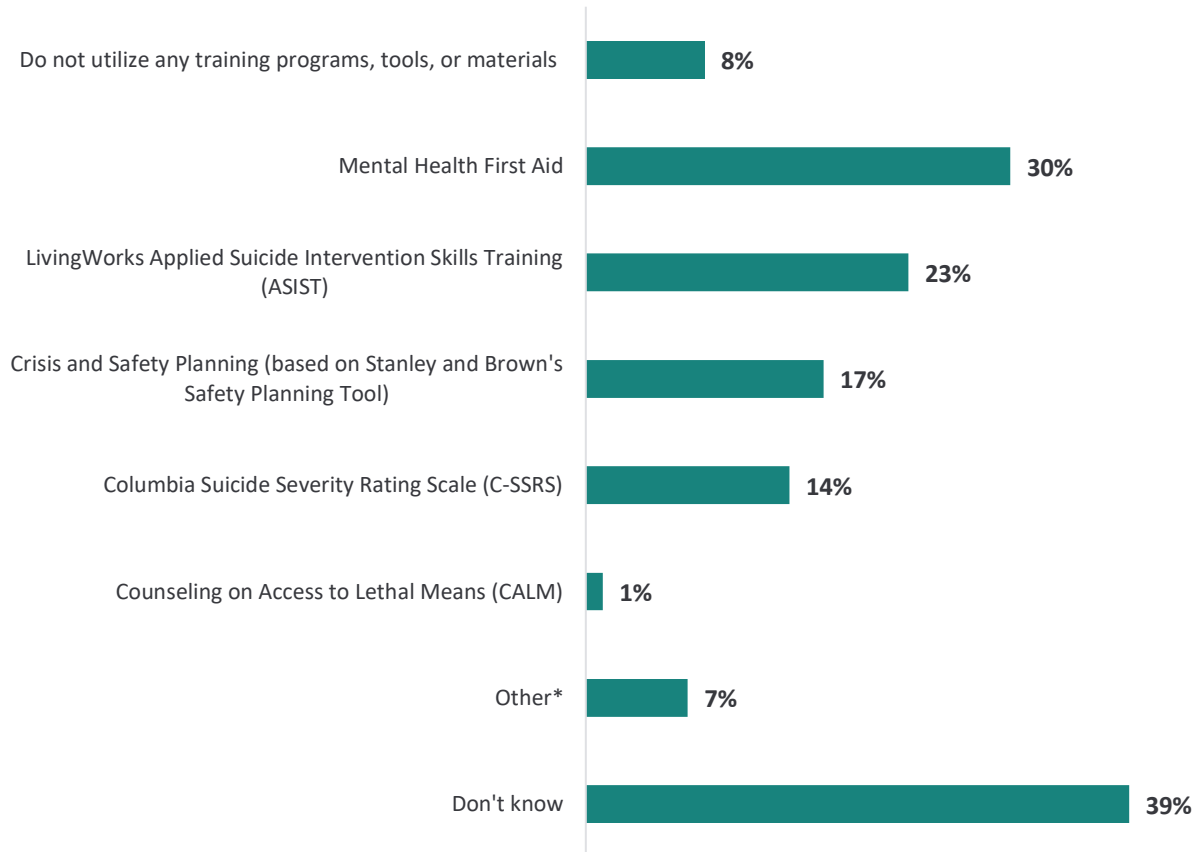
- Counseling on Access to Lethal Means (CALM)
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Crisis and Safety Planning (based on Stanley and Brown's Safety Planning Tool)
- LivingWorks Applied Suicide Intervention Skills Training (ASIST)
- Mental Health First Aid (MHFA)

They were also asked if they would like technical assistance and/or support on developing, revising, or utilizing suicide assessment, prevention, intervention and postvention policies. Organizations/agencies that completed the survey (and the percentage of overall respondents. Note: Percentages do not add up to 100% due to rounding):

1. Community Action Board (1%)
2. Encompass Community Services (2%)
3. Front Street (1%)
4. Janus (1%)
5. NAMI (1%)
6. Santa Cruz County Health Services Agency (90%)
  - a. Behavioral Health
    - i. Adult Mental Health Services
    - ii. Child and Adolescent Behavioral Health Services
    - iii. Substance Use Disorders Services
  - b. Public Health
  - c. Clinic Services
7. Santa Cruz County Probation Department (1%)
8. Sobriety Works (1%)

## SUMMARY OF SURVEY FINDINGS

**Do you or your organization currently utilize any of the following training programs, tools, or materials for suicide assessment, prevention, intervention, or postvention?**



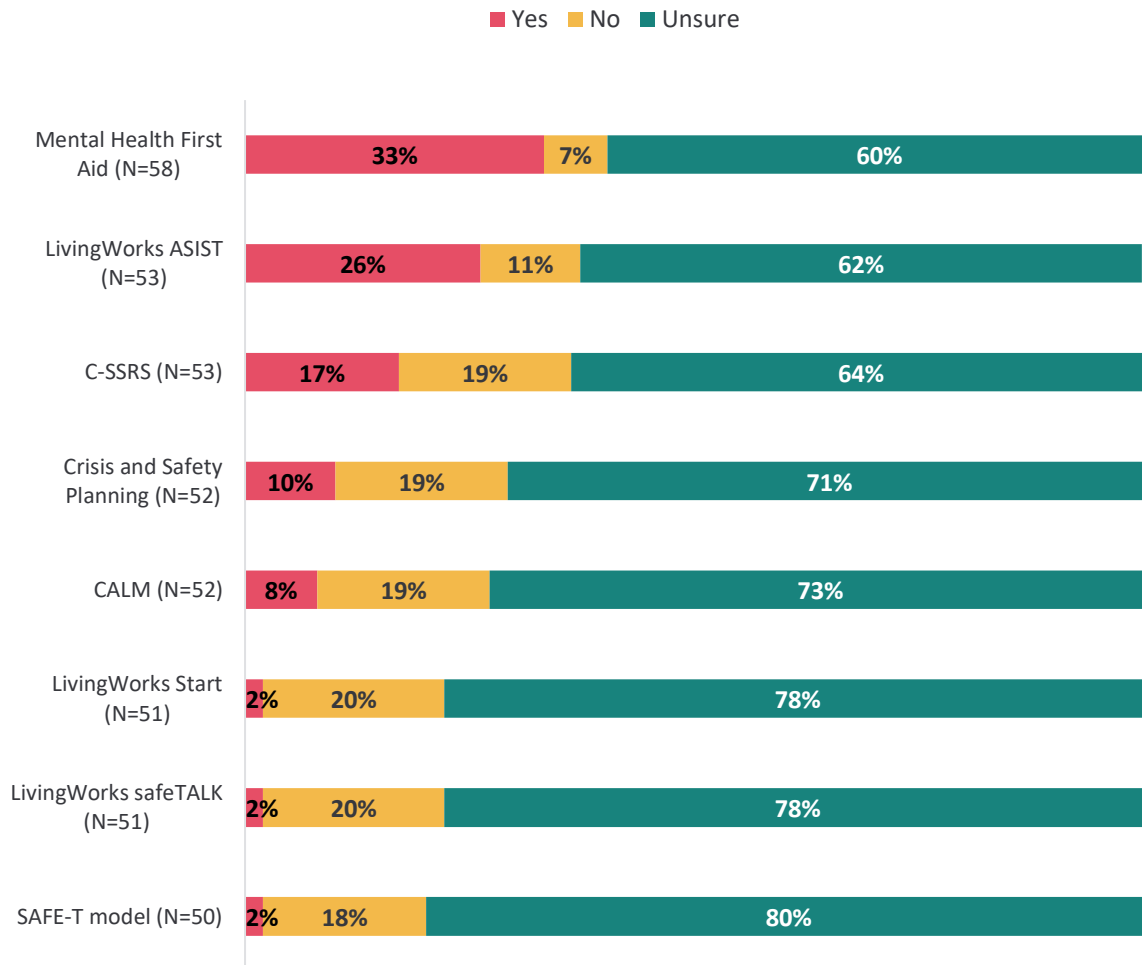
N=83 respondents offering 116 responses

Source: 2022 Building Hope & Safety Community Agency Survey.

Note: Multiple response question. Percentages may not add up to 100%.

\*Other includes the Child and Adolescent Needs and Strengths (CANS) assessment tool, the Adult Needs and Strengths Assessment (ANSA), the Patient Health Questionnaire (PHQ-9), the General Anxiety Disorder (GAD-7) scale, and trauma-informed surveys.

**If you or others at your organization use the following training programs, tools, or materials for suicide assessment, prevention, intervention, or postvention, does anyone receive or participate in any related training?**

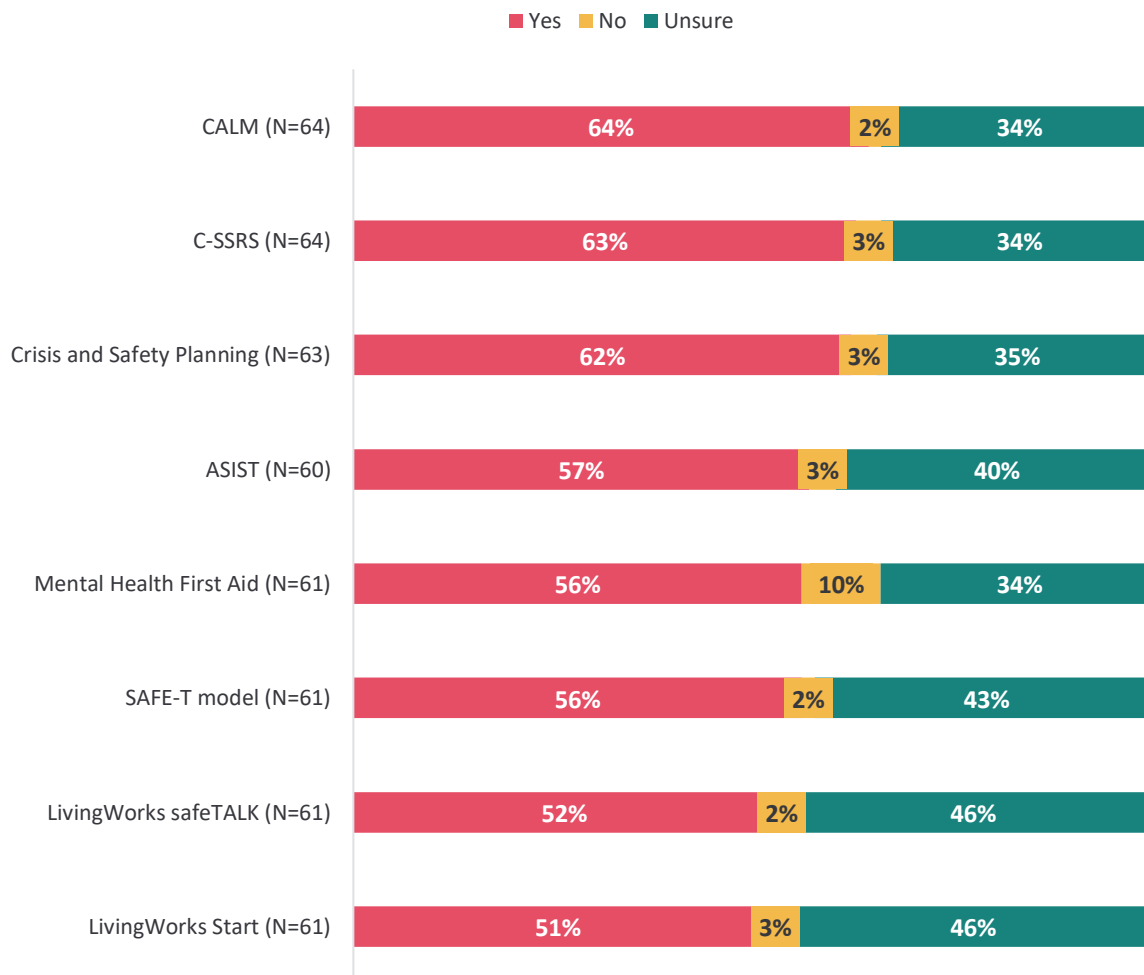


N=67

Source: 2022 Building Hope & Safety Community Agency Survey.

Note: Data does include respondents who answered, "Don't Use". The Ns for respondents answering 'Don't Use' varied from 9 to 17. Percentages may not add up to 100% due to rounding.

If you answered “No” or “Unsure” to the previous question, would you or your organization be interested in free training and/or technical assistance so that you can begin utilizing the following trainings?



N=66

Source: 2022 Building Hope & Safety Community Agency Survey.

Note: Percentages may not add up to 100% due to rounding.

If you are not interested in receiving any free training or technical assistance on the trainings listed above, please share why have no interest:

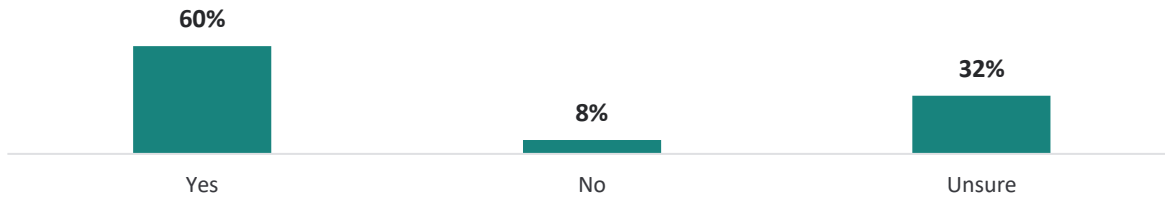
- Do not know enough about the trainings
- The trainings do not apply to their current role
- Already receiving training
- Already have assessment experience

N=8 respondents offering 9 responses

Source: 2022 Building Hope & Safety Community Agency Survey.

Note: Responses were coded and themed.

**Would you or your organization be interested in receiving technical assistance and/or support on developing, revising, or utilizing suicide assessment, prevention, intervention and postvention policies?**



N=65

Source: 2022 Building Hope & Safety Community Agency Survey.

**Please share any additional thoughts or ideas that can help inform our efforts to provide suicide assessment, prevention, intervention, and postvention training, technical assistance, and support to organizations and service providers:**

#### Additional Comments From Survey Respondents:

Theme: Continuing trainings and providing more of them	"Any and all trainings are welcome."
	"More trainings"
	"We would love more info and training but have limited staff time available for trainings that last over 3 hours due to staff shortages."
Theme: Feedback on current trainings and tools	"I am glad that future training on the [Columbia Suicide Severity Rating Scale] will be offered and that we at County BH will use this as our Evidence Based Assessment tool officially. Thank you"
	"I did the Crisis Intervention training, and it has a bit of everything. It was great and has really prepared me in working with clients."
Theme: Suggestions/ improvements for future trainings and support to organizations	"Due to heavy staff turnover annual suicide risk assessment and follow up training on de-escalation would be amazing"
	"Leverage the safety planning tools that we are currently using. Maybe they need revising, but they are a good start."
	"I would like to see ALL staff trained at some level of suicide prevention."
	"It would be great if non-clinical staff were invited to these trainings as well."
	"Provide live speakers who use a variety of these assessment tools who can attest to their effectiveness"
	"Short brush up sessions (1-2 hours) every 3-6 months to review and/or practice some of the primary interventions learned are sometimes helpful in being able to effectively implement the skills with clients."
	"Training focused on individuals with MH dx"
	"We are interested in training for youth, adults and PARENTS"
Other:	"Everyone I know who has committed suicide that were successful in killing themselves were smart, intelligent people that you'd never know were going to do it. Not sure how to prevent those."
	"I believe the progress note should include an obligatory section on suicide assessment, intervention, and debriefing section. "Patient made a contract" does not have any legal standing."

N=19

Source: 2022 Building Hope & Safety Community Agency Survey.

Note: Responses were coded and themed.