# Substance Abuse and Mental Health Services Administration
# Cooperative Agreements to Benefit Homeless Individuals for States
# Biannual Progress Report

**Government Project Officer:** Ruth Hurtado-Day

**Reporting Period Dates:** April 1, 2015 – September 30, 2015
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**Grant Year:** 2015-2016
**Reporting Period Number:** 2


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# I. Organization and Management

## A. Workforce

**1. List all State positions supported by grant funds, filled and vacant**

**Filled Positions**

| Position Title | State Agency | Full name | Full-Time Equivalent |
|---|---|---|---|
| Outpatient Administrator/Project Director | Nevada Division of Public and Behavioral Health | Ellen Richardson-Adams | .03 FTE |
| Clinic Program Planner II/Program Manager | Nevada Division of Public and Behavioral Health | Michael J. McMahon | .15 FTE |
| Administrative Services Officer I/Financial Manager | Nevada Division of Public and Behavioral Health | Christina Hadwick | .05 FTE |

**Vacancies**

There are no current vacancies

**2. List all provider positions supported by grant funds, filled and vacant**

**CABHI-States Filled Positions**

| Position Title | Provider Name | Full name | Full-Time Equivalent |
|---|---|---|---|
| Residential Program Director | New Frontier Treatment Center | Josh Cabral | .2 FTE |
| Residential Lead Counselor | New Frontier Treatment Center | Tiana Wilson | .1774 FTE |
| Clinical Assistance/Medication Management | New Frontier Treatment Center | Kathleen Hayhurst | .2 FTE |
| Data Collection/HMIS/MyAvatar/Housing First | New Frontier Treatment Center | Stacy Wilson | .2 FTE |
| Peer Navigator/Peer Recovery Specialist | New Frontier Treatment Center | Todd Streck | .4371 FTE |
| Administrative Support-Financial | New Frontier Treatment Center | Misty Alegre | .05 |
| Administrative Support-Janitorial and Maintenance | New Frontier Treatment Center | Javier Montez | .05 |

| Position Title | Provider Name | Full name | Full-Time Equivalent |
|---|---|---|---|
| Administrative Support-Grants Administration | New Frontier Treatment Center | Chris Murphey | .05 |
| Administrative Support-Computer and Networking | New Frontier Treatment Center | Chris Murphey | .05 |
| Project Director | ReStart (VOA) | Pat Cashell | .05 FTE |
| Grant Coordinator | ReStart (VOA) | Julianna Glock | .05 FTE |
| Clinical Director | ReStart (VOA) | Mickie Law | .158 FTE |
| Therapist | ReStart (VOA) | Mickie Law | .193 FTE |
| Case Manager | ReStart (VOA) | Sheree Shotts/Jeanine Fobbs | 1.1 FTE |
| Peer Navigator/Peer Recovery Specialist | ReStart (VOA) | Shane O'Neal | .5 FTE |
| Drug and Alcohol Counselor | ReStart (VOA) | MOU pending but position has been filled | 416 contract hours |
| Psychiatrist | ReStart (VOA) | Dr. Nielson | 198 contract hours |
| Program Manager | HELP of Southern Nevada | Mindy Torres | .1 FTE |
| Case Manager | HELP of Southern Nevada | Oscar Landgrave | 1 FTE |
| Case Manager | HELP of Southern Nevada | Stacy Winters | 1 FTE |
| Case Manager | HELP of Southern Nevada | Alicia Smith | 1 FTE |
| Peer Navigator/Peer Recovery Specialist | HELP of Southern Nevada | Jesse Robinson | 1 FTE |
| Statewide SOAR Coordinator | Clark County Social Service | Ambrosia Crump | 1 FTE |

**CABHI-States Supplemental Filled Positions**

| Position Title | Provider Name | Full name | Full-Time Equivalent |
|---|---|---|---|
| Program Director | WestCare | Erin Kinard | 1 FTE |
| Program Assistant | WestCare | Zea Gutierrez | 1 FTE |
| Case Manager | WestCare | Michael Thwing | 1 FTE |
| Case Manager | WestCare | Luther Kendrick | 1 FTE |
| Case Manager | WestCare | Sabrina Zamora | 1 FTE |
| Peer Support Specialist | WestCare | LeslieAnn Farrell | 1 FTE |
| Peer Support Specialist | WestCare | Rick Denton | 1 FTE |

**CABHI-States Vacancies**

There were no reported vacancies within the CABHI-States providers.

**CABHI-States Supplemental Vacancies**

The following vacancies were reported for CABHI-States Supplemental.

| Position Title | Provider Name | Full name | Full-Time Equivalent |
|---|---|---|---|
| Registered Nurse | WestCare | Vacant | 1 FTE |
| Psychiatrist | WestCare | Vacant | .4 FTE |
| Substance Abuse Counselor | WestCare | Vacant | .5 FTE |

**3. List staff changes (including contractors/consultants) within the reporting period. Include personnel hired, promoted, resigned, fired, etc. For each, include name, position, FTE, date change occurred, type of change.**

The following personnel changes were made by NFTC and HELP of Southern Nevada. No changes were reported by ReStart.

| Current Personnel | Previous Personnel | Position | FTE | Date of change | Type of Change |
|---|---|---|---|---|---|
| Stacy Winters | Jorge Castillon | Case Manager | 1 FTE | 5/1/15 | Replaced former Case Manager |
| Alicia Smith | Caralynn Scala | Case Manager | 1 FTE | 4/20/15 | Replaced former Case Manager |
| Josh Cabral | Janera Tucker | Residential Program Manager | .20 | 9/01/15 | Replaced former Residential Manager |

The following personnel changes were made by WestCare.

| Current Personnel | Previous Personnel | Position | FTE | Date of change | Type of Change |
|---|---|---|---|---|---|
| Luther Kenrick | None | Case Manager | 1 FTE | 7/20/15 | Transfer from another program into this position |
| Sabrina Zamora | None | Case Manager | 1 FTE | 7/20/15 | Transfer from another program into this position |

| Current Personnel | Previous Personnel | Position | FTE | Date of change | Type of Change |
|---|---|---|---|---|---|
| LeslieAnn Farrell | None | Peer Support Specialist | 1 FTE | 7/20/15 | Transfer from another program into this position |

4. **Discuss the impact of personnel changes on project progress. If applicable, include strategies for minimizing negative impact.**

No disruption to client services was experienced with personnel changes at HELP of Southern Nevada or at NFTC. No changes occurred at ReStart.

Personnel changes at WestCare included hiring staff for the Vivo Project. Because of these changes, they were able to begin seeing clients.

5. **List changes in addresses/phone numbers/e-mail addresses of key personnel.**

No changes were made in the addresses, phone numbers, or e-mail addresses of key personnel.

6. **Discuss obstacles encountered in filling vacancies (if any); prospects/strategies for filling vacancies and for minimizing negative program impact.**

WestCare has had difficulty finding a psychiatrist as the number in the area is limited. They have also found that some of the psychiatrists have limits on the number of hours they can work with the license they hold. WestCare shared this information during a CABHI Steering Committee. Steering Committee members are reaching out to their contacts to help publicize the vacancy.

7. **List staff who are hired specifically for their lived experiences of homelessness, substance abuse, mental illness and/or co-occurring mental and substance use disorders and their overall contribution towards the project (include barriers/challenges that peer-mentors/specialist face during the report period and program efforts to address).**

| Peer Navigators/Support | Organizations |
|---|---|
| Rick Denton | WestCare |
| LeslieAnn Farrell | WestCare |
| Shane O'Neal | ReStart (VOA) |
| Jesse Robinson | HELP of Southern Nevada |
| Todd Streck | New Frontier Treatment Center |

HELP's Peer Navigator experienced homelessness for over seven years. He is an honorably discharged veteran who receives VASH Housing and Medical Benefits from Veteran's Affairs. Jesse was using crack everyday he was on the streets. He was not addressing his mental health issues. When Jesse entered the program, he was ready for help. Jesse has been clean for over 6 years now.

Jesse is able to share his life experience with clients who are struggling with their addiction and mental health issues. He is supportive and continues to show the positives of being sober and stable with his mental health. But this is a process, when the clients are still using and don't believe it is possible to overcome addictions. Jesse has good rapport with all the clients in the program, and continues to be a positive role model for all the clients to see that it not just counseling and doing cleansing with a grown man, but an individual who has life to live. He just completed SOAR certification and is excited to have another tool to help clients.

The Peer Navigators at both ReStart and NFTC have been with their programs for a number of years, having gone through treatment themselves. As noted during site visits, they both report that clients are able to relate to them and they can empathize with the clients while painting a picture of how recovery works and the benefits they now experience including being stable, healthy, happy, and connected to the community.

Experience with substance use and mental health clients is in the background of the two personnel that transferred within WestCare to be part of the Vivo Project, the CABHI-States Supplemental project in Nevada. They have been working with individuals experiencing homelessness, substance abuse, mental illness and/or co-occurring mental and substance use disorders in a home-based setting for the past year. During the site visit in September, their experience and passion was evident as they described efforts to engage clients and outreach to difficult locations to ensure they reach anyone in need of the Vivo Project services.

All of the Peer Navigators express the importance of their role and how critical it is to the success of CABHI. No challenges were noted during the site visits and discussions with the Peer Navigators.

8. **Describe significant changes in the staffing structure or organization of the project that occurred during this reporting period. Include changes in relationships and/or working arrangements with collaborating agencies. List each change and summarize the implications of the change.**

No significant changes were made in the staffing structure or organization of the project during this reporting period.

## B. State Interagency Council

The State Interagency Council on Homelessness (ICH) oversees the implementation of the Strategic Plan. A Steering Committee was established by the ICH to serve as a Steering Committee for CABHI. Members of both are listed below.

1. **List the members of the ICH (to be completed by CABHI grantees only)**

| Member's Name | Affiliation |
|---|---|
| Betsy Aiello | Division of Health Care Financing and Policy-Medicaid |
| Stephanie Gordon | Self |
| Steven Fisher | Division of Welfare and Supportive Services |
| Michele Fuller-Hallauer | Clark County Social Service |
| CJ Manthe | Nevada State Housing Division |

| Member's Name | Affiliation |
|---|---|
| Mike McMahon | Division of Public and Behavioral Health (DPBH) - Substance Abuse Prevention & Treatment Agency (SAPTA) |
| Kat Miller | Veteran's Affairs- Targeted Populations – Veterans |
| Kevin Quint | Department of Health and Human Services |
| Ellen Richardson-Adams | Division of Public and Behavioral Health |
| Gilbert (Tony) Ramirez | US Department of Housing and Urban Services |
| Kelly Robson | HELP of Southern Nevada – Community-based CABHI Grantee |
| Kathleen Sandoval | The Children's Cabinet – Targeted Populations, Children & Youth |
| Stephen Shipman | Service Provider – Washoe County Health District |
| Sr. Pastor John Schmidt | Service Provider – Cornerstone Baptist Church |
| Tyrone Thompson | State Assembly, District 17 - Targeted Populations |

**2. List the members of the Steering Committee (to be completed by CABHI grantees only)**

| MEMBER'S NAME | Affiliation |
|---|---|
| Stephanie Gordon | Self |
| Michele Fuller-Hallauer | Clark County Social Service |
| Lana Henderson Robards | New Frontier Treatment Center |
| Ruth Hurtado-Day | SAMHSA |
| Erin Kinard | WestCare Nevada |
| Mickie Law | Volunteers of America – ReStart |
| Julianna Mayfield | Volunteers of America – ReStart |
| Mike McMahon | Division of Public and Behavioral Health |
| Chris Murphey | New Frontier Treatment Center |
| Brooke Page | Clark County Social Service |
| Ellen Richardson-Adams | Division of Public and Behavioral Health |
| Kelly Robson | HELP of Southern Nevada |
| | |

**3. List any changes in the Steering Committee within the reporting period, and the impact of the change on the committee.**

The Steering Committee, also referred to as the Nevada Governor's Interagency Council on Homelessness (NVICH) CABHI Subcommittee, continued to meet monthly during this reporting period. The only change made was the loss of Marka Turner with Nevada Rural Housing Authority as she relocated to Oregon. However, no impact was experienced. The monthly CABHI calls held between DPBH, Social Entrepreneurs, Inc. (SEI), the evaluator, and the grantees were combined with the monthly Steering Committee call so that the Steering Committee was aware of project progress and updates.

## C. Training, TA, and Site Visits

**4. Describe staff development for this reporting period (including orientation and training). Indicate:**

- **Purpose of the training, including target audience**
- **Date(s)/duration of the training**
- **Subject of the training**
- **Number of participants who attended**
- **Who provided the training**

- **Usefulness of the training**
- **Follow-up plans**

| Purpose/Target Audience | Date and Duration | Subject | # of participants | Training Provider | Usefulness | Follow-Plans |
|---|---|---|---|---|---|---|
| SOAR – for CABHI personnel | On-going/on-line training, began on August 22, 2014 | Providers were trained on SOAR so that they are able to assist clients with applying for SSI/SSDI benefits. | 8 (WestCare)<br>8 (HELP of Southern Nevada)<br>5 (NFTC) | Nevada Statewide SOAR Coordinator | CABHI personnel who have been trained are now able to connect their clients with SSI/SSDI benefits | Case managers will utilize SOAR with each client to ensure they are receiving their SSI/SSDI benefits |
| Case Managers | August 12, 2015 (1.5 hours) | Peer Run Organizations | 4 (NFTC) | SAMHSA | Case managers found training to be useful and felt they learned new skillsets | The Peer Navigator will continue to advocate for the clients' stability. |
| Management | July 24, 2015 (1 hour) | Best Practices in Strength-Based Supervision of Community Peer Workers Part 1 | 1 (NFTC) | SAMHSA | Greater understanding of best practices in working with Peer Navigators | NFTC plans to take Part 2 of the training |
| Management and Case Managers | July 28, 2015 (1.5 hours) | Privacy and Confidentiality in HMIS: 42 C.F.R. Part 2 | 1 (NFTC) | SAMHSA | Trained in the use of release of information request for HMIS that would be in compliance with 42 CFR Part 2 | Review current HMIS release of information, and plan to request to ensure compatibility |
| Management | July 31, 2015 (1 hour) | Best Practices in Strength-Based Supervision of Community Peer Workers Part 2 | 1 (NFTC) | SAMHSA | Trained in development of job disciplines and ethic requirements for peer workers | NFTC plans to review peer worker's job description |
| Case Managers | September 24, 2015 – 3 hours | SafeTALK | 1 | LivingWorks | ICM Supervisor is now trained in suicide alertness | Train another Intake/Case management staff on SafeTALK hopefully next month |

5. **If you received a SAMHSA site visit at any time, please list and provide updates on both TA Opportunities and Action Items.**

A Technical Assistance (TA) request was discussed during this reporting period on behalf of New Frontier Treatment Center (NFTC) for Medical Assisted Therapy (MAT) but with the intention to serve all sub-grantees. NFTC has admitted in excess of 500 clients annually agency-wide over the past two years. Of these non-duplicated clients, primary opioids use over this time period increased from 12.9 percent during SFY 2013-2014, to 17.6 percent for SFY 2014-2015 based on client assessments. For NFTC CABHI-State grant clients during the last grant cycle (March 1, 2014 through September 29, 2014), 44.4 percent reported opioid use while so far in the current grant cycle (September 30, 2014 through September 29, 2015) 60 percent reported opioid use. This equates to 51.5 percent of the CABHI-States grant clients having used opioids since the beginning of the grant. As opioid use increases and other evidenced based practices (EBP) become available, NFTC would like to be in the forefront in researching and implementing new EBPs such as MAT to better serve those suffering from opioid disorders. NFTC has requested that the lead clinical and medical staff are trained in all options available for medical assisted therapies, stipulate assessment procedures to properly match clients who would benefit most from these services, and provide consultation and follow-up that would be required for proper implementation of a MAT program. The Division of Public and Behavioral Health (DPBH) is reviewing the request for TA assistance in light of a larger policy issue of promoting the development of MAT programs throughout the state.

6. **If you received SAMHSA TA at any time, please describe TA and provide updates on recommendations.**

On August 25th, the Statewide SOAR Coordinator worked with SAMHSA and Policy Research Associates, Inc. to provide a statewide SOAR forum. The purpose of the forum was to provide fundamental SOAR information, best practices to implement at a local level to strengthen programs in Nevada, and to begin work on a statewide SOAR strategic plan. Although they were unable to complete a full plan during the forum, the statewide SOAR coordinator is working with the TA providers on next steps to ensure that the plan is completed. The TA received from PRA was not as effective as anticipated, largely due to a lack of communication, preparation, and coordination from PRA in advance of the forum.

7. **If any training or TA are planned for the next reporting period, describe purpose, topic, anticipated participants, and providers.**

Technical assistance has not been requested for the next reporting period as of September 2015. Additionally, providers have not identified any trainings in the next reporting period, although they will continue to attend applicable trainings as they become available.

# II. Project Implementation

## A. Project Workplan

1. **List and provide status reports of all currently approved project goals and objectives. If the grant is significantly behind or falling short in meeting any project goals/objectives, please explain and provide a plan for resolution /improvement.**

**Goal 1:** Service Capacity - Provide permanent housing, evidence-based treatment, and critical supportive services to a growing number of vulnerable people: chronically homeless men, women, and children who have co-occurring mental health and substance use disorders.

- **Status:** Progress has been made in the area of service capacity, and commitment to additional action has been prioritized:

    - Housing for CABHI-States clients. During this reporting period, two of the three CABHI-States agencies (HELP of Southern Nevada and NFTC) worked collaboratively with the housing authorities to secure permanent supportive housing vouchers. The third, ReStart, has a contract with a local jurisdiction for vouchers set-aside specifically for CABHI clients to support the permanent housing placements. However, despite these efforts, housing continues to be a challenge to secure for CABHI clients and agencies have wait lists due to the lack of housing stock or the strict federal bureaucratic requirements to obtain housing vouchers. In addition, as the economic recovery takes hold in parts of Nevada, all three regions report that affordable housing options continue to shrink, with apartment rents increasing and landlords adding requirements of deposits and background checks. Even with housing vouchers, this limits the number of options available to house CABHI clients. All of the grantees report working diligently with landlords in order to establish and maintain good relationships that can result in housing for their clients. According to the Las Vegas Review-Journal on October 20, 2015:

        > "Research firm Applied Analysis reported this week that Las Vegas rents averaged $850 a month during the third quarter, up 7.2 percent over the past year. That's the 12th consecutive quarterly increase in rents and up from a market low of $743 a month in the middle of 2011.
        >
        > That echoes similar findings from the Lied Institute for Real Estate Studies in its third-quarter apartment report. It reported rents are up 12.1 percent over the last year to $850 a month, just $27 or 3 percent below the peak in 2007. The vacancy rate fell 1.3 percentage points in the past year and is at its level since 2007 at 7.9 percent, according to Lied." Retrieved from http://www.reviewjournal.com/business/rental-rates-rising-sharply-las-vegas-valley

        Lack of affordable rental stock is also a concern in Northern Nevada as two companies, Tesla and Switch, have broken ground on facilities in the region which will result in an infusion of workers in need of housing. Finally, NFTC is located in the same community as the Fallon Naval Air Station. During site visits in September, a lack of rental housing was identified as a challenge because the Air Station is in the process of remodeling its base housing. It is moving individuals in base housing into apartments while their units are being remodeled. According to NFTC, the Air Station is remodeling 40 units at a time, which means a comparable reduction in available apartments as those apartments are being reserved for base members when their unit comes up for remodeling.

        CABHI-States Supplemental adds 50 CABHI clients in southern Nevada. Clark County Social Services has secured housing resources for the Vivo Project clients beginning September 2015. This will ensure those clients are stably housed.

Leadership across the state, including the NV ICH have identified availability of affordable housing for low-income individuals and families as a critical issue and are working to promote policies that incentivize development and set-asides for low-income, affordable housing.

- Enrollment in CABHI-States. Clients have been identified and enrolled in northern, rural, and southern Nevada for placement in CABHI-States and a waiting list now exists for admission into the program. As of September 30, 2015, 123 Year 2 clients have been enrolled. The client target was 120, making the intake coverage rate slightly over 100 percent.

**Table 1**

**Fiscal Year 2015 Clients Served by Site CABHI-States (1)**

| Agency | No. of New Clients Served | Annual Target | No. of 6 Month Follow Ups Completed* |
|---|---|---|---|
| Restart | 32 | 30 | 21 |
| Help | 74 | 70 | 40 |
| New Frontier | 17 | 20 | 10 |
| Statewide | 123 | 120 | 71 |

Notes for Table 1: New Frontier also continued to serve 7 clients who were still active from the previous fiscal year. *Follow ups completed may include clients who could not be located.

- Enrollment in CABHI-States Supplemental. Clients have been identified and enrolled in CABHI-States Supplemental, beginning in late July 2015. As of September 30, 2015, 17 clients have been enrolled. The client target was 50, but given the late implementation, it wasn't feasible to enroll that many clients in a 10 week period.

**Table 2**

**Fiscal Year 2015 Clients Served by Site CABHI-States Supplemental (2)**

| Agency | No. of New Clients Served | Annual Target | No. of 6 Month Follow Ups Completed |
|---|---|---|---|
| Clark County-the Vivo Project | 17 | 50 | n/a |

Notes for Table 2: Clark County has only recently accepted clients, therefore, no follow ups are due.

Numbers for fiscal year 2015 were collected by manually-generated aggregate reports from each site and are believed to be accurate for a point in time, but may vary slightly once data is electronically entered.

These numbers are the total number of follow ups completed. Please note not all clients would be in the program 6 months and require a follow up at the time the data was requested, so a rate cannot be calculated from these figures.

- Assisted Outpatient Treatment. DPBH identified existing opportunities to build on in order to address the "super-utilizers:" 1) specialized PACT teams, 2) assisted outpatient treatment, or 3) outpatient civil commitment (court mandated medication), 4) outpatient treatment, and 5) housing compliance. The state and other community partners are working together to assess and deliver those services.

- Housing First. This model of service delivery has been adopted in both northern and southern Nevada, including the three CABHI providers, and is being promoted and adopted as capacity allows in many counties in rural Nevada. Training was provided by SAMHSA on the Housing First approach, and several CABHI-States recipients attended this training in September 2014. In addition, the Housing First model is also reflected in the NVICH and northern Nevada Strategic Plan on Homelessness. Both Northern and Southern Nevada Continua of Care have adopted Housing First and are implementing it for all homeless service providers including CABHI. Rural Nevada communities are adopting it on a county by county basis.

- Development of a Peer Support Network. DPBH is working on several major Peer Support initiatives, which include:
  - Creating a statewide Peer Leadership Council consisting of both mental health and addictions Peers, and family members of Peers, to help provide guidance and advisory support representation of peers. The Peer Leadership Council has been established and is operating. They have worked closely with a contractor to develop the training curriculum for Peer Support Counselors. The curriculum combines mental health and substance abuse as 90% of the clients are co-occurring.
  - Establishing in Nevada state statutes pertaining to the development of criteria for licensed Peer Support Recovery Organizations (PSRO) that would ultimately employ and create workforce opportunities for mental health and addictions peers. The Division of Public and Behavioral Health submitted a Bill Draft (S.B. 489) to the State Legislator creating PSRO's. It was signed into law by Governor Brian Sandoval on June 5, 2015.
  - Establishing in Nevada state statutes pertaining to the development of a certification program for individual mental health and substance abuse peers, who complete the 40-hour training curriculum and meet other Medicaid requirements. The training modules have all been completed. However, no training was conducted as there is no infrastructure in place to support the process. Passage of S.B. 489 will provide the infrastructure, policy, and procedures needed for certification and monitoring.

- Working with Medicaid to assure the PSROs, which eventually become licensed and who employ peers which meet Medicaid criteria, are eligible for reimbursement, thus increasing workforce opportunities for peers. Nevada Medicaid regulations allow Peer Support services to be billed to Medicaid.
- Developing a website called Nevada Partners for Peers Supports (NPPS) where important information can go, including but not limited to agendas and minutes of Peer Leadership Council meetings, bylaws, job descriptions, jobs wanted, and agency and other peer updates. The project went live in July 2015.

- CABHI-States Supplemental Grant. DBPH was granted the CABHI-States Supplemental Application. The Supplemental Application added additional resources through the Vivo Project. The Vivo Project provides Intensive Case Management (ICM), combining permanent housing, evidence-based treatment, and critical supportive services to homeless veterans with severe mental illness and chronically homeless individuals with co-occurring mental health and substance use disorders. The CABHI-States Supplemental grant is specifically targeted to expanding the continuum of care, through ICM, targeting veterans and chronically homeless super-utilizers of emergency, hospital and law enforcement services. The target population are 50 (annually) "super-utilizers" of emergency, hospital and law enforcement services in Clark County with the goal of helping them achieve stability and wellness. With funding from the Division of Public and Behavioral Health, Clark County Social Service (CCSS) contracted with WestCare to implement the Vivo Project in the Clark County/Las Vegas metropolitan area, identifying consumers who would most benefit from ICM services. Housing is provided through CCSS's HUD Housing project. While WestCare is still working to secure a psychiatrist, their case managers have begun to see CABHI-Supplemental clients.

- CABHI-States Expansion Grant. In April 2015, Nevada applied for a CABHI expansion grant. The funding from the grant will be used to expand and enhance the scope of the project funded under the CABHI-States original grant. DPBH received notification of grant award (NOGA) in September 2015.

  According to the grant application narrative, the enhancement funds will be used to develop a system of care (SOC) that addresses the unique needs of homeless individuals. The CABHI Project Director will manage the System of Care (SOC) in the north and south to create a statewide approach. The enhancement will:

  - Increase current CABHI provider capacity through additional case managers,
  - Provide additional resources to provide rental deposits; utility deposits; additional beds targeting youth and young adults who have aged out of the foster system; and expanded a voucher program.
  - Expand the resources to provide a higher level of available wrap-around services to enhance the project design and results.
  - Add a Statewide Employment Specialist to provide a resource in the System of Care (SOC) to better link the homeless population with rehabilitation and vocational services as well as job services.
  - Promote working through the emergency room services to provide linkage to community case managers to minimize the use of the emergency rooms as primary care, and provide the key linkages to the SOC behavioral and mental service networks.

- Expand the opportunity for services providers to participate in the HMIS and work towards the integrated system of reporting for those who service Homeless individuals.

**Goal 2:** State Infrastructure - Increase Nevada's capacity to address homelessness by forming sustained partnerships across government, community and consumer sectors, including re-establishing the State Interagency Council on Homelessness, developing a statewide plan to end homelessness, and partnering with regional Continua of Care to access and coordinate housing and other critical resources.

Progress has been made on a number of fronts related to state infrastructure.

- Staffing. Since its establishment in July 2013, DPBH has redirected existing job functions and hired and/or contracted for a number of staffing positions specifically aimed at strengthening its ability to address homelessness by forming sustained partnerships across government, community, and consumer sectors:

    - The Statewide SSI/SSDI Outreach, Access, and Recovery (SOAR) Coordinator/Trainer was hired in January 2015. Up until then, Clark County Social Service had been providing training and assistance to CABHI-States service providers and Nevada state case managers in working with clients to obtain benefits from the US Social Security Administration (SSA). The SOAR Coordinator has continued to provide a number of online and in person trainings for CABHI personnel. In August 2015, the SOAR Coordinator worked with SAMHSA and Policy Research Associates, Inc. to host a statewide SOAR forum. SOAR fundamental information was provided as well as best practices to highlight strategies that could strengthen local SOAR programs. More than 60 (68) service providers attended across the state, marking the first time that case managers across Nevada came together to discuss the importance of SOAR and to share strategies for implementing SOAR in their agencies.

- Governor's Interagency Council on Homelessness. On November 4, 2013 Nevada Governor Brian Sandoval signed into effect an Executive Order to reinstate the Nevada State Interagency Council on Homelessness (NVICH). The Council has been recruited, appointed, and met for the first time on September 9, 2014. The three Continua of Care (CoCs) in Nevada entered into an interagency agreement to provide staff support and information to the Council. The Council meets bi-monthly and developed a statewide strategic plan to end homelessness. They established the CABHI subcommittee (also known as the CABHI Steering Committee) and a Strategic Planning subcommittee was used to develop a statewide strategic plan to end homelessness. The Strategic Planning subcommittee identified eight strategic issue areas in the strategic plan, as well as goals to address each area.

- Statewide Strategic Plan to End Homelessness. During this reporting period, the Council's strategic planning subcommittee completed the statewide strategic plan. It was adopted and forwarded to the Governor.

  The subcommittee identified a number of goals and strategies around eight strategic issue areas: housing, homelessness prevention and intervention, wraparound services, education and workforce development, coordination of primary and behavioral health, coordination of data and resources, policies, and long term planning. The Council adopted the statewide

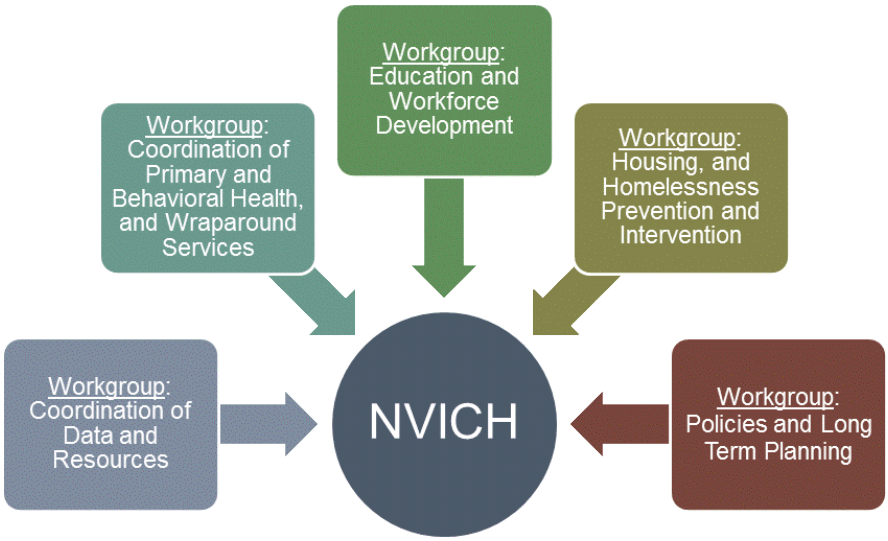
strategic plan in June of 2015, and began assigning workgroups to develop implementation plans for each of the strategic issue areas. The goals of the plan are as follows:

- Strategic Issue #1 - Housing
  - Goal 1: Preserve the existing affordable housing stock
  - Goal 2: Provide the resources necessary to further expand and develop the inventory by 2020.
  - Goal 3: Systemically as a state, identify, standardize, and promote all types of housing interventions in Nevada for subpopulations by 2017.
- Strategic Issue #2 – Homelessness Prevention and Intervention
  - Goal 1: Expand affordable housing opportunities (including Transitional Housing (TH)) through improved targeting of current housing programming that provide rental subsidies as well as an increase in construction of new or rehabilitated housing in all communities.
  - Goal 2: Coordinate housing programs and agencies to provide housing mediation opportunities for individuals and families who are at-risk of being evicted.
  - Goal 3: Rapidly rehouse people who fall out of housing.
  - Goal 4: Provide cash assistance to individuals and families who are at-risk of eviction to cover rent, mortgage, or utility arrears.
- Strategic Issue #3 – Wraparound Services
  - Goal 1: Increase access to all funding (federal, foundations, grants, private) for which Nevada may be eligible.
  - Goal 2: Each homeless or at risk of homelessness individual has a person-centered care plan, developed through appropriate credentialed personnel, that meets their medical and social needs.
- Strategic Issue #4 – Education and Workforce Development
  - Goal 1: Expand economic opportunities (through initiatives such as workforce development, education opportunities, and job skills training) for those who are at-risk or are homeless are self-sufficient through a living wage.
  - Goal 2: Increase access to education for people experiencing or most at risk of homelessness.
  - Goal 3: Determine eligibility and apply for all mainstream programs and services to reduce peoples' financial vulnerability to homelessness.
  - Goal 4: Improve access to high quality financial information, education, and counseling.
- Strategic Issue #5 – Coordination of Primary and Behavioral Health
  - Goal 1: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce peoples' vulnerability to and the impacts of homelessness.
  - Goal 2: Advance health and housing stability for people experiencing homelessness who have frequent contact with hospitals and criminal justice.
- Strategic Issue #6 – Coordination of Data and Resources
  - Goal 1: The system is integrated, streamlined, promotes data sharing and is captured consistently in HMIS.

- Goal 2: Implement centralized/coordinated intake assessment and access for all housing programs throughout the state for the homeless or those at risk of homelessness.
- Goal 3: Regularly identify options to coordinate resources.

- Strategic Issue #7 – Policies
  - Goal 1: Public and private partnerships who provide services to prevent and end homelessness will coordinate policy to ensure that barriers are eliminated and goals of the strategic plan are achieved.
  - Goal 2: Close the gap in appropriate credentialed health professionals statewide.
  - Goal 3: Break the cycle of incarceration that leads to disrupted families, limited economic prospects and poverty, increased homelessness or at risk of homelessness, and more criminal activity.
- Strategic Issue #8 – Long Term Planning
  - Goal 1: The strategic plan document is re-assessed and updated at least every five years to prevent and end homelessness.
  - Goal 2: Public outreach and education is conducted to remove the stigma around homelessness and create awareness.

Workgroups were established in July and temporary chairs were identified for each workgroup. Workgroups will meet at least quarterly and report back to the ICH. Each workgroup is charged with implementation of the goals and action plans assigned to their workgroup. The workgroups include:




In addition, the regional strategic plan for rural Nevada was finalized and adopted during this time period. The plan addresses goals related to coordinated assessment and centralized intake, housing, wrap-around services, data, funding, and advocacy. Northern Nevada's regional plan was completed prior to the reporting period and many of the implementation activities have already begun. Southern Nevada has been engaged in planning via the Governor's Council on Behavioral Health and Wellness, which submitted a plan to the Governor in December 2014.

- Enhanced Homeless Enrollment, Case Management System Capabilities (Clarity). The statewide HMIS committee for the CoC has continued to work with the vendor, Bitfocus, to increase functionality of the HMIS system including development of a statewide centralized intake process. Bitfocus also is under contract to develop a communication platform, known as an Application Program Interface (API). The API is a published specification outlining the types of initial data and formats that can be exchanged between systems. In terms of the API functionality, the vendor has completed Years 1 and 2 of development. The patch will not be usable until the end of Year 3 when all of its functionalities are implemented, due to complexities of the HMIS system. Additionally, the VI-SPDAT vulnerability index assessment tool has been implemented statewide. It is used by all CABHI providers, and data from the VI-SPDAT is now entered into the HMIS system.

- Creation of the Division of Public and Behavioral Health. On July 1, 2013, the Nevada State Legislature created a new Division within the Department of Health and Human Services (DHHS), which combined three state agencies (Public Health, Mental Health and Substance Abuse Prevention and Treatment) into the Division of Public and Behavioral Health (DPBH). Current strategic initiatives and priorities have been identified as:

    - Build Community Capacity. Historically, Nevada has been responsible for providing public mental health services. DPBH is prioritizing partnering with key stakeholders across Nevada to provide community-based, collaborative behavioral health services. To move this effort forward, the CABHI enhancement grant includes strategies for DPBH to provide direct oversight of the homeless service providers and service providers who provide services to chronically homeless veterans, unaccompanied youth, women with trauma histories and senior citizens. As oversight of this project, DPBH will sub-grant to hire a Behavioral Health Program Coordinator for northern and southern Nevada to enhance the no wrong door approach and provide greater linkage with the behavioral and mental health systems with homeless services to streamline and provide greater, more timely access to services.
    - Crisis Prevention including Screening and Early Intervention. DPBH, the Governor's Council on Behavioral Health and Wellness and policymakers across the state are focused on providing an entry point into the system aside from local emergency rooms, because 90 percent of those needing behavioral health care are not in need of acute medical care. This includes developing mobile outreach and crisis intervention teams. The Vivo Project, which is now operational, is targeting outreach to this population.
    - Stable Housing. DPBH is working to develop community-based housing plans and community-based housing authorities to assist in the delivery of housing services for homeless individuals and clients with mental illness. The Policy and Advocacy workgroup of the ICH is evaluating policy changes and incentives needed to develop more housing options statewide.
    - DPBH policies. DPBH is in the process of revising polices to reflect a person-centered approach to the provision of all services to meet the identified bio-psychosocial needs of the individuals served. In particular the Division is focused on strengthening housing options for individuals with mental health, substance abuse, and co-occurring disorders.

- Access to Medicaid. Policies are in place where upon entry into any DPBH behavioral health program, all individuals will be screened for Medicaid eligibility and, if eligible, are immediately assisted with expedited enrollment for Medicaid. Efforts will continue in discussion with the Division of Welfare and Supportive Services (DWSS) to establish a process to expedite the applications for individuals with mental/behavioral health disorders. The three community service providers for the PATH program are the three providers for the CABHI-States Grant Project and all three are Medicaid providers. Many DPBH providers have received Silver State Health Exchange Certified Application Counselor (CAC) training to assist individuals in enrolling with third party payers. Ensuring access to Medicaid is also a strategy in each of the regional strategic plans. In December, 2014 the Housing and Healthcare (H2) initiative convened a two day summit to discuss streamlining Medicaid and housing. This Initiative continues to move forward.

  Medicaid is also being addressed in the goals of the Statewide Strategic Plan to End Homelessness through the following goals and strategies:
  - Goal: Increase access to all funding (federal, foundations, grants, private) for which Nevada may be eligible.
    - Strategy 3.1.1 Advocate to Medicaid to expand habilitative services through 1915(i) funds.
    - Strategy 3.1.2 Research expanding Targeted Case Management (TCM) billings to benefit all Medicaid providers.
  - Goal: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness.
    - 5.1.2 Provide services in the homes of people who have experienced homelessness including using Medicaid-funded Assertive Community Treatment Teams for those with behavioral health needs by 2018.
    - 5.1.3 Support and evaluate the effectiveness of a "medical home" model to provide integrated care for medical and behavioral health, and to improve health and reduce health care costs in communities with the largest number of people experiencing homelessness by 2019.
    - 5.1.4 Support medical respite programs in southern and northern Nevada to allow hospitals to discharge people experiencing homelessness with complex health needs to medical respite programs that will help them transition to supportive housing by 2019.
    - 5.1.5 Increase availability of behavioral health services by 15% in southern, northern, and rural Nevada, including community mental health centers, to people experiencing or at risk of homelessness.
  - Goal: Public and private partnerships who provide services to prevent and end homelessness will coordinate policy to ensure that barriers are eliminated and goals of the strategic plan are achieved.
    - 7.1.4 Implement Medicaid program changes by 2018 to improve behavioral and physical health care delivery in supportive housing.

  The NV ICH will continue to track and report on implementation of these strategies.

- Development of Medicaid provisions (e.g., Medicaid billable services). Medicaid provisions are being developed to cover the various services needed for those who

experience chronic homelessness. DPBH will continue to partner with the Division of Health Care Financing and Policy (DHCFP) in order to ensure all billable services and opportunities are maximized to include ongoing advocacy for new programs/policies targeted to ensure services are available to individuals who experience chronic homelessness. An example of this is the discussion of habilitative services for individuals with mental/behavioral health disorders.

- Assisting substance abuse treatment and homeless providers in becoming Medicaid providers and developing Medicaid reimbursement mechanisms. The Substance Abuse Prevention and Treatment Agency's (SAPTA) ongoing collaborative efforts in working with SAPTA providers have resulted in expanded capacity to serve the homeless population. DPBH has assisted in the development of a new substance abuse/co-occurring disorders provider (Provider Type 17) in partnership with Medicaid or the Division of Health Care Finance & Policy (DHCFP). Provider Type 17 is a clinic model that is available only to SAPTA funded treatment agencies. All potential SAPTA clients are screened for Medicaid eligibility by treatment program staff. This investment in building the capacity of substance abuse and mental health providers to bill Medicaid is showing positive results. Typically, Medicaid reimburses for assessments and outpatient levels of care. SAPTA can reimburse for services that Medicaid does not typically reimburse. This affords a greater ability for Medicaid eligible clients to access a wide variety of treatment and support services. More providers are billing, and receiving reimbursement from Nevada Medicaid, as well as from the Managed Care Organizations (clients in urban counties are covered by the MCOs).

- Engaging and enrolling persons who experience chronic homelessness into Medicaid and other mainstream benefit programs (e.g., SSI/SSDI, TANF, SNAP, etc.). As with chronic homelessness, whenever a client is determined to have needs, the individual is referred for targeted case management to assist in linkage to needed benefits and services. DPBH is also in the process of adding clinical verbiage required for SSI/SSDI benefits to the standard electronic medical record to document impediments to employment. With the PATH Grant funds, these three providers aggressively engage in outreach activities to homeless individuals with mental illness or a co-occurring mental illness and substance abuse disorder. A review of client records during the provider site visits indicate that many have or are being enrolled in Medicaid. In addition, the CABHI enhancement grant will add to state infrastructure by providing an additional SOAR Benefits Specialist (Case Manager II) to work with referral sources and community partners to identify candidates, Veterans, and those with mental health disorders through referrals and outreach. In addition, there would be enhanced ability to track submission rates of the SOAR-trained service providers, by agency. This position would carry the following responsibilities: 1) Initiate paperwork with consumers referred to program by filing initial documentation of representation with SSA office; 2) Complete interviews with consumers to gather information to complete SSI/SSDI applications; 3) Gather medical records and other information to complete SSI/SSDI applications; 4) Accompany consumers to appointments at the Social Security Administration office; 5) Coordinate visits to medical doctors, psychiatrics, and other specialist to obtain evidence for case And 6) Assist the team with administrative tasks as needed.

- Streamlining Eligibility processes. Implementation of the Affordable Care Act (ACA) required each state to develop a single-streamline application (SSA) for Medicaid services. The SSA was designed to be an online tool as part of the state or federal based exchange used to obtain healthcare coverage. In Nevada, the Silver State Health Insurance Exchange (SSHiX) was tasked with the creation and implementation of the SSA. Once the SSA was developed and coded into the SSHiX web site, that page became the only access point to submit an application for healthcare coverage (Medicaid or Qualified Health Plan).

    - The State of Nevada Division of Welfare and Supportive Services (DWSS) reached out to the community-based providers to provide instruction on how to use the web site and take in comments to improve the application process. The effort was well received. A great many of the community-based providers participated, and continue to participate, in these efforts. Additionally, a number of community-based providers became Certified Application Counselors (CAC's) in order to assist people in submitting applications for healthcare coverage.

**2. Describe evaluation activities during the reporting period.**

The following evaluation activities occurred during this reporting period.

| Evaluation Activities | Date Completed |
|---|---|
| Visits to state officers and provider sites, meetings with project manager, site provider staff | Week of 9/22/2015 |
| Review of program documents | October 2014 to present |
| Training in GPRA, CDP and HMIS/Clarity systems | October 2014 to April 2015 |
| Review of state materials including homeless census reports | April 2015 |
| Work with program staff on data systems and access for the evaluation | October to present |
| Evaluation plan developed and approved | 2/20/15 |
| *Monthly* statistical reports produced at time of monthly call. | Only one monthly report could be produced from the CDP before it was taken down, but it was provided and discussed at the monthly sub-committee meeting |
| *6 month summary report* | Provided to state Project Manager on 3/22/15 |
| Logic Model drafted for state level goals | Provided and approved by state project manager 4/7/15 |
| *Annual Evaluation report* outline/template to include 6 month template data plus interview data. | Provided 3/30/15 and approved April 7, 2015 |

| Evaluation Activities | Date Completed |
|---|---|
| Data administration -<br>- Generate reports with demographics and summary of 6 month follow-up rates, etc. | Only one monthly report could be produced from the CDP before it was taken down, but it was provided and discussed at the monthly sub-committee meeting |
| Monthly calls to providers to check in on evaluation needs, issues | Monthly and continuous |
| Preparation for annual site visits, interview protocols for stakeholders and clients. | Completed. IRB approvals obtained for client focus groups |
| Stakeholder Interviews<br><br>Annual Site Visits & focus group Interviews | Completed during the weeks of August 24th, September 14th and September 21st |
| Annual Evaluation Report | Report delivered to the state mid-October, but no numerical data is available at this time. Alternative plans for data entry have been discussed and verbally approved by Federal Project Officer |

- **Discuss how evaluation findings were used to improve the project.**

The six month evaluation report was completed in April and discussed with the state project manager. The report was geared to address the central goals of the project including: disparity access, numerical goals, and outcomes as identified and reported through the legacy Government Performance and Results Act (GPRA) system. Client outcomes appear to be positive. At follow up site visits, the evaluation findings were discussed with programs, focusing on two elements. Ensuring that programs understood when to conduct follow up reports with each client was discussed. In addition, clarity about the difference between race and ethnicity, and the need to collect both race and ethnicity data was discussed. Discussion of the data was used to determine whether adjustments need to be made in the programs as they are currently being implemented. No major adjustments were made, but the use of a common assessment tool the VI-SPDAT was implemented.

- **Discuss any problems encountered in conducting the evaluation, the impact of these problems on the evaluation and on the overall project, and plans for resolving the problems.**

The loss of the GPRA system and its data, as well as the loss of the new CDP system has prevented the sites from entering data into the system. No data could be extracted in either report form or raw data via a download.

The state proactively explored and proposed a number of interim solutions that were discussed with the Federal Project Officer as cost effective ways to obtain the existing paper GPRA forms and convert them into an electronic format for this report as well as to collect data in the future until a new system is put in place. Options include (1) full or partial entry of the data fields into a database for analysis to meet the short term reporting requirements and (2) requiring all sites to enter the GPRA legacy form data into

Nevada's HMIS system. This would require substantial time and expenditure of funds to develop the screens and output reporting. After discussion with the Federal Project Officer, option 1 with a partial set of data, will be used to collect and report data going forward.

**3. Present evaluation findings to date, including outcomes, process findings, results of special studies, etc.**

The six month report is attached which provides numerical targets for each site and their numbers and headcount, information on the outcomes and characteristics of the population. Disparity goals and comparisons to point in time census figures for the state were also provided. Highlights of the findings to date include:

- The project has positively influenced the state's capacity to address the needs of the homeless population throughout the state. The ongoing planning efforts have been rigorous and helpful to inform and motivate agencies and develop collaborations. The simple process of receiving this grant, learning about the federal award process, and having the ability to take in clients with high need was uniformly noted to be beneficial and a positive learning experience.
- The case managers carry very heavy loads and are not always able to care for the highest need-populations to the extent they would like.
- Staff feel that greater peer-to-peer communications among the sites would be beneficial.
- Criteria for enrolling, discharging, and determining when a client becomes a CABHI client appears to be ambiguous in some cases. As a result, a statewide forum is being planned to bring all grantees together and ensure uniform processes are in place for enrolling, discharging and determining when a client becomes a CABHI client.
- Data collection and entry has been problematic, largely because the federal reporting system is not functioning. Steps should be taken to ensure data collected locally can be entered into a uniform system across the sites. Obstacles are lack of sufficient funds for housing; lack of housing options in the rural areas and higher than ideal caseloads. Because enrollment has been strong in the programs, caseloads are over limit and thus outside of fidelity for Integrated Case Management (ICM).

Focus groups with clients as well as interviews with local staff and peer navigators were conducted at each of the sites. The purpose of the focus groups was to gain insight into the operation of the program from the clients' perspectives and to obtain feedback on issues that could help improve the program for the next cohort of clients. The program was uniformly highly praised for providing housing and for the case managers who worked with the clients. Typical comments included that their case managers are always there for them, that they take each person where they are and adapt the services to what the client needed.

No negatives were reported by the clients regarding the program. Clients felt that the intake process was relatively straightforward and, in some cases, actually easy. The only issue was the wait for housing. Even there, if there was a delay in getting housing, clients often took responsibility for the delay themselves by indicating they didn't follow through or began using substances again. However, once they were back working with the case manager, everything worked great.

Fear of losing their current housing was of high to existential concern for most of the clients. Some felt that twelve months was not enough time and needed three years. Others volunteered that one year was enough to get on your feet if the person could work.

A theme that arose in each of the client groups was a mix of shame at having fallen so far, lost so much, and in taking help from the government, but at the same time, pride in what they had accomplished and where they were now. Clients who expressed these opinions also expressed skepticism of those whom they observed were not participating in recovery and were viewed as using the system to get free housing.

According to the evaluation report, CABHI is over and again attributed with giving clients hope, the peace of mind necessary to concentrate on something other than worries of "where am I going to sleep?" and "how can I eat today?" Freed from this anxiety, and with their case worker serving as an impetus, they begin to work on their addictions, restore their self-confidence, and develop a sense of a different future.

See attachment 3 for the evaluation report and recommendations.

4. **If the GPRA intake is below 100 percent or 6-month follow-up is below 80 percent, please explain the plan for reaching the targets.**

The follow up rate prior to the close of the GPRA system was 55.7% at mid-year and the issue was addressed with sub grantees at site visits in the spring of 2015. CABHI sites report conducting follow-up. However, now that both the GPRA and the CDP systems are down, data has not been updated since providers are not able to access the system.

The plan for remedying this at mid-year was simple. Within two weeks of their gaining access and the ability to enter data, providers were requested to enter the follow up data they had on hand. The project manager was monitoring the information and reports from CDP were generated, but the data from the CDP appeared to be inaccurate or incomplete and now isn't accessible at all.

## B. Significant Project Activities

1. **Provide details if there were any adverse events during the reporting period, such as deaths or injuries to clients or staff. Discuss any actions taken following the events to learn from the experience and prevent future adverse events.**

Event: During the September site visits, one record reviewed during a site visit with HELP of Southern Nevada noted that a client had been beaten up by friends staying in his apartment. The client continued to let friends stay in the apartment.

Solution: The case record noted the HELP of Southern Nevada case manager who assisted the client in a number of ways. The case manager took pictures of the client's bruises, encouraged the client to file a police report and supported the client in contacting the police. The case file included documentation of the pictures and the police report and outlined the discussions the case manager had with the client to solve this issue. The client eventually agreed to move to a new address in a safer neighborhood away from the friends. The support was provided in a respectful, non-judgmental manner that was consistent with Housing First. The client continues to be a CABHI client and work with his case manager. The client's move and new address were documented in the client record.

2. **Discuss problems or barriers encountered during the reporting period (including GPO-initiated Corrective Action Plans). Describe the barrier, the impact on the project implementation, and steps taken or planned to overcome the barrier.**

Barrier: Because of the lack of housing stock available in northern, southern, and rural Nevada, as well as strict requirements to obtain housing vouchers, providers currently have long wait lists and have difficulty placing clients into permanent housing.

Solution: Providers continue to work with their local Housing Authorities to remove barriers to receiving housing vouchers. They are also creating relationships with landlords to locate housing for their clients. They continue to work with the local housing authorities to obtain Section 8 vouchers for their clients. During this reporting period, vouchers through Nevada Rural Housing Authority were placed on a hold due to lack of funds. Churchill County Social Services was able to work with NFTC to provide some vouchers for their NFTC CABHI clients. In addition, they continue to pursue additional funding for housing and advocate for additional housing through the NV ICH.

Barrier: The CABHI-States grant requires that providers enroll a specific number of clients per each year. However, the grant does not provide additional funding to support additional case managers to handle the increased caseload. Because of this, CABHI case managers who had caseloads of 1:30 in Year 1 in some cases experienced a ratio of 1:60 with the addition of Year 2 clients. If additional case managers are not hired, caseloads will be 1:90 in Year 3.

Solution: DPBH has submitted a carryover request to SAMHSA that would allow carryover funds to be used to hire additional case managers to support the increase in CABHI clients in Years 2 and 3. The carryover request has been approved, and DPBH is working to issue work orders to the three providers in order to provide them the needed funds to hire additional case managers. It is anticipated this will be completed in October 2015. In addition, DPBH applied for an expansion grant to address the case manager's caseloads through hiring more case managers. DPBH received notification in September that it was awarded funds. In site visits with CABHI providers in September, they all noted that they had potential candidates for case manager positions and could hire quickly once the funds are available. This will allow each project to reduce caseloads and increase the number of home visits conducted with clients.

3. **Discuss any other project activities or events that occurred during the reporting period that may be important in understanding the progress of the project or the circumstances under which the project operates.**

During this reporting period, there were a number of technical issues with the CDP system, which eventually failed entirely, leaving providers with no system in which to report. Despite attending webinars and trainings prior to the transfer, providers and staff were unable to gain access to the system. This means that providers have been unable to enter client data into the system, and instead are tracking data through the use of hard copies. As of September 30, 2015, no one has been able to gain entry and updates from SAMHSA indicate that the CDP system will be down for the foreseeable future. The State has worked with the GPO and evaluator to identify potential solutions and is implementing an internal data collection and reporting system for the next grant period.

As part of the program management of CABHI – States and CABHI – Supplemental grants, bi-annual site visits were conducted with HELP of Southern Nevada, WestCare, Volunteers of American/ReStart and New Frontier Treatment Center. Fifteen staff across the four sites participated in the site visits which took place across two weeks from September 14-23, 2015 and were conducted by the program manager, often accompanied by the evaluator. The results provide a snap shot of the project, identifying successes and challenges experienced by those providing services.

**Successes**

A number of successes were articulated during the site visits. These include:

- Enhanced collaboration with jurisdictions resulting in the designation of additional vouchers for housing for CABHI clients
- Implementation of effective Peer Recovery supports
- Anecdotal reports from CABHI clients who are doing well
- Achievement of client targets for numbers served during the year
- Evidence that implementing Housing First and harm reduction works to stabilize clients who have been on the street and are chronically homeless and keep them housed
- Implementation of Coordinated Entry leading to efficiencies in admitting clients
- Additional staff completing SOAR training
- Better data on SOAR Outcomes being captured

**Challenges**

Several challenges were identified during the site visits. They include:

- Reporting CABHI clients in Clarity
- Lack of access to housing vouchers and affordable housing stock
- Lack of employment options that pay a living wage for clients who can and want to work
- Confusion about clear admission and discharge criteria for CABHI compared to other programming
- Financial Counseling – there are a number of clients that are on SSI/SSDI who need financial coaching on how to save/manage a fixed amount of income
- Wrap-around Services – because of the target population, there is a need for comprehensive wrap-around care and insufficient resources
- Transportation – client need bus passes to get to necessary appointments and to meet their basic needs
- Insufficient salaries for CABHI Peer Navigator and Case Managers to maintain an appropriate ratio of staff to clients
- Funding for supportive services such as urinalysis, bus passes, forms of identification, starter kits for apartments, food vouchers, toiletries, and feminine hygiene products were all identified as ongoing needs
- Additional case managers are needed

4. **Sustainability plans:**
    - **Describe efforts to implement the Sustainability Plan and the steps taken during the award period to ensure continuance of the program after the**

**award period has ended (e.g. decrease dependence on grant funding by gradually increasing the availability of other funds over the life of the award).**

Components of the sustainability plan have been developed as part of the Statewide Strategic Plan to End Homelessness. A number of goals have been developed to ensure continuance of the program after the award period has ended through the development of the following goals and strategies:

- Goal: Provide the resources necessary to further expand and develop the inventory by 2020.
  - Strategy: Secure affordable permanent housing units statewide as determined by an annual evaluation to identify ongoing needs.
  - Secure permanent supportive housing units based on a Housing First approach, primarily for chronically homeless, as determined by an annual evaluation to identify ongoing needs.
- Goal: Expand affordable housing opportunities (including transitional housing) through improved targeting of current housing programming that provides rental subsidies as well as an increase in construction of new or rehabilitated housing in all communities.
  - Strategy: Increase rental housing subsidies to individuals and families experiencing or most at risk of homelessness by 20 percent in federal, state, local, and private resources.
  - Strategy: Increase the total number of affordable rental homes constructed and rehabilitated by 10 percent in southern, northern, and rural Nevada.
- Goal: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness.
  - Strategy: Link housing providers and health and behavioral health care providers to co-locate or coordinate health, behavioral health, safety, and wellness services with housing and create better resources for providers to connect patients to housing resources by 2018.
  - Strategy: Provide services in the homes of people who have experienced homelessness including using Medicaid-funded Assertive Community Treatment Teams for those with behavioral health needs by 2018.
  - Strategy: Support and evaluate the effectiveness of a "medical home" model to provide integrated care for medical and behavioral health, and to improve health and reduce health care costs in communities with the largest number of people experiencing homelessness by 2019.
  - Strategy: Support medical respite programs in southern and northern Nevada to allow hospitals to discharge people experiencing homelessness with complex health needs to medical respite programs that will help them transition to supportive housing by 2019.
  - Strategy: Increase availability of behavioral health services by 15% in southern, northern and, rural Nevada, including community mental health centers, to people experiencing or at risk of homelessness.

In addition, CABHI providers have sought approval as Provider Type 17 for Medicaid reimbursement. Special Clinics authorized by the Division of Health Care Financing and Policy (DHCFP) include Community Health, Family Planning, Federally Qualified Health Centers (FQHCs), HIV, TB, Methadone, Rural Health (RHC), Special Children's clinics, School Based Health Centers (SBHC) and Substance Abuse Agency Model (SAAM) clinics. Two of the three CABHI-

States sites have Provider 17 status. All four CABHI sub grantees are able to bill Medicaid which creates a funding stream for some of their reimbursable services.

- **Include demonstration that any new resources or resources from existing programs that are included in the funding plan are being allocated specifically to the GBHI/SSH program.**

During this reporting period, the State obtained contract approval and the CABHI-States Supplemental grant and the sub grantee, WestCare, has begun implementation. This includes hiring staff and admitting CABHI clients.

In addition, a CABHI-State expansion grant application was awarded. The CABHI-State expansion grant specifically outlined a strategy to add resources from the Nevada Department of Employment Training and Rehabilitation (DETR). DETR will provide an Employment Specialist to enhance state and community capacity to provide and expand evidence-based supported employment programs for the population of focus through the funds available for Vocational and Rehabilitation (for Veterans); registration into JobConnect at one-stop American Job Centers (AJC); coordination with community colleges and apprenticeship programs through Jobs for American Graduates (JAG); and be part of the SOC activities for linkage into the programs. The Nevada JobConnect is a current partner with DPBH to provide linkage to Veterans programs, access to tax credit programs for Veterans, and to provide all unemployed individuals with access to job programs, resume' development and support. This would not require any additional funding through the CABHI grant. These resources will be used to support the sustainment of programs.

## C. Housing Component

| **A. Funding Source** | **Housing Type[1]** | **Total # of Units** | **# of Persons Served this Reporting Period[2]** |
|---|---|---|---|
| HELP of Southern Nevada | Scattered Site | 70 | 74 |
| New Frontier Treatment Center | Congregate/project-based | 20 | 20 |
| ReStart (VOA) | Scattered Site | 30 | 30 |

[1]scattered, congregate/project-based, or mixed

[2]explain if the number of persons served reflects turn over in units or multiple occupancies per unit

| **B. Funding Source** | **Housing Type[1]** | **Total # of Units** | **# of Persons Served this Reporting Period[2]** |
|---|---|---|---|
| WestCare | Scattered Site | 50 | 17 |

[1]scattered, congregate/project-based, or mixed

[2]explain if the number of persons served reflects turn over in units or multiple occupancies per unit

**List and describe any changes to required housing (i.e. additional housing secured, loss of housing, and any other challenges faced) during the reporting period.**

- Rural Nevada Housing Authority closed its application system and no further housing vouchers were available to NFTC since August 2015. Five additional vouchers for CABHI clients were secured from Churchill County Social Services for NFTC clients in September 2015.
- ReStart received notification in September 2015 that the City of Reno will continue to provide funding for CABHI clients in Year 3 of the project.
- HELP of Southern Nevada continued to receive housing support funding from the City of Las Vegas, Henderson, and North Las Vegas.
- WestCare received notification of 50 housing vouchers for the Vivo Project from a grant secured by Clark County Social Service.

## D. Mainstream Benefits

Site visits were used to sample client records at each sub grantee site. A review of client records indicated that case managers were assisting clients in accessing mainstream resources. In addition, a site visit with the SOAR Coordinator indicated the following:

- Eighteen individuals in Nevada have completed all aspects of the training which was an increase of 5 from the previous reporting period.
- 172 have enrolled in the online course and 121 have passed the online course.
- For the period of 7/1/14 to 6/30/15 (SOAR Reporting timeframe), 18 SSI/SSDI initial applications were approved during that period with one application denied.
- The average number of days to initial decision was 107 days.
- The total General Assistance (GA) dollar amount eligible for reimbursement to state/county as a result of SOAR was $14,400.
- This funding was for 13 clients.

**Review of records**

| Mainstream Benefit Type | Status of Benefit | | | |
|---|---|---|---|---|
| | **Benefits approved** | **Benefit application filed** | **Appeal filed** | **Benefits Denied** |
| Medicaid* | 9 of 13 records randomly sampled had evidence of Medicaid | | | |
| SSI/SSDI | 3 of 13 records had evidence of SSDI income | | | |
| Food Stamps | 6 of 13 records had evidence of SNAP | | | |
| General Assistance** | | | | |
| Veteran's Benefits/Pension | 2 of 13 records indicated Veteran Benefits | | | |
| TANF | Not Applicable | | | |
| Other (specify) | | | | |

* HMIS does not have the ability to track if a Medicaid application has been filed, if an appeal has been filed or if benefits were denied as these statuses are not part of the HMIS data standards. Providers are only able to see if benefits were approved.

**Churchill County, Washoe County and most rural counties do not have this option.

## E. Interim Financial Status

1. **Report of grant expenditures through the end of the reporting period. Report expenditures, not obligations. For instance, if you have a contract with an evaluator for $50,000 a year, but pay it out monthly, report the amount actually paid, not the amount obligated. [In the 'Total Funding' cell, please enter the total amount of grant funding drawn down since the initiation of the grant.] Calculate 'Remaining Balance' by subtracting total cumulative expenditures to date from the total funding amount.**

   Interim financial status as of September 30, 2015.

| | **Total Funding**: $711,181 | |
|---|---|---|
| **Expenditures** | | |
| **Expense Category** | **Expenditures This Period** | **Cumulative Expenditures to date** |
| Staff salaries | $ 229,452 | $ 326,410 |
| Fringe | | |
| Contracts | $ 29,857 | $ 34,695 |
| Equipment | $ 0 | $ 0 |
| Supplies | $ 27,510 | $ 37,084 |
| Travel | $ 1,402 | $ 1,402 |
| Facilities | $ 0 | $ 0 |
| Training | $ 0 | $ 0 |
| Other | $ 18,853 | $ 29,752 |
| Total direct expenditures | $ 0 | $ 0 |
| Indirect costs | $ 6,235 | pmp$ 9,139 |
| Total expenditures | $ 313,309 | $ 438,482 |
| Remaining balance | | |

**2. Describe any "significant budget modification(s)" during the reporting period (i.e., shift funds originally budgeted for one purpose, such as Personnel, to another, such as space). A "significant" modification is any amount greater than 25% of your total award, or any amount $250,000 or greater. Specify and document SAMHSA approval prior to implementation of the change(s).**

There were no significant budget modifications during this period. However, it is important to note that there was a delay in the start-up of the CABHI – Supplemental project. The administrative process to receive the funds and sub-grant them to a County entity consumed an inordinate amount of time to accomplish. Once the funds were available, the sub-contractor still needed to hire qualified staff for the project. This resulted in unspent project funds.

**3. Describe other budget modifications less than 25% of the total award or below $250,000.**

Not applicable

# III. Attachments

The following attachments are included in the submission of this biannual report:

1. Nevada Interagency Council on Homelessness Statewide Strategic Plan
2. Nevada Governor's Interagency Council on Homelessness May and June meeting minutes – The meeting minutes are also posted at: http://mh.nv.gov/Meetings/Interagency Council on Homelessness (ICH)/
3. 2015 Annual CABHI Evaluation Report