TOW / PATH Homeless Case Management	BHD/CSE	Grace Guerrero x4846 America Caro x4865
Program Purpose	Engage consumers who experience homelessness and behavioral health challenges in treatment and link them to supports to reduce homelessness.	

Program Information	• Treatment on Wheels/Programs for Assistance in Transition from Homelessness (TOW/PATH) services are for individuals with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or who are at risk of becoming homeless.
	• Services include community-based outreach and case management to assist clients and facilitate linkage to longer-term behavioral healthcare and other support services.
	• Open group services are provided in community shelters four days a week. Groups cover such topics as independent living, substance use, and community reintegration.
	• Outreach services are provided at the homeless person's location, which helps those seeking assistance to receive services without concerns of potential barriers, such as transportation.
	• TOW/PATH serves as the front door to a continuum of care, including mental health and substance use services, and primary healthcare.
	• TOW/PATH clinical staff have extensive experience in working with homeless persons and victims of domestic violence; crisis services; case management, including advocacy and collaboration; and assessment and treatment of adults in individual and group counseling.
	• The PATH program (1.0 FTE) is funded through state dollars.
	• The TOW program is funded through county dollars. These funds support 1.8 FTEs.
	• Partners include
	  ○ PathForward shelter
	  ○ Residential Program Center shelter and substance use stabilization program
	  ○ Doorways for Women and Families and Doorways Safe House
	  ○ Bridges to Independence
	  ○ DHS Economic Independence Division Clinical Coordination Program
	  ○ Hospitals
	  ○ Arlington Public Library
	  ○ Arlington residents	

Service Delivery Model	• The COVID-19 pandemic had an impact on the program starting in late March 2020. Services were reduced and reallocated during this time, with efforts focused on emergent client needs in the community. This affected the number of clients served and housing placement efforts, as community partners also put their services on hold. However, the program also participated in delivering innovative services to clients, including voluntary COVID-19 vaccination, outreach to homeless clients sheltering in Metro stations, and events to increase participation in housing grant lotteries. Due to a staffing shortage and the effects of the pandemic, outreach was limited in FY 2021.	

- In FY 2022, most services were provided in-person and in the community. A few services were conducted via telehealth, as TOW worked with shelters to set up video conferencing software.
- In FY 2023, it is anticipated that most services will continue to be provided in person in the community.

PM1: How much did we do?

Staff

- Total 2.8 FTEs:
  - 0.8 FTE Supervisor
  - 1.0 FTE Mental Health Therapists
  - 1.0 FTE Outreach Worker

Customers and Service Data

	FY 2019	FY 2020	FY 2021*	FY 2022
Number of identified individuals served (unduplicated)	125	95	77	65
Number of PATH outreach clients (unduplicated)	80	55	38	42
Group sessions offered in shelter locations	166	93	114	149

*Clients served in FY 2021 decreased due to the COVID-19 pandemic and a vacancy in the outreach worker position. Outreach was conducted by the program manager for most of FY 2021 and the start of FY 2022.

PM2: How well did we do it?

2.1	Days from intake to first ongoing service
2.2	Clinical documentation compliance

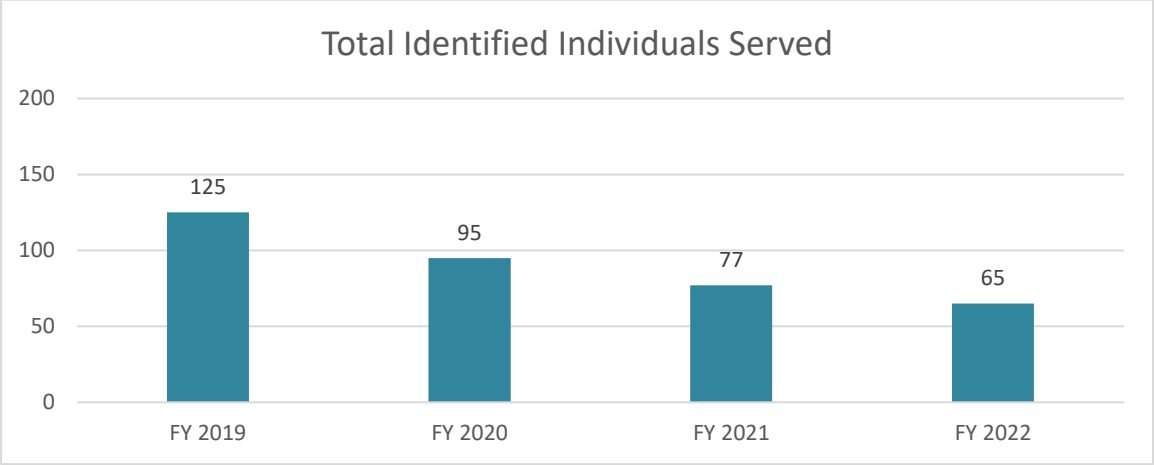
PM3: Is anyone better off?

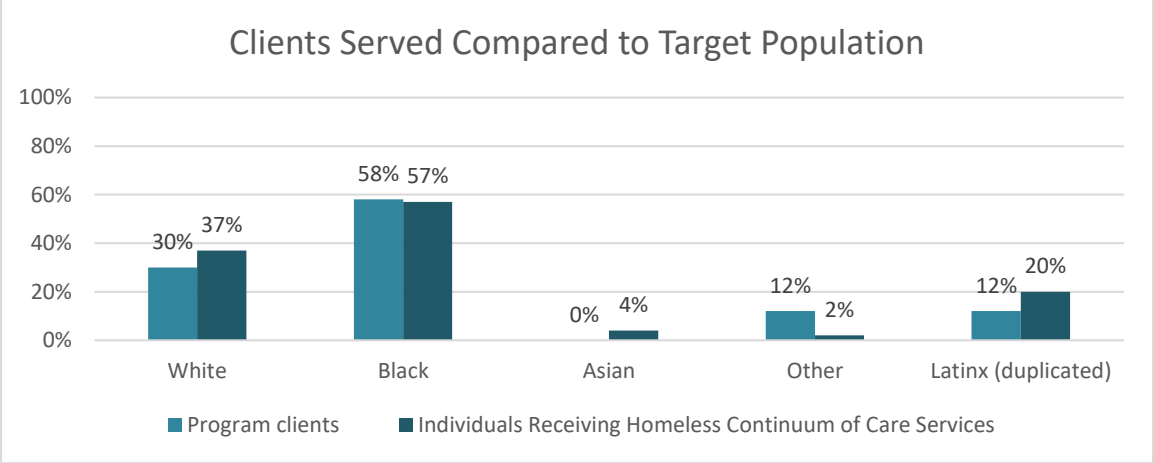
3.1	Clients who obtain permanent housing
3.2	Connection to behavioral healthcare providers
3.3	Access to psychiatric services
3.4	Linkage to physical healthcare

Homeless Case Management

Measure	1	Total clients served (unduplicated)

Data





Data Summary

- From FY 2019 to FY 2022, the number of clients served decreased 47%.
- The selected comparison population for the racial equity analysis is Homeless Continuum of Care Services clients. Ideally, the Treatment on Wheels program should serve a representative proportion of Arlington's unhoused population.
- Data for this measure is collected in the agency's electronic health record.
- 9% of program clients (6) are missing data on race and 21% of program clients (14) are missing data on ethnicity. They have been excluded from the race and Latinx calculations.

What is the story behind the data?

- A high proportion of program clients are Black. This may be the result of systemic issues in housing that have led to a higher proportion of Black individuals being unhoused in both Arlington and across the greater United States. This is evidenced by the fact that over half of clients receiving Homeless Continuum of Care Services are Black.
- The Treatment on Wheels team uses practices based in trauma informed care theory. This includes acknowledging that systemic racism is traumatic, and that it compounds other existing traumas each individual may have already experienced. To support clients who may have suffered from the burdens of racism, the program offers natural supports and positive

community resources to each client. Each individual has the right to choose or decline any resources offered to them, as this is core to client rights.

- A significant number of program clients are working through substance use issues. In FY 2022, 68% of clients had a listed substance use issue.
- FY 2022 was a year of connections for the program. Relationships with PathForward and Arlington County Police Department were strengthened as the agencies worked together to serve the homeless population. The TOW program restarted open hours in the shelters, allowing clients to meet with staff on a regular, unscheduled basis. In addition, the outreach position was filled in FY 2022, which allowed the program to start more new connections with potential clients out in the community.
- Of clients referred to the outreach program in FY 2022, 61% were street homeless and 39% were living in a shelter.
- At the start of FY 2022, many clients were staying in County-sponsored placements in hotels as part of a COVID mitigation technique. In January, these clients were transitioned back to shelter placements. TOW staff provided extensive support to both clients and shelter staff during this period.
- There were significantly fewer volunteers for the homelessness point in time count in FY 2022 than in previous years, perhaps because of a COVID case spike that was occurring at the time. Because of this, program staff stepped up to help plan and implement the process. This took significant time and resources from other program responsibilities.
- In FY 2022, the agency transitioned to a new electronic health record. It is believed that some of the clients served during the year were not fully captured in the system, and that was the big driver of the decrease in identified clients served in FY 2022.

Recommendations	**Target Dates**
• Continue serving Arlington's homeless clients and help their connection to ongoing services.	• Ongoing
• Identify gaps in staff documentation in the electronic health record and ensure that all clients are recorded properly.	• FY 2023 Q2

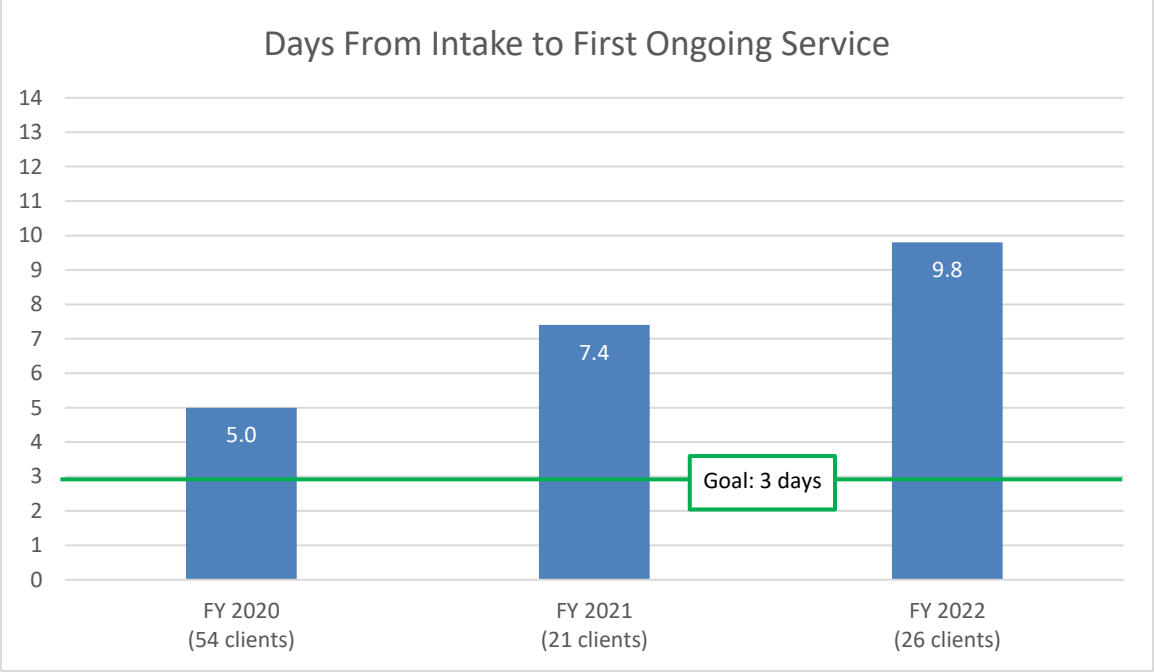
Forecast

- In FY 2023, the program projects serving 80 clients.

Homeless Case Management

Measure	2.1	Days from intake to first ongoing service

Data



Data Summary

- Data reflects the number of days to transition from outreach to ongoing TOW case management services after going through Intake.
- Clients waited as little as their first clinical appointment being on the same day as their intake to as many as 41 days. The average number of days is reported in the above chart.
- Data is obtained from the Electronic Health Record.

What is the story behind the data?

- In FY 2022, wait time from Intake to first ongoing service increased. This was primarily driven by a subset of clients who were difficult to contact. Some clients may give a phone number during the intake assessment, but when program staff call that phone, they find the client has no minutes. If the TOW program cannot contact clients, staff will reach out to the shelters to try and get ahold of them. The program's staff members are tenacious and ensure that the client gets connected, even if it takes several days.
- For clients who are referred to TOW outreach services, it takes an average of 1.7 days for program staff to make contact. Staff are able to connect to outreach clients more quickly as they have to coordinate with fewer providers. The first ongoing appointment often includes ongoing psychiatric providers and other CSB staff.
- The TOW team is flexible in offering first clinical appointment time slots, which facilitates rapid connection to services.
- Many Homeless Case Management services occur before client intake, as program staff work to build a relationship with the client and encourage them to engage with agency services.

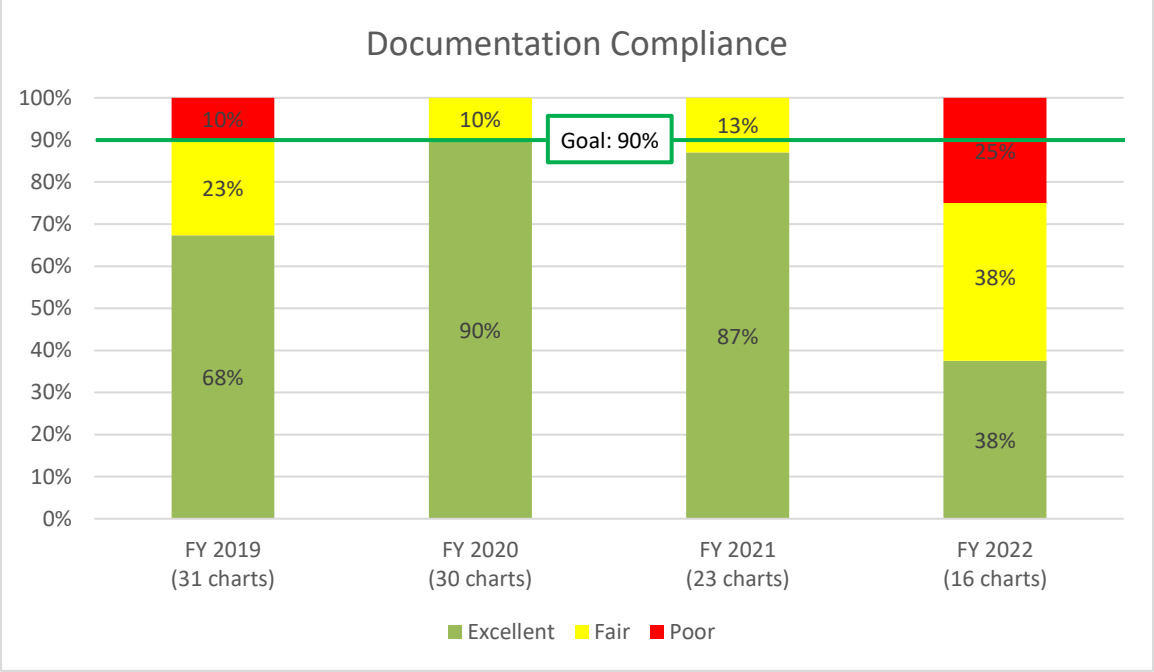
Recommendations	Target Dates
• Continue going into the shelters regularly to provide access to services for clients	• Ongoing

• Continue to collect and monitor the time from intake to first service.	• Ongoing
• Begin the Mobile Support Team, which will include a clinician and a peer, which will reach out to clients quickly after their intake.	• FY 2023 Q4
Forecast	
• In FY 2023, it is expected that an average of seven days will elapse from intake to first ongoing service.	

Homeless Case Management

Measure	2.2	Clinical documentation compliance

Data



Data Summary

- The Compliance Review Team (CRT) and the program manager review the same charts each month and come to consensus on scores when there is a discrepancy.
- Of the 16 charts reviewed, 6 (38%) were rated as "excellent," scoring 90% or above on the criteria reviewed.

What is the story behind the data?

- In FY 2022, the agency transitioned to a new electronic health record, which caused challenges as staff had to take the time to learn the new system. This led to a decrease in overall chart compliance. Before the launch of the new record system, most scores were above 90%.
- The new electronic health record that debuted in FY 2022 required some reconfiguring to fully capture the scope of TOW services. Because of this, some required TOW documentation was unable to be completed, which impacted chart scores. Active discussions are continuing with the Compliance team to determine ways to effectively and accurately document in the new record system.
- In FY 2022, Compliance was down multiple staff and was thus not able to review each team each month, leading to fewer charts being counted in this measure.
- Some TOW clients do not receive assessments, as the program is focused on engaging them in long term services. When the charts of these clients are reviewed, there are fewer overall pieces of documentation to review, meaning that an error on one of these documents has a larger impact on the overall score. That was the case for some of the charts below 90%.

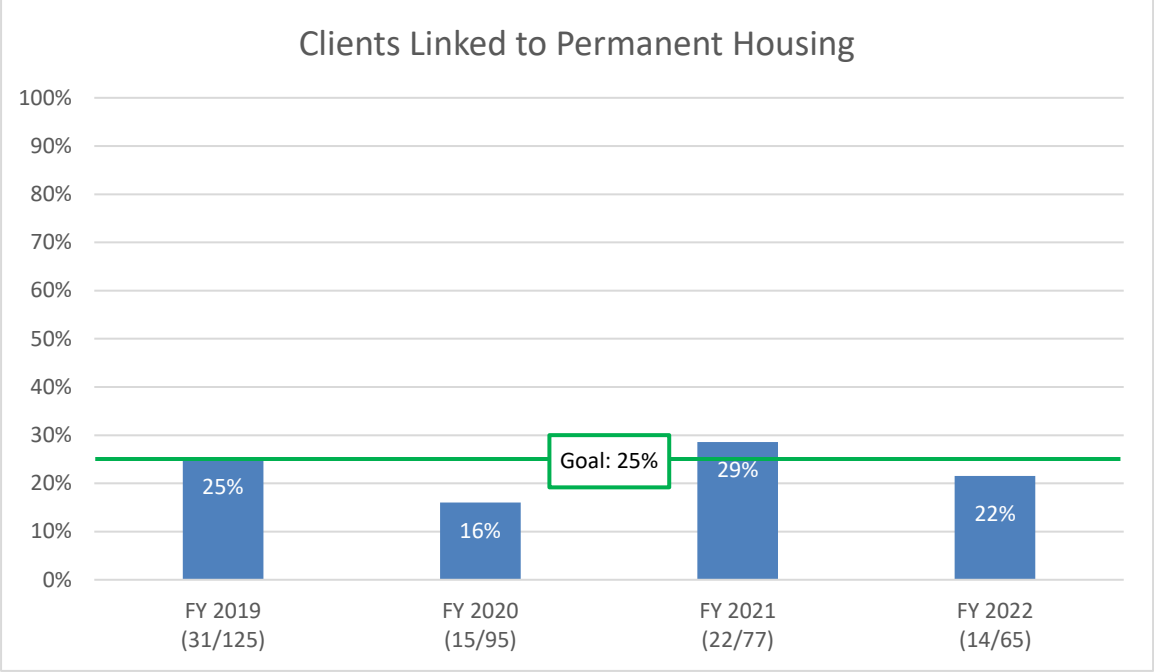
Recommendations	Target Dates
• Continue monthly chart reviews.	• Ongoing

• Continue working with CRT staff to improve inter-rater reliability. Encourage staff to reach out to the Compliance team when they have questions to ensure documentation issues are resolved quickly.	• Ongoing
• Continue to schedule meetings to align expectations across reviewers.	• Ongoing
• Manager will review documentation standards and processes with staff members during team meetings.	• Ongoing
• Coordinate with CRT staff to ensure that the new outreach worker can fully document in the electronic health record.	• November 2022
Forecast	
• In FY 2023, it is anticipated that chart scores will increase to 68%.	

Homeless Case Management

Measure	3.1	Clients who obtained permanent housing

Data



Data Summary

- Program staff track clients' housing status in a spreadsheet. This chart reflects the number of clients who obtained stable housing at any point during the fiscal year while receiving TOW/PATH services.

What is the story behind the data?

- In FY 2022, 22% of TOW/PATH clients were linked to housing during program enrollment, a decrease from FY 2021.
- In FY 2021, the program worked with Arlington County Police Department (ACPD) to set up multiple staging areas around the county where individuals could complete applications for the federal housing voucher lottery system. The goal of these staging areas was to increase access for individuals experiencing homelessness. One of these staging areas was set up near a hotel used as temporary COVID-related housing for those without homes. While this led to a significant increase in placements in FY 2021, the vouchers now have long waitlists which led to less clients being connected in FY 2022.
- Program staff found that the impacts of the pandemic slowed access to housing for clients. Leasing offices in FY 2022 were not open as many hours as they were pre-pandemic, and many had restrictions on the number of people allowed in an office. This made each housing placement take substantially longer.
- The program's strong partnership with Arlington's shelters and Arlington's Economic Independence Division continued in FY 2022.
- The Homeless Case Management program helps clients with additional housing-related needs once they have procured a physical place to live. These include helping clients find beds, furniture, and cooking implements.
- There are multiple barriers that limit clients' ability to obtain and maintain stable housing. As the County's Action Plan to End Homelessness proceeds, the remaining homeless clients face some of the largest barriers.

- Clients who obtain housing often lose it because of ongoing issues. Being evicted makes it more difficult to get these clients rehoused.
- At the end of FY 2022, several clients were on the waiting list for housing. Clients on average wait 8 to 16 months to get housed, and sometimes longer.
- Some clients served by the TOW program and transferred to outpatient therapy obtain housing after transfer. These clients are not counted in this measure.

Recommendations	Target Dates
• Continue partnering with county initiatives to provide the necessary stabilization activities to increase the possibility of a lasting housing placement for clients.	• Ongoing
• Continue researching new and innovative ways to enhance access to housing vouchers for program clients	• Ongoing
• Utilize new housing locations that are opening up at the beginning of the fiscal year to place more clients in housing.	• FY 2023 Q1

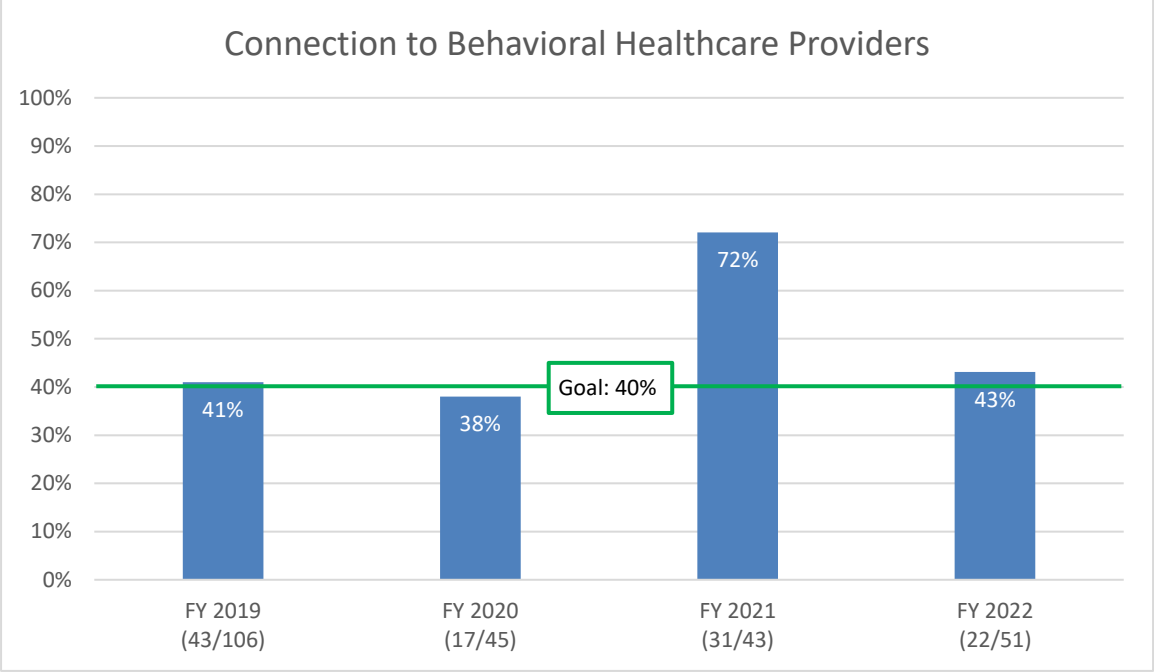
Forecast

- In FY 2023, it is expected that at least 30% of clients served by the program will be linked to stable housing at one point during the year, as multiple housing opportunities are opening at the beginning of FY 2023.

Homeless Case Management

Measure	3.2	Connection to behavioral healthcare providers

Data



Data Summary

- Data reflects all closed TOW/PATH clients who received services from Arlington CSB outpatient behavioral healthcare providers after receiving services from the TOW/PATH program.

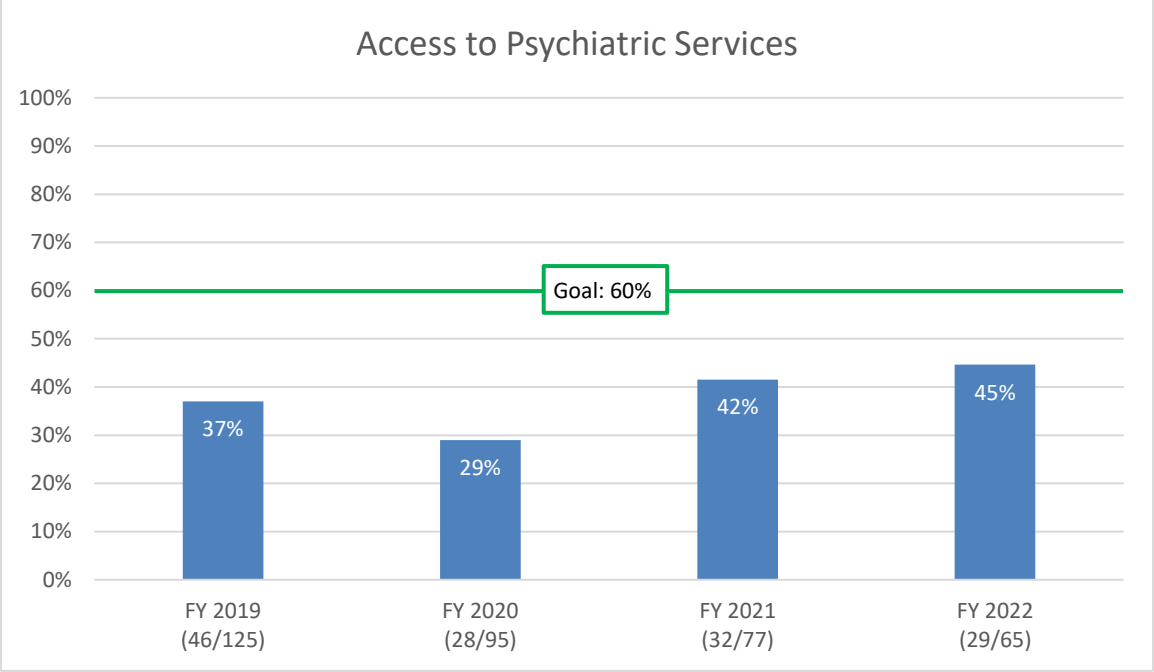
What is the story behind the data?

- All of the clients served by the TOW/PATH program have a serious mental illness and/or a substance use issue. One of the goals of the program is to link these clients to behavioral healthcare services in the CSB.
- In FY 2022, the number of clients connected to behavioral healthcare providers decreased from historic highs the previous year. However, connections remained above the program average across the years.
- Program staff noted that behavioral healthcare appointments were harder to come by in FY 2022 than in previous years, due to the outpatient teams having significant staffing shortages. Because there were fewer appointments, it was harder to place clients into the programs.
- Throughout FY 2022, policies were still being ironed out on how to refer clients to ongoing services in the new electronic health record. This impacted efforts to connect clients to services.
- In FY 2021, significantly more clients expressed an interest in therapy services than in years past. These services must be provided by a behavioral healthcare provider, which drove the increase in connections to these providers.
- An enhanced warm handoff process was put into place in FY 2021. As part of this process, clients are not closed to the Homeless Case Management team until the new provider builds a relationship with the client. If a client does not attend their first session with their behavioral healthcare provider, the program will reach out and see what they need. Staff can leverage their strong, trusting relationships to ensure continuity of client treatment.

• Even after a client is connected to an ongoing behavioral healthcare provider, the Homeless Case Management team will often work with them to help them thrive in the community. This can include helping clients procure identification documents or locate housing.	
Recommendations	**Target Dates**
• Continue to explore closer community connections with BHD outpatient staff, such as having staff accompany TOW/PATH workers to visit with potential clients in the shelter before arranging a meeting in the office.	• Ongoing
• Continue exploring technological solutions to barriers faced by this population, such as wi-fi phones and hubs in the shelter.	• Ongoing
• Streamline the process of referring clients to the behavioral healthcare teams	• FY 2023 Q2
Forecast	
• In FY 2023, it is anticipated that 43% of clients will connect to ongoing services.	

Homeless Case Management		
Measure	3.3	Access to psychiatric services

Data



Data Summary

- Data reflects all TOW/PATH clients who received services from Arlington CSB psychiatric providers after beginning services from the program.

What is the story behind the data?

- In FY 2022, access to Psychiatric Services continued to improve. This was thanks to strong collaboration with the specific psychiatrist who serves the TOW team. Because one individual serves all the TOW clients, he is able to thoroughly collaborate with program staff on each individual case.
- While working with one psychiatrist has been a boon for the program, it has sometimes presented a challenge when clients are transitioned to ongoing teams. As part of the transition, clients are connected to a new psychiatric provider. This can cause clients to disengage with Psychiatric Services, as they may not feel comfortable working with a new individual on their medical plans.
- As TOW continues to help clients achieve stability, remaining clients may have additional challenges. Program staff noted a high number of clients who felt cautious about engaging with community services and declined the opportunity to meet with the psychiatrist.
- Successful linkage to psychiatry is due to collaboration with prescribers in weekly meetings and easy access via the Crisis Intervention Center.

Recommendations	Target Dates
• Continue regularly scheduled collaboration with psychiatric staff to monitor services and identify clients who may be having challenges with accessing services.	• Ongoing
• Continue ensuring that psychiatric services staff attend weekly Homeless Case Management meetings.	• Ongoing

• If a client expresses hesitation to transition to a new psychiatric provider, offer to sit in with them on the first few meetings to provide a warm handoff and client comfort.	• FY 2023 Q2

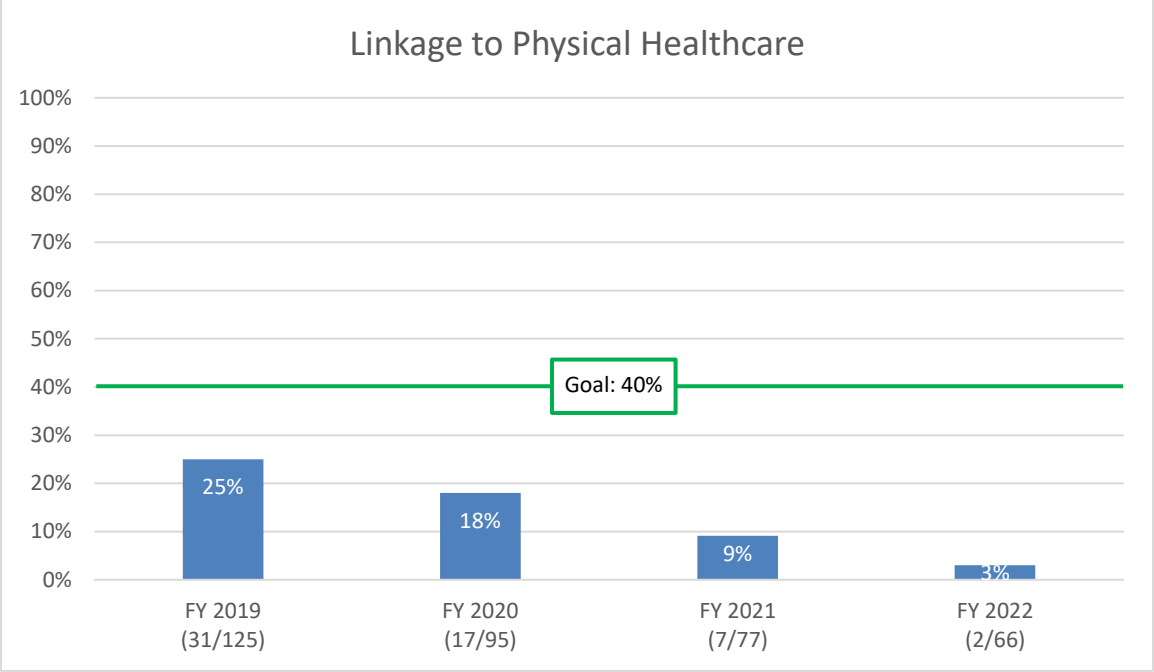
Forecast

- In FY 2023, it is anticipated that 49% of clients served will be linked to psychiatric services.

Homeless Case Management

Measure	3.4	Linkage to physical healthcare

Data



Data Summary	• Data reflects all TOW/PATH clients who received services from the Neighborhood Health primary care initiative after beginning services from the program.

What is the story behind the data?

- In FY 2022, the percentage of clients linked to the primary-care program continued decreasing. This is because the program has transitioned to primarily fulfilling client's physical health needs through PathForward. PathForward has a mobile healthcare clinic which can provide holistic, integrated services to clients in the community. Feedback about this change has been very positive, as many clients feel more comfortable being served in a space known to them. Clients served by PathForward are not captured in the above chart.
- The TOW/PATH program recognizes the importance of access to primary health care. Clients are offered a referral to the Neighborhood Health program at intake.
- Linking clients to Neighborhood Health can be more challenging than linkage to internal psychiatric services, since Neighborhood Health is a separate entity with separate record-keeping systems, which makes it difficult for TOW/PATH staff to monitor services. In addition, Neighborhood Health made changes to administrative and referral processes, which led to delays in seeing clients. Clients report long waitlists at Neighborhood Healthcare.
- The TOW/PATH program helps link clients to physical health needs beyond connection to primary care. For example, in FY 2021 the program stood up a COVID-19 vaccine clinic that vaccinated 70 individuals experiencing homelessness.

Recommendations	Target Dates

• Continue exploring options for developing a closer collaborative relationship with Neighborhood Health staff to improve linkage to services, including regular case consultations to identify clients who may be having difficulties following through with appointments.	• Ongoing
• Determine the feasibility of incorporating data from PathForward's mobile healthcare clinic in this measure.	• FY 2023 Q2
Forecast	
• In FY 2023, it is anticipated that 35% of clients will be linked to Neighborhood Health or PathForward for physical healthcare.	