FY 2024 PERFORMANCE PLAN

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 (1.25 FTE) is funded through state dollars.
	• The TOW program is funded through county dollars. These funds support 1.8 FTEs.
	• The TOW program recently started a re-launch of a Reentry Program Unit. This unit offers a six-bed wrap around, shelter program to SMI/DD individuals involved in the criminal justice system who are transitioning to the community from the Arlington County Detention Facility. This program includes case management, peer support, and supportive services.
	• 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
	  ○ Reagan National Airport
	  ○ DC Metro
	  ○ Arlington County Detention Facility
	  ○ Arlington residents

<table>
<tr><td>Service Delivery Model</td><td>

- In FY 2024, most services were provided in-person and in the community. A few services were conducted via telehealth through video conferencing software in shelters.
- In FY 2025, it is anticipated that most services will continue to be provided in person in the community.

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<tr><td colspan="2">PM1: How much did we do?</td></tr>
<tr><td>Staff</td><td>

- Total 3.05 FTEs:
  - 0.8 FTE Supervisor
  - 1.0 FTE Mental Health Therapist
  - 1.0 FTE Outreach Worker
  - 0.25 FTE Recreation Therapist

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<tr><td>Customers and Service Data</td><td>

	FY 2021	FY 2022	FY 2023	FY 2024
Number of identified individuals served (unduplicated)	77	65	56	51
Group sessions offered in shelter locations	114	149	65	28

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<tr><td colspan="2">PM2: How well did we do it?</td></tr>
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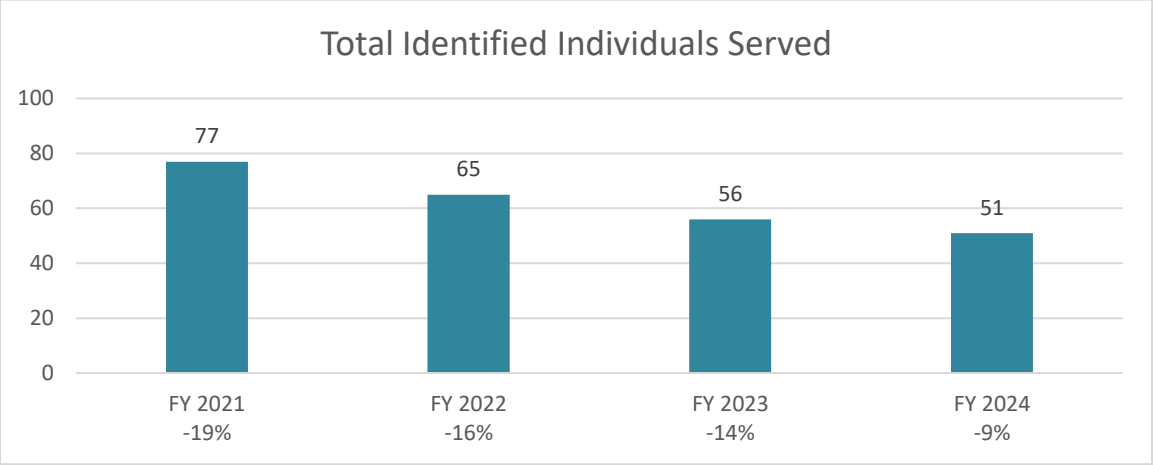
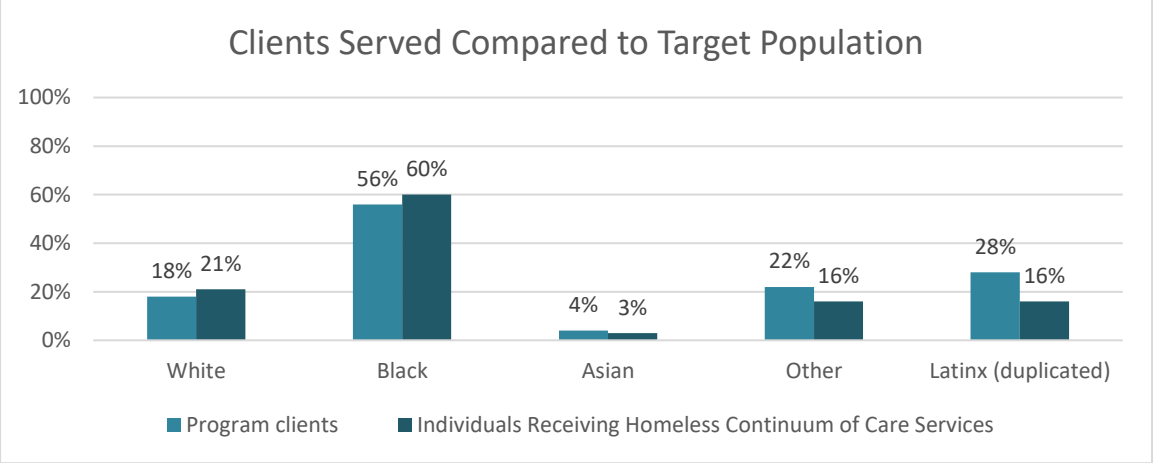
Homeless Case Management

Measure	1	Total clients served (unduplicated)

Data





Data Summary

- From FY 2021 to FY 2024, the number of clients served decreased 34%.
- 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.
- 2% of program clients (1) are missing data on race and 8% of program clients (4) are missing data on ethnicity. They have been excluded from the race and Latinx calculations.

What is the story behind the data?

- In FY 2024, the number of identified clients served and the number of group therapy services decreased. This was mainly because the mental health therapist position was vacant until November of 2023 with a training period that lasted into spring of 2024.
- To maintain program operations, the supervisor took on a case load and provided therapy services. They also continued to manage the program and perform other responsibilities across the agency.
- Despite being short staffed, the program participated in several initiatives including:

  - Developing and launching the new Mobile Outreach Support Team (MOST). MOST provides mobile services including assessment, de-escalation, suicidality screening, assessment, peer support, care coordination, and homeless outreach. Launching MOST took about nine months of FY 2024 and involved close work with initiative stakeholders and program consultants. During FY 2024 the program served 221 people.
  - Working closely with first responders in the Key Bridge Marriott crisis. In June 2024, a large number of unhoused individuals were removed from a vacant hotel in Arlington. Many of these unhoused individuals experienced significant trauma in the hotel including sexual exploitation and abuse. TOW team staff were deployed to triage their immediate mental health needs and connect them to ongoing care. Many of these clients were from other jurisdictions, and significant case management work was needed to ensure they were properly connected to services in their locality. Staff continued to communicate with these individuals even after connection to ensure needs were being met.
- Each case that comes to the Homeless Case Management program is unique and complex. Staff must first work to build a rapport with clients, then help them find their way through complex bureaucracies. One day, program staff may help a homeless veteran remain calm in the waiting room of the Veterans Affairs office. Another day, staff may transport an individual to a consulate so they can secure a way home.
- In FY 2024, the program continued to offer open hours in the shelters, allowing clients to meet with staff on a regular, unscheduled basis.
- A significant number of program clients are working through substance use issues. In FY 2024, 26% of clients had a listed substance use diagnosis. Usage can impact housing opportunities and adds significant complexity to these cases.
- Many program clients (59% in FY 2024) are male. This aligns with national trends, which show that over two-thirds of those who are homeless are men.
- A high proportion of program clients have a listed race of Black. These clients may face 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.
- The biggest variance in race/ethnicity between clients receiving TOW services and clients receiving homeless continuum of care services was the number of clients who selected "Latinx" as an ethnicity. Many of the Latinx clients the program works with are undocumented and need significant case management work from the Homeless Case Management program to gather all the documentation they need. By the time they are ready to move on to ongoing services, they may no longer wish to receive intensive agency services. Additionally, many of these clients are monolingual and may prefer a Spanish-speaking therapist. Hiring Spanish-speaking therapists is an ongoing challenge for the agency.
- 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.

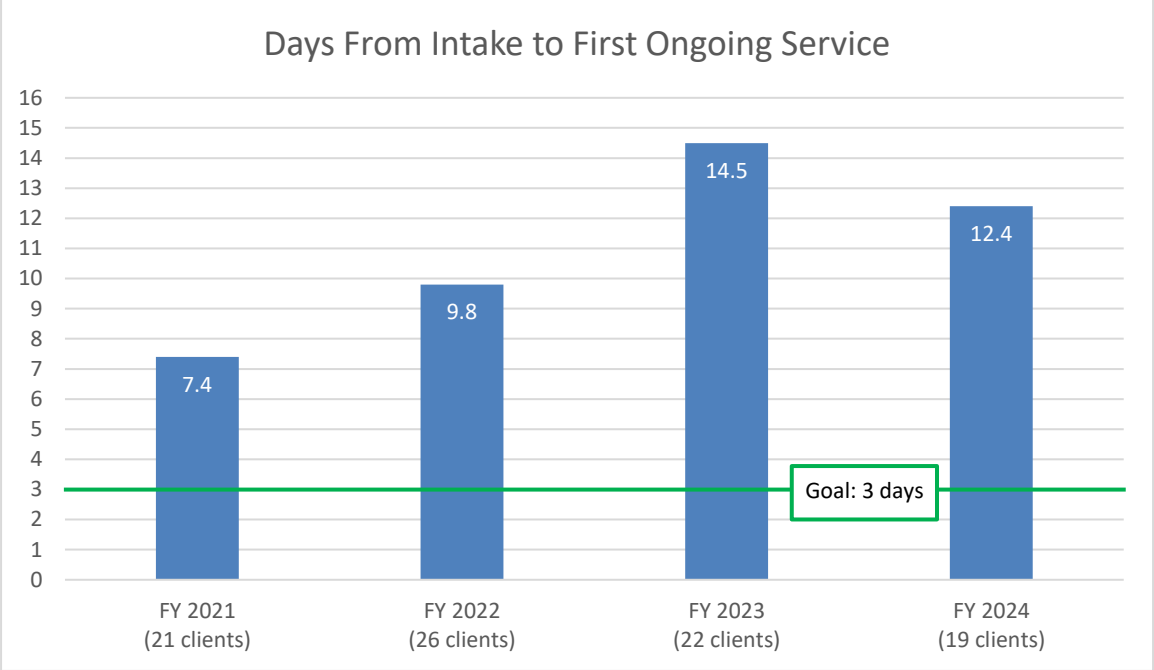
Recommendations	**Target Dates**
• Build and strengthen the newly re-launched Reentry Programming Unit to full capacity.	• FY 2024 Q3 and Q4

• Collaborate with Quality Assurance to arrive at the most appropriate and accurate representation of the program through data sources such as HMIS.	• FY 2025 Q2
• Provide education and support to other teams BHD teams and system stakeholders so that they may best support unhoused people when they encounter them.	• Ongoing
Forecast	
• In FY 2025, the program projects serving 65 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 47 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?

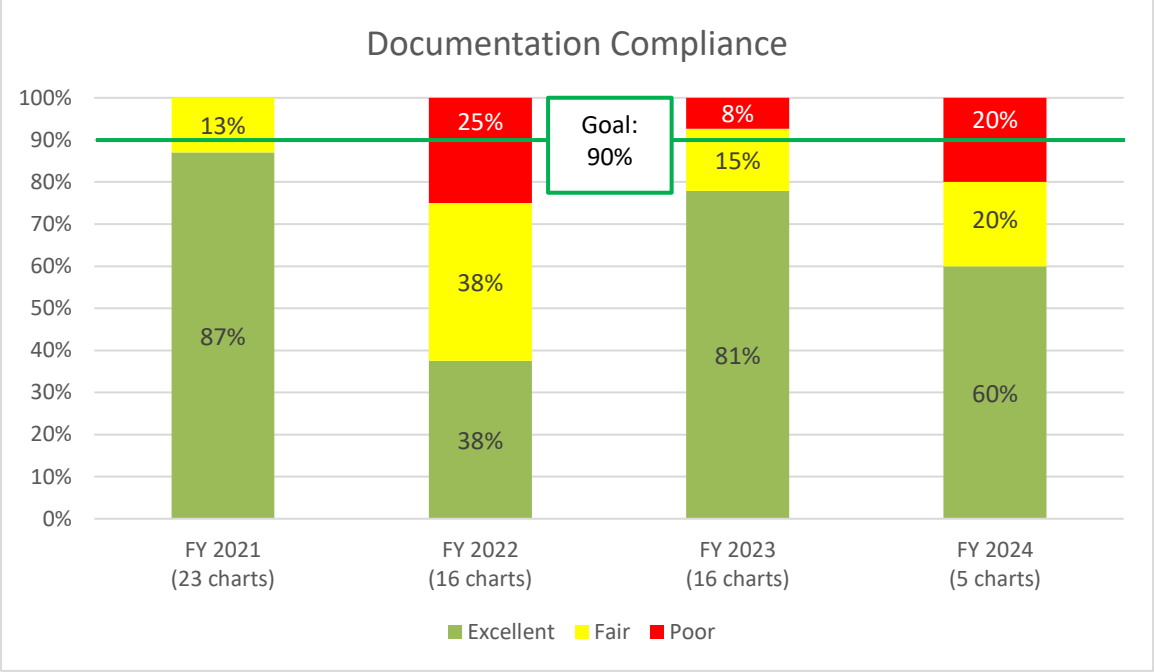
- In FY 2024, average wait time from Intake to first ongoing service decreased. Nine clients (47%) were seen within the goal of three days.
- The primary driver of this decrease was the filling of the vacancy in the Mental Health Therapist position, as that is the role that generally sees clients connected to ongoing care. Before that role began working at full capacity in early 2024, coverage was provided and all clients were seen, however the program did not have the capacity to see the client as quickly as in prior years.
- The average days from intake to first ongoing service remained well above the goal in FY 2024. One primary factor continued to be the decreased capacity on the mental health outpatient teams, which led to the creation of waitlists for services. The program typically transfers clients to outpatient care as soon as clients are ready for that level of service. However, some TOW clients were placed on the outpatient waitlist, so the program continued to provide services until a slot was available. This strained program capacity and led to longer wait times for clients entering services. Despite this, the waitlists decreased substantially across FY 2024 with just 14 clients at the end of the year on the waitlist suggesting days from intake to first ongoing service may go down in FY 2025.
- 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 to work closely with non-profit shelters to manage increasing trends in the unhoused community population.	• Ongoing
• Ensure the new mental health therapist prioritizes meeting with new clients as soon as they are connected, to increase the likelihood of their continued engagement.	• FY 2025 Q1
• Continue to work with the Mobile Outreach Support Team (MOST) to identify clients who would benefit from ongoing services and offer them admission to the TOW program.	• Ongoing
Forecast	
• In FY 2025, it is expected that an average of 10 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 five charts reviewed, three (60%) were rated as "excellent," scoring 90% or above on the criteria reviewed.

What is the story behind the data?

- In FY 2024, the program manager monitored documentation closely and reached out to the compliance team when they needed support. In addition, the Reentry Programming Unit excelled at communicating documentation needs to the CRT and technology team to better harness EHR resources. This may have helped with timeliness and accuracy of documentation.
- In FY 2024, the reviewers stressed the importance of supporting new staff to independently complete documentation to meet expectations. Thus, the chart scores likely were affected from the onboarding of the team's new clinician.
- 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.
- 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%.

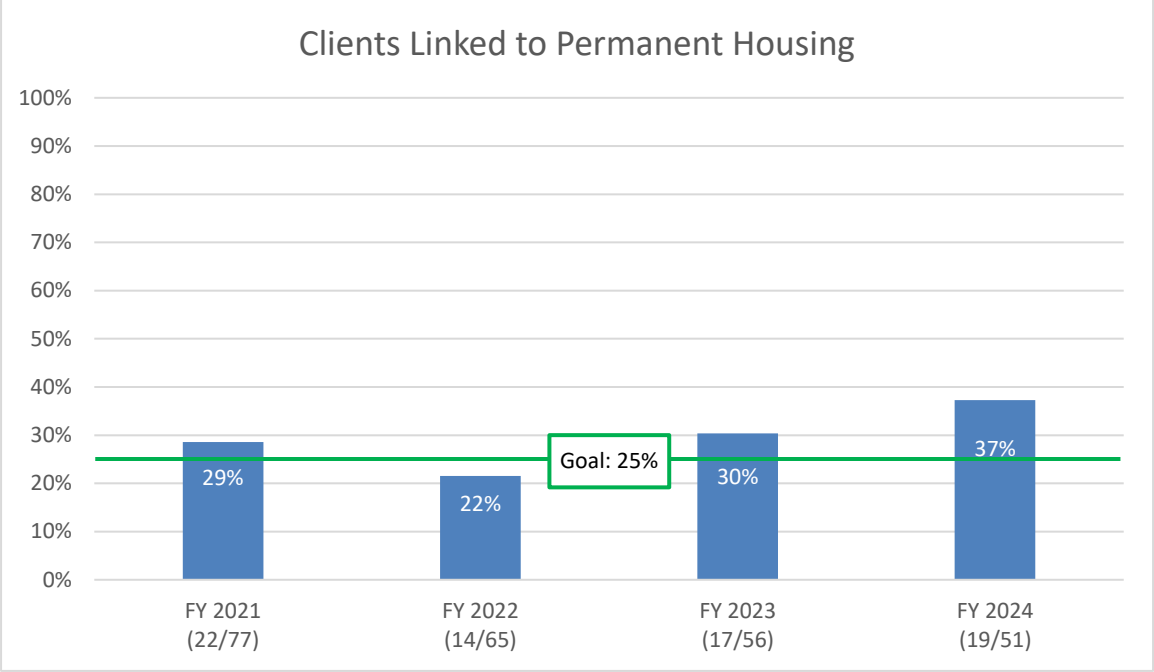
Recommendations	Target Dates
• Continue to work with new staff to learn and navigate EHR and HMIS systems. Having two systems presents special challenges for new staff.	• Ongoing

• Use the new BHD data dashboards to track and improve new staff performance.	• Ongoing
Forecast	
• In FY 2025, it is anticipated that chart scores will be at 65%.	

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 2024, 37% of TOW/PATH clients were linked to housing during program enrollment, an increase from FY 2023.
- This increase was due to two primary factors. First, additional housing locations became available in FY 2023 and continued to be used in FY 2024. The team was able to utilize the increased supply to help place clients. Second, TOW was able to leverage its strong partnerships with Arlington's Economic Independence Division (EID). By regularly having program staff sit in on EID meetings, staff were able to better share client-specific information and collaborate on housing solutions.
- 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 2024, several clients were on the waiting list for housing. Clients on average wait 8 to 16 months to get housed, and sometimes longer. Shelters and non-profits in the area meet periodically to problem solve and allocate resources to reduce wait times for housing as much as possible.
- 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

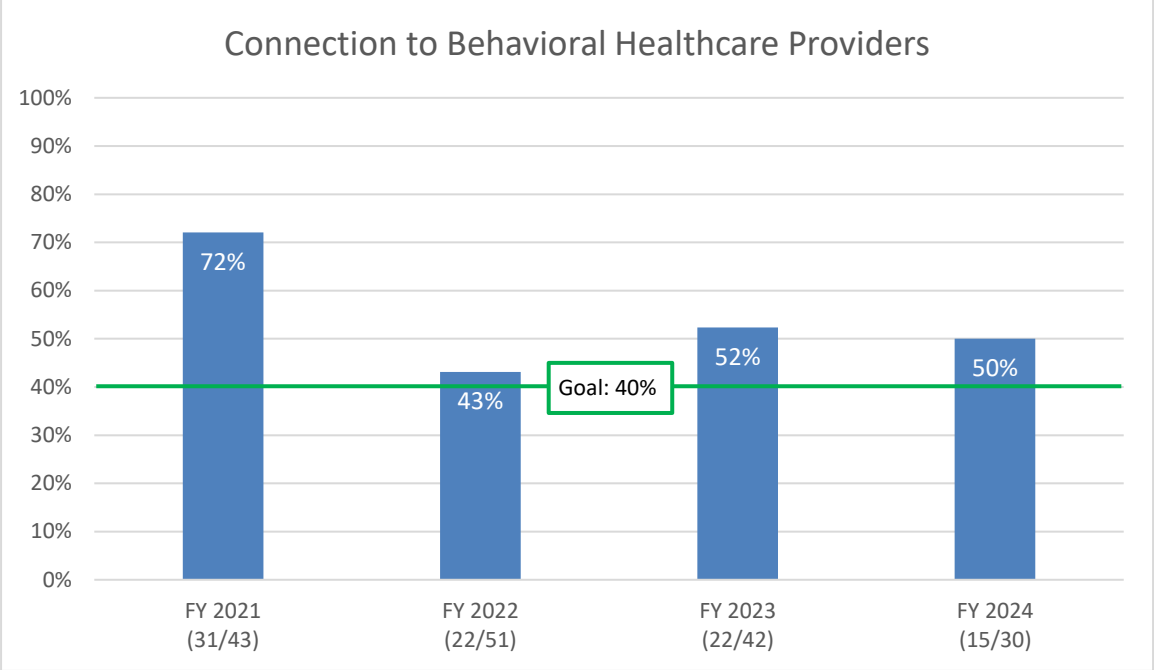
Forecast

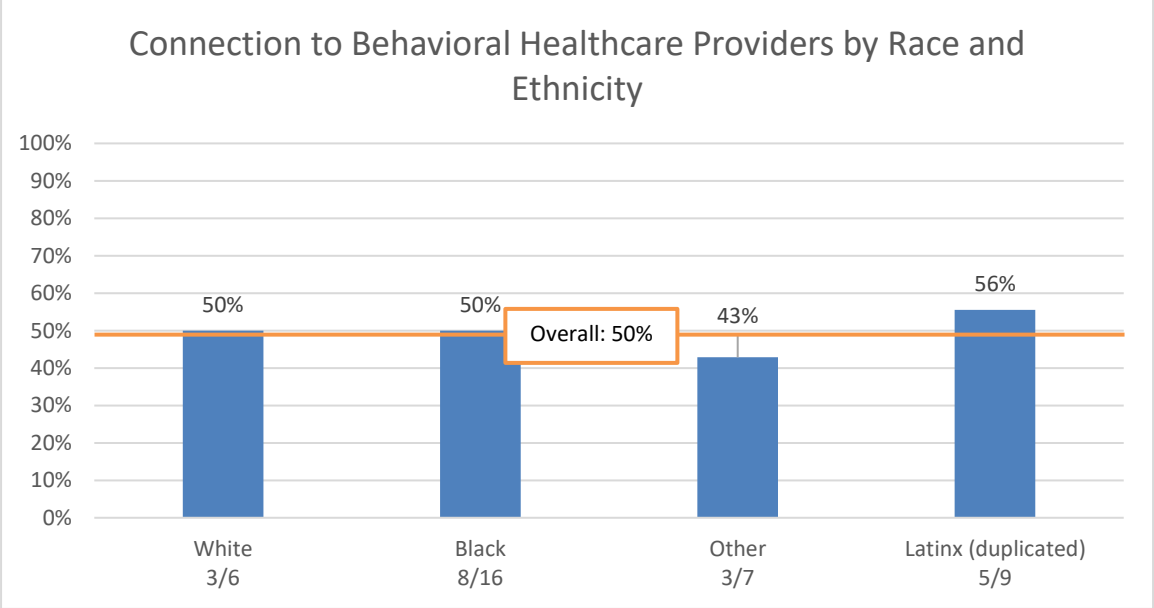
- In FY 2025, it is expected that 35% of clients served by the program will be linked to stable housing.

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 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 2024, the number of clients connected to behavioral healthcare providers decreased slightly.
- Clients in the TOW/PATH program typically do not match-up with traditional, more structured outpatient care. They benefit most when approached with more flexibility and responsivity than your typical outpatient client. This approach is a best practice for supporting clients who are unhoused as it helps clients learn how to navigate the traditional medical system, a system they are often unfamiliar with.
- In FY 2024, the continued behavioral healthcare outpatient programs' waitlist impeded clients' ability to connect to behavioral healthcare. Because of the transient nature of TOW/PATH clients, there's more sensitivity to any wait for services. Waitlists have gone down substantially from the beginning of the year. Program staff regularly met with homeless case management clients who were on waitlists to ensure that they would not disengage from agency care.
- 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.
- An initial equity analysis was completed in FY 2024 to determine if there were any systematic challenges in connection to care. Clients who identified as Other racial category were connected to care at slightly lower rate.

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
• Explore why clients who identify as Other race are less likely to end up connecting to outpatient care.	• FY 2025 Q2

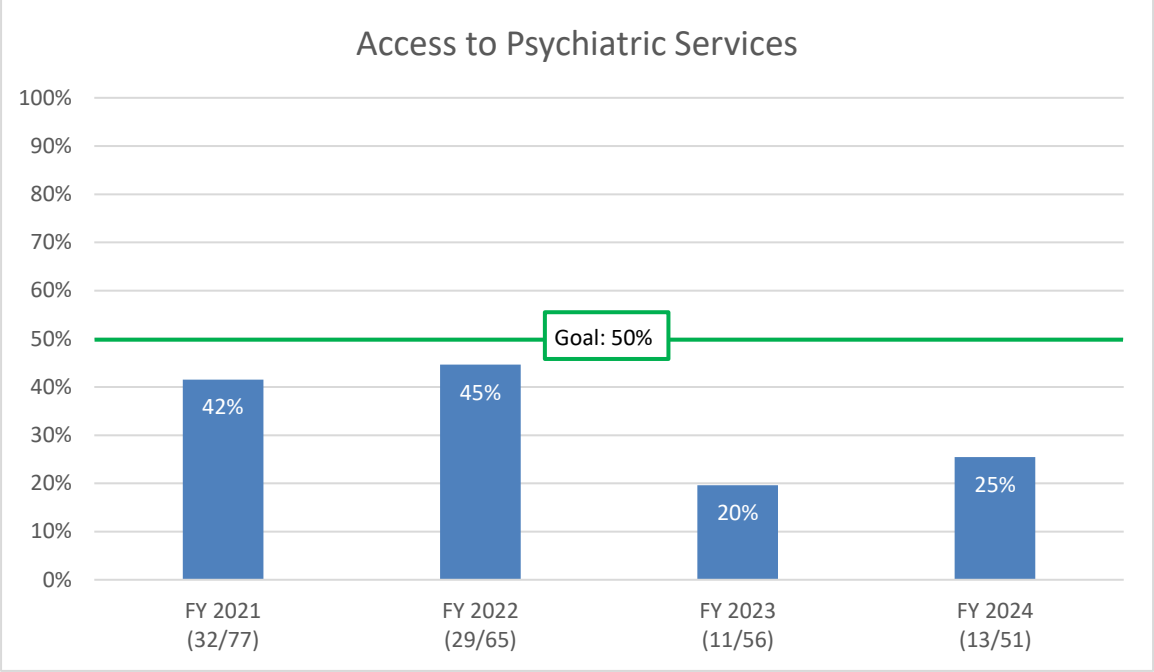
Forecast

- In FY 2025, it is anticipated that 50% 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.
- The goal for this measure was decreased from 60% to 50% to better reflect program trends.

What is the story behind the data?

- In FY 2024, connections to Psychiatric Services increased from 20% to 25%, although it remained lower than FY 2021 and FY 2022.
- One reason for the increase may be that the clinician who began in FY 2024 worked to help remind and assist clients with making their appointments.
- One reason for the continued lower connection rates was a reduction in the amount time the team's psychiatrist was devoting to the program. This was due to the doctor's decreased availability and a lack of engagement from some clients.
- In addition, clients sometimes had to wait a significant amount of time to meet with a psychiatric provider. Program staff noted that there is a "sweet spot" for clients who are considering accepting services. If there is too long a wait time between a client accepting psychiatric care and receiving that care, the client may change their mind on whether they still want the service.
- One issue the program continues to work on is challenges with scheduling psychiatric appointments. The program plans to look at similar programs in other cities and counties to see if innovative solutions exist for providing onsite psychiatric care to unhoused individuals.

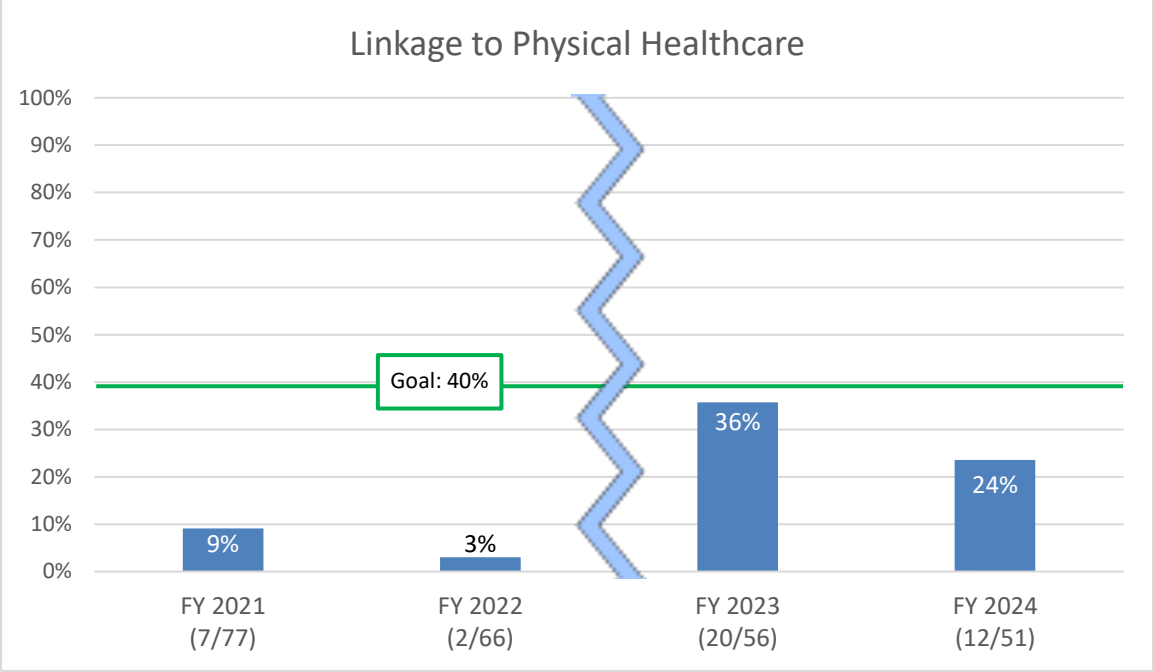
Recommendations	Target Dates
• Explore possibilities for finding more flexible prescribing options that can be administered more easily in the community like telepsychiatry.	• FY 2025 Q3

• Look for a national standard for the goal of connecting clients to psychiatric care	• FY 2025 Q2
Forecast	
• In FY 2025, it is anticipated that 30% 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 physical healthcare services from PathForward after beginning services from the program.
- Prior to FY 2023, the data reflected the number of clients connected to Neighborhood Health.

What is the story behind the data?

- The TOW program works closely with PathForward to ensure that program clients are seen by a healthcare provider to meet their physical health needs. In FY 2024, 12 clients received medical care from PathForward. Some clients also receive physical healthcare from outside providers, but the program is unable to track these connections. Data from HMIS suggests that 15 clients were referred to physical healthcare.
- In FY 2024, the drop in linkage to physical healthcare was likely related to staffing challenges at PathForward resulting in them being down two of their three nurses.
- PathForward has designated specific times as available for walk-in nursing services. The Homeless Case Management program has utilized these opportunities by physically transporting clients to the facility and staying with them while they receive medical care.
- The program has also booked specific times for clients to meet with healthcare workers, and staff provide case management services to ensure clients go to these scheduled appointments.
- Homeless Case Management staff pay particular attention to risk factors when referring clients to care. When a client has additional risk factors, such as a current or recent pregnancy, the program iterates to them the need to get medical care.
- One program client had private insurance in FY 2024. When a client does not have any insurance, TOW staff work to connect them to Medicaid when possible. By the end of FY 2024, 41% of program clients were receiving Medicaid and an additional 12% had some type

of insurance other than Medicaid such as Medicare or insurance from the Veterans Administration.	
Recommendations	**Target Dates**
• Continue exploring options to greater expand connections to PathForward and other providers for primary care.	• Ongoing
Forecast	
• In FY 2025, it is anticipated that 35% of clients will be linked to PathForward for physical healthcare.	