

2018 GRANT SUMMARY PAGE
MENTAL HEALTH, CHEMICAL DEPENDENCY, AND THERAPEUTIC COURTS RFP
KITSAP COUNTY HUMAN SERVICES DEPARTMENT

Organization name: Kitsap Public Health District

Proposal Title: Kitsap Connect/Crisis Response and Coordinated Care Project

Please Check One New Grant Proposal Continuation Grant Proposal

Please check which area of the Continuum this project addresses:

<input type="checkbox"/> Prevention, Early Intervention and Training <input checked="" type="checkbox"/> Crisis Intervention <input type="checkbox"/> Outpatient treatment	<input type="checkbox"/> Medical and Sub-Acute Detoxification <input type="checkbox"/> Acute Inpatient Care <input type="checkbox"/> Recovery Support Services
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Proposal Summary:

This collective impact project helps some of the most vulnerable (and at risk) residents in Kitsap County who are experiencing mental illness, chemical dependency, physical illnesses, and homelessness by improving access to the care they need. Using a multi-disciplinary, mobile outreach team that includes intensive care coordination services, this project provides the critical engagement and connective tissue to link these residents with desperately needed services that will ultimately reduce the severity of behavioral health issues, serious physical health complications, and homelessness. This will, in turn, reduce inappropriate or unnecessary utilization of costly services. Over the 12-month grant, we anticipate serving 30 individuals. Lessons learned from the 18-month demonstration project (2016-2017) are being applied to refine the program design with the intent of scaling up to the entire county over the next two years.

Requested Funds Amount: \$ 450,510.50

Matching/In-kind Funds Amount: \$ 61,329.75

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Primary Contact: Katie Eilers Phone:(360) 728-2224 E-Mail: katie.eilers@kitsappublichealth.org

Non-Profit Status: 501C3 of the Internal Revenue Code? Yes No

Federal Tax ID Number: 42-1689063

- If incorporated, attach a list of the members of the Board of Directors, including names and addresses.
- If not incorporated (sole proprietor or partnership), attach a list of the names and addresses of the principals.


Signature

ADMINISTRATOR
Title

7/28/17
Date

2017 KITSAP PUBLIC HEALTH BOARD OFFICERS

Chair: Commissioner Ed Wolfe
Vice Chair: Mayor Patty Lent

2017 KITSAP PUBLIC HEALTH BOARD COMMITTEE ASSIGNMENTS

**Finance &
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Commissioner Charlotte Garrido
Mayor Patty Lent

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Mayor Becky Erickson
Commissioner Rob Gelder
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Councilperson Sarah Blossom
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1. Current Project Summary

Kitsap Connect is a multi-disciplinary collective impact program that provides innovative outreach, engagement, and care coordination services to Kitsap residents in Bremerton and Central Kitsap who are inappropriately engaged with costly health and social services including EMS, emergency departments, law enforcement and jail, *and* to those who are not effectively utilizing existing health and social resources, placing them at high risk for housing instability, eviction, homelessness, untreated or poorly managed mental illness, untreated chemical dependency, and complications from complex illness and disease. It aims to promote wellness and reduce the use of costly health, public, and social services. Agencies refer participants to outreach, engagement, and/or intensive care coordination because they exhibit risk for or signs of mental illness, chemical dependency, housing instability/ homelessness, or a combination of these, to the multi-disciplinary Coordinated Care Team. Team members are the problem solvers of last resort for people who are falling through the cracks and needlessly suffering and even dying. Referring agencies include: law enforcement, EMS, primary care, behavioral health, social service, emergency department and inpatient discharge, housing and homeless service providers.

Kitsap Connect is housed in The Bremerton Salvation Army Services Center. Comprised of a Program Coordinator, Behavioral Health Professional, Public Health Nurse, and Housing Outreach and Stabilization Coordinator, the Coordinated Care Team engages clients via telephone, face to face meetings, home visits, and street outreach with the goal of identifying key barriers to stability and resource needs. The team maintains engagement with participants by coordinating care among these resources, and by providing chronic disease and health education as needed. The team anticipates serving 30 clients in 2018 and clients remain "in the program" for 6-9 months.

The Coordinated Care Team focuses interventions on resources to maintain housing for those already housed, which often requires addressing chemical dependency and mental health issues. For youth and adults who are homeless and struggling with mental illness or drug/alcohol problems, securing stable housing is critical to recovery and stabilization of their symptoms. Similarly, for elderly persons whose primary health concern relates to physical barriers and housing, the ability to age in place will be protected against exacerbating existing or future behavioral health issues.

A key focus of this program is to improve system efficiency and remove organizational silos through enhanced cooperation and collaboration. An Advisory Committee has been established, comprised of decision-makers from key sectors to offer a platform for higher level system change discussions. The Committee meets twice annually. and plays an important role in quality improvement of the program moving forward, and potentially stimulating other strategies for this critical and innovative collective impact program.

2. Accomplishments to Date

A. The Kitsap Connect start-up occurred very rapidly with the recruitment of the Program Coordinator in late July 2016 followed by the recruitment of two part-time (0.5 each) Public Health Nurses in early August. From July 25th through August 15, 2016 the framework for Kitsap Connect team protocol and service provision was set and initial clients were identified and provided with intake services beginning on August 15, 2016. This was a monumental undertaking with partner agencies participating collectively to provide this responsive forward momentum.

Kitsap Connect has successfully addressed the 2014 Behavioral Health Strategic Planning goals, or gaps, #1, 2, 3 as follows:

Gap #1: Behavioral Health Prevention, Early Intervention, and Training

Kitsap Connect has created shared planning through ongoing collaboration and increased care coordination among mental health, substance abuse, health, and justice stakeholders.

Gap #2: Crisis Intervention/Triage Services

Kitsap Connect has established a Mobile Crisis Team and infrastructure to handle attempts by law enforcement or mental health outreach teams to preempt entry into the legal system, jail or the hospital and has established specialized homeless outreach services.

Gap #3: Outpatient Care – Psychiatry, Medical and Medication Management, Counseling Services

Kitsap Connect has enhanced linkage to comprehensive services including care coordination, access to medication, prompt access to benefits, health care, housing with/without supportive services, and mental health & substance abuse treatment.

In addition, we have accomplished the successful reaching of the Kitsap Connect goals and objectives initially called out on our 2016-2017 grant application.

Goal A- Improve the mental and physical health and well-being of highly vulnerable clients: To date, sixty identified potential high-utilizer clients with mental health and/or chemical dependency conditions have been screened for eligibility. Twenty-four clients are currently enrolled in Kitsap Connect services, with another six clients pending admission; the current client caseload is twenty-four clients, with length of service engagement an average of 7.2 months. 100% of engaged Kitsap Connect clients (3 months of engagement or longer), have tailored care plans, 100% of clients report at least moderate improvement in well-being as evidenced by self-report at time of quarterly and exit of program surveys.

Goal B- Reduce usage of costly health, social, and public services resulting in cost savings: Since January 2017 (beginning of data sharing availability), specific client encounters with the CHI/Harrison Hospital Emergency Department, Fire Department (county-wide) 911/EMS, Kitsap County Jail, and Law enforcement, are being tracked. Usage data is being compiled from the nine-month period prior to service engagement. Data collected is used as a client baseline to compare to client encounters during the nine-month period of service engagement in Kitsap Connect. We anticipate that we will

have specific client outcome data and cost savings analysis at the end of the 2017 contract period to share, though we have experienced promising results thus far. *Goal C- Improve systems efficiency through enhanced coordination and collaboration of social, public and health service providers:* Partner Service Agreements are in place, and partner participation in care team conferences is occurring. An Advisory Committee has been initiated and had their first meeting during the third quarter of 2017. An electronic Systems Assessment Survey was conducted and the majority of feedback from agencies participating in care coordination conferences indicated positive responses.

B. Barriers to Implementation

One barrier to implementation of the Kitsap Connect program included the inability to secure critical client high-usage data from partner and community agencies due to the unique and stringent confidentiality laws and agency protocols that are specific to each agency around data sharing related to mental health, chemical dependency and medical information. It wasn't until January 2017 that we were able to accurately target and document client usage data which allowed us to identify the highest-users/misusers of costly services rather than relying solely on client self-report. Currently we have access to several information systems including medical, mental health, 911/EMS and law enforcement which have been instrumental in our ability to effectively determine client eligibility for our services.

Another barrier during the Kitsap Connect start-up was that both Kitsap Mental Health Services (KMHS) and the Housing Solutions Center (HSC) had difficulty staffing the subcontractor positions for the Behavioral Health Specialist and Housing Outreach and Stabilization Coordinator. Recently, this has been resolved by securing our present full-time Behavioral Health Specialist and recruitment just ended successfully for the Housing Outreach Stabilization Coordinator who will be on board with us on site in mid-August. Both positions were very intermittently staffed from August 2016 until May 2017.

The **most** pressing and critical barrier to successful implementation of Kitsap Connect has been the limited availability of housing units for our homeless Kitsap Connect clients. Specifically, there are a limited number of housing units available county-wide, but in addition, a very limited number of landlords have interest in providing units to our hardest to serve high-need clients due to prior direct experiences with them in the past, history of eviction, and criminal history. Being unhoused or unsheltered combined with severe mental health and chemical dependency symptomology seriously limits our client's ability to achieve emotional and physical wellness and any real quality of life.

Lastly, the degree of complex, co-morbid medical conditions experienced by the majority of Kitsap Connect clients has been staggering. The severity and complexity of client medical conditions have stretched our nursing staff beyond expectation.

C. Kitsap Connect Outreach Plan

Agencies refer clients who they have identified as “in need of outreach, engagement, and/or intensive care coordination” because they exhibit risk for, or signs of mental illness, chemical dependency, housing instability/homelessness, or a combination of these, to the multi-disciplinary crisis response and coordinated care team. Referrals are received at Kitsap Connect via secured fax, encrypted email, by telephone, or by hand. Kitsap Connect is housed in the Bremerton Downtown Core at the Salvation Army Services Center, with shared team office space and an interview room in which to meet with individuals. The Center is located two buildings down from the Kitsap Rescue Mission and within two blocks of KCR and the HSC, KPHD, and the Bremerton Housing Authority (BHA). Its location creates ease for a quickly responsive “mobile” team to provide services on site or conduct outreach and engagement activities in the Bremerton-Central Kitsap Community. Outreach can be conducted in person but depends on the preference of the client. Many clients frequent the Salvation Army and the Kitsap Rescue Mission for meals and shelter and utilize a myriad of their services, making outreach and initial engagement simple. For potential clients that have telephones, an outreach call can be made to inquire about interest in receiving Kitsap Connect services. Because very few of our clients are housed, the mobile outreach team often travels to community sites, or provides outreach at public locations. Community and home-based outreach is conducted in teams for safety purposes.

D. Integration & Collective Impact

Kitsap Connect was collectively conceived by housing and health leaders who share a deep concern for marginalized persons in the community, particularly for people struggling from multiple complex issues related to homelessness, mental illness, chemical dependency, and un-managed chronic health issues. Partners continue to have a shared passion to reduce suffering among the most vulnerable in our community, and at the same time, amidst health care reform, partners have become increasingly aware of the critical need to reduce costly use of health and social services by a highly vulnerable, small percentage of the population. This program is designed to be collaborative, and is succeeding because partners utilize mutually reinforcing activities and open communication, and together depend on each other’s expertise.

Kitsap Connect is integrated with existing and emerging services. The Care Conference component of this program, which requires providers from different partner agencies to meet weekly, services clients “jointly” to create Care Plans for each client, and to provide an “open table.” Information is shared across providers to the degree possible while observing all applicable privacy regulations.

In the last twelve months, we have established close alliances with many existing *and* new community partner agencies. For example, we coordinate closely with Department of Social and Health Services, Home and Community Services Division to assess and place clients who are in desperate need of Adult Family Home or Skilled Nursing

models of care. A newer partnership we have developed is with the Brain Injury Alliance, which provides financial assistance, case management, and other supports to clients with traumatic brain injuries and cognitive disorders. Over several years, we anticipate our collective impact will be reduced suffering and fewer deaths of persons experiencing mental illness, homelessness, and chemical dependency with critical by-products of this work to be; reduced health care and social service costs, improved system efficiency, and the reduction of provider silos through collaborative partnerships and more effective coordination of care.

E. Key Accomplishments

The Kitsap Connect program was implemented on time. This included a massive collective effort on the part of the Kitsap Connect team and partner agencies. Program protocol was developed, our client record management system was identified, and training was completed. Utilization of the client data system began in November 2016. Processes and supporting documents for client Outreach and Engagement were developed and implemented. Tools for assessing client eligibility, vulnerability, and progress were developed. Staff training of therapeutic service delivery models related to best and evidenced based practices was completed this first year to include; motivational interviewing, ACES, Personality Disorders, Mental Health First Aid. Safety and Active Shooter training were also completed. Agency Partner Agreements were implemented and close partnerships have been established. We are leveraging community resources whenever possible. The HSC and BHA have been instrumental in ramping up housing/shelter and related supports. Over the past 12 months, eighteen clients gained access to housing and/or shelter, many permanently, utilizing HSC funding (10B and SHP) and BHA vouchers (SHP).

More than 80% of Kitsap Connect clients have been re-engaged or have participated in initial engagement at KMHS. Several have opted out of mental health services completely, however, they are engaged with interim mental health support through Kitsap Connects' Behavioral Health Specialist, who provides crisis intervention and serves as the liaison to KMHS. Three clients have been admitted to detox services and seven have participated in inpatient chemical dependency treatment services. We are accurately identifying the most vulnerable high utilizers in the community via data collected through community information systems. We are now able to access medical, mental health, emergency response, and law enforcement data which assists us in providing outreach and engagement at the right place, at the right time, in the right way, which was a key initiative of the collective agencies that developed the concept of the Kitsap Connect program. The number of clients that we are serving is in alignment with our originally anticipated client activity, and all clients engaged in services have established care plans. Quarterly KBS (Knowledge, Behavior, and Status) scores indicate client progress in key areas of: Healthcare Supervision, Income, Mental Health,

Chemical Dependency, and Residence as measured by the Omaha System, and quarterly Satisfaction Surveys show moderate to high client satisfaction of services received.

We are proud to report that Kitsap Connect was selected as the recipient of the 2016 "Innovation Award," as designated by the Kitsap Continuum of Care Coalition. The Kitsap Continuum of Care Coalition is a forum of community providers in Kitsap County that work collectively "to provide a coordinated, compassionate and effective environment to help homeless persons achieve self-sufficiency.

3. Budget Narrative

A. Expenditures (July 1, 2016 - June 30, 2017)

Personnel

Manager and Staff (Program Related) = \$159,713.88

Fringe Benefits = \$49,877.65

SUBTOTAL = \$209,591.53

Supplies and Equipment

Equipment = \$1,911.92

Office Supplies = \$1,732.69

Computer/Software = \$5796.54

SUBTOTAL = \$9,441.15

Administration

Communication = \$2,009.62

Training/Travel/Transportation = \$3,410.63

% Indirect = \$26,764.43

Client Incidentals = \$3,032.33

Subcontracts: KMHS, KCR = \$40,158.89

SUBTOTAL = \$75,375.90

TOTAL EXPENDED FUNDS = \$294,408.58

*We have been expending Kitsap Connect Funds at a slower rate than expected. We currently have 43.21% of funds and 33% of the grant year remaining. We had difficulty maintaining staffing through our subcontractors, Kitsap Community Resources and Kitsap Mental Health services as previously mentioned. We have 76% of that line item balance remaining. We have overspent in the line item for client incidentals, as there has been a greater need for these items than expected when we first started this project. There is a projected remaining balance of \$56,042 at the end of the grant period. In October, we will be requesting of the Citizens Advisory Board that these

unexpended funds be rolled over into 2018 to cover the cost of office rent at Salvation Army, provide salary for a part-time Security Guard previously funded by the City of Bremerton (they do not have funding for 2018 for this position) and for additional client incidental costs particularly related to medical necessities that are not covered under client insurance.

B. Funding Request

For 2018, we are requesting the Citizens Advisory Board consider increasing the annual support to our program. This increased request is related to the following:

-Original projections for hiring of a Program Coordinator of Kitsap Connect were low. Finding the right person for the position required increasing the salary allocation towards that position.

-We underestimated how substantial the physical needs of Kitsap Connect clients would be, and did not initially include subcontracted funds to PCHS to help coordinate medical care for these clients. We have included a request to fund 0.25 FTE of a PCHS health care specialist for this purpose. PCHS would like to develop a mobile primary care team, and if they are successful in this, the cost of the HCS may be reduced.

-KMHS had matching Medicaid funding the pilot year of Kitsap Connect, but the change in the health care landscape has eliminated that funding as a matching option. Their subcontract request has therefore increased.

-KCR has slightly higher program management costs for 2018. Salary and benefit cost increases for all participating agencies are projected.

Personnel

Managers:

0.06 FTE of Assistant Director of Health X 12 months = \$7565

1.0 FTE Program Coordinator X 12 months = \$92,893

Staff:

.5 FTE Public Health Nurse X 12 months = \$40,679

.5 FTE Public Health Nurse X 12 months = \$38,755

Total Benefits (taxes, benefits, retirement) = \$63,256

SUBTOTAL = \$243,147

Supplies and Equipment

Office supplies - \$50 per month X 12 months = \$600

SUBTOTAL = \$600

Administration

Communication: 4 cell phones at \$50/ month X 12 months = \$2,400

Client incidentals: \$3,000 over a 12-month period to pay for items needed by clients to improve chance of successful engagement in services, including bus vouchers, medical equipment and supplies, clothing & shoes, phone minutes, hygiene items, bedding, etc.

Training/Travel/Transportation = \$4,000
% Indirect = \$40,955.50

Other: Professional Services/Sub Contractors

Subcontract to KMHS: 1.0 FTE Behavioral Health Specialist = \$88,161 for 12 months

Subcontract to KCR: 1.0 FTE Housing Outreach and Stabilization Coordinator = \$51,048 for 12 months

Subcontract to PCHS: .25 FTE Health Care Specialist = \$17,199 for 12 months

SUBTOTAL = \$206,763.50

TOTAL REQUESTED FUNDS = \$450,510.50

C. Funding Modifications

As previously noted under the Barriers to Implementation section of this application, we are requesting a .25 HCS position in partnership with PCHS with the aim of increasing much needed medical support services to Kitsap Connect clients. We anticipate this position will also further support the successful engagement/re-engagement of clients into the PCHS system (subsequently reducing misuse of the Emergency Department). In addition, the HCS position will allow the nursing staff of Kitsap Connect to focus on emergent crises intervention and engagement for our most debilitated clients.

On our present caseload, four clients have Type 1 diabetes with co-occurring mental health and substance use disorders which makes the 3-5 blood sugar checks and daily insulin dosing difficult especially when trying to keep up with their other medical and mental health needs. These same clients are homeless and several have moderate to severe memory impairment which further creates difficulty with follow-through and means there is no place to store their insulin. Once insulin reaches 86 degrees, it is no longer effective.

Three other Kitsap Connect clients are non-ambulatory (wheelchair bound), and another five use mobility aides such as walkers or canes that limit their ability to get up and down stairs. As a result, we have been unable to house ANY of our wheelchair bound clients, due to a lack of wheelchair accessible units and have struggled to find housing that does not have stairs for our other clients with mobility aides. Their physical disabilities also limit acceptance into inpatient chemical dependency treatment as they are told their medical issues are primary, or they cannot not accommodate their disabilities, while their history of drug use prevents them from being accepted into skilled nursing facilities or adult family homes.

We have at least seven current clients who struggle with incontinence issues that jeopardize their ability to stay in hotels, shelters, housing etc. We have multiple clients who are banned from both shelters and hotels from ruining beds/furniture from incontinence, including a client facing eviction from her shelter due to her urinary

incontinence. Because home health only sees “home-bound” individuals, and caregivers are difficult to get for homeless clients, this is a continued, systemic, severely debilitating issue that afflicts a great number of our clients. These issues persist even with the use of adult briefs, incontinence pads, and regular catheterizations. Kitsap Connect nurses are faced daily with the persistent medical crises of clients and currently spend an estimated 85% of their time providing direct face to face intensive services including intake, medical assessment and education, referral to wellness resources and chronic disease and health education. This intensive model leaves little time to complete client charting and documentation and important follow-up with community resources. We anticipate that the proposed HCS position would provide critical medical assistance to clients who are engaged or seeking re-engagement with PCHS, and would help absorb case management type tasks for our nurses giving them the time necessary to focus on emergent medical crises. HCS supports would include; general support and encouragement using motivational interviewing and goal setting with patient/families, conducting medical intake interviews including enrolling and/or referring patients back into PCHS, following-up with patients via phone calls, assisting patients with completing applications and registration forms, helping patients set personal and medical goals that support more consistently attending medical appointments, providing referrals for services to community agencies, helping patients connect to transportation resources for medical appointments and giving medical appointment reminders.

The HCS would function as a liaison between Primary Care Doctors and Kitsap Connect, and would alert Kitsap Connect when a mutual patient has been to visit their Primary Care Doctor, the emergency room, or has been hospitalized. Mutual patients will be flagged by the HCS and PCHS visits will be tracked. Medical summaries of mutual clients will be forwarded from PCHS to Kitsap Connect nursing staff to assist in coordinated care planning and to provide additional medical engagement and follow-up if necessary. The HCS position will be located at PCHS 6th Street clinic which is two blocks from the Kitsap Connect office.

4. Sustainability

A. Sustainability Plan

Several agencies have committed financial and in-kind resources to this project. KCR, a subcontracting agency for the project, has agreed to provide matching funds/in-kind support toward the project: KCR will provide \$9,800 of in-kind supervisory support, along with rapid rehousing & rental assistance to clients valued at \$25,000 for access to KCR Housing Programs for eligible clients. They, along with staff from EMS, BHA, and Salvation Army, have agreed to attend care conference sessions at no cost. BHA is provisionally contributing 10 housing vouchers valued at of \$102,780. As the backbone agency, KPHD will contribute \$50,929.75 of local dollar funds to this project beyond grant funds. Kitsap Connect is in direct alignment with the goal of the Treatment Sales Tax because it focuses directly on reducing the impacts of disabling chemical

dependency and mental illness. Programs of its kind in other communities have shown significant outcomes in creating effective, data driven programs that support a continuum of recovery-oriented systems of care. We will continue to apply for Treatment Sales Tax funds in the future but at the same time, we are committed to seek out additional resources to fund the program as previously mentioned. Because this year has been largely focused on launching the program and allowing time to track program outcomes, we have not been positioned to date to aggressively seek additional funding for Kitsap Connect. As staffing stabilizes and the program becomes more refined, we will have more time to dedicate to soliciting additional funds.

The following agencies have submitted Commitment Letters: Bremerton Fire Department, Bremerton Housing Authority, Kitsap Community Resources, Kitsap Mental Health Services, Kitsap County Department of Human Services Housing and Homelessness Program, and Salvation Army.

A. Leveraged Funds

Kitsap Connect has made great progress in the leveraging of funds and services to help support the program. Our partnership with The Salvation Army (TSA) has afforded our clients the opportunity to utilize basic need services such as the food bank, hygiene center, breakfast and lunch on weekdays, laundry services, haircuts, bus passes, and hotel vouchers intermittently when no other funds were available through partner agency programs. They have donated valuable medical equipment including wheelchairs and walkers that would have been otherwise unavailable to our clients, due to unaffordable insurance co-pays and spend downs. Clients also have access to the PCHS after-hour walk-in clinic, Monday through Friday at 6:00pm.

The HSC has provided bus tickets, assistance accessing Social Security Benefits, HARP's funding for housing, 10B hotel vouchers, SHP vouchers (through the BHA), case management services, and immediate access to the HSC housing navigators when appropriate. KMHS has provided HARP's Peer Specialists and KMHS Peer Specialists for long term peer support, and housing sustainability case management once a client has become housed.

Kitsap Recovery Center, Agape' Unlimited and West Sound Treatment Center have all been very flexible when working with our hardest to serve clients, often allowing walk-in appointments and other concessions. West Sound Treatment Center has provided transportation, peer-based case management support, and funding for client travel to treatment out of county, and client incidentals when available.

Over time, low-barrier housing initiatives in the community will likely provide some level of intensive care for high utilizers, and housing stability itself will maintain positive program impacts at the individual level. Additionally, the establishment of an Advisory Committee has been formed to take the collective impact to the next level of leadership and scalability, both geographically and within systems.

EVALUATION WORKSHEET

INSTRUCTIONS:

Evaluation is the collection of information about a program in a systematic and defined manner to demonstrate success, identify areas for improvement and lessons learned. Every program has at least one end goal and might have several – one or more activities are required to make progress toward meeting the goal. Progress is measured with one or more objectives that might cover an output (number of something) or outcome (change over time) due to the program. The type of outcome (column D) and expected timeframe for change (column E) should be defined. Objectives must follow the “SMART” guideline: specific, measurable, attainable, realistic, and time-bound (column C). Each objective should include an expected target result and completion date (“time-bound” part of column C).

New and continuing grant proposals must fill out the Evaluation Worksheet.

DEFINITIONS:

Goal:	A broad statement or a desired, longer-term, outcome of a program. A program can have one or multiple goals. Each goal has one or more related specific objectives that, if met, will collectively achieve the stated goal.
Activity:	Actions taken or work performed to produce specific outputs and outcomes.
Objective:	A statement of a desired program result that meets the criteria of being SMART (specific, measurable, achievable, realistic, and time-bound).
Output:	Results of program activities; the direct products or deliverables of program activities; such as number of: sessions completed, people served, materials distributed.
Outcome:	Effect of a program (change) - can be in: participant satisfaction; knowledge, attitude, skill; practice or behavior; overall problem; or a measure of return-on-investment or cost-benefit. Identify any measures that are “fidelity” measures for an evidence based practice.
Timeline:	Is the outcome expected to measure short-term, medium-term or a longer-term change? When will measurement begin? How often will measurement be done (frequency: quarterly, semi-annual, annual, other)?
Baseline:	The status of services or outcome-related measures before an intervention against which progress can be assessed or comparisons made. Should include data and time frame.
Source:	How and from where will data be collected?

EVALUATION WORKSHEET

PROJECT NAME: Kitsap Connect

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE Data and time	G. SOURCE
Improve the mental health and physical health and well-being of highly vulnerable clients	<p>Agencies identify clients for potential services and refer to Crises and Care Coordination Team</p> <p>Outreach to referred clients conducted and intake assessments completed</p> <p>Crises & Care Coordination Team members work with partners through care conferences to establish tailored care plan for client</p>	By December 31, 2018, serve at least 30 highly vulnerable, costly clients with established care plans	<input checked="" type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill <input type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Other: <u>Ongoing</u>	0 as of 1/1/18	Client Referral Forms Client Intake Forms
Click here to enter text.	Crises & Care Coordination Team members track progress on care plan goals and record change in behavior/practice for each participant	By December 31, 2018, maintain 50% of enrolled clients (those participating at least 3 months- does not have to be consecutive) will make progress on their tailored care plan as evidenced by improved Knowledge, Behavior and Status (KBS) scores.	<input type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input checked="" type="checkbox"/> Outcome: Knowledge, attitude, skill <input checked="" type="checkbox"/> Outcome: Practice or behavior <input checked="" type="checkbox"/> Outcome: Impact on overall problem (status) <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input type="checkbox"/> Other: _____	50% as of 1/1/18	KBS Data/Score
Click here to enter text.	Click here to enter text.	By December 31, 2018, 80-90% of clients will maintain improvement in well-being as measured by an Anonymous Services Survey at exit of program	<input type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input checked="" type="checkbox"/> Outcome: Knowledge, attitude, skill <input checked="" type="checkbox"/> Outcome: Practice or behavior <input checked="" type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Other: _____	90% as of 1/1/18	Anonymous Services Survey

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE <small>Data and time</small>	G. SOURCE
				One time at exit		
	Clients engaged in the program administered internal quarterly Satisfaction Survey	By December 31, 2018, clients maintain 80-90% moderate to high level of satisfaction with program as measured by internal quarterly Satisfaction Survey	<input type="checkbox"/> Output <input checked="" type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill <input type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input type="checkbox"/> Other: ____	80-90% as of 7/1/17	Satisfaction Survey
Reduce usage of costly health, social, and public services resulting in cost savings	Crises & Care Coordination Team identify usage pattern baseline for each client Crises & Care Coordination Team provide intensive care coordination for clients resulting in more efficient usage of system resources by client	By December 31, 2018, maintain at least 50% of clients enrolled in the program (those participating at least 3 months-does not have to be consecutive) decrease use of costly services compared to their baseline	<input type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill <input checked="" type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Other: <u>Ongoing</u>	50% as of 1/1/18	Intake- self-report Community data: EPIC/ED ERS-911/EMS KMHS
		By December 31, 2018, inappropriate or high emergency department utilizers enrolled in the program (those participating at least 3 months- does not have to be consecutive) maintain reduction of ED visits at 15% of baseline	<input type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input checked="" type="checkbox"/> Outcome: Knowledge, attitude, skill <input checked="" type="checkbox"/> Outcome: Practice or behavior <input checked="" type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable:	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input type="checkbox"/> Quarterly	15% as of 1/1/18	Community data: EPIC/ED

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE <small>Data and time</small>	G. SOURCE
			<input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Other: <u>Ongoing</u>		
Improve system efficiency through enhanced coordination and collaboration of social, public, and health service providers	Referring agencies will complete Partner Service Agreements with KPHD outlining shared commitment to care conferences and collaboration	By March 31, 2018, the following seven diverse agencies will maintain Partner Service Agreements for 2018 to refer to the program and participate in case conferences as appropriate: Law Enforcement, EMS, KMHS, community health and treatment centers, KCR/HSC, PCHS	<input checked="" type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill <input type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input checked="" type="checkbox"/> Short <input type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>3/31/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Other: <u>Once</u>	7 as of 7/1/17	Partner Service Agreements
	Program Manager will establish timeline for care conferences with referring agencies and convene conferences	100% of partners maintain participation in at least 75% of requested care conferences	<input checked="" type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill <input type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input checked="" type="checkbox"/> Short <input type="checkbox"/> Medium <input type="checkbox"/> Long Start date: <u>1/1/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input checked="" type="checkbox"/> Other: <u>As requested</u>	80% of partners as of 7/1/17	Program Data
	Kitsap Connect Advisory Committee will convene to minimize duplication of	By June 30, 2018 and December 31, 2018, the Kitsap Connect Advisory Committee, consisting	<input checked="" type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill	<input type="checkbox"/> Short <input checked="" type="checkbox"/> Medium <input checked="" type="checkbox"/> Long	0 as of 1/1/18	Program Data

EVALUATION WORKSHEET

A. GOAL	B. ACTIVITY	C. SMART OBJECTIVE	D. TYPE OF MEASURE	E. TIMELINE	F. BASELINE <small>Data and time</small>	G. SOURCE
	services and increase care coordination between partner agencies	of stakeholders, elected officials, and partner agencies will convene at least twice	<input type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	Start date: <u>6/30/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Other:		
		By December 31, 2018, 90% of agencies participating in care coordination conferences and/or on the Advisory Committee will report improved collaboration via a Systems Assessment Survey during the 4 th Quarter of program.	<input checked="" type="checkbox"/> Output <input type="checkbox"/> Outcome: Participant satisfaction <input type="checkbox"/> Outcome: Knowledge, attitude, skill <input type="checkbox"/> Outcome: Practice or behavior <input type="checkbox"/> Outcome: Impact on overall problem <input type="checkbox"/> Return-on-investment or cost-benefit If applicable: <input type="checkbox"/> Fidelity measure	<input type="checkbox"/> Short <input type="checkbox"/> Medium <input checked="" type="checkbox"/> Long Start date: <u>12/31/18</u> Frequency: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Other:	90% as of 7/1/17	Systems Assessment Survey

**Kitsap Public Health District
OPERATING BUDGET WITH ACTUALS**

REVENUES	UNAUDITED ACTUAL 2016	BUDGET 2017	BUDGET 2018
Contracts & Grants	\$ 5,246,053	\$ 3,691,840	\$ 3,991,840
Fees	5,553,245	5,531,518	5,531,518
Local Government Contributions	2,466,371	2,459,645	2,459,645
Local Government NDGC Mortgage	60,150	62,250	62,250
Miscellaneous Income	28,714	21,541	21,541
TOTAL REVENUES	\$ 13,354,533	\$ 11,766,794	\$ 12,066,794
EXPENDITURES	UNAUDITED ACTUAL 2016	BUDGET 2017	BUDGET 2018
Personnel Costs	\$ 9,042,148	\$ 9,556,970	\$ 9,939,249
Supplies	286,404	215,941	215,941
Office Equipment <\$5,000	19,894	8,660	8,660
Computer Software <\$5,000	17,107	11,400	11,400
Computer Hardware <\$5,000	68,837	19,400	19,400
Professional Services	2,028,214	966,320	966,320
Legal Services	53,644	41,600	41,600
Communications	154,249	109,544	109,544
Travel & Mileage	99,035	95,482	95,482
Parking & Commute Trip Reduction	16,289	20,695	20,695
Advertising	3,397	10,650	10,650
Rentals & Leases	53,125	40,738	40,738
Insurance	106,921	109,082	109,082
Utilities	3,221	1,300	1,300
Repairs & Maintenance	137,002	135,175	135,175
Operations & Maintenance: Government Center	307,484	319,714	319,714
Training	79,776	88,116	88,116
Miscellaneous	66,553	66,822	66,822
Equipment >\$5,000	80,952	-	-
Computer Hardware >\$5,000	-	13,000	13,000
Government Center Debt Principal	150,000	165,000	165,000
Government Center Debt Interest	150,756	146,250	146,250
Non-Expenditures	4,464	-	-
TOTAL EXPENDITURES	\$ 12,929,472	\$ 12,141,859	\$ 12,524,138
REVENUES OVER (SHORT) OF EXPENDITURES *	\$ 425,061	\$ (375,065)	\$ (457,344)

* Includes use and reserve of designated and reserved funds.

KPHD Kitsap Connect Proposal
Expenditures Greater than 10% of total project budget

PERSONNEL

	Salary	Benefits	Total
0.06 FTE Division Director for 12 Months	\$ 7,565	\$ 1,217	\$ 8,783
1.0 FTE PM for 12 Months	\$ 92,893	\$ 33,946	\$ 126,838
0.5 FTE PHN for 7 months (pre Step increase, K. Stedman)	\$ 23,210	\$ 7,928	\$ 31,138
0.5 FTE PHN for 5 months (post)	\$ 17,469	\$ 4,652	\$ 22,121
0.5 FTE PHN for 7 months (pre Step increase, J. Stuntz)	\$ 22,119	\$ 9,805	\$ 31,924
0.5 FTE PHN for 5 months (post)	\$ 16,635	\$ 5,707	\$ 22,342
Revised Funding Request			\$ 243,146

PROFESSIONAL SERVICES - SUBCONTRACTORS

KCR Subcontractor Budget	2018 Budget	2018 KCR Match
Admin	4,048.00	
Supervision		9,800.00
Salaries & Benefits	45,000.00	
Supplies & Expenses	1,000.00	
Training	500.00	
Mileage	500.00	
Total	51,048.00	9,800.00

1.0 FTE Housing Coordinator

KMHS Subcontractor Budget	2018 Budget
Salaries and Benefits	\$74,587.00
Training	\$1,000.00
Office Supplies	\$467.25
Data Management System	\$1,008.00
Travel/Mileage	\$1,319.85
Cell phone	\$756.00
Liability Insurance	\$567.00
Printing	\$441.00
Admin	\$8,015.00
Total	\$88,161.10

1.0 FTE Behavioral Health Specialist + 2 hours/ week supervision

PCHS Subcontractor Budget	2018 Budget
Community Health Worker	\$10,400.00
Benefits	\$2,600.00
SUBTOTAL	\$10,400.00
Supplies/Materials = (\$520 One time)	\$520.00
Travel (25 miles per week)	\$715.00
Other (Describe): Lap Top Computers	\$1,700.00
Other (Describe): Cell Phones (\$150/mo)	\$1,800.00
Other (Describe): Training	\$500.00
SUBTOTAL	\$5,235.00
% Indirect (10%)	\$1,563.50
Total	\$17,198.50

0.25 FTE

Total Subcontractor Budget \$156,408

Special Project Budget Form

Agency Name:
Kitsap Public Health District

Project:
Kitsap Connect

Enter the estimated costs associated with your project/program	Total Funds		Requested Funds		Other Matching Funds	
	Budget	Percent	Budget	Percent	Budget	Percent
Personnel						
Managers	\$ 100,458.00	20%	\$ 100,458.00	22%		0%
Staff	\$ 79,433.00	16%	\$ 79,433.00	18%	\$ -	0%
Total Benefits	\$ 63,256.00	12%	\$ 63,256.00	14%	\$ -	0%
SUBTOTAL	\$ 243,147.00	48%	\$ 243,147.00	54%	\$ -	0%
Supplies & Equipment						
Equipment	\$ -	0%		0%		0%
Office Supplies	\$ 1,200.00	0%	\$ 600.00	0%	\$ 600.00	1%
Other (Describe):	\$ -	0%		0%	\$ -	0%
SUBTOTAL	\$ 1,200.00	0%	\$ 600.00	0%	\$ 600.00	1%
Administration						
Advertising/Marketing	\$ -	0%		0%		0%
Audit/Accounting	\$ -	0%	\$ -	0%	\$ -	0%
Communication: Cell Phones	\$ 2,400.00	0%	\$ 2,400.00	1%	\$ -	0%
Insurance/Bonds	\$ -	0%	\$ -	0%	\$ -	0%
Client Incidentals	\$ 3,000.00	1%	\$ 3,000.00	1%	\$ -	0%
Training/Travel/Transportation	\$ 4,000.00	1%	\$ 4,000.00	1%	\$ -	0%
% Indirect (Limited to 10%)	\$ 91,885.25	18%	\$ 40,955.50	9%	\$ 50,929.75	83%
Other: Professional Svcs.-Sub Contractors	\$ 166,208.00	32%	\$ 156,408.00	35%	\$ 9,800.00	16%
SUBTOTAL	\$ 267,493.25	52%	\$ 206,763.50	46%	\$ 60,729.75	99%
Ongoing Operations & Maintenance						
Janitorial Service	\$ -	0%		0%		0%
Maintenance Contracts	\$ -	0%	\$ -	0%	\$ -	0%
Maintenance of Existing Landscaping	\$ -	0%	\$ -	0%	\$ -	0%
Repair of Equipment and Property	\$ -	0%	\$ -	0%	\$ -	0%
Utilities	\$ -	0%	\$ -	0%	\$ -	0%
Other (Describe):	\$ -	0%	\$ -	0%	\$ -	0%
Other (Describe):	\$ -	0%	\$ -	0%	\$ -	0%
Other (Describe):	\$ -	0%	\$ -	0%	\$ -	0%
SUBTOTAL	\$ -	0%	\$ -	0%	\$ -	0%
Other						
Debt Service	\$ -	0%		0%		0%
Other (Describe):	\$ -	0%	\$ -	0%	\$ -	0%
SUBTOTAL	\$ -	0%	\$ -	0%	\$ -	0%
Total Project Budget	\$ 511,840.25		\$ 450,510.50		\$ 61,329.75	

NOTE: Indirect is limited to 10%

Project Salary Summary

Description

Number of Professional FTEs	2.50
Number of Clerical FTEs	0.00
Number of All Other FTEs	0.00
Total Number of FTEs	2.50

Salary Information

Salary of Executive Director or CEO	\$ 7,565.00
Salaries of Professional Staff	\$ 172,326.00
Salaries of Clerical Staff	\$ -
Other Salaries (Describe Below)	\$ -
Description:	\$ -
Description:	\$ -
Description:	\$ -
Total Salaries	\$ 179,891.00
Total Payroll Taxes	\$ -
Total Cost of Benefits	\$ 63,256.00
Total Cost of Retirement	\$ -
Total Payroll Costs	\$ 243,147.00

July 12, 2017

**KITSAP
MENTAL
HEALTH
SERVICES**

Kitsap County Citizens Advisory Board
C/O Kitsap County Human Services
614 Division Street MS-23
Port Orchard, WA 98366

**Re: Letter of Commitment to provide Mental Health, Chemical
Dependency and Therapeutic Court Programs**

Dear Citizens Advisory Committee:

On behalf of Kitsap Mental Health Services, I am writing to express our support and commitment for the Kitsap Public Health District grant proposal to provide Mental Health, Chemical Dependency and/or Therapeutic Court Programs.

Kitsap Mental Health Services staff have a long history of working with the Kitsap Public Health District in our mutual efforts to work with vulnerable individuals in need of behavioral health and physical health services, housing, and social service supports. We have been strong partners with the Health District in the Kitsap Community Health Improvement Priorities and the projects that have resulted as a result of this prioritization for our community. One of these priorities was to better address housing and homelessness. This project is an outgrowth of much shared discussion and strategy setting to improve our crisis response and care coordination for persons at risk of or homeless and experiencing behavioral health issues. We believe its design will help reduce homelessness, improve likelihood of engagement in needed treatment and assist people in becoming more able to live successfully in our community.

Kitsap Mental Health Services is pleased to commit staffing capacity that will support this endeavor and commit the following resources to the KPHD proposal:

- 1 FTE KMHS behavioral health professional
- Administrative oversight of therapist and regular supervisory guidance

The KMHS Behavioral Health Professional will, under the guidance of the KMHS Adult Outpatient Director or her supervisor designee, provide clinical outreach and engagement and care coordination services.

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*The mission of Kitsap
Mental Health Services
is to shape the future of
mental health through
state of the science
service delivery,
community partnerships
and advocacy.*

Ph (360) 373-5031
TDD (360) 478-2715
Fax (360) 377-0458

5455 Almira Drive NE
Bremerton, WA 98311-8331

www.kitsapmentalhealth.org

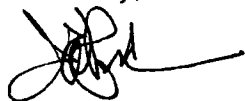


KMHS does not discriminate against any person on the basis of race, color, national origin, sex, disability, marital status, religion, ancestry, age, veteran status, or other protected status under applicable laws in its programs and activities.

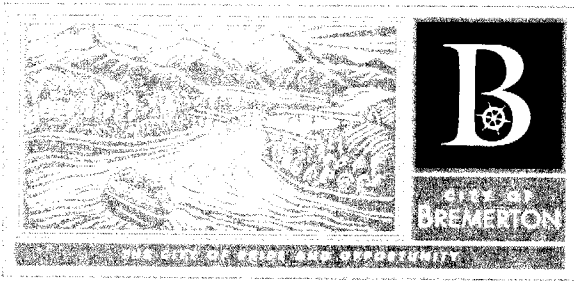
Kitsap Mental Health Services is an active member in the Kitsap County Coalition on Homelessness and has been engaged in the development of our community's homeless housing plan, as well as providing services to some of the most impacted individuals. We work closely with the partners involved in this application to help our clients with their behavioral health concerns, including reducing likelihood of homelessness by helping individuals maintain or secure housing. We are familiar with the Kitsap County Behavioral Health Strategic Plan and are pleased to work together with KPHD and allied partners in this critical effort to end the service gaps identified in the plan.

We believe our support and commitment will significantly improve the availability of Mental Health and Chemical Dependency services to some of the most vulnerable adults in the County and we look forward to working with you on this important endeavor.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joe Roszak', with a long horizontal flourish extending to the right.

Joe Roszak
Chief Executive Officer



BREMERTON FIRE DEPARTMENT
Doug Baier, Medical Officer
Doug.baier@ci.bremerton.wa.us

Tel: 360-473-5384
Fax: 360-473-5397
911 Park Avenue
Bremerton, WA 98337

July 12, 2017

Kitsap County Citizen Advisory Board
c/o Kitsap County Human Services
614 Division Street, MS-23
Port Orchard, WA 98366

Re: Letter of continued commitment

Dear Citizen Advisory Committee,

I am writing to express my continued support and commitment for the Kitsap Public Health District's Mental Health, Chemical Dependency and/or Therapeutic Court Programs.

Kitsap Public Health District (KPHD) serves as the backbone agency for the evolving collective impact project - the Crisis Response and Coordinated Care Demonstration Project, which services the Bremerton and Central Kitsap areas. KPHD is Kitsap County's governmental public health agency committed to preventing disease and protecting and promoting the health of all persons in Kitsap County. KPHD works closely with mental health, chemical dependency, primary care, acute care, and social service providers to identify and address the most pressing health issues in our community.

There is a significant need in our community for a crisis response and coordinate care team to service our most fragile residents who over-utilize and/or ineffectively utilize behavioral health, physical health, and social services in our community.

The Bremerton Fire Department (BFD) continues to commit staff time devoted to support the project, including serving on the case conference meetings as appropriate and referring clients to the Crisis Response and Care Coordination Team

The BFD has played an integral role in the development of this collective impact approach to reducing inappropriate use of costly services. The BFD has come to recognize that individuals frequently encountered during emergency medical service delivery often suffer from challenging and complex health or social circumstances particularly, mental illness, substance abuse and/or chronic homelessness. Their underlying psychosocial issues remain unaddressed and needs unfilled as they seek and receive primary assistance from ill-suited, ill-equipped emergency medical services. The resulting episodic, uncoordinated, unfocused care is of inferior quality and of substantially higher community and societal cost while simultaneously consuming valuable public safety resources better addressed by a Crisis Response and Care Coordination Team. Our most vulnerable residents require a collaborative and coordinated approach to addressing their highly complex needs.

We believe our support and commitment will significantly improve the availability of Mental Health, Chemical Dependency and/or Therapeutic Court Program services in the County and we look forward to continuing working with you.

Sincerely,
Doug Baier, Medical Officer
Bremerton Fire Department



The Salvation Army

Founded in 1865

Serving Kitsap County since 1920

832 Sixth Street • P. O. Box 886 • Bremerton, WA 98337-0204

(360) 373-5550 FAX (360) 373-2134 • www.bremerton.salvationarmynw.org

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Our mission: to save souls, grow saints and serve suffering humanity in Bremerton, Kitsap County and beyond as God enables

July 14, 2017

Kitsap County Citizens Advisory Board

C/O Human Services

614 Division Street, MS-23

Port Orchard, WA 98366

RE: **Kitsap Connect Project**
The Salvation Army – Bremerton, Corps.

To Whom It May Concern,

I am writing to express the support and on-going commitment of The Salvation Army for the Crisis Response and Care Coordination Demonstration Project (Kitsap Connect) as submitted by the Kitsap Public Health District called Kitsap Connect. The Project addresses a critical need in the Bremerton/Central Kitsap community for a crisis and housing response that is designed to engage highly vulnerable people within the service gap areas defined in the Mental Health, Chemical Dependency and/or Therapeutic Court Programs and Behavioral Health Strategies Plan.

In 2016, the Kitsap Public Health District, through its Community Health Improvement Plan and process, identified increasing services to the unengaged, homeless and 'high utilizers' of services who would benefit by outreach/engagement and care coordination as a priority area. The Kitsap County Health District has worked together with housing and social service agencies and successfully created the Kitsap Connect Project. Partners in the demonstration project included Housing Solutions Center with Kitsap Community Resources, Kitsap Public Health District, Bremerton Housing Authority, the Salvation Army, Peninsula Community Health Services, and Kitsap Mental Health

In the beginning, these organizations concluded that The Salvation Army, as the "place of last resort" for the homeless (many of who struggle with mental illness, chemical dependency and chronic disease), which feeds up to 250

WILLIAM BOOTH
Founder

ANDRE COX
General

KENNETH G HODDER
Territorial Commander

BILL DICKINSON
Divisional Commander

MAJORS SCOTT & CHERILEE RAMSEY
Corps Officers



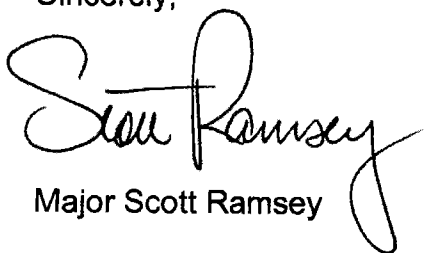
meals per day and during the winter shelter, averages 50 people per night, is an ideal location for program staff to be housed. Consequently, The Salvation Army was the prime location to place a Project Team, a location where development of relationships and trust among individuals who can be difficult to engage in services can be readily made.

The Salvation Army recognizes that the Kitsap Connect team is mobile and will be serving individuals at other locations as well, but The Salvation Army is please to serve as a "home base," and to that end we are committed to providing space to the Crisis Response and Care Coordination Team Demonstration Project. Two rooms, a space of about 450 square feet total, is valued at appropriately \$7,500.00 annually with access to the conference rooms.

The Salvation Army is an active member of the Kitsap County Continuum of Care Coalition on Ending Homelessness and is highly engaged in the development of our community's homeless housing plan, as well as providing services to some of the most impacted individuals. We work closely with the partners involved in this application to help our clients with their daily survival needs. We are aware of the Kitsap County Behavioral Health Strategic Plan and are pleased to continue to work together with our partners in this critical effort to end the service gaps identified in the plan.

The Salvation Army is in full support and a strong commitment to the Kitsap Connect project because over the months since its inception in August of 2016, we have seen the program significantly improve the availability of Mental Health, and Chemical Dependency services to some of the most vulnerable adults in the County and we look forward to working with you on this very important endeavor.

Sincerely,

A handwritten signature in black ink that reads "Scott Ramsey". The signature is written in a cursive style with a large, looping initial "S".

Major Scott Ramsey



600 Park Avenue
Bremerton WA 98337
(p) 360-479-3694
(f) 360-616-2927
www.bremertonhousing.org

July 14, 2017

**Kitsap County Citizens Advisory Board
C/O Kitsap County Human Services
614 Division Street MS-23
Port Orchard, WA 98366**

Re: Letter of Commitment to provide Mental Health, Chemical Dependency and Therapeutic Court Programs

Dear Citizens Advisory Committee:

I am writing to express my support and commitment for the Kitsap Public Health District's grant proposal to provide Mental Health, Chemical Dependency and/or Therapeutic Court Programs.

Kitsap Public Health District (KPHD) will serve as the backbone agency for the evolving collective impact project-the Crisis Response and Coordinated Care Demonstration Project, which services the Bremerton and Central Kitsap areas. KPHD is Kitsap County's governmental public health agency committed to preventing disease and protecting and promoting the health of all persons in Kitsap County. KPHD works closely with mental health, chemical dependency, primary care, acute care, and social service providers to identify and address the most pressing health issues in our community. Through an extensive data review and prioritization process, KPHD joined with community partners in identifying limited access to behavioral health and housing services as top health priorities for the County. The proposed project addresses the significant need in our community for a crisis response and coordinated care team to service our most fragile residents who over-utilize and/or ineffectively utilize behavioral health, physical health, and social services in our community. Participating agencies will be able to refer participants in need of outreach, engagement, and/or intensive care coordination because they exhibit risk for or signs of mental illness, chemical dependency, and/or housing instability/homelessness to a multi-disciplinary crisis response and coordinated care team who will provide tailored care to these residents.



Bremerton Housing Authority does not discriminate on the basis of race, color, creed, national origin, religion, disability, sex, sexual orientation, gender identity, age (over 40), military status, whistleblower retaliation, or familial status in admission or access to its programs.
Equal Opportunity Employer.

If you need to request a reasonable accommodation, contact the BHA Section 504 Coordinator at (360) 816-7122. Telecommunication for the hearing impaired TRS dial 7-1-1.



BARRIER FREE

Bremerton Housing Authority (BHA) will conditionally commit the following resources based on an approved proposal outlined in the PVB Administrative Plan:

- A minimum of 10 Project Based Vouchers in the support of creating a "housing first" project.

BHA supports the concept of Housing First, which embraces the notion that vulnerable clients are more easily engaged in robust clinical services and experience greater success once the chaos of living on the streets has been eliminated from their lives. Addressing this debilitating chaos is achieved when a chronically homeless adult is provided a safe and permanent apartment of their own.

Kitsap County has established a need for this type of housing in the homeless housing plan. BHA will commit to 10 Project Based Vouchers under the condition the units meet Housing Quality Standards for clients who meet the requirements for Housing First model of residential living. The cost of providing this ongoing rental subsidy averages \$78,000.00 per year.

Without safe, decent, and affordable shelter it is extremely unlikely that any progress will be made towards ending the cycle of homeless for vulnerable populations in Kitsap County. The value of these 10 Project Based Vouchers is a critical component to the success of a Housing First initiative.

We believe our significant financial support and commitment will significantly improve the availability of Mental Health, Chemical Dependency and/or Therapeutic Court Program services in the County. We look forward to working with you on this exciting endeavor.

Sincerely,


Sarah Van Cleve



Department of Human Services

Doug Washburn
Director

**KITSAP COUNTY
DEPARTMENT OF HUMAN
SERVICES**

Hannah Shockley, Office
Supervisor
507 Austin Drive
614 Division Street, MS-23
Port Orchard, WA 98366
Phone: 360.337.7185
Fax: 360.337.5721

Developmental Disabilities
Kelly Oneal, Coordinator
Phone: 360.337.4624

Mental Health
Anders Edgerton, Administrator
Phone: 360.337.4886

**Mental Health/Chemical
Dependency/Therapeutic Court**
Gay Neal, Coordinator
Phone: 360.337.4827

**Substance Abuse Prevention/
Treatment and Youth Services**
Laura Hyde, Coordinator
Phone: 360.337.4879
**Substance Abuse Prevention
Coalition**
Deanne Montgomery, Prevention
Coordinator
Phone: 360.337.4878

**Aging & Long Term
Care/Senior Information &
Assistance**
Givens Community Center
1026 Sidney Avenue, Suite 105
614 Division Street, MS-5
Port Orchard, WA 98366
Phone: 360.562.6418 (Sr. I&A)
Fax: 360.337.4609
Stacey Smith, Administrator
Phone: 360.337.5624

**Community Development Block
Grant**
Norm Dicks Government Center
345 6th Street, Suite 400
Bremerton, WA 98337
Fax: 360.337.4609
Bonnie Tufts, Coordinator
Phone: 360.337.4606
Housing and Homelessness
Kirsten Jewell, Coordinator
Phone: 360.337.7286

Kitsap Recovery Center
1975 NE Fuson Road
Bremerton, WA 98311
Fax: 360.377.7027
Bergen Starke, Clinical Manager
Phone: 360.337.4625

Workforce Development
1300 Sylvan Way
Bremerton, WA 98311
Bob Potter, Director, OWDA
Phone: 360.337.4873

Veterans Assistance
Andrew Sargent, Coordinator
Phone: 360.337.4811

July 14, 2017

Kitsap County Citizens Advisory Board
C/O Kitsap County Human Services
614 Division Street MS-23
Port Orchard, WA 98366

**Re: Letter of Support for Mental Health, Chemical Dependency and Therapeutic
Court Programs Application**

Dear Citizens Advisory Committee:

I am writing to express my support for the Kitsap Public Health District's grant proposal to continue the important work of the Kitsap Connect program.

During 2014 I participated with many other community stakeholders in an extensive data review and prioritization process to identify community health priorities. Through that KPHD-lead process, improving access to behavioral health and housing services were identified as top health priorities for the County. Although progress has been made, these complex and challenging issues continue to need our focused attention to achieve the kind of progress that improves lives and has a positive impact in the community.

Over the last year the Kitsap Connect program has assisted many fragile Kitsap County residents who over-utilize and/or ineffectively utilize behavioral health, physical health, and social services in our community. Previously, because of their complex needs and barriers to housing, these residents had been "falling through the cracks" and not successfully accessing supportive services that address their underlying needs. These are some of the most vulnerable, and visible, people living on the streets in Kitsap County. Kitsap Connect assists these residents to navigate the array of services they need and, as a result, move towards housing stability and recovery from long-term mental health and substance uses disorders.

The need for this type of program is identified in the Kitsap Homeless Housing Plan: 2016 Update, which was developed through extensive stakeholder input, and approved by the Board of Commissioners in November 2015. The Kitsap Homeless Housing Plan is a strategic planning instrument that provides a blueprint for a coordinated approach to making homelessness rare, brief, and one-time for residents of our county. Specifically identified in the Plan:

Strategy 2.4. Prioritize ending homelessness as soon as possible for people who are unsheltered and/or chronically homeless



Action Step B. Expand outreach case manager positions to engage unsheltered homeless individuals on a pathway to stable housing

Action Step C. Create crisis response/engagement mobilization teams to work with first responders to assist people experiencing homelessness

The Housing and Homelessness Program is committed to providing technical assistance on an on-going basis to the Kitsap Connect Advisory Committee, as the program relates to serving clients experiencing homelessness.

The Kitsap Connect program significantly improves the lives of extremely vulnerable residents through improving their access to mental health, chemically dependency and housing support services in Kitsap County. We are excited to continue working with KPHD on this project that will help achieve the goal of making homelessness rare, brief, and one-time in Kitsap County.

Sincerely,



Kirsten Jewell
Housing and Homelessness Program Coordinator
Kitsap County Department of Human Services



KITSAP COMMUNITY
Resources

A Community Action Partnership helping people, changing lives

July 21, 2017

Kitsap County Citizens Advisory Board
c/o Kitsap County Human Services
614 Division Street MS-23
Port Orchard, Washington 98366

Re: Letter of Commitment to provide Mental Health, Chemical Dependency and Therapeutic Court Programs

Dear Citizens Advisory Committee:

I am writing to express my support and commitment for the Kitsap Public Health District's grant proposal to the Mental Health, Chemical Dependency and/or Therapeutic Court Programs for the continuation of the Kitsap Connect project. .

For the past year, Kitsap Public Health District served as the lead agency, assembling a high impact, crisis response team including partnerships with Kitsap Mental Health Services, The Salvation Army, and Kitsap Community Resources. Since program implementation, Kitsap Connect has organized to address the significant need in our community for a crisis response and coordinated care team to serve the most fragile residents who over-utilize and/or ineffectively utilize behavior health, physical health and social services in our community. Partner agencies have had the opportunity to make referrals of outreach engagement and/or intensive care coordination, because they exhibit risk for or signs of mental illness, substance use disorder, and/or housing instability/homelessness to a multi-disciplinary crisis to this team who provides care tailored to the person.

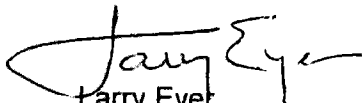
As the provider of housing outreach and stabilization services on this team, KCR is committed to working closely with program participants to identify appropriate housing resources and related funding opportunities to support that housing. In support of this program, Kitsap Community Resources will commit the following resources over a 12-month period to the proposal submitted by KPHD:

- Housing Outreach and stabilization Coordinator position, including wages and benefits
Estimated Value \$45,000 (Note: funding for this position included in this proposal)
- Supervision of Housing Outreach position
Estimated Value: \$ 9,800
- Access to KCR Housing Programs including deposit and rent assistance for eligible participants. *Estimated Value \$25,000*

Kitsap Community Resources is committed to the continued success of this collective impact initiative. Through our extensive experience managing housing units, emergency shelters and rent assistance programs, we understand well the complex nature of assisting individuals with multiple barriers to stabilized housing. With overlapping issues of substance use disorder, chronic disease and mental illness, coupled with poverty and involvement in the criminal justice system, Kitsap Connect is providing the coordination of multiple agencies to stabilize people into long term housing. Once achieved, this stability not only results in improved health outcomes for the individual served, but it also reduces the costly over-reliance on EMS, local law enforcement and hospital emergency department services.

We believe our continued support and commitment to Kitsap Connect will significantly improve the availability of Mental Health, Chemical Dependency and/or Therapeutic Court Program services in the county and look forward to working with you in the future.

Sincerely,



Larry Eyer,
Executive Director



Peninsula Community Health Services

Provides accessible, affordable, compassionate, quality health care services for our communities.

July 25, 2017

Kitsap County Citizens Advisory Board
C/O Kitsap County Human Services
614 Division Street MS-23
Port Orchard, WA 98366

Dear Citizens Advisory Committee:

I am writing to express my support and commitment to Kitsap Public Health District's (KPHD) Kitsap Connect proposal. Kitsap Connect has been working diligently with a small group of hard to engage patients in Bremerton out of the Salvation Army over the last year or so.

Peninsula Community Health Services understands how important it is to open up access to services by bringing care to patients who face multiple barriers. The vast majority of Kitsap Connect patients are assigned through the managed care system to PCHS for their primary care services. They are among the highest utilizers of healthcare services, often at inappropriate access levels such as the emergency room and urgent cares. Having Kitsap Connect provide intense care coordination services to these patients to try to get them to engage the healthcare and social service systems appropriately saves money and provides better overall care.

We already collaborate with Kitsap Connect on the community based team that shares best practice ideas for patient management. We prioritize Kitsap Connect patients within our care coordination team to ensure patients do not get lost in the complex system of healthcare. Through continued funding, we will be adding designated community health worker time for just this population to ensure that there is a designated individual for the personal touch needed with this group of the highest needs living with food, housing and financial insecurities, along with mental health and substance abuse issues.

Peninsula Community Health Services is pleased to work in partnership with KPHD to make this a successful endeavor by our continued overall commitment to the program and our through the addition of a new allocated resource.

Sincerely,

Jennifer Kreidler-Moss, PharmD
Peninsula Community Health Services
PO Box 960
Bremerton, WA 98337
360-475-6707
jkreidler@pchswb.org

