Project Narrative | Pinellas County Board of County Commissioners
Continuation Application | Federal Award Identifier SM063331

Reporting Period: January 1, 2017 through December 31, 2017

DESCRIPTION AND EXPLANATION OF CHANGES, IF ANY, MADE DURING THIS BUDGET PERIOD AFFECTING GOAL AND OBJECTIVES:

The purpose of the Pinellas County Cooperative Agreement to Benefit Homeless Individuals (CABHI) is to increase capacity of services available to individuals who have experienced chronic homelessness and who are also struggling with substance use disorders, mental health disorders, or co-occurring substance abuse/mental health disorders. During this reporting period, Pinellas County has continued towards the goals and objectives identified in the initial application and identified in the table below. Three (3) local mental health and/or substance abuse service providers have executed agreements with Pinellas County and have actively participated in grant activities. No changes to the proposal's goals and objectives have been made during this reporting period.

Goal 1: Reduce chronic homelessness
Objective A: House individuals and families who experience chronic homelessness and have SUDs, SMI, SED or CODs.
Objective B: Reduce the rate of return to homelessness for individuals experiencing chronic homelessness and have SUDs, SMI, SED or CODs.
Goal 2: Strengthen behavioral health care for individuals experiencing chronic homelessness
Objective A: Improve integration of behavioral healthcare system with homeless system
Objective B: Improve the accessibility of substance abuse and mental healthcare services for individuals experiencing chronic homelessness.
Objective C: Determine best practice for serving individuals experiencing chronic homelessness who have SUDs, SMI, SED or CODs.
Goal 3: Reduce behavioral health disparities among racial and ethnic minorities
Objective A: Reduce differences in Access to Service.
Objective B: Reduce the differences in Service Use.
Objective C: Decrease the differences in Outcomes.

DESCRIPTION AND EXPLANATION OF CHANGES, IF ANY, MADE DURING THIS BUDGET PERIOD AFFECTING THE PROJECTED TIME LINE FOR PROJECT IMPLEMENTATION

During the reporting period, Pinellas County Human Services chaired weekly Program Coordination Committee Meetings to ensure the appropriate coordination of services to individuals referred to the CABHI program. This weekly meeting is completed via conference call with one meeting a month being conducted in-person to discuss all active clients. Through these weekly calls and monthly in-person meetings, programmatic staff have been able to communicate client needs and challenges in a constructive manner which has led to the identification of further opportunities to assist CABHI clients with connecting to additional resources and more effectively engaging in program services. Examples of

the facilitation of effective engagement includes the transition of clients from one counselor's caseload to a different counselor, with whom they feel more comfortable working with; coordination of treatment staff with case managers to facilitate individualized introductions/rapport development; communication of client behavioral cues that may assist the provider in connecting with the individual; and discussion of a client's need for certain services to include multiple staff in encouraging participation in additional services that can positively impact the client's progress.

Included below is the updated timeline of key activities with the current status listed, as of the end of the reporting period.

Proposed Date *Source: Year 2 NCC application*	**Key Activities**	**Responsible staff**	**Status** *as of 12/31/18*
Activity Proposed and In-Progress in Year 2 NCC application	Development and execution of Memorandums of Understanding with Housing Providers	Abigail Stanton, Planning & Contracts, Pinellas County Human Services	Completed March 2017
November 1, 2016	Housing providers identify potential project participants for year 1	Pinellas Hope, HEP, SvDP (Housing provider staff) via referrals	Completed Yr 1
November 15, 2016 and quarterly thereafter	Local Government Steering Committee Meeting	Project Director	Meetings Held: January 18, 2017 February 22, 2017 May 17, 2017 August 16, 2017 November 15, 2017
December 15, 2016	Begin engagement, screening and face-to-face GPRA interviews	Operation PAR Case manager	In Progress as of February 11, 2017
***Activity not previously proposed* Began January 31, 2017 and occurs weekly**	**Program Coordination Committee Conference Call**	**Facilitated by Pinellas County Human Services and attended by Programmatic Staff**	**Ongoing activity**
January 2, 2017 – September 30, 2017	Service delivery: Direct mental health and SUD treatment, case management, enrollment in Medicaid, SSI/SSDI, TANF, SNAP, etc.	Contracted Service Providers	First Client Referred to Service Provider(s) February 18, 2017
Activity Proposed and In-Progress in Year 2 NCC application	Non-Competing Continuation Application Submission	Pinellas County Human Services	January 20, 2017
March 1, 2017 and semi-annually thereafter	6-month GPRA interviews of all clients	Evaluator	CABHI Staff initiated 6-Month GPRA Interview activities in July 2017 (i.e., locating clients, scheduling interviews, etc.)

Proposed Date *Source: Year 2 NCC application*	**Key Activities**	**Responsible staff**	**Status** *as of 12/31/18*
March 1, 2017 and semi-annually thereafter	Report of progress and performance to SAMHSA via Local Performance Assessment	Evaluator	Submitted with Progress Report Submissions on: April 28, 2017 October 30, 2017
***Activity not previously proposed* Began April 25, 2017 and occurs monthly**	**In-Person Program Coordination Meeting**	**Facilitated by Pinellas County Human Services and attended by Programmatic Staff**	**Ongoing**
August 1, 2017	Housing providers identify potential project participants for year 2	Housing provider staff referrals	In Progress/ongoing
September 1, 2017	Begin engagement, screening and face-to-face GPRA interviews	Operation PAR Case manager	In Progress/ongoing
October 1, 2017-September 30 2018	Service delivery: Direct mental health and SUD treatment, case management, enrollment in Medicaid, SSI/SSDI, TANF, SNAP, etc.	Contracted Service Providers	In Progress/ongoing
August 1, 2018	Housing providers identify potential project participants for year 2	Housing provider staff referrals	No timeline changes anticipated
September 1, 2018	Begin engagement, screening and face-to-face GPRA interviews	Contracted Service Providers	No timeline changes anticipated
October 1, 2018-September 30 2019	Service delivery: Direct mental health and SUD treatment, case management, enrollment in Medicaid, SSI/SSDI, TANF, SNAP, etc.	Contracted Service Providers	No timeline changes anticipated
As required by SAMHSA	Participate in Cross-Site Evaluation as needed	Evaluator, Project Director	In Progress/ongoing Completed Site Visit November 14-15, 2017

DESCRIPTION AND EXPLANATION OF CHANGES, IF ANY, MADE DURING THIS BUDGET PERIOD AFFECTING THE APPROACH AND STRATEGIES PROPOSED IN THE INITIALLY APPROVED AND FUNDED APPLICATION:

A few changes have been implemented during this reporting period, including: transitioning from an ARNP staff member to a Fee for Service Model; delayed implementation and low demand for telehealth services; and the identification of additional service opportunities for CABHI clients.

The transition from a specific ARNP staff position to a Fee for Service Model was done to provide for an increase in access to services in the community via more flexible scheduling options by offering more than one individual provider. Through utilizing the contractor's full medical psychiatric services staff, CABHI clients are able to realize the scheduling flexibility of multiple providers.

The Pinellas County CABHI Program realized a delay in implementation of and low demand for telehealth services during the reporting period. The delayed implementation was due, in part, to some hesitation on the part of the identified housing provider sites. Housing providers were hesitant to agree to the placement of telehealth equipment at their sites due to perceived concerns related to the location, security, distribution and subsequent collection of telehealth equipment. CABHI staff worked to alleviate the concerns with continued education of the housing providers regarding the potential benefits of client access to telehealth equipment.

The program's slower than anticipated start resulted in a smaller client census, thus reducing the demand for telehealth services. With a lower than anticipated client load in the first year, treatment staff have had the flexibility of scheduling to allow for onsite care without a greater need for telehealth services. As the client census increases towards the program's target GPRA rates, it is anticipated the program will realize more emphasis being placed on telehealth services.

CABHI program staff have identified the need for a few additional positions, including: a Peer Support Specialist position to assist in recruitment and engagement efforts; an additional Mental Health Counselor; and an additional SOAR Specialist. These positions will assist current staff with the case load and provide CABHI clients additional scheduling options.

REPORT ON PROGRESS RELATIVE TO APPROVED OBJECTIVES, INCLUDING PROGRESS ON EVALUATION ACTIVITIES

APPROVED OBJECTIVES:

House individuals and families who experience chronic homelessness and have SUDs, SMI, SED or CODs.

The Pinellas County CABHI Program does not house individuals. The program was designed to offer services to individuals already housed through the County's Coordinated Entry Process.

Reduce the rate of return to homelessness for individuals experiencing chronic homelessness and have SUDs, SMI, SED or CODs.

Treatment staff working on the Pinellas County CABHI Program work closely with the local permanent supportive housing providers to ensure CABHI clients on the verge of losing housing are afforded every opportunity to maintain their residence. Efforts may include additional treatment services to minimize disruptions at the housing sites due to a client's behavioral health concerns. Additionally CABHI staff have worked with clients during a substance abuse relapse to connect them with detox services and maintain connections throughout the client's flow through these services and transition back into permanent housing. As of this report, of the 24 clients with a 6-month follow-up GPRA entered into SPARS, 23 (95.8%) have remained in permanent housing.

The Pinellas County CABHI Program utilizes a SOAR Specialist to assist eligible clients in obtaining disability benefits. The inclusion of such a position in the CABHI program has been beneficial in aiding the SOAR staff with obtaining the documentation necessary from behavioral health treatment providers to

ensure the client's need is appropriately articulated in an application for such benefits. SOAR staff have assisted 28 CABHI clients.

Improve integration of behavioral healthcare system with homeless system.

The Pinellas County CABHI Program has made great progress in integrating the behavioral healthcare system with the homeless system. CABHI Program staff have developed good working relationships with the three primary permanent supportive housing providers within Pinellas County: Homeless Emergency Project; Pinellas Hope; and Boley Centers. These relationships have provided program staff with the space necessary to maintain an onsite presence at the housing locations and provided an avenue for communication amongst the CABHI staff and the housing site staff. Additional outreach activities continue to connect the CABHI program with other local housing providers, such as the housing authority and Ready for Life, a nonprofit dedicated to providing assistance to foster care youth as they transition to adulthood. The Pinellas team has connected with the local coordinated entry continuum of care, the Homeless Leadership Board, to identify potential clients at the point of housing or immediately prior to. Through identifying potential clients through coordinated entry, the program has the opportunity to reach out to the housing provider regarding the individual's suitability for a program referral.

Improve the accessibility of substance abuse and mental healthcare services for individuals experiencing chronic homelessness.

Through hiring four (4) counselors (3 Substance Abuse/Co-Occurring and 1 Mental Health); two (2) case managers; a peer support specialist; and a SOAR benefits specialist, the CABHI program has been able to increase service capacity for clients with histories of chronic homelessness who have recently been permanently housed and having a serious mental illness (SMI), substance abuse disorder (SUD), serious emotional disturbance (SED), and/or co-occurring disorder (COD). These dedicated program staff are able to focus efforts at the housing sites, thus increasing accessibility by meeting the clients where they are at. The SOAR specialist affords eligible CABHI clients with focused assistance efforts with applications for disability benefits. These efforts will assist clients with receiving the benefits necessary to assist with not only maintaining housing, but further accessing the necessary behavioral health services beyond the CABHI program. The program intends to further rollout telehealth services as the client census increases to provide greater flexibility for clients whom have transportation struggles. The program has enrolled 95 clients to date, all of whom had identified behavioral health needs. These clients were provided access to CABHI treatment staff for services which may not have been accessible prior to the program's implementation.

Determine best practice for serving individuals experiencing chronic homelessness who have SUDs, SMI, SED or CODs.

The program utilizes evidence based therapeutic practices to provide clients with behavioral health treatment services. One key to client engagement in these services has been the regular coordination amongst CABHI staff to ensure each individual client is met where they are. Staff communicate individual client struggles and identified opportunities to mitigate these to further engage the client in treatment.

Reduce differences in Access to Service.

The project has worked to increase access to service for all races and ethnicities. Regarding race, according to the 2012-2016 American Community Survey 5-Year Estimates, 82.5% of Pinellas County consists of one race and Caucasian resulting in 17.5% of the population being non-Caucasian or mixed race. To date, the project has enrolled 95 clients of which 28.4% are non-Caucasian or mixed race. Additionally, the same census estimates indicates that 8.8% of the population is of Hispanic origin. To date of the 95 clients enrolled, 11.6% of clients served are Hispanic.

Reduce the differences in Service Use.

The project monitors the number and types of services provided to the clients and has worked to ensure clients receive the services they need. The project employs a number of methods to ensure clients receive services. When the client is capable, bus passes are distributed to clients so that they can attend treatment sessions. If the client finds using bus passes too stressful, transportation is provided the partnering agencies to ensure the client receives treatment. Also, many clients receive services on-site which eliminates transportation issues and reduces and inequity in service accessibility. An additional tool used the project is behavioral telehealth.

Decrease the differences in Outcomes.

Of the 95 clients enrolled, only 12 have been discharged. As a result, many post-discharge outcomes do not have an adequate sample size to say anything definitive regarding client outcomes. As more clients are discharged and more 6-month follow-ups are completed (to date 24 6-month follow-ups have been completed), the project can better assess differences in outcomes and determine if the project was able to decrease any disparities that may have existed.

EVALUATION ACTIVITIES:
Local Activities – Please detail

The Evaluation Activities follows the plan set forth in the Evaluation Plan which is broken into three sections Local Evaluation Activities (Process and Outcome Measures), GPRA Evaluation and Cross-Site Evaluation. Each will be addressed below.

LOCAL PROCESS EVALUATION
The project will review the following process questions in the table below. The program will be analyzed using gender, race, ethnicity and other variables identified at the time of analysis as variables to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

Process Questions		
Question	**Data Source**	**Progress**
What activities and actions taken by the Steering Committee helped improve the clinical and housing outcomes for individuals served?	Identification of activities, their timeline and implementation and correlated outcomes	The Steering Committee first and foremost informed community members of the project and its intent by

		holding regularly scheduled quarterly meetings. One accomplishment was the buy-in from the Pinellas County Homeless Leadership Board.
How did the strategies and interventions used by the Steering Committee assist in the overall quality improvement of the system of care for individuals served?	Provider input over time of the project to assess referral, access, retention and outcomes for participants and assess if the project improved the system of care.	Early in the Project, the Steering Committee was influential in identifying Performance Measures it believed would best serve the Project and the Community. Since then they have directed the Project Leadership as to what direction the project needs to go for sustainability.
Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics), in what context (system, community), and at what cost (facilities, personnel, dollars)?	Data from the Case Manager/Outreach Specialist provided to the evaluator as well as project expenses to identify what services were provided and their effectiveness.	Two case managers who provide in-person contact with housing providers and potential clients, four counselors (three substance abuse and one mental health) to see clients on-site, one SOAR specialist to provide services to assist clients with additional benefits on-site are active in the project. To date, the project has had excess funds and has requested a Prior Approval for Carryover to address the enrollment issues in the Project.
Are the targets and indicators linked and used to inform quality improvement activities?	Review of minutes from weekly staff meetings to address targets and indicators.	The Project staff meet weekly to review project targets. A dashboard is produced quarterly to inform the Local Government Steering Committee. The major issue at present is recruitment and those numbers are constantly reviewed to develop quality improvement activities to increase enrollment.

What efforts have been taken to overcome administrative and clinical barriers in enrolling individuals in Medicaid and other benefit programs and how are these efforts informing the implementation and/or enhancing the long term sustainability of integrated community systems that provide permanent housing and supportive services?	Review of minutes from weekly staff meetings to address barriers.	The SOAR team works with our clients who need assistance in getting other benefits (such as Medicaid). At each weekly meeting, the SOAR staff is given the opportunity to review their caseload and needs. Other clinical staff also interact to make warm handoffs of their clients to the SOAR team. SOAR staff are diligent in informing treatment staff of documentation required for a disability application to ensure the most complete application submission for each client.

Additional process questions include the monitoring of the following processes to track access and efficiency of client engagement:

- Monitoring referral rates from the different housing providers,
  - Progress: This information is monitored and published quarterly in a Project Dashboard developed and produced by Pinellas County with assistance from the Evaluation Team.
- Monitoring time from referral to screening
  - Progress: This information is monitored analyzed by the Evaluation Team. The average time from referral to screening is 12.7 days.
- Monitoring time from screening to assigning the client to a provider
  - Progress: This information is monitored analyzed by the Evaluation Team. The average time from screening to assigning a client to a behavioral health provider is 8.8 days.
- Monitoring the time from assignment to a provider till admission in the providers program.
  - To evaluate this last measure, a new survey has been developed which monitors service type, service date and service dose (length of session). Since the treatment providers do not share the same electronic health record, this form allows the project to track client treatment sessions.

LOCAL OUTCOME EVALUATION

Outcomes Questions: The project will review the following outcome and process questions in the table below. The program will be analyzed using gender, race, ethnicity and other variables identified at the time of analysis as variables to assure that appropriate populations are being served and that disparities in services and outcomes are minimized.

Outcome Questions		
Question	**Data Source**	**Progress**
How many individuals were reached through the program and how many	Data from GPRA and Case Manager/Outreach Specialist	To date, 95 clients have been enrolled. This data is still

were enrolled in Medicaid and other benefit programs as a result of participation in this program?		under analysis. Data is being collected by the SOAR team and relayed to the Evaluation Team.
What effect did linkage to HUD's Coordinated Entry system have on housing goals?	Data from Housing Providers on how they accessed HUD's Coordinated Entry System.	At present, the Coordinated Housing Data is being received and reviewed by the Evaluation Team to be presented to the Case Managers. This linkage is still being reviewed for effectiveness.
What program/contextual factors were associated with increased access to and enrollment in Medicaid and other benefit programs?	Case Manager/Outreach Specialist to identify factors addressing enrollment in Medicaid and other benefit programs.	This data is still under analysis. Data is being collected by the SOAR team and relayed to the Evaluation Team.
What was the effect of the permanent housing, recovery support, or treatment on key outcome goals?	Review of identified variables and correlation with patient results and project outcomes and goals.	Not enough clients have been discharged at this time (12 at the writing of this report) to assess the effect of permanent housing, recovery support or treatment on key goals.
Was the permanent housing and recovery support effective in maintaining the project outcomes at client follow-up interviews?	Review of identified variables and correlation with patient results and project outcomes and goals.	Permanent housing was extremely effective in maintaining client follow-up interviews. Of the 29 clients eligible for follow-up interviews, only 5 were not completed with 3 of the 5 having left housing and could not be found. Note that at present, an additional 35 clients are eligible for follow-up interviews and are still within the follow-up window. The reason they have not been completed is because there was a lapse in receiving the client incentive cards. That has been corrected and the project expects to start

		collecting follow-up interviews soon.
What program and contextual factors were associated with positive clinical and housing outcomes?	Focus group/questionnaires of participants are correlation with project outcomes.	Two focus groups were performed by RTI during the Cross-Site Evaluators' site visit. Unfortunately, the results of those interviews have not been made available to the project.

***Project Goals and Objectives*:** The following table outlines the project's goals, expected outcome and Performance Measure to assess local performance. These will be reviewed at the weekly staff meetings and acted upon accordingly.

Local Project Goals, Objectives and Performance Measures	
Goal 1: Reduce chronic homelessness	
Objective	**Performance Measure**
Objective A: House individuals and families who experience chronic homelessness and have SUDs, SMI, SED or CODs.	**Performance Measure:** Enroll 125 project-eligible chronically homeless individuals per year. **Progress:** To date, 95 clients have been enrolled. The enrollment issues has been addressed elsewhere in the application renewal.
Objective B: Reduce the rate of return to homelessness for individuals experiencing chronic homelessness and have SUDs, SMI, SED or CODs.	**Performance Measure:** At 6 months post-intake, 60% of all clients enrolled will have remained in permanent housing as measured by the GPRA tool. **Progress:** As of this report, of the 24 clients with a 6-month follow-up GPRA entered into SPARS, 23 (95.8%) have remained in permanent housing.
Goal 2: Strengthen behavioral health care for individuals experiencing chronic homelessness	
Objective	**Performance Measure**
Objective A: Improve integration of behavioral healthcare system with homeless system	**Performance Measure:** Increase the percentage of homeless referrals to the project by 10% from year 1 to 2 and 20% from year 2 to 3. **Progress:** The project is currently in the first four months of Year 2. As a result this Measure cannot be calculated at this time.
Objective B: Improve the accessibility of substance abuse and mental healthcare services for individuals experiencing chronic homelessness.	**Performance Measure:** Increase the percentage of homeless receiving tele-health/mobile MH services by 10% from year 1 to 2 and 20% from year 2 to 3. **Progress:** The project is currently in the first four months of Year 2. As a result this Measure cannot be calculated at this time.
Objective C: Determine best practice for	**Performance Measure:**

serving individuals experiencing chronic homelessness who have SUDs, SMI, SED or CODs.	1. Increase the percentage of participants who reduce the number of times they utilize emergency room services, are arrested or are Baker Acted in the 6 months after admission to the project compared to the 6 months preceding admission to the project. 2. Increase the percentage of participants from Year 1 to Year 2 and from Year 2 to Year 3 who upon discharge from the project, complete at least 50% of their treatment plan objectives. 3. Increase the percentage of participants who are successfully discharged from the project from Year 1 to Year 2 and from Year 2 to Year 3. 4. For those clients subject to drug screens, increase the percentage of clients from Year 1 to Year 2 and from Year 2 to Year 3 who test negative in 75% of their drug screens. **Progress:** The project is still working with county officials to track and monitor this data. No results are available at this time.
Goal 3: Reduce behavioral health disparities among racial and ethnic minorities	
Objective	**Original Performance Measure**
Objective A: Reduce differences in Access to Service.	**Performance Measure:** Increase the yearly percentage of racial and ethnic minorities admitted to the program using, year 1 as the base rate. **Progress:** The project is currently in the first four months of Year 2. As a result this Measure cannot be calculated at this time.
Objective B: Reduce the differences in Service Use.	**Performance Measure:** Increase the yearly percentage of racial and ethnic minorities who remain in treatment for at least 30 days, using year 1 as the base rate. **Progress:** The project is currently in the first four months of Year 2. As a result this Measure cannot be calculated at this time.
Objective C: Decrease the differences in Outcomes.	**Performance Measure:** Increase the yearly percentage of racial and ethnic minorities who are successfully discharged from the project, using year 1 as the base rate. **Progress:** The project is currently in the first four months of Year 2. As a result this Measure cannot be calculated at this time.

- GPRA: The following GPRA numbers were taken from the SPARS report on 1/9/2018. For Intake, 93 clients have been enrolled out of an expected 156 for a rate of 59.6%. The project is awaiting 2 more clients that have been enrolled but have yet to get the GPRA collected due to scheduling. That would bring the rate to 60.9%. At present, the project is short 30 intakes to meet an 80% intake rate and 61 short of meeting a 100% intake rate. At the end of the second fiscal year (9/29/2018) the project's goal is 250 clients enrolled. To meet that number, the project must enroll 155 clients over the next 38 weeks for an average intake of 4 per week. To reach an 80% intake rate (200 clients enrolled), the project will need to enroll 105 clients over the next 38 weeks for an average intake of 3 clients per week. The project is confident it can meet these rates.
- Regarding Follow-Up, the project as of 1/9/2018 has a 6 month follow-up rate of 63.2% (24 out of 38 due). The project is behind due to a delay in obtaining incentive cards for the clients. This has been corrected. To reach 80%, the project needs to collect 6 more follow-ups. All clients are well within the collection window and the project foresees no issues in meeting the mandated rate.
- SCI: The project has worked hard to obtain the Supplemental Client Interviews along with the GPRA interviews. To date, 10 Interviews were submitted in October, 2017; 20 in November, 2017; and 19 in December, 2017; and 11 in January, 2018.

SUMMARY OF KEY PROGRAM ACCOMPLISHMENTS TO DATE AND LIST PROGRESS

To date, the Pinellas County Cooperative Agreement to Benefit Homeless Individuals (CABHI) has accomplished the following:

- The Cross-site study site visit occurred on November 14-15, 2017
- The project has teamed with the Pinellas County's Homeless Leadership Board, the areas coordinated entry provider, to utilize the coordinated entry process as a referral source.
- Program staff continue to meet weekly to coordinate client needs and maintain the lines of communication to ensure the best possible outcomes for program clients.
- Program staff meet in-person once-a-month to discuss all active clients and address any successes or challenges.
- Program staff have developed good working relationships with housing provider case managers to ensure the most appropriate care and mitigate any impact to a client's housing due to relapse or crisis needs.
- Expanding and enhancing the SA/MH needs to the community for those individuals experiencing chronic homelessness.
- The project has exceeded the general census population figures for non-Caucasian and Hispanic origin clients. Pinellas County's 2012-2016 American Community Survey 5-Year Estimates for non-Caucasian or mixed-race population at 17.5% and Hispanic origin population at 8.8% with the project's client census indicating 28.4% of the clients served were non-Caucasian or mixed race and 11.6% of clients served being of Hispanic origin.

DESCRIPTION OF DIFFICULTIES/PROBLEMS ENCOUNTERED IN ACHIEVING PLANNED GOALS AND OBJECTIVES - BARRIERS TO ACCOMPLISHMENT

The main difficulty encountered by the project has been recruitment of clients. CABHI funded staff began the grant program with intense outreach efforts to seek buy-in from the local housing providers. It was anticipated that this buy-in would translate into program referrals. While the housing providers saw the benefits of the program's availability, the referrals were slow at the onset of the CABHI program. Upon increased referrals rates, CABHI staff transitioned activities away from the intensive outreach efforts. While uncertain in reasoning, it appears the decreased outreach efforts may have translated into decreased referrals. The program's evaluator has worked in conjunction with the Vice President of Community Relations to beef up outreach efforts to reengage the housing providers that are the majority source of program referrals.

Additionally during the month of September 2017, the State of Florida realized the threat and braced for the impact of Hurricane Irma. While Pinellas County was spared direct impact by the storm, the impact of Irma on the area resulted in a local declaration of a state of emergency with evacuation orders and a majority of the area realizing power outages. Many residents and were displaced and services disrupted. County and contractor offices were closed for several days and CABHI services impacted.

DESCRIPTION OF DIFFICULTIES/PROBLEMS ENCOUNTERED IN ACHIEVING PLANNED GOALS AND OBJECTIVES - ACTIONS TO OVERCOME DIFFICULTIES

The program continues enhanced outreach efforts to obtain the 125 clients per year served goal, although success has not yet been achieved. CABHI staff are located onsite at several of the larger permanent supportive housing provider facilities and work with case managers and residents to educate them on the availability of services through the program. Staff will continue outreach efforts to all identified service providers whom work with clients having histories of chronic homelessness to educate them on the CABHI referral process and program capacity. Outreach efforts include smaller provider organizations that work with the program's target population. Such organizations work with foster youth aging out of the system, assisted living facilities, and domestic violence shelters.

REPORT ON MILESTONES ANTICIPATED WITH THE NEW FUNDING REQUEST

The Pinellas County CABHI Program anticipates utilizing the new funding request to continue services to the program's current clients, meeting the program's intake goal, and enhance utilization of telehealth services.

KEY STAFF CHANGES (NEW OR ANTICIPATED) MUST BE REQUESTED IN ADVANCE AS STATED IN THE TERMS AND CONDITIONS OF AWARD. DESCRIBE THE CHANGE AND SUBMIT RESUMES AND JOB DESCRIPTIONS, LEVEL OF EFFORT AND ANNUAL SALARY FOR EACH POSITION.

There are currently no new or anticipated changed to Key Staff.