



# Define - Measure - Analyze - Improve - Control

**Project or Program: Pinellas County Behavioral Health High Need/High Utilizer (HNHU) Pilot Program**

**Goal:** HNHU Pilot clients stabilized in the community

INPUTS		ACTIVITIES		OUTCOMES	
What we invest	What we do	Who we reach	Short-term results	Intermediate results	Long-term results
<p><b>\$ 964,441.50 (proposed budget)</b></p> <p><b>Provider Partners:</b></p> <p><u>Law Enforcement</u> – Liaison, Law Enforcement Representative<sup>1</sup></p> <p><u>Behavioral Health</u> – Case Manager<sup>1</sup>, Therapist<sup>1</sup></p> <p><u>Housing</u> – facilities to temporarily house up to 33 pilot participants in collective locations</p> <p><u>Hospital/Medical providers</u> – Emergency Rooms Liaison, Department of Health</p>	<p>Client engagement</p> <p>Client Assessment</p> <p>Rapidly house homeless clients</p> <p>Provide indicated treatment and support</p> <p>Arrange supportive services</p> <p>Case Management</p> <p>Rapid team response to system re-entry or other crises</p>	<p>Top 33 High Need/High Utilizers (HNHUs) of CSU and Jails identified using Baker Act (PEMHS<sup>2</sup>), HNHU (CFBHN<sup>3</sup>), and Arrests (PCSO) data.</p>	<p>#/% Clients engaged and enrolled in pilot</p> <p>#/% of Homeless clients housed within 1 week of pilot entry by type of housing (transitional, Permanent Supportive Housing, etc.)</p> <p>#/% of Clients receive LOCUS<sup>4</sup> or other approved assessment within one week of pilot entry</p> <p>#/% of clients receive SPDAT<sup>5</sup> assessment within one week of pilot entry</p> <p>#/% of clients have housing and service plans within one week of pilot entry</p> <p>#/% of clients who receive treatment indicated in service plan</p> <p>#/% Clients receive indicated wrap-around services:</p> <p>Financial Assistance Self-sufficiency Employment training Budgeting</p>	<p>Reduction in #/% of clients arrested 1 &amp; 3 months post pilot entry</p> <p>Reduction in # jail bed-days 1 &amp; 3 months post pilot entry</p> <p>Reduction in #/% of clients with Baker Acts 1 &amp; 3 months post pilot entry</p> <p>Reduction in #/% clients hospitalized 1 &amp; 3 months post pilot entry</p> <p>Reduction in #/% clients with ER visits 1 &amp; 3 months post pilot entry</p> <p>#/% Clients enrolled in training/skills program (eg. Vincent House)</p>	<p>#/% Clients who successfully complete treatment</p> <p>Increase in #/% Clients in permanent/permanently supported housing &gt;6 months</p> <p>Reduction in #/% of clients arrested &gt;6 months months post entry</p> <p>Reduction in # jail bed-days &gt;6 months months post entry</p> <p>Reduction in #/% of clients with Baker Acts &gt;6 months post entry</p> <p>Reduction in #/% of clients with Baker Acts&gt;6 months post entry</p> <p>Reduction #/% Clients admitted to Detox &gt;6 months</p> <p>Reduction in #/% Clients hospitalized &gt;6 months (to be defined)</p> <p>Increase in #/% Clients stable in community/self-sufficient (eg. receiving Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI))</p> <p>Increase in #/% Employed in paid positions</p> <p>Increase in #/% Engaged in meaningful, productive activity, eg., school, day services, volunteer work</p>

<sup>1</sup> Members of Treatment Team

<sup>2</sup> Personal Enrichment Through Mental Health Services

<sup>3</sup> Central Florida Behavioral Health Network

<sup>4</sup> Level of Care Utilization System Assessment - used to determine the resource intensity needs of individuals who receive adult mental health services

<sup>5</sup> Service Prioritization Decision Assessment Tool - used for intake and service delivery to prioritize clients for housing and wrap-around services



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