2020-2021

Cooperative Agreement to Benefit Homeless Individuals

Program Guide

Pinellas County Board of County Commissioners
Human Services Dept.
(revised October 2018)

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Overview

Background

Pinellas County received grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide mental health and substance abuse treatment services to individuals who have experienced homelessness and have serious mental illness (SMI), substance abuse disorder (SUD), serious emotional disturbance (SED), and/or co-occurring disorder (COD). This program is focused on formerly chronically homeless individuals who have recently been housed in permanent housing or permanent supportive housing.

Funding from this grant opportunity will increase capacity to provide evidence based mental health and substance abuse treatment services for individuals who experience homelessness and have serious mental illness (SMI), substance use disorder (SUD) , serious emotional disturbance (SED), and/or co-occuring disorder (COD).

Partners

The County has partnered and contracted with several local agencies providing services that work with homeless youth, families, and veterans. The contracted treatment providers include Operation PAR, WestCare Gulfcoast, and Directions for Living.

This funding opportunity also strongly encourages a commitment to permanently house eligible clients. While funding does not support housing, we are looking to work with housing placement specialists working with the population. Our housing partners include Homeless Empowerment Program, Catholic Charities/Pinellas Hope, Boley, and the Pinellas County Housing Authorities.

It will also allow the County to provide outreach and other engagement strategies for individuals served, including screening and assessment. Once fully implemented, the County's homeless population will be on a path to secure housing, coordinated behavioral health services and reduce their likelihood to use the emergency room for behavioral health and linkage services.

Governance

Local Government Steering Committee

Human Services | Operation PAR | WestCare Gulf Coast | Directions For Living
Pinellas County Housing Authority | Boley Centers| Catholic Charities/Pinellas Hope | HEP
Ready for Life | PEMHS | FL Dept. of Health | HLB | SAMHSA

The Local Government Steering Committee will meet at least quarterly per year. The Steering Committee will be 1) responsible for monitoring the performance goals of the program; 2) increasing coordination with other entities engaged in planning the jurisdiction's response to homelessness (e.g., HUDS's COCs or ESG recipients, HUD Coordinated Entry Systems, active SAMHSA targeted homeless grants, those involved in implementing local plans to end homelessness), and 3) ensure the provision of direct treatment and recovery support services to the population of focus. Membership is comprised of, at a minimum, local or regional representatives from SUD and mental health providers; health department; public housing authorities and/or housing providers; members of the population of focus who are currently experiencing homelessness or have experienced homelessness; and the SAMHSA GPO.

Management Committee

Human Services | Operation PAR | WestCare Gulf Coast | Directions For Living

The Management Committee began meeting monthly in December 2017 (1st qtr of Y2) as a way to discuss operational aspects of the program. The Project Director (HS) leads the meetings and check progress toward the program's stated goals and objectives; identify any barriers and solutions identified in the implementation of the program; review budget modifications and carryover requests; outreach efforts; and reporting and evaluation outcomes.

Program Coordination Committee

Human Services | Operation PAR | WestCare Gulf Coast | Directions For Living

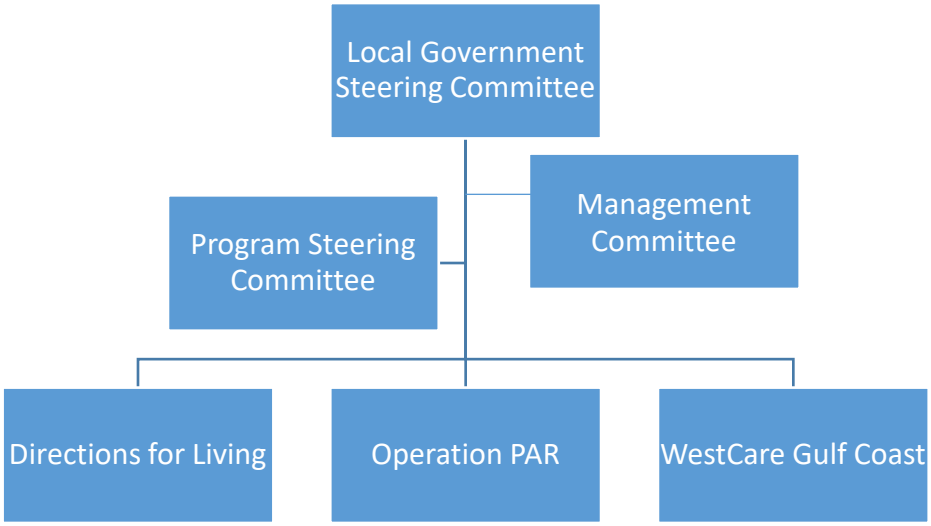
The Program Coordination Committee will meet weekly to review new client referrals, address any challenges with active clients as identified by the provider, and will meet monthly in person to review individual active clients. The Project Director (HS) will lead the meetings and check progress toward the program's stated goals and objectives; identify any barriers and solutions identified in the implementation of the program.

Contracted Services

DIRECTIONS FOR LIVING	OPERATION PAR	WESTCARE GULF COAST
Responsible to: Human Services, Project Director/Health Care Administrator Roles & Responsibilities: • Clinical Service Provider for SMI, SED, COD clients • SOAR Provider • Program & Local Gov't Steering Committee Participation Grant Funded Staff Positions: • Psychiatric ARNP • Counselor • SOAR Specialist	Responsible to: Human Services, Project Director/Health Care Administrator Roles & Responsibilities: • Clinical Service Provider for SUD, COD clients • Clinical Program Coordination • Program Evaluation • Program & Local Gov't Steering Committee Participation Grant Funded Staff Positions: • Clinical Program Coordinator • Evaluator • Counselor • Case Managers (2)	Responsible to: Human Services, Project Director/Health Care Administrator Roles & Responsibilities: • Clinical Service Provider for SMI, SED, COD clients • Peer Recovery • Program & Local Gov't Steering Committee Participation Grant Funded Staff Positions: • Outpatient Director • Counselors (2) • Peer Recovery Support Specialist

Organizational Structure

The organizational chart below briefly illustrates the reporting structure to Pinellas County as the grantee of the federal award from SAMHSA.



Program Criteria & Referral

Program Criteria:

Individual adult clients may be eligible to receive treatment services if:

- Client has a history of chronic homelessness
- Client is currently in permanent housing or permanent supportive housing
- Client scores 6 or above on the Vi-SPDAT housing assessment tool; or other identified intake assessment utilized by a housing provider that identifies a client's need related to chronic homelessness and behavioral health issues.
- Client self reports or is known to have a mental health or substance abuse diagnosis *(Detailed clinical assessment will be completed by program staff to determine clinical diagnosis and eligibility)*
- Client is not currently receiving treatment services; or is receiving inadequate treatment services by another licensed behavioral health treatment provider.
- Eligible individual clients include adults and veterans (*note: veteran clients need only have experienced homelessness and are not required to have been identified as chronically homeless*).

Family or youth clients may be eligible to receive treatment services if:

- Families or youth experience homelessness
- Families or youth are linked to the Pinellas County Continuum of Care Coordinated Entry system *(note: family and youth clients, while encouraged to be placed in permanent housing, need only be connected to Pinellas County Coordinated Entry to receive CABHI services)*
- Families are considered eligible if one or more family members self report or are known to have a mental health or substance abuse diagnosis *(Detailed clinical assessment will be completed by program staff to determine clinical diagnosis and eligibility)*
- Families or youth are not currently receiving treatment services; or are receiving inadequate treatment services by another licensed behavioral health treatment provider.

Referral Process

If an organization identifies a client who may be eligible for the program, the referring entity shall complete the program referral form (Appendix A) for the Pinellas County's Cooperative Agreement to Benefit Homeless Individuals (CABHI) Program. Individuals who participate in educational sessions or learn about the program may also self-refer themselves by completing the program referral form and ROI.

Completed referrals may be submitted by:
FAX: (727) 507-6310
EMAIL: CABHI@operpar.org

Upon receipt, a Program Coordinator from Operation PAR, will reach out to both the referring party and the client to schedule an intake screening. Once the client completes the intake screening, Operation PAR will present the client information to the Program Coordination Committee (meets weekly) to assess each client's eligibility for services and identify the appropriate treatment provider.

Outreach

Operation PAR is responsible for clinical program coordination, including referral coordination and outreach. Outreach to potential referring entities may include educational group sessions, community or staff presentations, or one-on-one meetings with organizations who are interested in enrolling clients into the program.

Release of Information

The Referral Form includes a Release of Information to be signed by the client at the time of referral. The Release of Information legally allows the participating treatment providers to share Personal Identifiable Information (PII) and protected health information (PHI). (See Appendix B).

Definitions

Behavioral Health: The term "behavioral health" refers to a state of mental/emotional health and/or choices and actions that affect wellness. Behavioral health problems include substance use or misuse, alcohol and drug addiction, serious psychological distress, suicidal ideation, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders and related problems, treatments and services for mental and substance use disorders, and recovery support.

Permanent housing means community-based housing without a designated length of stay (e.g., no limit on the length of stay). Permanent housing shall be safe, affordable, and integrated in the community. It may include an apartment or single room occupancy in a building (congregate housing), rent-subsidized apartments, or houses in the open housing market (scattered housing), as well as designated units within privately owned buildings.

Permanent supportive housing refers to housing that is considered permanent (rather than temporary or short-term) and offers tenants a range of supportive services aimed at promoting recovery from mental and/or substance use disorders. There should not be any arbitrary limits for the length of stay for the tenant as long as the tenant complies with the lease requirements (consistent with local landlord-tenant law).

Homeless as characterized under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, and defined by the December 5, 2011, Final Rule: Defining "Homeless" (76 FR 75994), establishes four categories of homelessness. These categories are: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution; (2) Individuals and families who will imminently lose their primary nighttime residence; (3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or (4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Chronic homelessness means: (1) A homeless individual with SUD, SMI, SED, or COD issues, who:

(i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

(ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Doubled Up: In addition, for the purposes of this program, the terms "homeless" and "chronic homelessness" also may include individuals who are "doubled-up" – defined as sharing another person's dwelling on a temporary basis where continued tenancy is contingent upon the hospitality of the primary leaseholder or owner and can be rescinded at any time without notice.

Referral Intake & Assessment

GPRA Evaluation

GPRA data will be collected at intake, discharge and 6-months post-intake and entered into the SPARS data collection system. This data will be readily available to evaluate demographics, drug and alcohol use, family and living conditions, education/employment, criminal justice status, mental/physical health and social connectedness. As adequate sample sizes are obtained, reports will be shared with the program coordination committee and the local government steering committee to assess program effectiveness.

Incentives

Incentives will be given to a client upon completion of the GPRA at intake, 6-months post intake and discharge for a maximum benefit of $30 per client. PAR, as the Program Evaluator and administrator of the GPRA assessments, will issue the gift card to the client upon completion. Per the SAMHSA Funding Opportunity Announcement, “In no case may the value of an incentive paid for with SAMHSA discretionary grant funds exceed $30.”

Hard to Reach Clients

Every attempt to reach a client by phone or in-person will be made by the assigned Case Manager upon receipt of the referral. At times, there will be clients that program staff are having trouble connecting with, and at that time, staff will reach back out to the referring entity and individual for assistance in touching base with the client. Only after exhaustive attempts have been made by the program staff and referring entity will the client be listed as inactive from the list of active eligible clients.

Assignment of Clients

Within seven (7) days of completion of the GPRA, the client information will be presented to the program coordination committee for review and determination of the lead and/or secondary treatment provider. Once agreed upon by the committee, the full assessment and referral package will be securely delivered to the treatment organization(s) within 24 hours.

Coordination of Care

Treatment Services

While some clients may be assigned to multiple entities, there will only be one (1) lead provider responsible for the client and will coordinate the treatment plan with the secondary provider, where applicable. Each month, the Program Coordination Committee will meet in person to briefly review the active client list to identify any potential challenges or issues and discuss successes. Communication amongst providers is key to coordinating care and assisting with clients who are hard to reach.

- **Telehealth:** The contracted providers have been grant funded to set-up and administer services via telehealth. Each agency shall have its own policies and procedures for administration and use of telehealth services. Each agency is responsible for educating the clients and working with the designated locations on scheduling, software use, and administration.
- **Loss of Housing:** Clients who lose their permanent housing during their enrollment in the CABHI program will still be eligible for CABHI services, unless the individual becomes incarcerated. The treatment provider should work with the Homeless Leadership Board's Coordinated Entry Program to assist the client with new housing opportunities.

SSI/SSDI, Access, Outreach & Recovery (SOAR) Services

Directions for Living is the contracted Provider for SOAR services of which one Benefit Specialist has been identified to serve CABHI clients. SOAR Program for Pinellas County provides increased access to SSI/SSDI, Access, Outreach and Recovery (SOAR) for residents who are identified by referral or community outreach as homeless who also have a severe mental health or substance abuse disorder or co-occurring medical impairment.

All clients referred into CABHI will complete the SOAR Screening Criteria Questionnaire (See Appendix E). If the client qualifies, the SOAR Benefit Specialist's for CABHI will provide active case management, navigation and supportive interventions to the applicants. The specialist will continue communication with the applicant to ensure that the specialist will be able to gather the longitudinal medical histories and assistance with benefit enrollment to SSA, develop independent medical evaluations, documenting an individual's functioning for the examiner, and creating summary reports to accompany the applications.

Peer Recovery Services

WestCare Gulf Coast is the contract provider for peer recovery services for clients with Substance Use or Co-Occurring Disorders. All clients referred into the program with the SUD or COD diagnosis will be eligible to receive peer recovery services.

Discharge

Clients may be discharged from the CABHI program for various reasons. Each treatment agency will classify the discharge of a client according to its own Agency policies and procedures. Examples of discharge reasons include clients who continuously do not attend scheduled appointments, those incarcerated, those successfully completing their treatment plan, those who leave the County service area to name a few.

- **Incarceration:** In the FY16 CABHI FOA Part II, Appendix D Funding Restrictions, bullet #2 states that funds may not be used to: Provide services to incarcerated populations (defined as those persons in jail,

prison, detention facilities, or in custody where they are not free to move about in the community). Clients in this situation must be discharged from the program until release and re-engaged.

All discharges from the program will be reported on the Discharge Form (See Appendix D) to the CABHI Program Evaluator within 10 days of discharge.

Grant/Performance Reporting

Bi-Annual Progress Report

The grantee is required to provide a bi-annual report in April and October. This progress report is designed to inform SAMHSA about the grant's progress during a specific reporting period. The baseline goals and objectives from the grant application will be used to identify progress, including specific achievements, barriers, events, changes to the project, and issues that arose during the reporting period. Additionally, responses from this progress report can also be used to identify opportunities for additional technical assistance (TA).

GPRA Evaluation

GPRA data will be collected at intake, discharge and 6-months post-intake and entered into the SPARS data collection system. This data will be readily available to evaluate demographics, drug and alcohol use, family and living conditions, education/employment, criminal justice status, mental/physical health and social connectedness. As adequate sample sizes are obtained, reports will be shared with the program coordination committee and the local government steering committee to assess program effectiveness.

SPARS (GPRA Entry)

SAMHSA's Performance Accountability and Reporting System (SPARS) is the new centralized data platform for GPRA performance measures for the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS). The SPARS training and technical assistance services support discretionary grantees and SAMHSA project officers in the data collection and management process, as well as in the use of data to enhance performance monitoring, reporting and continuous quality improvement.

Grantees will use SPARS to enter baseline, reassessment, and discharge data of clients receiving direct services, as well as other grantee level infrastructure, best practices, and performance measurement data.

Client Clinical Update Form

Each month, contracted providers will complete a client sessions update sheet for each active client served during the previous month (See Appendix C: Client Clinical Update). Staff should only include services rendered face-to-face (including telehealth and/or no-shows). This information will be utilized as performance data to provide an overall look at how the program is operating. Sheets should be turned in to Mark Vargo, Program Evaluator, at Operation PAR by the 10th of the following month.

Cross Site Evaluation/Supplemental Client Interview

SAMHSA is conducting a cross-site evaluation of CABHI grantees. One of the activities associated with the cross-site evaluation is a Supplemental Client Interview (SCI). The SCI will capture data not collected via the GPRA interview. Administration of the SCI will be via Operation PAR staff and will occur at the time of administration of the GPRA interview. Clients will provide voluntary informed consent for participation in this aspect of the project.

Performance Measures

Revisions Based on the Discussion from the meeting on 1/17/2017

Goal 1: Reduce chronic homelessness		
Objective	**Original Performance Measure**	**Revised 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.	Enroll 125 project-eligible chronically homeless individuals per year. NO CHANGE
Objective B: Reduce the rate of return to homelessness for individuals experiencing chronic homelessness and have SUDs, SMI, SED or CODs.	**Performance Measure:** Decrease the percentage of clients at 6 months post intake who leave permanent housing using year one of the project as the base rate	Increase the percentage of clients at 6 months post intake who leave permanent housing for independent permanent housing using year one of the project as the base rate. Potential Replacement: At 6 months post-intake, 60% of all clients enrolled will have remained in permanent housing as measured by the GPRA tool.
Goal 2: Strengthen behavioral health care for individuals experiencing chronic homelessness		
Objective	**Original Performance Measure**	**Revised 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.	Increase the percentage of homeless referrals to the project by 10% from year 1 to 2 and 20% from year 2 to 3. NO CHANGE
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.	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. NO CHANGE
Objective C: Determine best practice for serving individuals experiencing chronic homelessness who have SUDs, SMI, SED or CODs.	**Performance Measure:** Increase the percentage of participants who have stabilized their SUD, SMI, SED or COD by 10% from year 1 to 2 and 20% from year 2 to 3 as measured at 6 months post intake.	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 the majority 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.
Goal 3: Reduce behavioral health disparities among racial and ethnic minorities		
Objective	**Original Performance Measure**	**Revised Performance Measure**
Objective A: Reduce differences in Access to Service.	**Performance Measure:** Compare the percentage of all individuals referred to the program who are admitted among racial and ethnic groups.	Increase the yearly percentage of racial and ethnic minorities admitted to the program using, year 1 as the base rate.
Objective B: Reduce the differences in Service Use.	**Performance Measure:** Compare the percentage of all individuals admitted who remain in treatment for at least 30 days among racial and ethnic groups.	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.
Objective C: Decrease the differences in Outcomes.	**Performance Measure:** Compare the percentage of successful outcomes among racial and ethnic groups.	Increase the yearly percentage of racial and ethnic minorities who are successfully discharged from the project, using year 1 as the base rate.

Program Evaluation

Evaluation Plan

INTRODUCTION

The local performance assessment is designed to determine whether the project is achieving its goals, objectives and outcomes the program intended to achieve and identify whether adjustments need to be made to the project. In the grant proposal, the project identified four areas for performance assessment:

1) Standard agency performance measures
2) Progress towards goals and objectives,
3) Outcomes and Process Questions and
4) Tracking disparities in sub-populations.

To track these four areas, an Evaluation Plan is provided and consists of the following components:

- Local Process Evaluation
- Local Outcome Evaluation
- GPRA Evaluation
- Cross-Site Evaluation

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**
• 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
• 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.
• 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.
• 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.

• 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.

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,
- Monitoring time from referral to screening
- Monitoring time from screening to assigning the client to a provider
- Monitoring the time from assignment to a provider till admission in the providers program.

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**
• How many individuals were reached through the program and how many were enrolled in Medicaid and other benefit programs as a result of participation in this program?	Data from GPRA and Case Manager/Outreach Specialist
• 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.
• 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.
• 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.

• 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.
• What program and contextual factors were associated with positive clinical and housing outcomes?	Focus group/questionnaires of participants are correlation with project outcomes.

***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.
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.
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.
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.
Objective C: Determine best practice for serving individuals experiencing chronic homelessness who have SUDs, SMI, SED or CODs.	**Performance Measure:** 5. 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.

	6. 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. 7. 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. 8. 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.
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.
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.
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.

Treatment Outcome Analysis Collected from each Behavioral Health Provider: Due to the collaborative nature of the project that involves three treatment providers, a form has been created that will capture the necessary outcomes for each client treated by each provider. Since the project evaluator will not have access to each providers electronic health record, the use of a paper form will be the most efficient method to capture the data elements needed to assess the client clinical outcomes in the project. Appendix C contains the data form.

Tracking disparities in sub-populations: Performance assessments will be used to determine whether the project is having/will have the intended impact on behavioral health disparities as demonstrated by increased admission rates for the populations of focus. This performance measure will be reviewed monthly as adequate sample sizes are obtained for evaluation. Periodic reports will contain information regarding progress achieved, barriers encountered, and remedies to overcome the barriers. This information will be compiled and reported to program staff and the Federal Project Officer in the performance assessment report to be submitted at least semi-annually.

Many of the methods to track and assess changes in sub-population disparities are based on the fact that EHR and GPRA data is readily available that allows the program to identify subpopulations (i.e., racial, ethnic, sexual/gender minority groups) vulnerable to disparities quickly and implement strategies to address the differences in access, services use, and outcomes by implementing the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS). Additionally, demographic profiles of the housing providers will also be reviewed and compared to the clients treated. These standards comprise mandates, guidelines, and recommendations that are intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. Strategies for implementing CLAS standards include upholding the following principles to address subpopulation disparities: 1) ensuring services are patient-centered so that they are active participants in planning and managing their treatment; 2) maintaining respect for diverse cultural and linguistic backgrounds; and 3) recognizing personal, social, and institutional barriers and how to overcome these barriers. To track and assess deviations from these principles, the program data on access, utilization, and outcomes will be tracked and assessed.

GPRA Evaluation

GPRA data will be collected at intake, discharge and 6-months post-intake and entered into the SPARS data collection system. This data will be readily available to evaluate demographics, drug and alcohol use, family and living conditions, education/employment, criminal justice status, mental/physical health and social connectedness. As adequate sample sizes are obtained, reports will be shared with the treatment team and the steering committee to assess program effectiveness.

Cross-Site Evaluation

The cross-site analysis will be conducted in conjunction with RTI and SAMHSA and will follow their protocol. RTI provided a copy of the Cross –Site Evaluation Fact Sheet (Appendix G). The RTI staff conducted an initial site visit in November 2017 (Appendix H – Agenda).

Grant Budget Management

The Human Services Grants Management staff works with each contracted agency to develop the annual budget; prepares a comprehensive budget for submission to SAMHSA; ensures that any budget modifications are within the scope of the grant program; reviews and approves invoices according to federal requirements for allowable expenses and supporting documentation; reviews and approves federal drawdowns; processes carryover requests; and provides technical assistance related to federal requirements.

Annual Budget

The grant was awarded for a three-year project period from 2016-2019. The Year One budget period is from 9/30/2016 – 9/29/2017; the Year Two budget period is from 9/30/2017 – 9/29/2018; the Year Three budget period is from 9/30/2018 – 9/29/2019. Each year, the grantee must submit a non-competing continuation application to be awarded funds for each budget period.

The annual budget is divided between two federal centers within SAMHSA: The Centers for Mental Health Services (CMHS) and The Center for Substance Abuse Treatment (CSAT). The County will work with each contracted agency to ensure that the budget is appropriately divided according to the Notice of Funding Availability.

The budget must also identify the related infrastructure expenditures which shall not exceed 15% of the total budget and evaluation expenditures which may not exceed 20% of total expenditures.

Grant funding for direct services are to be funding of last resort.

Program Income

Program Income: gross income – earned by a recipient, subrecipient, or a contractor under a grant - directly generated by a grant supported activity, or earned as a result of the grant. Program Income must be used to further the objectives and shall only be used for allowable costs as set forth in the applicable OMB Circulars and CFR as described in the terms and conditions of the award. Program Income is to be reported in the Federal Financial Report (FFR), thus Pinellas County requests submissions with each invoice.

Examples of Program Income:

- Medicare/Medicaid reimbursement, or private insurance reimbursement.
- Co-pays paid by clients for substance disorder or mental health treatment services.
- Services billed and received for clients entered into the CABHI Program (via the GPRA) creates program income.

Reporting Program Income:

- Program Income will be included as a line item on the Budget and Expenditure Report for inclusion in the invoice submission to Pinellas County.
- Program Income is to be deducted from the reported expenses to provide a resultant total reimbursement request.
- Program Income must be supported within the invoice through the inclusion of a spreadsheet format to include the client ID, date of service, service type, payor, and cash receipts. Additional supporting documentation must be maintained and provided upon request by the County.

Use of Program Income, costs may be used for any of the following categories for which the contractor has identified in their approved budget:

- Personnel
- Fringe Benefits
- Travel
- Equipment and Supplies
- Contractual
- Other
- Indirect Costs

The CABHI Grant requires the treatment of Program Income as Additional Costs per the Notice of Award. With prior approval of the HHS awarding agency, program income may be added to the Federal award by the Federal agency and the non-Federal entity. The program income must be used for the purposes and under the conditions of the Federal award.

Record Retention: The contractor must maintain records that adequately identify the sources of funds for federally assisted activities and the purposes for which the award was used, including any program income. Accounting records must be supported by source documentation such as cancelled checks, paid bills, payrolls, and time and attendance records. Documents must be maintained for three (3) years after the final disposition of the grant closeout.

Carryover

A carryover is when an unobligated balance from a previous budget period is carried forward into the current budget period to support incomplete activities from prior budget periods.

There are two types of carryover actions. Recipients may only submit one type of carryover per budget period.

- Expanded Authority (10 percent or less of the total approved current year budget. See below for full information.)
- Formal Carryover requiring prior approval (formal requests that do not fall under the expanded authority. See below for full information.)

Carryover is not intended to solely spend down unobligated funds. Carryover funds must be used to support the approved goals and objectives of the grant program based on the funding opportunity announcement.

All carryover requests must be submitted within 90 days after the end of the prior budget period.

Expanded Authority for Carryover
SAMHSA authorizes expanded authority for automatic carryover of unobligated funds from the previous budget periods to the current budget period for recipients who meet the following specific criteria:

- The recipient must not be on Restricted Status.
- The proposed carryover amount is 10 percent or less of the total federal share of the current budget period (the year in which the funds are needed).
- The funds cannot be identified as restricted in the notice of award's terms and conditions.

Notification to SAMHSA
The intent to carryover and the carryover amount (in dollars only) must be stated in FFR Remarks, section 12. Subsequent FFRs must reflect the actual carryover amount.

Formal Carryover requiring prior approval

A prior approval request must be submitted if the carryover request does not meet the expanded authority criteria.

Based on the nature, extent, and timing of the request, the SAMHSA GMO may approve, deny, or request additional material to further document and evaluate your request. Only responses provided by the GMO are considered valid. If SAMHSA approves the request, an amended Notice of Award will be issued. Verbal authorization is not approval and is not binding on SAMHSA. Recipients that proceed on the basis of actions by unauthorized officials do so at their own risk, and SAMHSA is not bound by such responses.

Formal carryover requests must be submitted no later than 90 days after the end of the previous budget period. Requests submitted in an untimely manner may not be granted.

What to Include in The Request: The prior approval request must contain the following:

- Cover Letter/Narrative
  - Explain why an unobligated balance (UOB) exists.
  - Explain and support the need for carryover funds.
  - Describe how the unobligated funds will be used in the current budget period (the proposed work must be allowable under the grant).
  - Describe the impact on the project if the carryover is not approved.
  - Justify how increased matching or cost sharing will be met if the carryover is approved (as applicable).
- An SF-424A for the carryover request amount
- Line-item budget and budget narrative for the unobligated balance requested for carryover. As applicable, the budget must include matching or cost sharing. To ensure a timely review, the budget should follow the formatting requirements outlined in the Funding Opportunity Announcement.
- The HHS Checklist

Appendix A - CABHI Program Criteria & Referral Form

Cooperative Agreement to Benefit Homeless Individuals

Program Criteria

Background:

Pinellas County received grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide mental health and substance abuse treatment services to individuals who have experienced homelessness and have serious mental illness (SMI), substance abuse disorder (SUD), serious emotional disturbance (SED), and/or co-occurring disorder (COD). This program is focused on formerly chronically homeless individuals who have recently been housed in permanent housing or permanent supportive housing.

Program Criteria:

Clients may be eligible to receive treatment services if:

- Client has a history of chronic homelessness
- Client is currently in permanent housing or permanent supportive housing
- Client scores 6 or above on the Vi-SPDAT housing assessment tool; or other identified intake assessment utilized by a housing provider that identifies a client's need related to chronic homelessness and behavioral health issues.
- Client self reports or is known to have a mental health or substance abuse diagnosis *(Detailed clinical assessment will be completed by program staff to determine clinical diagnosis and eligibility)*
- Client is not currently receiving treatment services; or is receiving inadequate treatment services by another licensed behavioral health treatment provider.
- Eligible clients include adults, families, veterans, and youth.

Referral Process

If your organization identifies a client who may be eligible for the program, please complete the attached referral form for the Pinellas County's Cooperative Agreement to Benefit Homeless Individuals (CABHI) Program.

Completed referrals may be submitted by:
FAX: (727) 507-6310
EMAIL: CABHI@operpar.org

Upon receipt, a Program Coordinator from Operation PAR, will reach out to both the referring party and the client to schedule an intake assessment. Once the client completes the intake assessment, a clinical review team will assess each client to determine eligibility for services and identify the appropriate treatment provider.

Questions:

Please call Marvin Coleman at (727)422-9907 or mcoleman@operpar.org for more information.

Cooperative Agreement to Benefit Homeless Individuals

Program Criteria - Definitions

Behavioral Health: The term "behavioral health" refers to a state of mental/emotional health and/or choices and actions that affect wellness. Behavioral health problems include substance use or misuse, alcohol and drug addiction, serious psychological distress, suicidal ideation, and mental and substance use disorders. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders and related problems, treatments and services for mental and substance use disorders, and recovery support.

Permanent housing means community-based housing without a designated length of stay (e.g., no limit on the length of stay). Permanent housing shall be safe, affordable, and integrated in the community. It may include an apartment or single room occupancy in a building (congregate housing), rent-subsidized apartments, or houses in the open housing market (scattered housing), as well as designated units within privately owned buildings.

Permanent supportive housing refers to housing that is considered permanent (rather than temporary or short-term) and offers tenants a range of supportive services aimed at promoting recovery from mental and/or substance use disorders. There should not be any arbitrary limits for the length of stay for the tenant as long as the tenant complies with the lease requirements (consistent with local landlord-tenant law).

Homeless as characterized under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, and defined by the December 5, 2011, Final Rule: Defining "Homeless" (76 FR 75994), establishes four categories of homelessness. These categories are: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution; (2) Individuals and families who will imminently lose their primary nighttime residence; (3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or (4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Chronic homelessness means: (1) A homeless individual with SUD, SMI, SED, or COD issues, who:

> (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
>
> (ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least four separate occasions in the last three years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Doubled Up: In addition, for the purposes of this program, the terms "homeless" and "chronic homelessness" also may include individuals who are "doubled-up" – defined as sharing another person's dwelling on a temporary basis where continued tenancy is contingent upon the hospitality of the primary leaseholder or owner and can be rescinded at any time without notice.

Cooperative Agreement to Benefit Homeless Individuals (CABHI)

Client Referral Information

Referring Agency Name:	**Date of Referral:**
Referring Agency Address: **Phone Number:**	
Client Name:	**Date of Birth**
Client Address: **Phone Number:**	

Is the client currently receiving services for: **(circle all that apply)**

Substance Abuse **Mental Health** **Co-occurring Disorders** **Serious Emotional Disturbance**

Does the Client have a VI-SPDAT Score? **Yes** **No** **If yes, score**_____

Is the client currently permanently housed? **Yes** **No** **If yes, location**_____

Has the client been referred to or through the "Coordinated Entry" process? **Yes** **No**

Reason for Referral:	
Is the referring agency a Tele-Health Node? **Yes** **No**	
Person making the Referral (print):	**Email:** **Phone:**
Signature:	**Date:**

Fax Form To: Operation PAR (727)507-6310 Email:cabhi@operpar.org

For Internal Use Only

Date Received:	**Method Received:**
Date Assessment Scheduled:	**Date Assessment Completed:**
Client Referred for Services to the Following Agency:	**Circle One: MH / SA / BOTH**
Operation PAR Case Manager Name:	**Operation PAR Case Manager Phone Number:**
Agency Counselor Name:	**Agency Counselor Phone Number:**

Appendix B - CABHI Release of Information

Operation PAR, Inc.
Health Information Management Department · 6720 54th Avenue North · St. Petersburg · FL 33709
Phone: 727-545-7544

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – CABHI GRANT

I, _____, DOB _____
(Client Name)

Authorize Operation PAR, Inc., to exchange with and receive information with the following organizations: (Initials Required)

_____ Directions for Living -1437 S Belcher Rd Clearwater ,FL 33709, Operation Par Follow up , WestCare-1735 Dr Martin Luther King Jr. St. South, St. Petersburg, FL 33756, Pinellas County CABHI-440 Court Street Clearwater, FL 33756

_____Other _____

Purpose for the disclosure: To exchange with and receive the following information to and from one another as necessary, in connection with my referral, treatment and Grant funding

Draw a line through information not needed:

Follow up Survey, Full Name, Date of Birth, Phone Number, Address, Residential Status, Affiliation with Operation Par, Assessment, and Referral Records

Optional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: Client Initials _____

Information may be disclosed by the following methods: Mail, Verbal, Faxing, and Encrypted email unless otherwise specified.

I understand if I do not agree to consent for each of these entities, services under this grant may not be provided to me. Other services may be available.

Sign Here If you do NOT wish to participate _____ **Date** _____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. I understand that I have a right to request a copy of this form.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration: One Year from Date Signed

I understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release Operation PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date: _____ Signature: _____
Client Signature

Date: _____ Signature: _____
Witness

Date: _____ Signature: _____ _____
Authorized Representative Legal Authority to Act

Appendix C – Client Flow Diagram

WHERE THEY LIVE/REFERRAL SOURCE

- VI-SPDAT Housing Assessment Tool Administered

Pinellas Hope	Boley Centers	HEP	Ready for Life	WestCare	PCHA Section 8

Unhoused/HLB Coord Entry

PAR (Gain Q3 – short)

INTAKE & ASSESSMENT

PROGRAM COORDINATION TEAM

HUMAN SERVICES	PAR SUD/COD	WestCare SUD/COD	Directions SMI/SED/COD

TREATMENT PLAN & SUPPORT SERVICES IDENTIFIED

Treatment Plan	Peer Recovery (WestCare)	SOAR Benefits (Directions)

Pinellas Hope 156 PH Units	Boley Centers XX PSH Units	HEP ## PSH Units

Ready for Life ## Indiv/Families	WestCare ## PSH Units	Section 8 ## Indiv

Appendix D – Client Clinical Update Form

Client Clinical Update

Provider Agency_____ Date of Report_____

Please complete the table below for each client in your care from the CABHI Grant. Also please include dates that client was a no show.

Client Name:_____

Being Treated For:_____

Diagnosis: SMI ❑ SUD ❑ SED ❑ COD ❑

Date of Service	Type of Service	Length of Service	Was Session Done via Tele-Health (Y/N)	Attending Practitioner

Please provide any additional comments you feel are pertinent to the client's treatment. (e.g., Client Attitudes toward treatment, client motivation, client level of participation, etc)

_____

_____

Appendix E - CABHI Discharge Data Sheet

To Be Completed By Agency Discharging the Client

Client Name:_____Agency delivering services:_____

Admission date:_____ Discharge date:_____

Discharge

Discharge outcome (i.e, successful, unsuccessful, administrative, etc.):_____

Reason for Discharge Outcome:_____

Treatment Plan

How many objectives were in the client's treatment plan?_____

How many objectives were met.?_____

Sessions

Number of sessions received by client:_____

Number of Sessions that were conducted using the following service type:

In Person Face-to-Face:_____

Tele-Health:_____

Types of services received (Check all that apply):

SMI_____ SUD_____ SED_____ COD_____

Drug Screens

If client was drug screened, how many screens did they receive?_____

How many were positive?_____

Name of Person Completing the form:_____

Phone number of person completing this form:_____

Email of person completing this form:_____

Appendix F – SOAR: Ten Screening Criteria

THE TEN SCREENING CRITERIA TO QUALIFY/REFERRAL FOR THE SOAR PROGRAM / SSI-SSDI OUTREACH ACCESS & RECOVERY

Copy to Soar Coordinator: callen@directionsforliving.org or Fax to 727-524-4474

Name & Contact Info: _____ Date: _____

Referral Source, Name & Contact Info: _____

To clarify SSA criteria for a person to qualify for the SOAR Program we are providing the following pre-screening questions to assist you before making a SOAR referral. If you need our assistance or have questions please contact us by email please. If question one is answered NO the person is ineligible for SOAR. In questions 2-9 if the person has answered YES to 3 or more questions the person should be referred to SOAR to determine eligibility for SSA listing requirements. . If you need assistance or have questions please contact us by phone or email. We appreciate you helping the SOAR Program identify adults who are experiencing or at risk of homelessness who may be eligible for Social Security Administration (SSA) disability benefits.

1. Is the client currently experiencing or at risk of homelessness? (Homeless in the last year, they were documented homeless 3 times in that year) ..... No ⟶STOP..... Yes→Continue
2. Does the person have a *mental impairment* or *severe physical impairment* that is expected to last 12 months or longer or result in death (terminal)? ..... No ⟶STOP..... Yes→Continue
3. Does the person have *current* medical records and *evidence* to prove the disability? .... No →STOP .....Yes →Continue
4. Has the person *applied* for Social Security and are in active status? .....Yes → STOP .....No→ Continue
5. Does the *impairment* affect their ability to work? ..... No →STOP ..... Yes →Continue
6. Does their *impairment* keep them from working enough to earn $1,169 or more a month? .... No →STOP ..... Yes →Continue
7. Individual is currently exhibiting symptoms of mental illness or has periods with worsening of symptoms
   - Psychotic Symptoms (positive or negative)
   - Depressive Symptoms (decreased energy, lack of motivation, suicide attempts)
   - Manic Symptoms (racing thoughts, disorganized thoughts)
   - Anxious feelings (paranoia, nervousness)
   - Cognitive deficits (brain injury; problems with concentration, memory, etc.)
   - History of trauma (history of abuse, posttraumatic stress disorder, etc.)
   - Other: _____ ..... No →STOP ..... Yes →Continue
   - DSM-5 Diagnosis_____ Name of provider and Date Diagnosis Given_____
8. For applicants with mental illness, he/she has marked restrictions in at least 2 of these functional areas, or extreme limitations in one area: **Indicate area below ↓**
   - Understand, remember, or apply information (memory, following instructions, solving problems, etc.)
   - Interact with others (getting along with others, anger, avoidance, etc.)
   - Concentrate, persist, or maintain pace (as they relate to the ability to complete tasks)
   - Adapt or manage oneself (hygiene, responding to change, setting realistic goals, etc.)
9. Has the person's disability been getting progressively worse even with *current treatment*? .....Yes ..... No If not, need more information for what is stopping them from being able to work _____ _____
10. Has the person been hospitalized 3 or more times in the past year? ..... Yes ..... No If No, SSA Requires at least 6 mos.to 1 year of new/current records of care.

If you answered YES to 3 or more of questions 2–9 Please make the referral and we will determine if the person will meet the SSA listing requirement.

(Rev 6.27.2017)

Appendix G – Cross-Site Evaluation Fact Sheet

CABHI Evaluation Site Visit Fact Sheet

July 2017

Purpose of the Site Visit

We look forward to visiting your CABHI grant project and learning more about your community and project. The site visit will help us to understand your grant project and its impact from multiple stakeholder perspectives, as well as how it fits into the larger community service and housing systems. We will tailor each visit to each site, but will use a common approach across sites to later "compare and contrast" grant projects. As with the larger cross-site evaluation, the site visits are not for us to check up on whether you are complying with grant requirements or adhering to your grant proposal – this is a not a "grant monitoring" visit. Also, by leveraging information and understanding gained through the monthly site team calls and other information and materials you have already shared with us, we will come prepared to dive deep into the details of your CABHI project.

What will the site visit entail?

We plan to spend approximately 2 days meeting with your CABHI program staff and stakeholders including the project director, project manager, local evaluator, treatment/clinical staff, case managers, peer support specialists, housing providers and support staff, external and internal stakeholders (e.g., partner agencies, steering committee members, etc.), and program clients (18 years or older). Other than the project director, we expect that we will ask for at most 2 hours of time from each participant; we will likely ask for more time from the project director but it will be a few hours, not the entire 2 days. For the client focus group, RTI will pay for food (up to $100) to thank clients for their participation.

What are the topics and content of the meetings?

The topics and discussion of the meetings will vary by respondents and the specific service approaches of your CABHI program. In general, the types of information we will ask about on the site visit include:

- The organization of the CABHI project and partners - roles, experience, coordinating bodies, and collaborative activities
- The community context and resources as they relate to your CABHI program
- A detailed discussion on how a typical client participates in the program, including outreach/engagement, enrollment, service delivery, and housing and housing supports
- A discussion of your CABHI program's evidence-based practices, including any modifications, training activities, fidelity measurement, etc.
- Client experiences, perceptions, and satisfaction with services (client focus groups)
- Local evaluation activities, early findings, and future plans
- Implementation barriers and facilitators, and early "lessons learned"

What help do we need from you?

Your assistance is essential to a successful site visit. We will ask for your help with the following:

- Identifying the best dates for the site visit (in October, November or December)
- Identifying the right individuals for the meetings, inviting them, and confirming participation
- Identifying and securing space for meetings, ideally at one location for most meetings
- Coordinating the client focus group – identifying and inviting clients, providing or facilitating transportation, and assisting in arranging for food
- Providing recommendations for a hotel, whether we will need a rental car, etc.

Your evaluation site team will work with you to plan the details of the site visit and address any questions.
Thank you in advance for your support and participation!

Appendix H – Cross-Site Evaluation Site Visit Agenda

Cross-Site Evaluation of SAMHSA's CABHI Program SITE VISIT AGENDA SM063331 – Pinellas County Board of County Commissioners, Pinellas County Cooperative Agreement to Benefit Homeless Individuals November 14, 2017 – November 15, 2017 Pinellas County, Florida				
DAY 1: Tuesday, 11/14/2017				
Time	**Topic**	**Purpose**	**Participants**	**Location**
9:00 am- 10:45 am	Overview of the CABHI Program and Services	• Understand Grantee agency, services, and role in community; • Understand the context and background for grant program; • Understand how program is organized to deliver services, including partners and staffing; • Understand treatment services and housing process for program clients.	Daisy Rodriguez, Project Director, Pinellas County Elisa DeGregorio, Grants Manager, Pinellas County Meghan Lomas, Grants Section, Pinellas County Mark Vargo, Evaluator, Operation PAR	Operation PAR, 13800 66th St N, Largo, FL 33774 (Research Center Conference Room, 3rd FL)
10:45 am- 11:00 am	*Break*			
11:00 am-12:45 pm	Treatment/Clinical Services/ Case Managers	• Understanding the treatment services for the intervention, from client identification to program discharge; • Understand how clinical services are linked with other services (e.g. housing, case management); • Understand any challenges to service delivery.	CABHI Program Coordination Committee (see attached list of participants)	Operation PAR, 13800 66th St N, Largo, FL 33774 (Training Room, 3rd FL)
12:45 pm-1:45 pm	*Lunch*	*Site Visitors on own*		
1:45 pm– 3:15 pm	Clients: Services, Needs and Satisfaction	• Understand services from client perspective, including what they receive, from who, as well as satisfaction.	Client Focus Group (lunch provided for clients after group)	Pinellas Hope (confirmed)
3:15 pm- 3:30 pm	*Break*			

3:30 pm- 4:30 pm	Local Evaluation	• Understand evaluation design and role in project, including data collection, fidelity assessment, and reporting; • Understand evaluation integration with program and coordination with national evaluation.	Mark Vargo, Evaluator, Operation PAR	Operation PAR, 13800 66th St N, Largo, FL 33774 (Research Center Conference Room, 3rd FL)

DAY 2: Wednesday, November 15, 2017				
Time	**Topic**	**Purpose**	**Participants**	**Location**
9:00 am – 10:30 am	Clients: Services, Needs and Satisfaction (cont.)	• Client Focus Group	Clients	Homeless Empowerment Program (HEP), 1120 N. Betty Lane, Clearwater FL
10:30 am – 11:00 am	*Travel*			
11:00 am- 12:00 pm	Housing and Supports	• Understanding the housing and housing support services available to clients, including how connected to CoC, how it is accessed and the types of support provided; Understand barriers and facilitators to get clients housing.	Daisy Rodriguez, Project Director, Pinellas County Susan Myers, Executive Director, Homeless Leadership Board Elisa Galvan, Pinellas County Housing Authority	Pinellas County Human Services, 440 Court Street, 2nd Fl, Clearwater FL 33756
12:00 pm – 1:00 pm	*Lunch*			
1:00 pm - 3:00 pm	Partners/Stakeholders Involved with the Project (including steering committee members)	• Understand role of community providers and stakeholders in the program; • Understand their perspective on program services, including barriers and facilitators to service delivery; • Understand their involvement in sustainability.	Local Government Steering Committee, see attached.	Pinellas County Human Services, 440 Court Street, 2nd Fl, Clearwater FL 33756
3:00 pm - 3:30 pm	Meeting Close-out	Informal debrief with the Project Director, clarify any questions, discuss next steps	Daisy Rodriguez, Project Director, Pinellas County	Pinellas County Human Services, 440 Court Street, 2nd Fl, Clearwater FL 33756

Appendix I – Pinellas County CABHI Program Income Guide

PINELLAS COUNTY CABHI PROGRAM INCOME GUIDE

Program Income: gross income – *earned by a recipient, subrecipient, or a contractor under a grant* - directly generated by a grant supported activity, or earned as a result of the grant. Program Income must be used to further the objectives and shall only be used for allowable costs as set forth in the applicable OMB Circulars and CFR as described in the terms and conditions of the award. Program Income is to be reported in the Federal Financial Report (FFR), thus **Pinellas County requests submissions with each invoice**. For the CABHI program, the grant is to be the payor of last resort. Other opportunities for the payment of services rendered under the award must be explored.

Examples of Program Income:

- Medicare/Medicaid reimbursement, or private insurance reimbursement.
- Co-pays paid by clients for substance disorder or mental health treatment services.
- Services billed and received for clients entered into the CABHI Program (via the GPRA) creates program income.

Reporting Program Income:

- Program Income will be included as a line item on the Budget and Expenditure Report for inclusion in the invoice submission to Pinellas County.
- Program Income is to be deducted from the reported expenses to provide a resultant total reimbursement request.
- Program Income must be supported within the invoice through the inclusion of a spreadsheet format to include the client ID, date of service, service type, payor, and cash receipts. Additional supporting documentation must be maintained and provided upon request by the County.

Use of Program Income, costs may be used for any of the following categories for which the contractor has identified in their approved budget:

- Personnel
- Fringe Benefits
- Travel
- Equipment and Supplies
- Contractual
- Other
- Indirect Costs

Record Retention: The contractor must maintain records that adequately identify the sources of funds for federally assisted activities and the purposes for which the award was used, including any program income. Accounting records must be supported by source documentation such as cancelled checks, paid bills, payrolls, and time and attendance records. Documents must be maintained for three (3) years after the final disposition of the grant closeout.

The CABHI Grant requires the treatment of Program Income as Additional Costs per the Notice of Award. **With prior approval** of the HHS awarding agency, program income may be added to the Federal award by the Federal agency and the non-Federal entity. The program income must be used for the purposes and under the conditions of the Federal award.

FY 17-18 Budget and Expenditure Report

Please note: This form is to accompany all requests for reimbursement.
Please be sure that Program Reports are current; Fiscal Request will not be processed without current program reports on file.
Proof of insurance coverage (liability) must also be on file.

Agency Name: _____
Contact Person and Title: _____
Agency Remit Address _____
Program Name: _____
Month/Quarter: _____

CATEGORY	TOTAL ALLOCATION	CURRENT REQUEST	PREVIOUSLY EXPENDED TO DATE	GRAND TOTAL EXPENDED TO DATE	BALANCE
PERSONNEL EXPENSES					
Salaries	$	$	$	$	$ 0.00
Fringe Benefits	$	$	$	$	$ 0.00
TOTAL PERSONNEL EXPENSES	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
OTHER EXPENSES					
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
N/A	$	$	$	$	$ 0.00
TOTAL OTHER EXPENSES	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
LESS PROGRAM INCOME					
Program Income Received	$	$	$	$	$ 0.00
Totals	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Prepared By: _____
Date: _____
Phone Number: _____
Email: _____
Approved by: _____
Remarks: _____

OFFICE USE ONLY:
Received by/date: _____
Contract approval/date: _____
Grants approval/date: _____
Date(s) corrections requested: _____
Notes: _____

Attachment FY2017